Modern Help for the Pelvic Floor

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Urinary Incontinence

- Stress Urinary Incontinence (SUI)
- Overactive Bladder (OAB)
- Mixed Incontinence
- Sinister causes

The History

- Is a poor tool for accurate diagnosis
- 1/3 women who initially report SUI have OAB not SUI
- 2/3 women with mixed symptoms only have SUI and no OAB

Associations

- Childbirth
- Recurrent UTIs
- Menopause
- Prolapse
- PMH, DH (eg Prazosin, diuretics, oestrogen?)
- Cigarettes
- Asthma
- Fluid intake
- Constipation
- Caffeine, Alcohol

Frequency Volume Diary

- Improves history
- Information about learned behaviour
- Fluid intake information
- Lifestyle questionairre
- Frequent small painful voids point to interstitial cystitis

Your Daily Bladder Diary

Your name: _____

Date: _____

This diary will help you and your health care team understand your bladder function.
It is a 24 hour record of your intake and output as well as leakage episodes.
The "sample" line (below) will show you how to use the diary.

Time	Drinks		Urine		ACCIDENTS					
			How many times did you "pee" during the hour?	How much? Use measuring cup (ml's or oz's)	Accidental Leaks How much? (check one)			Did you feel a strong urge to go? Circle one		What were you doing at the time? Sneezing, exercising, having sex, lifting, etc.
	What kind?	How much?			sm	med	lg			
Sample	Coffee	2 cups	2	2 oz or 2 ml	√			Yes	No	Running
6-7 am								Yes	No	
7-8 am								Yes	No	
8-9 am								Yes	No	
9-10 am								Yes	No	
10-11 am								Yes	No	
11-12 noon								Yes	No	
12-1 pm								Yes	No	
1-2 pm								Yes	No	
2-3 pm								Yes	No	
3-4 pm								Yes	No	
4-5 pm								Yes	No	
5-6 pm								Yes	No	
6-7 pm								Yes	No	
7-8 pm								Yes	No	
8-9 pm								Yes	No	
9-10 pm								Yes	No	
10-11 pm								Yes	No	
11-12 mid								Yes	No	
12-1 am								Yes	No	
1-2 am								Yes	No	
2-3 am								Yes	No	
3-4 am								Yes	No	
4-5 am								Yes	No	
5-6 am								Yes	No	

Physical Examination

- General e.g. leg oedema and nocturia
- Pelvic (prolapse, tone, mass, fistula)
- Local neurological
- UVJ hypermobility
- Post void residual? (in-out catheter or scan <100mls is normal, >200 abnormal)
- Cough test of some use
- Dipstick / MSU / ?cytology of EMUs

Urodynamic Assessment

- A test to exclude OAB and outflow obstruction
- Homework and Pad test
- Voiding flowmetry and then catheter for PVResidual
- Attach lines and pressure transducers incl rectal and fill up to around 500ml
- Stress test lying and standing
- Normal capacity is 350-400ml. Suspect Interstitial Cystitis if <300, rule out if >350
- Supine positive empty stress test ?ISD

The Overactive Bladder

- Urgency +/- urge incontinence usually accompanied by Frequency and Nocturia
- Freq (>10 in 24 hours)
- Nocturia (>1)
- DD severe SUI, stone, fistula, infection, tumour
- Neurological causes (MS, CVA, PD)
- Prolapse, Drugs, Idiopathic

Treating the Overactive Bladder

- Bladder (re)Training cures 10% with urge incontinence
- It makes 60% much better
- eg void every hour whether you want to or not and increase the interval fortnightly by 15-30 minutes until 2.5-3 hours gap achieved
- Pelvic floor exercises

Drugs; Oxybutynin (Ditropan)

- Muscarinic Acetylcholine antagonist
- 2.5mg up to 5mg tds
- 20-50% reduction in incontinence episodes
- Side effects include dry mouth, constipation, blurred vision, drowsiness, dizziness, urinary retention, delirium
- Contraindications; narrow angle glaucoma, bowel obstruction, toxic megacolon, paralytic ileus
- Imipramine 10-25 mg up to tds (anticholinergic and alpha-adrenergic to increase urethral tone)

Solifenacin (Vesicare)

- Antimuscarinic agent with relative selectivity for the bladder (M3)
- Well tolerated
- Subsidised
- ‘Any relevant practitioner’
- Must have documented intolerance to Oxybutynin

Royal Hallamshire Study 2003 placebo vs Detrusitol vs Vesicare

- Urgency stat significantly lower only with Vesicare 5 and 10mg
- U incontinence stat significantly lower only with VC
- Number of voids in 24 hours stat lower with both (similar but Vesicare better)
- Dry mouth; placebo 5%, VC5mg 14%, Det 19%, VC10mg 21%
- Constipation with VC around 7% Blurred vision 3%
- Discontinuation for Side-effects was highest in the placebo group 3.7%!

Drugs continued

- Basra (2008) continuation rates at one year 63% (Oxy), 62%(Det), 81%(VC)
- Discontinued because of SE 24,15,4.7

Summary for OAB in General Practice

- Assess including examination
- MSU
- Refer if microscopic or more haematuria
- If symptoms suggest OAB lifestyle (fluid etc), medications review, retraining / PFEs? and Oxybutynin….Vesicare
- Any doubt or no success, refer

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Case 1 RD 51 P1 SVD (Busy)

- Urgency freq UI nocturia spasms
- h/o LAVH / colposuspension (USI) / Lap adhesiolysis / DM
- Repeat UDs with urologist showed slow flow risk of retention so no Botox
- Oxybutynin SEs, Vesicare trial pack worked so bought it for 6 months now subsidised- with good effect

Case 2 MW 64 P2 SVD's

- H/O breast and colon cancer
- Aug 09 nurse referral as smear showed adenocarcinoma cells
- Colposcopy LLETZ HDC Cystoscopy and biopsies all normal MDM MRI abdo/pelvis then TAHBSO Omentectomy, washings
- Atypical hyperplasia
- FU offered PET scan - declined
- Routine review January 2010; well but feeling of 'spasm' in bladder, nil else
- MSU microscopic haematuria EMU X 3 for cytology- adenocarcinoma, Vault smear adenocarcinoma cells
- Cystoscopy by urologist normal
- Subsequent tumour right kidney collecting system

Treating Stress Urinary Incontinence

- Pelvic floor exercises to hypertrophy the denervated pelvic floor muscles
- It will take 3 months of 3 sets of 20 for 4s each (and ‘quick flicks’ for fast fibres). 50% can achieve significant improvement
- Electrical stimulation (reflex relaxation of the bladder)
- ERT?
- Devices eg pessaries and plugs

Surgery for SUI

- Tension-free Obturator Tape (mid-urethral)
- Classic Tension-free Vaginal Tape
- Elevation of the Bladder Neck e.g. Burch Colposuspension
- Laparoscopic Burch Colposuspension

Prolapse
(prolapsus ‘to slip forth’)

- 20% general Gynae’s wait list
- 1/3 parous women need seek help
- ‘something coming down’
- Urinary symptoms
- Bowel symptoms
- ‘Ache’
- Sexual dysfunction

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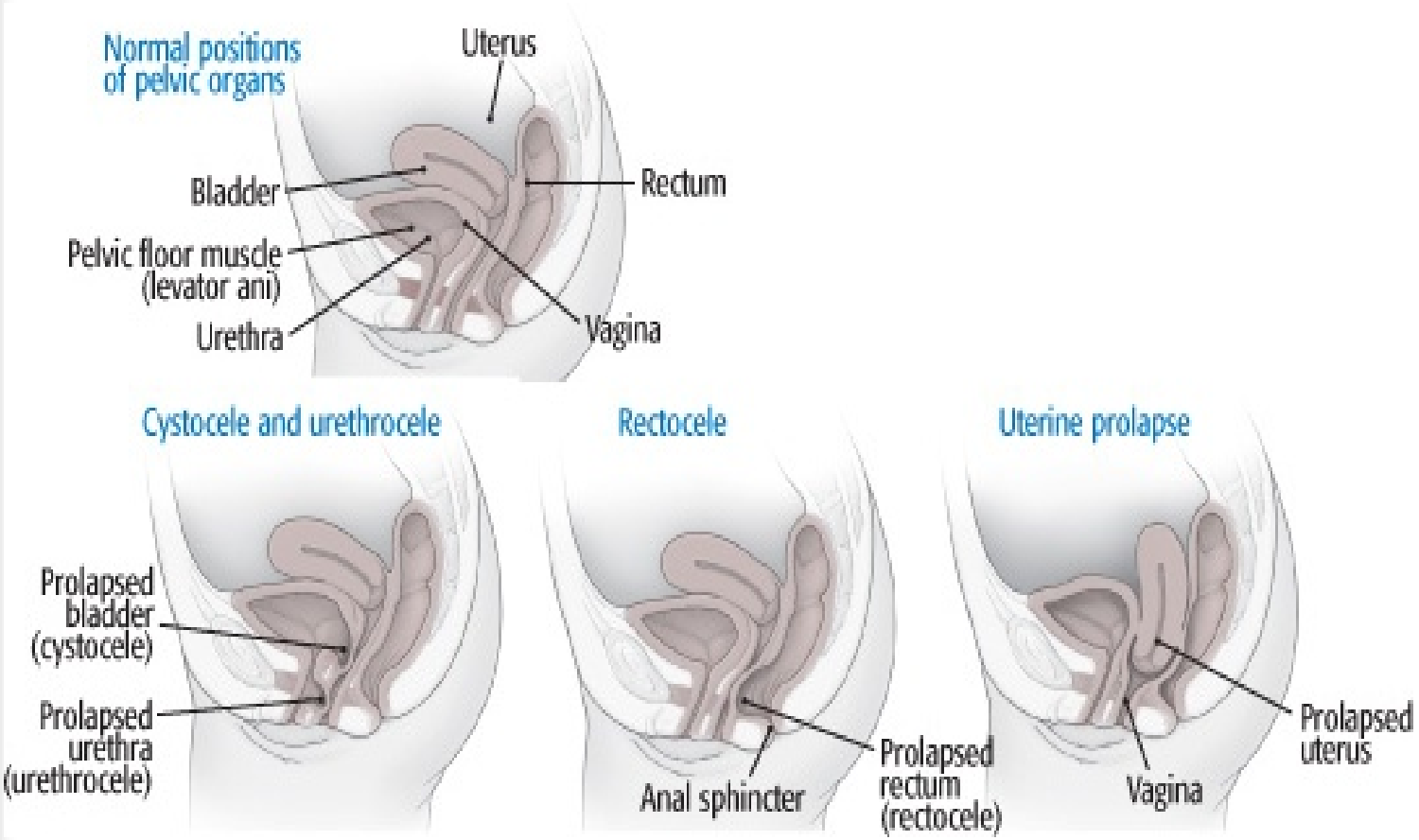
Types and Examination

- Compartments; Ant, middle, posterior
- Degrees vs POPQ
- Sims position
- Exclude a Mass
- Assess Tone
- Tests eg MSU, UDs?
- Colorectal opinion?

Prolapse; Anatomy



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Causes of Prolapse

- Congenital (tissues)
- Childbirth; trauma and denervation
- Raised IAP eg constipation, obesity, CORD heavy lifting, smoking
- Menopause
- Iatrogenic;

  Total Hysterectomy (7% at 10-15 years)

  SSFixation increases cystocoele

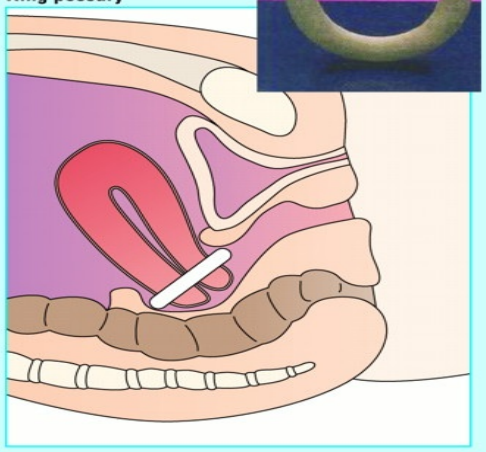
  Colposuspension also

Prevention (poorly researched)

- Pelvic floor exercises
- Elective LSCS?
- A ‘normal’ length 2nd stage
- HRT
- Stop smoking
- Lose weight
- ?Close POD at hysterectomy

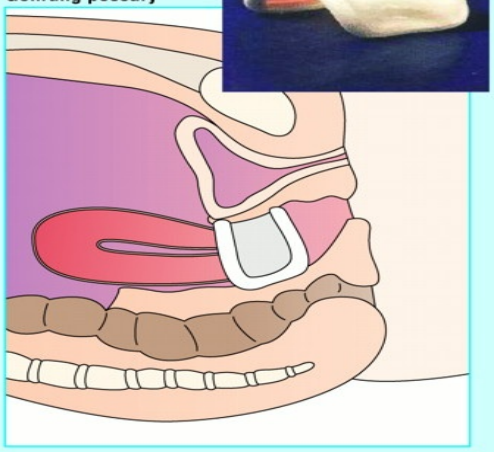
Support pessaries

Ring pessary



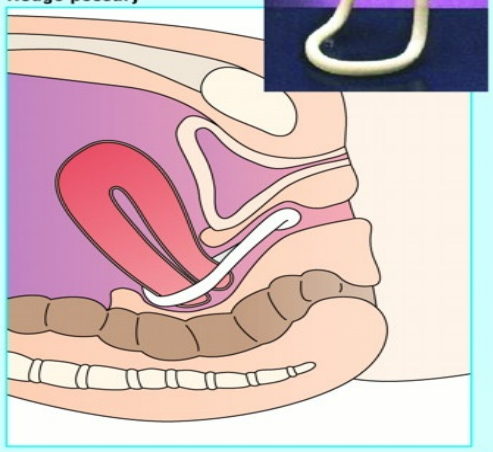
First and second degree uterovaginal prolapses
The most common pessary, and the easiest to use

Gehrung pessary



Cystoceles and rectoceles, with or without uterine collapse
Can be manually moulded. It rests along the anterior vaginal wall to straddle the bladder, and the lateral bars straddle the rectum, providing support via the legator sling

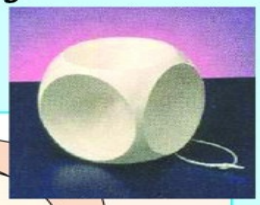
Hodge pessary

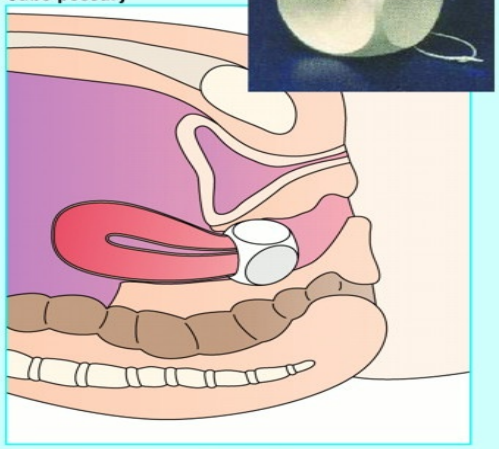


Mild cystoceles in women with a narrow pubic arch, and for correcting a retroverted uterus

Space occupying pessaries

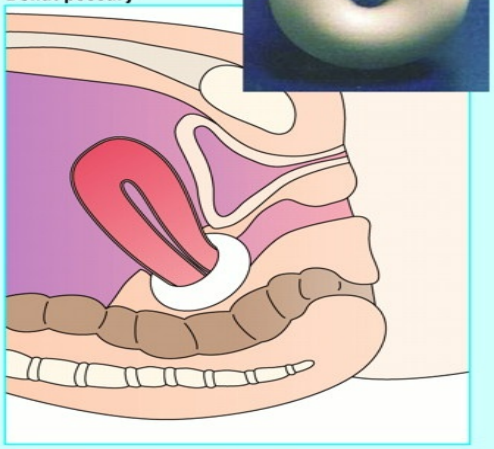
Cube pessary





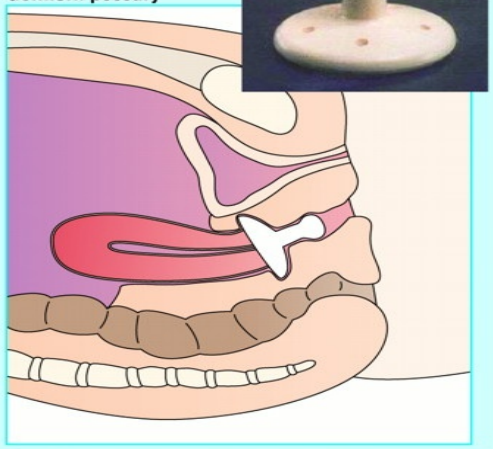
Third degree uterovaginal prolapse
Maintains its position by creating suction between itself and the vaginal wall. Has no area for drainage and has to be removed nightly

Donut pessary



Third degree uterovaginal prolapse
Remains in place by having a larger diameter than the genital hiatus. Usually latex, but an inflatable version allows for easy insertion and removal and an individualised fitting

Gellhorn pessary



Third degree uterovaginal prolapse with decreased perineal support
Concave surface fits against the cervix or vaginal cuff. Stem should be positioned just behind the introitus, so perineum must be intact

Surgery

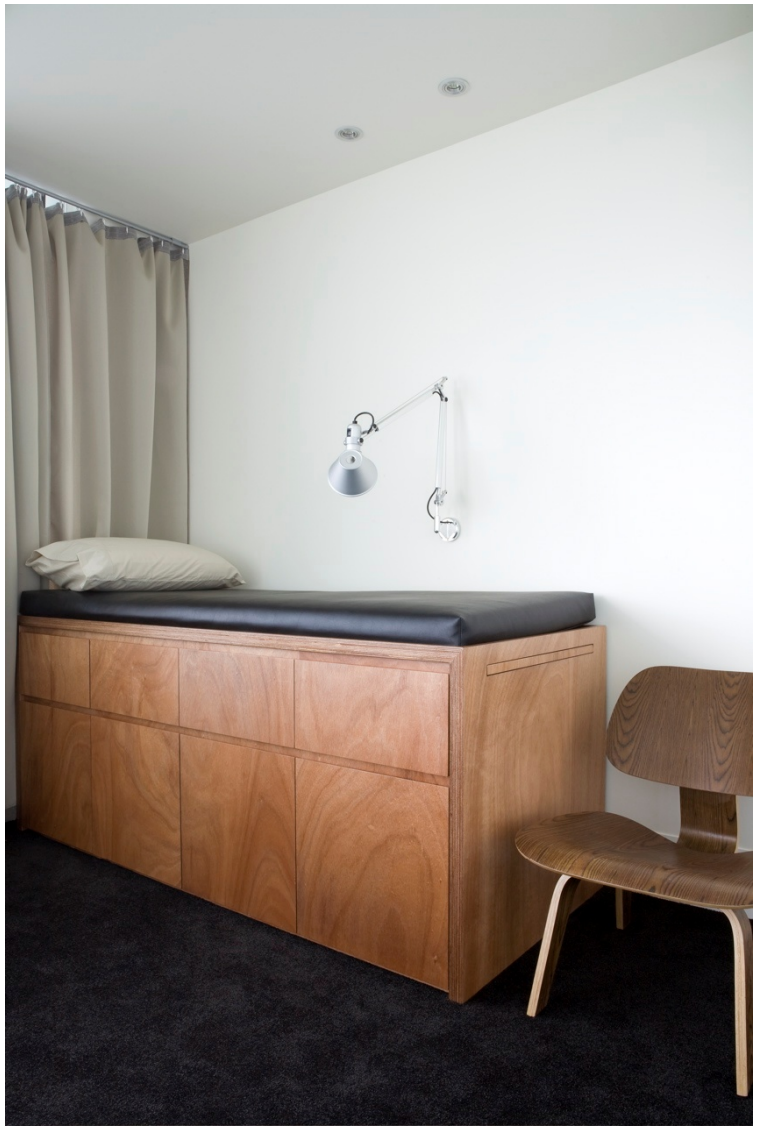
- 11-30% chance of surgery for prolapse or urinary incontinence by the age of 80 years
- VH APR is inadequate for many
- 25-50% chance of recurrent prolapse
- Vaginal vs abdominal / laparoscopic
- Polypropylene Mesh
- Biological Mesh out of favour

Mesh Procedures

- Restore anatomy?
- Controversial
- Polypropylene
- Erosion, Infection, Dyspareunia
- Efficacy and support
- Mesh for all?

I have opinions of my own, strong opinions, but I don’t always agree with them.

George W Bush



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Thank you.

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