AAGL 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

Debate 639

Mesh Versus Burch for Stress Urinary Incontinence

HONORARY CHAIR
Charles H. Koh, MD

SCIENTIFIC PROGRAM CHAIR
Nash S. Moawad, MD

PRESIDENT
Michael Hibner, MD, PhD



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Debate-639: Mesh Versus Burch for Stress Urinary Incontinence

Chair: Sven Becker
Faculty: Dean Conrad, Cheryl B. Iglesia

Course Description

No area of advanced gynecologic surgery has been more controversial than pelvic floor reconstruction and urinary incontinence surgery. After an initial fast adoption of novel mesh-based techniques that revolutionized the field, there has been an almost ideologic backlash against the use of any foreign material – mostly in the face of terrible complications.

Legal questions, cooperate decision making, teaching deficits and controversial representation by the media have made this just one more mine-field gynecologic surgeons need to navigate.

We want to learn the facts and come up with a pragmatic recommendation for the future.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Explain the different surgical approaches to stress urinary incontinence treatment; 2) Select the most appropriate approach for an individual patient; and 3) Identify the different indications and complications of both approaches.

Course Outline

2:00 pm	Welcome, Introduction and Course Overview	S. Becker
2:05 pm	Pro Mesh	C. Iglesia
2:25 pm	Pro Burch	D. Conrad
2:45 pm	Discussion Questions & Answers	All faculty
3:00 pm	Adjourn	

ADA Statement: In accordance with the Americans with Disabilities Act (ADA), please contact CMEsupport@aagl.org should you require any special assistance.

Disclosure of Relevant Financial Relationships

As an ACCME-accredited provider, AAGL is responsible for ensuring that accredited education is fair, balanced, free of commercial bias, and supports safe, effective patient care. AAGL maintains control over all aspects of educational planning, content, faculty selection, delivery, and evaluation.

All individuals in a position to control educational content are required to disclose financial relationships with ACCME-defined ineligible companies within the past 24 months. AAGL identifies and mitigates all relevant financial relationships before individuals assume their respective roles. Educational content is also subject to independent peer review by individuals without relevant financial relationships.

Disclosure information and acknowledgment of any commercial support are provided to learners before the activity to promote transparency and maintain the independence and integrity of the education.

Asterisk (*) denotes no financial relationships with ACCME-defined ineligible companies to disclose.

PLANNER DISCLOSURES

The following members of AAGL have been involved in the educational planning and/or review of this course (listed in alphabetical order by last name).

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Nash Moawad, MD, MS, Chairman – Consultant (ended 12/2024): Medtronic, Womed, Integra Life Sciences
Amani Harris, MD*
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Angela Chaudhari, MD - Consultant: Tag/Dream Medical, Johnson & Johnson; Speakers Bureau: Johnson & Johnson
Linda D. Bradley, MD, Medical Director*
Linda Michels, Executive Director, AAGL*

COURSE CHAIR DISCLOSURE

Sven Becker, MD, PhD*

FACULTY DISCLOSURES

The following faculty have agreed to support their presentations and clinical recommendations with the best available evidence from the medical literature (in alphabetical order by last name).

Dean H. Conrad, MBBS, MRMed (UNSW), FRANZCOG - Speakers Bureau: Device Technologies, Medtronic; Educational and fellowship program support: Baxter
Cheryl B. Iglesia, MD*

MITIGATION OF RELEVANT FINANCIAL RELATIONSHIPS

All relevant financial relationships have been mitigated.

Drs. Lee, Lemos, Mikhail, and Chaudhari's planning decisions, as part of the Scientific Program Committee (SPC), were peer reviewed by other planners on the SPC who had disclosed no financial relationships with ineligible companies, and found to be fair, balanced, and free of commercial bias. Dr. Moawad's financial relationships ended 12/2024, thus mitigating them. For most of his AAGL Professional Education Committee service, Dr. Mourad had no financial relationships to disclose. He recently disclosed a new relationship as a Proctor for Intuitive Surgical. Since then, he has not participated in activities involving control or influence over accredited educational content; therefore, no additional mitigation was necessary.

The presentation content for course faculty, Dr. Conrad, has been peer reviewed and found to be fair, balanced, and free from commercial bias.

Midurethral Sling vs. Burch

Cheryl B. Iglesia, MD · MedStar / Georgetown University

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

I have no financial relationships to disclose.

I am a US FDA Special Government Employee ObGyn Devices Panel.
I served on the 2011 Vaginal Mesh Panel

2

Objectives

- Justify synthetic midurethral sling use as gold standard for stress incontinence over Burch.

3

Why are we still talking about this?



4

Most Studied Device in Urogyne History



5

2014 Position Statement AUGS / SUFU

AUGS
Advancing Female Pelvic Medicine and Reconstructive Surgery

SUFU

Position Statement on Mesh Midurethral Slings for Stress Urinary Incontinence

The polypropylene mesh midurethral sling is the recognized worldwide standard of care for the surgical treatment of stress urinary incontinence. The procedure is safe, effective, and has improved the quality of life for millions of women.

6

Supporting Organizations to the 2014 statement

ACOG American College of Obstetricians & Gynecologists

AGL ELEVATING GYNECOLOGIC SURGERY

IUGA

7

The Evidence for Polypropylene Mesh Slings

- Macroporous, monofilament, lightweight mesh
- >2000 publications since 1997
- >17-year follow-up
  - **Safe**
  - **Effective**
  - **Less pain, faster recovery**
  - **Shorter hospitalization**
- Multiple RCT sling v. non-mesh or other slings
  - Patient satisfaction
  - Clinical effectiveness

8

RCT TVT v Open Burch (BMJ 2002 Hilton, Ward, AJOG 2004, BJOG 2008)

- 344 women, 14 sites
- 175 TVT and 169 Burch
- Primary outcome: Negative stress test and 1 hour pad test

Objective cure	6 month	2 years	5 years
TVT	66%	63%	81%
Burch	57%	51%	90%
P-value	ns	ns	
Complications	TVT bladder perforation 9% Burch Longer OR and recovery	More enterocele/ rectocele	Prolapse TVT 23% Burch 42% P=.026

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Instagram Post

A BURCH Procedure!

10

Long-term Outcomes of Laparoscopic Burch

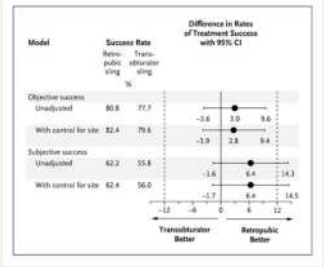
Conrad D et al ANZJOG 2019

- 157 Laparoscopic Burch
- Follow-up 50.6 months (range: 13–89 months)
- Primary outcome of successful treatment in 90.5%.
- 10.2% new-onset or worsened symptoms of OAB
- 8.8% symptomatic voiding dysfunction
- **11.7% reported new-onset or worsening symptoms of prolapse.**

11

Assessment of Equivalence at 12 Months between a Retropubic and a Transobturator Midurethral Sling as Treatment for Urinary Incontinence

N = 597



Richter HE et al. N Engl J Med 2010;362:2066-2076

The NEW ENGLAND JOURNAL of MEDICINE

12

Adverse Events, According to Treatment Group, Severity, and System

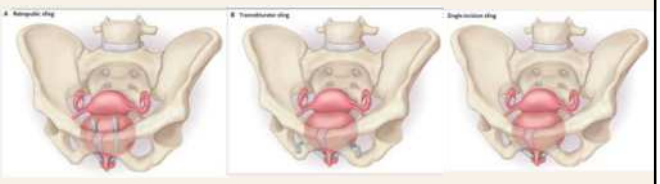
AE	TVT n=298	TOT n=299	P value
Mesh exposure	8 (2.7%)	1 (0.3%)	0.30
Mesh erosion	1 (0.3%)	1 (0.3%)	
Bladder perforation	15 (5%)	0	0.09
Vascular event	1 (0.3%)	1(0.3%)	
Voiding dysfunction	8 (2.7%)	0	
Neurologic Sx			
numbness	6 (2.0%)	7 (2.3%)	0.01 *
weakness	7 (2.3%)	21 (7.0%)	

Richter HE et al. N Engl J Med 2010;362:2066-2076

The NEW ENGLAND JOURNAL of MEDICINE

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Evolution of slings



Wu J. NEJM 2021

14

RP vs SIS

Meeting Papers ajog.org

Selected papers: 50th Annual Meeting
SOCIETY OF GYNECOLOGIC SURGEONS
Next annual meeting March 31–April 2, 2025

SGS

A randomized trial of retropubic vs single-incision sling among patients undergoing vaginal prolapse repair

Catherine A. Matthews, MD; Charles R. Rardin, MD; Andrew Sokol, MD; Cheryl Iglesia, MD; Sarah Collins, MD; Cecile Ferrando, MD; Harvey Winkler, MD; Kimberly Kenton, MD; Julia Geynisman-Tan, MD; Robert E. Gutman, MD

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SIS non-inferior to RP

TABLE
Primary outcome at 6 weeks and 12 months

Outcome data	6 weeks		< 6 weeks-12 months		TOTAL at 12 months		
Variable	SI sling N = 117 (49%)	RP sling N = 124 (51%)	SI sling N = 118 (46%)	RP sling N = 122 (48%)	SI sling N = 118 (46%)	RP sling N = 122 (48%)	p-value for non-inferiority
Normal lower urinary tract function? (All No)	95 (81)	100 (81)	91 (77)	101 (83)	89 (75)	98 (80)	
Abnormal lower urinary tract function? (Yes to any of the 3 below)	22 (19)	24 (19)	27 (23)	21 (17)	29 (25)	24 (20)	0.001
Subjective SUI >1 PFDI Question 17	22 (19)	22 (18)	24 (20)	21 (17)	24 (20)	21 (17)	
Retreatment for SUI							
Physical therapy	2 (2)	0 (0)	1 (1)	0 (0)	3 (3)	0 (0)	
Pessary	0 (0)	1 (<1)	0 (0)	0 (0)	0 (0)	1 (<1)	
Surgery for urinary retention	0 (0)	2 (2)	2 (2)	0 (0)	2 (2)	2 (2)	

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Sling complications are fortunately rare

- Mesh exposure or erosion
- Mesh infection
- Bladder injury
- Vascular injury
- Bowel injury
- Nerve injury
- Voiding dysfunction
- De novo or persistent urge incontinence

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Justification for Synthetic Midurethral Sling

- Polypropylene mesh slings are safe and effective
- Extensively studied
- Standard of care for SUI

18

References

- AUGS SUFU position statement (access October 12, 2027) https://sufuorg.com/docs/mus/augs-sufu-mus-position-statement.aspx
- Ward K, Hilton P; United Kingdom and Ireland Tension-free Vaginal Tape Trial Group. Prospective multicentre randomised trial of tension-free vaginal tape and colposuspension as primary treatment for stress incontinence. BMJ. 2002 Jul 13;325(7355):67
- Ward KL, Hilton P; UK and Ireland TVT Trial Group. A prospective multicenter randomized trial of tension-free vaginal tape and colposuspension for primary urodynamic stress incontinence: two-year follow-up. Am J Obstet Gynecol. 2004 Feb;190(2):324-31.
- Ward KL, Hilton P; UK and Ireland TVT Trial Group. Tension-free vaginal tape versus colposuspension for primary urodynamic stress incontinence: 5-year follow up. BJOG. 2008 Jan;115(2):226-33.
- Richter HE, Albo ME, Zyczynski HM et al. Retropubic versus Transobturator Midurethral slings for Stress incontinence. N Engl J Med 2010; 362:2066-2076.
- Wu, JM. Stress Incontinence in Women. N Engl J Med 2021; 384: 2428-2436.
- Matthews C, Rardin C, Sokol A et al. A randomized trial of retropubic vs single-incision sling among patients undergoing vaginal prolapse repair. American Journal of Obstetrics & Gynecology, 2024; 231, 261.e1-261.e10

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Rebuttal

- Maybe the question is not Sling vs. Burch
- The real debate is Sling vs. Bulking
- Who needs mesh?
  - Completed childbearing?
  - Severe SUI / ISD
  - Failed Burch or Bulking
- Long-term follow-up Lap Burch, Midurethral Sling, Autologous Sling Needed!

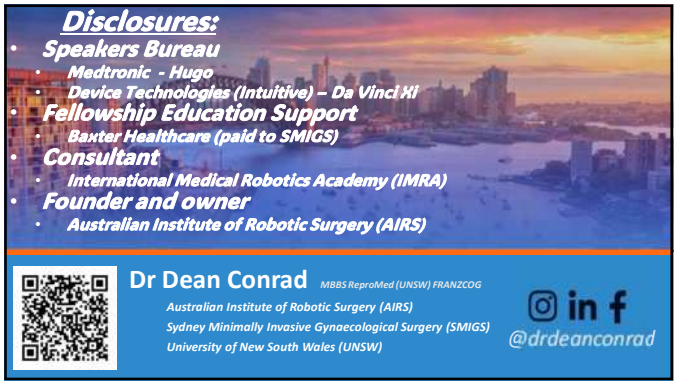
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AAGL26
Mesh Versus Burch for Stress Urinary Incontinence
Dr Dean Conrad MBBS ReproMed (UNSW) FRANZCOG
Sydney Minimally Invasive Gynaecological Surgery (SMIGS)
NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

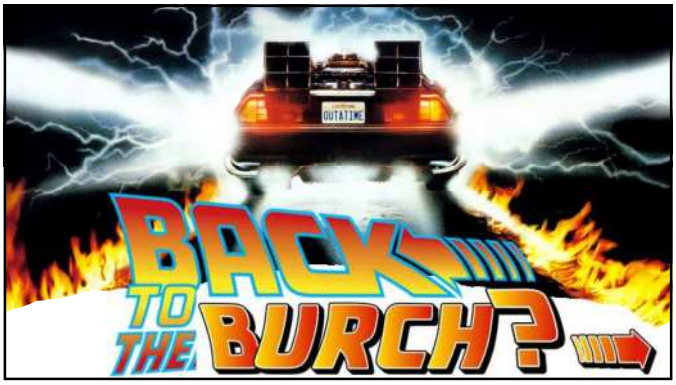
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Pro Burch
Mesh Versus Burch for Stress Urinary Incontinence
Dr Dean Conrad MBBS ReproMed (UNSW) FRANZCOG
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2


Disclosures:
Speakers Bureau
Medtronic - Hugo
Device Technologies (Intuitive) – Da Vinci Xi
Fellowship Education Support
Baxter Healthcare (paid to SMIGS)
Consultant
International Medical Robotics Academy (IMRA)
Founder and owner
Australian Institute of Robotic Surgery (AIRS)
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3


OUTATIME
BACK TO THE BURCH?

4



5


47th Global Congress on MIGS
MGM Grand Hotel and Convention Center, Las Vegas, Nevada
NOVEMBER 11-15, 2018
252 Video Session 5 – Laparoscopy
(3:25 PM – 5:05 PM)
4:50 PM – GROUP C
Contained Laparoscopic Power Morcellation for Large Pelvic Masses
Conrad DH, Saar TD, Choi S, Rosen D, Cario G, Chou D. Sydney Women's Endosurgery Centre, Sydney, Australia
SWEC
Contained Laparoscopic Power Morcellation:
Espiner Medical Ltd
Contained Laparoscopic Power Morcellation for Large Pelvic Masses
414 views
AAGL Administrator
Published on Apr 23, 2019

6

c. 400 BCE

Succussion

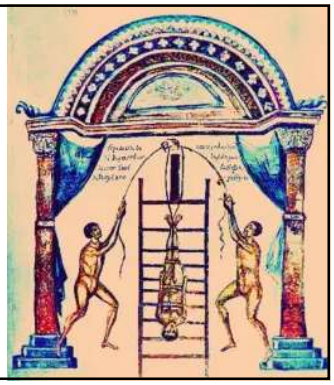
An ancient treatment for uterine prolapse

A woman was suspended upside down, then shaken or bounced.

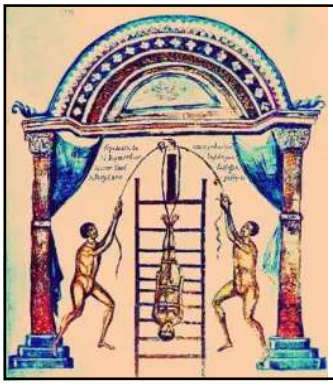
Gravity was expected to reduce the prolapse.

Later rejected by Soranus

It worked... while she remained upside down.



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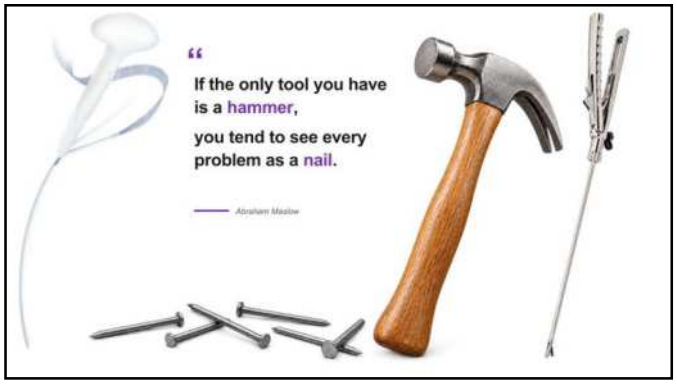
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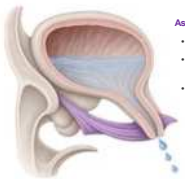
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Two mechanisms of stress urinary incontinence

Common and often overlapping

SUPPORT FAILURE

Urethral hypermobility



Assessment clues

- Q-tip test: urethral mobility
- Translabial ultrasound: descent and rotation
- POP-Q Aa: anterior wall support (indirect)

Loss of bladder neck and urethral support allows descent during increased abdominal pressure.

CLOSURE FAILURE

Intrinsic sphincter deficiency



Assessment clues

- Maximum urethral closure pressure
  - MUCP
- Valsalva leak-point pressure
  - VLPP

The urethra cannot generate or maintain adequate closure pressure.

12

Current Options in the management of SUI

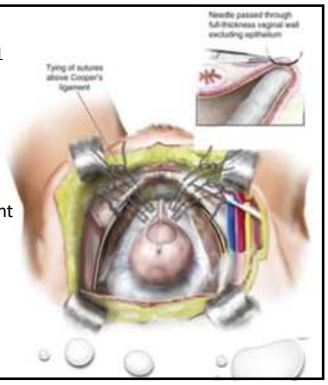


https://www.safetyandquality.gov.au/our-work/transvaginal-mesh/resources/care-pathway-sui

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Burch Colposuspension[1]

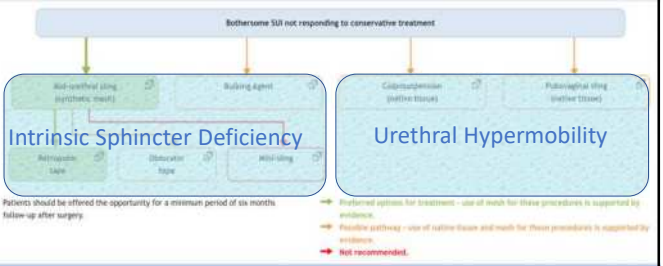
- Retropubic space (Space of Retzius)
- Restore anatomic support to the bladder neck and mid-urethra
- Endopelvic fascia → Cooper's ligament
  - +/- tendinous arch of the fascia pelvis
- Treatment for urethral hypermobility
  - NOT ISD



1: Burch JC. Urethrovaginal fixation to Cooper's ligament for correction of stress incontinence, cystocele, and prolapse. Am J Obstet Gynecol 1961; 81: 281–290.

14

Current Options in the management of SUI



15

NOT EVERY PROBLEM IS A NAIL

Stress urinary incontinence is not one anatomical problem



Identify the mechanism. Then choose the operation.

16

Let's meet Sarah

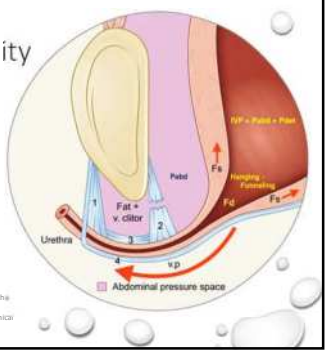
- Early 30's and family complete
- SUI with marked urethral hypermobility
- Preserved urethral closure function
- Normal BMI
- Wishes to avoid permanent mesh
- Planning salpingectomy



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Urethral Hypermobility

- Hammock Hypothesis[1]
- Integral Theory[2]
- Urethral Hanging Theory[3]

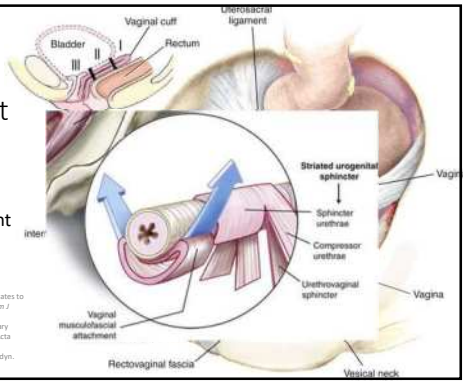


1: DeLancey JO. Structural support of the urethra as it relates to stress urinary incontinence: the hammock hypothesis. *Am J Obstet Gynecol.* 1994;170(6):1713
2: Petros P, Ulmsten U. An integral theory of female urinary incontinence. Experimental and clinical considerations. Acta Obstet Gynecol Scand. 1990;153:7–31.
3: Bergström BS. Urethral hanging theory. Neurourol Urodyn. 2017;36.3:826–827

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Urethral Support

- Arcus tendinous
- Endopelvic fascia
- Pubo-urethral ligament



1: DeLancey JO. Structural support of the urethra as it relates to stress urinary incontinence: the hammock hypothesis. *Am J Obstet Gynecol*. 1994;170(6):1713
2: Petros P, Ulmsten U. An integral theory of female urinary incontinence. Experimental and clinical considerations. Acta Obstet Gynecol Scand. 1990;153:7–31.
3: Bergström BS. Urethral hanging theory. Neurourol Urodyn. 2017;36.3:826–827

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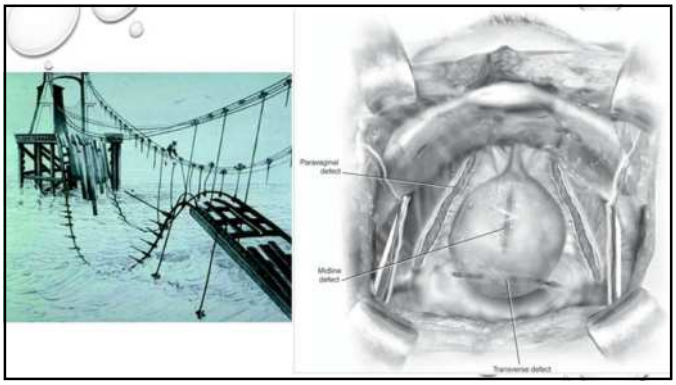
Catenary Curve



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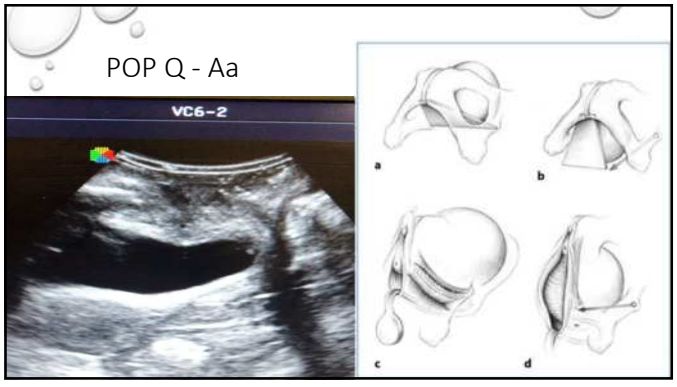


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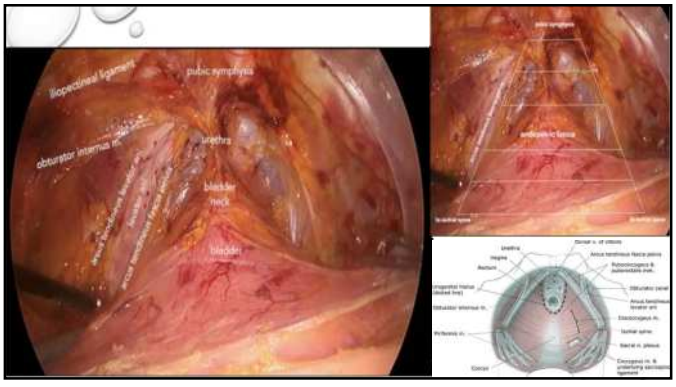


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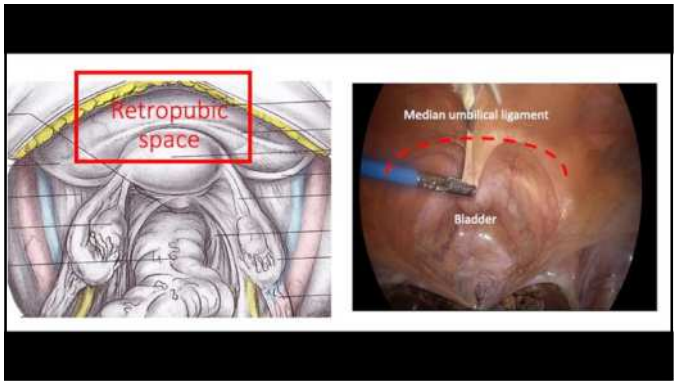
POP Q - Aa



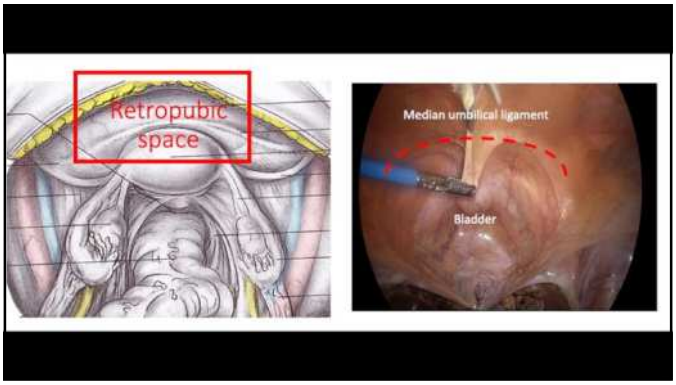
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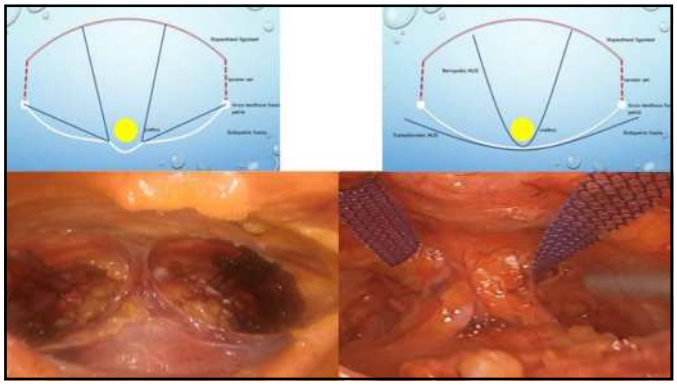
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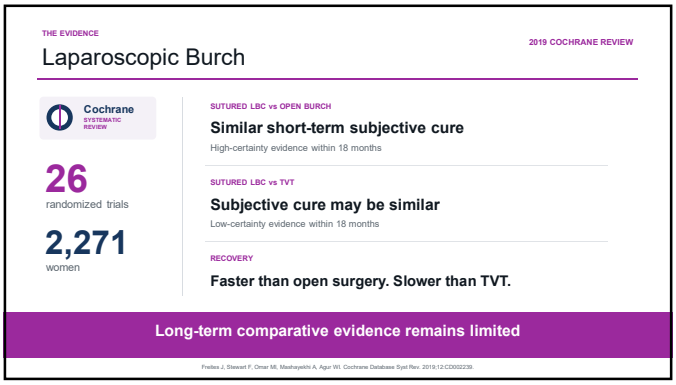
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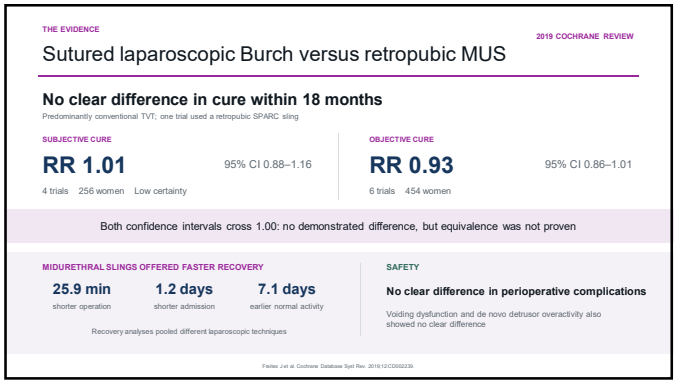
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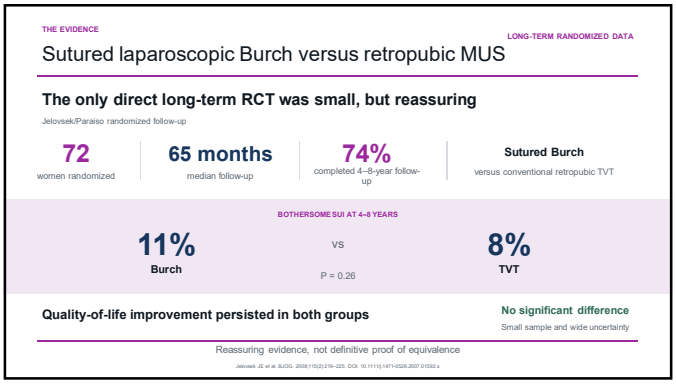
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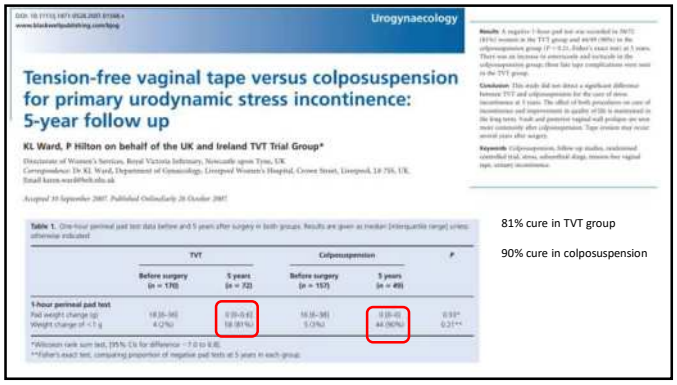
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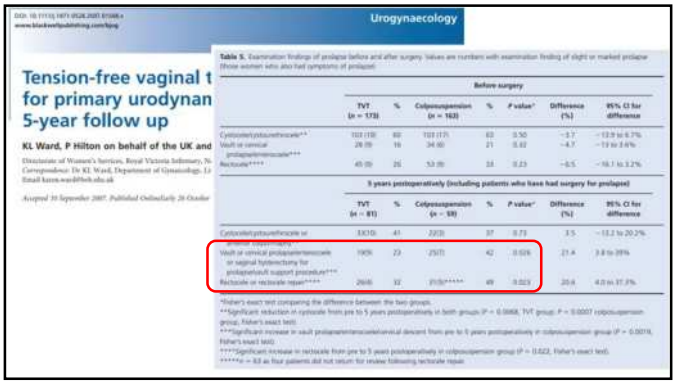
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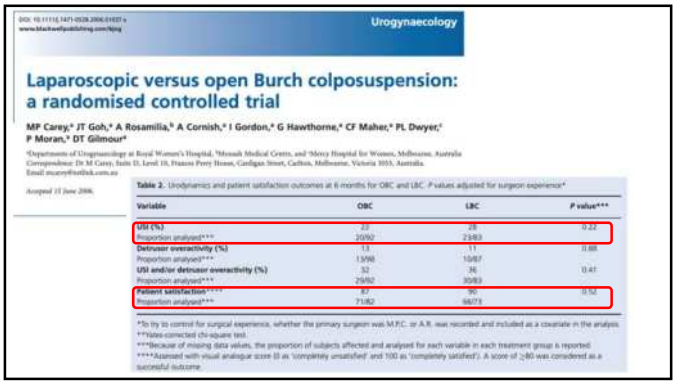
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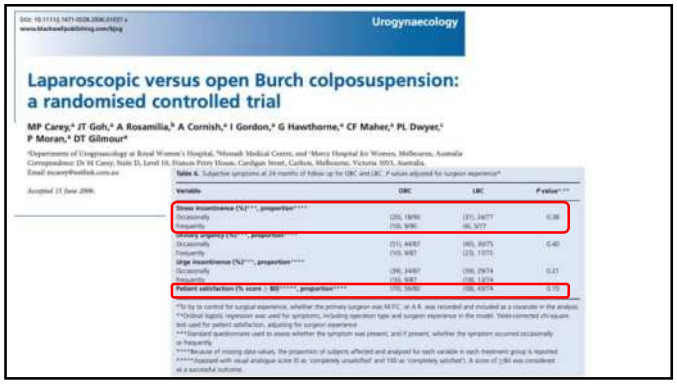
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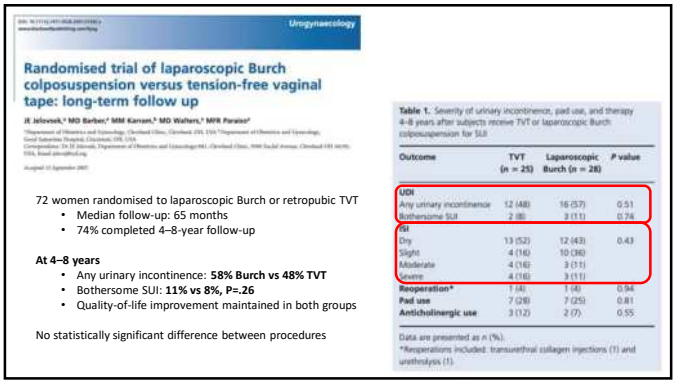
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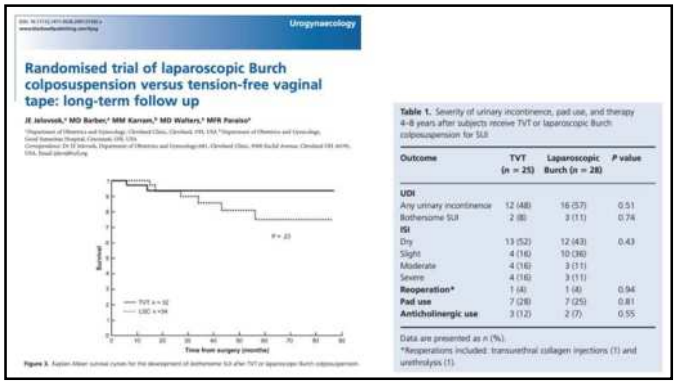
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Urogynaecology

Randomised trial of laparoscopic Burch colposuspension versus tension-free vaginal tape: long-term follow up

Table 1. Severity of urinary incontinence, pad use, and therapy 4–8 years after subjects receive TVT or laparoscopic Burch colposuspension for SUI

Outcome	TVT (n = 25)	Laparoscopic Burch (n = 28)	P value
UDI			
Any urinary incontinence	12 (48)	16 (57)	0.51
Bothersome SUI	2 (8)	3 (11)	0.74
ISI			
Dry	13 (52)	12 (43)	0.43
Slight	4 (16)	10 (36)	
Moderate	4 (16)	3 (11)	
Severe	4 (16)	3 (11)	
Reoperation*	1 (4)	1 (4)	0.94
Pad use	7 (28)	7 (25)	0.81
Anticholinergic use	3 (12)	2 (7)	0.55

Data are presented as n (%).
*Reoperations included: transurethral collagen injections (1) and urethrolysis (1).

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The evidence: LBC 5 year follow up


ANZJOG

ORIGINAL ARTICLE

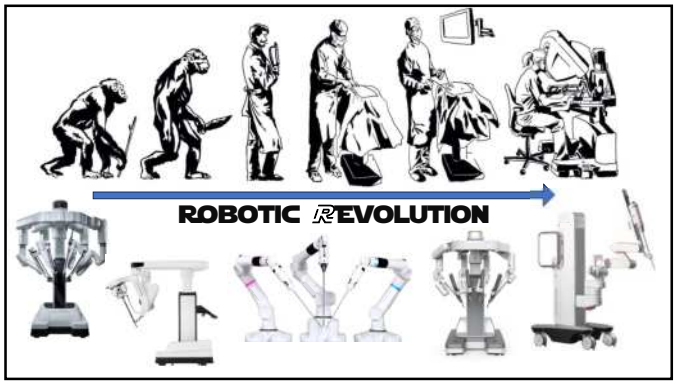
Long-term patient-reported outcomes after laparoscopic Burch colposuspension

Dean H. Conrad, Stefaan Pacquee, Tal D. Saar, Caroline Walsh, Danny Chou, David Rosen and Gregory M. Carlo

TABLE 3 Outcomes as per standardised questionnaire

Outcome	n	%
Stress urinary incontinence		
No symptoms	107	78.1
Improved	17	12.4
Not improved	13	9.5
Overactive bladder		
New onset	14	10.2
Voiding dysfunction		
New onset	12	8.8
Prolapse		
New onset	16	11.7
Physician confirmed	9	
Second operation	9	6.6
Re-operation		
Incontinence	3	2.2
Prolapse	9	6.6

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Robotic Burch and retropubic MUS: similar observed cure

Melnyk et al. 2023 | retrospective matched cohort

Subjective cure at longest follow-up

83% Robotic Burch

85% Retropubic MUS

Difference: 2 percentage points

p = 0.76

Study outcomes

47 robotic Burch

188 retropubic MUS

No detected difference in

Early complications 30% vs 26% p = 0.58
Additional SUI treatment 9% vs 5% p = 0.49
Time to recurrence p = 0.90

Encouraging comparative evidence — Observed outcomes were similar in this selected cohort

Melnyk AI et al. J Robot Surg. 2023;17:1645–1652. doi:10.1007/s11701-023-01573-3

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Limits of the robotic comparison

The treatment groups were clinically different before surgery

Baseline characteristic	Robotic Burch	Retropubic MUS
Age	44 years	55 years
BMI	27.1	29.3
Positive empty-bladder cough stress test	11%	61%
Concomitant procedure	68%	26%
Median follow-up	654 days	239 days

Study design

Retrospective and non-randomised

Subjective cure derived from clinical records

One expert surgeon performed 45 of 47 robotic cases

No prespecified equivalence or non-inferiority margin

Best interpretation: promising outcomes in selected patients and experienced hands

Melnyk AI et al. J Robot Surg. 2023;17:1645–1652. doi:10.1007/s11701-023-01573-3

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WHAT DOES THE LITERATURE TELL US?

- Sutured laparoscopic Burch is effective
- Short-term cure similar to retropubic TVT
- TVT offers faster surgery and recovery
- Burch avoids permanent mesh
  - but… carries risks of prolapse
- Long-term comparative evidence is limited



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Let's return to Sarah

- Early 30's and family complete
- SUI with marked urethral hypermobility
- Preserved urethral closure function
- Normal BMI
- Wishes to avoid permanent mesh
- Planning salpingectomy



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Let's return to Sarah

The mesh sling will treat her incontinence



The Burch treats her incontinence in a way that fits

- ✓ her anatomy,
- ✓ her planned surgery,
- ✓ her preferences.



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The right operation for the right patient…

Pro Burch ≠ Anti Mesh

- Burch is particularly suited to:
  - Primary SUI with urethral hypermobility
  - Preserved urethral closure function
  - Informed preference to avoid mesh
  - Concurrent laparoscopic or robotic surgery
- Counsel Honestly
  - More invasive than a midurethral sling
  - Later posterior and apical prolapse
  - Long-term comparative evidence remains limited
- Requires an experienced minimally invasive surgeon
  - No role for planned open Burch!

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CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) outlines standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations which began on January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the CLC and IB standards page on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.
Bill Text – AB-241 Implicit bias: continuing education: requirements.
Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)
Implicit Bias, Microaggressions, and Stereotypes Resources | NEA
Act, Communicating, Implicit Bias (racialequitytools.org)
https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn
https://pubmed.ncbi.nlm.nih.gov/34016820/
https://hr.ucdavis.edu/departments/learning/certificate/implicit-bias
https://pmc.ncbi.nlm.nih.gov/articles/PMC7011228/