**National Mesh Exceptions MDM**

**MDM Referral Guideline**

**National Mesh Exceptions MDM Referral Guidelines:**

1. Intention to submit a referral to the MDM to be received no later than **10-days** prior to the MDM date. Notifications to be sent to [NZFPMSNationalMDM@waitematadhb.govt.nz](mailto:NZFPMSNationalMDM@waitematadhb.govt.nz) with subject line ‘**Attention MDM Coordinator – Mesh Exception Request’**.
2. Completed MDM referral forms are to be submitted to the MDM Coordinator no later than **7-days (5 working days)** prior to the meeting.
3. A completed MDM referral form is required for patients to be added to the MDM agenda.

***NOTE:* sections in RED indicate a mandatory field, this includes all boxes where the column on the left has RED text.**

1. The referring practitioner is required to send appropriate clinic letters, reports (UDS, USS, MRI etc.) and UDS tracing at the time of referral. The MDM coordinator will load these to the clinical portal records prior to the MDM event.
2. If the mandatory fields in the referral form are incomplete it will be returned to the referrer, if not completed and returned within 96 hours of the MDM date, the patient case will be deferred to the next MDM.
3. Radiology imaging (current and comparison scans) can be pushed to the Waitemata DHB PACS team, for availability prior to the MDM discussion. Please use [PACS.Mailbox@waitematadhb.govt.nz](mailto:PACS.Mailbox@waitematadhb.govt.nz)
4. Allocation to an MDM date will be based on clinical priority/urgency.
5. This discussion and outcome will be recorded on during the MDM. A PDF version of the form and outcome document will be sent back to the referring practitioner.
6. The MDM Coordinator will send monthly reporting on activity and outcomes the appropriate Ministry of Health lead for Mesh Exceptions process .

**National Mesh Exceptions MDM**

Do not hand write on this form. Please complete electronically and email to [NZFPMSNationalMDM@waitematadhb.govt.nz](mailto:NZFPMSNationalMDM@waitematadhb.govt.nz)

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| **MDM Referral**  (Filled in by referring practitioner) |

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| **Patient and Referrer details** | | | | | |
| Patient full name | | |  | | |
| DOB  Age | NHI | | BMI | | ACC accepted claim for Maternal Birth Injury  🞎 Yes 🞎 No |
| Referring Clinician Name | | Referrer email (this is where the outcome will be sent to) | | Referring Hospital | |
| Reason for referral: | | | | | |
| Referral date | | | Preferred date of MDM dd/mm/yyyy | | |

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| **Patient History** | | | | | | | | | | |
| Presenting complaint (including severity of symptoms) | Stress  Urge or urge incontinence  Mixed  Nocturnal enuresis  Flooding incontinence  Insensate loss | | | | | 🞎 Yes 🞎 No  🞎 Yes 🞎 No  🞎 Yes 🞎 No  🞎 Yes 🞎 No | | | | |
| **Severity:**  Degree of bother  Pads used/day.  Number of episodes | | | | |  | | | | |
| Screening for non-index features | Presence of voiding dysfunction (slow flow/ hesitancy etc) | | | | | | | | 🞎Yes 🞎 no | |
| Presence of complex features (haematuria, pelvic radiotherapy, neurological disease, recurrent UTI, radical pelvic surgery, pelvic/bladder pain syndromes, hypertonic pelvic floor) | | | | | | | | 🞎Yes 🞎 no | |
| Diagnosis |  | | | | | | | | | |
| Effects on QoL |  | | | | | | | | | |
| Patient goals of treatment |  | | | | | | | | | |
| Previous pelvic surgery | 🞎 Yes  🞎 No | If yes:  Incontinence surgery  🞎 Yes 🞎 No | If yes; what type  🞎 mesh 🞎 sling 🞎 fascia 🞎 Burch 🞎bulking 🞎 other  Specify other\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Prolapse surgery  🞎 Yes 🞎 No  If yes specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Significant/relevant surgical history | 🞎 Yes 🞎 No  If yes -specify | | | | | | | | | |
| Significant/ relevant medical history | 🞎 Yes 🞎 No  If yes, select as many as required  🞎 diabetes 🞎 neurological disease/event 🞎pelvic radiotherapy 🞎 chemotherapy 🞎 MI 🞎 other | | | | | | | | | |
| Parity  (free text box)  Pre/Post-menopausal | Future fertility desired  🞎 Yes  🞎 No | | | | Patient has been informed of MDM discussion and process.  🞎 Yes  🞎 No | | | PROMs captured  🞎 Yes 🞎 No  Responses  \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Sexual function  Sexually active  🞎 Yes  🞎 No | If No, is this due to (select as many as indicated)  🞎 pain 🞎 obstruction 🞎 incontinence 🞎 not due to gynaecological issues  🞎 no partner 🞎 not planning on becoming SA | | | | | | | | | |
| Pain (describe)  🞎 Yes 🞎 No  If yes tick as many boxes as indicated  🞎 Dyspareunia  🞎 Chronic pelvic pain endo/adenomyosis  🞎 CRPS  🞎 Rheumatology type pain  🞎 Bladder pain  🞎 other – specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Prolapse Symptoms  vaginal bulge symptoms only  🞎 Yes  🞎 No | | | Significant/relevant bowel symptoms  🞎 Yes 🞎 No  Rectal exam  🞎 Yes 🞎 No  Findings:  \_\_\_\_\_\_\_\_\_\_\_\_  Free text what is relevant to this diagnosis  \_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **Examination findings** (\*all sections in this field) | General | | | | | | | | Urine stress test (Supine/standing)  Urethral hypermobility:  🞎 Yes 🞎 No | |
| Bimanual exam  🞎Normal 🞎 Abnormal 🞎 Not done  Size of uterus  Reasons for not completed.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | Pelvic floor  Pain 🞎 Yes 🞎 No 🞎 not assessed  Strength (use modified Oxford grading)  🞎 no contraction 🄋  🞎 Flicker ➀ 🞎 Weak ➁  🞎 Moderate➂ 🞎 Good ➃  🞎strong ➄ | |
| Uroflow/PVR | | | MSU result normal/ abnormal | | | | | If mesh already in situ  Mesh exposure 🞎 Yes 🞎 No  Pain over mesh 🞎 Yes 🞎 No | |
| POP-Q (optional)  <https://www.augs.org/patient-services/pop-q-tool/>  Click on link to tool – enter scores here.   |  |  |  | | --- | --- | --- | | Aa | Ba | C | | gh | pb | tvl | | Ap | Bp | D | | | | | | | | | | Other (Mandatory)  POP-Q Grade  (enter score)  Anterior:  Apical:  Posterior: |
| **Urodynamics (results)**  (\*all sections in this field)  **Attach UDS tracing** | Date performed & location | | | | | | | | Bladder Diary  🞎 Yes 🞎 No | |
| Free Flow/PVR | | | | | | | | First sensation | |
| Bladder Capacity | | | | | | | | DO Yes/no | |
| SUI – LPP  (cmH20) | | | | | | | | Voiding  Qmax  Pdet@Qmax | |
| Optional   * Comment on detrusor contraction * BOOif * BCI * Tracing attached for review 🞎 Yes 🞎 No | | | | | | | | | |
| **Radiology Findings** | Date | Location | | | | Modality | | Finding | | |
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| **Non-surgical management to date**  (\*all sections in this field) | Supervised pelvic floor training.  🞎 Yes 🞎 No  Duration of PFT  Date completed dd/mm/yyyy | | | | Continence Pessary offered/trialled.  🞎 Yes 🞎 No  Weight loss | | | | | Relevant medications trialled. |
| **Written information on treatment options given to patient.** | Name MH document here[[1]](#footnote-1)  🞎 Yes 🞎 No | | Other – name | | | | | | | |
| **Surgical options discussed with patient.**  (\*all sections in this field) | List surgical options discussed with patient (tick all that apply).   * Mesh 🞎 Yes 🞎 No * Fascial sling 🞎 Yes 🞎 No * Burch Colposuspension 🞎 Yes 🞎 No * Urethral bulking 🞎 Yes 🞎 No   If **NO** to any of above, enter rationale why it has not been offered, including clinical reasons.  Enter details of the benefits and risks the patient was advised for their situation.  \*Complete this for each procedure they are suitable for.  🞎 Mesh  🞎 Fascial sling  🞎 Burch Colposuspension  🞎 Urethral bulking  🞎 Other - (free text) | | | | | | Patient indicated preference for treatment options discussed:  **Tick all that apply**  🞎 Mesh  🞎 Fascial  🞎 Burch Colposuspension  🞎 Urethral bulking  🞎 Other - (free text) | | | |
| **Referring clinician recommend surgical options**  (\*all sections in this field) | 🞎 Mesh  🞎 Fascial  🞎 Burch colposuspension  🞎 Urethral bulking  🞎 Other – please type | | | | | | **Rational for referring surgeon recommendation.** | | | |

**Note:** *Index = standard, clear diagnosis without UDS v's non-index where diagnosis is not so clear cut*

Following Section to be completed by the MDM Panel

# MDM Outcome Form (all sections are mandatory)

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| **MDM Discussion** | | | |
| Date | | Chair | |
| Attendees designation and name | | | |
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| Quorum achieved 🞎 Yes 🞎 No  Present:  🞎 MDM Chair (NZFPMS) 🞎 1 x tier 3 SMO (NZFPMS) 🞎 1 x tier 2 (vocationally registered gynaecologist) 🞎 Patients named surgeon. 🞎 CNS Incontinence 🞎 Pelvic health Physiotherapist | | | |

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| **MDT Recommendations** | |
| Additional investigations recommend |  |
| Additional non-surgical treatment recommended | 🞎 Yes 🞎 No [please specify] |
| Is the insertion of a surgical mesh sling endorsed by the MDM | 🞎 Yes 🞎 No |
| If no, what surgical options is recommended | 🞎 Yes 🞎 No |
| Rationale for alternative treatment recommendation |  |
| Will the alternative treatment option help achieve the patients’ goals for treatment | 🞎 Yes 🞎 No |
| Follow up plan |  |
| Other MDT recommendations |  |

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| **High Vigilance and Mesh Exception Monitoring** | | |
| Does the patient meet the High Vigilance criteria | | 🞎 Yes 🞎 No |
| Have pelvic floor muscle exercises been trialled | | 🞎 Yes 🞎 No |
| Have urodynamics been performed and interpreted by an appropriately trained clinician | | 🞎 Yes 🞎 No |
| Has the patient been through a shared decision-making | | 🞎 Yes 🞎 No |
| Has the patient been through an informed consent process including the use of a patient decision aid? | | 🞎 Yes 🞎 No |
| Has the patient been offered treatment that would benefit the patient but is not offered by the referring clinician?   * If yes: Has the patient had second opinion from NZ credentialed surgeon for any/all of SUI options NOT offered by the referring (primary) clinician | | 🞎 Yes 🞎 No  🞎 Yes 🞎 No |
| Is the surgeon credentialed to perform the recommended surgery | | 🞎 Yes 🞎 No |
| Is a follow up plan documented | | 🞎 Yes 🞎 No |
| Name of person recording outcome of discussion |  | |

1. [Considering Surgical Mesh to Treat Stress Urinary Incontinence? | Ministry of Health NZ](https://www.health.govt.nz/publication/considering-surgical-mesh-treat-stress-urinary-incontinence) [↑](#footnote-ref-1)