Dr John Short

Obstetrician & Gynaecologist

Christchurch

News for Pelvic Floors/ Ring Pessaries - Concurrent Breakout sessions repeated

Sunday, 31 July 2011	Start 8:30am	Duration: 50mins	Greenslade Room
	Start 9:30am	Duration: 50mins	Greenslade Room

“News for Pelvic Floors”

John Short
Obstetrician and Gynaecologist
Christchurch

What's happened down there?

- http://www.youtube.com/watch?v=4-UbR4vfxBc

Urinary Incontinence

- remember the basics

- urine is made in the kidneys
- various factors influence urine production
- bladder is a reservoir that expands and contracts as required
- it has a sensory and motor nerve supply

Continence

- Bladder Pressure vs Urethral Pressure
- (similar relationship exists for prolapse)

Continence

- Bladder Pressure vs Urethral Pressure
- BP = abdo pressure + detrusor pressure

Continence

- Bladder Pressure vs Urethral Pressure
- BP = abdo pressure + detrusor pressure
- UP = sphincter + “pelvic floor”

Continence

- Mental function
- Mobility
- Motivation
- Manual dexterity

- Our goal is to improve quality of life

Urinary Incontinence

- remember the basics
- take a good history
- remember underlying medical problems

history

- Categorise type of incontinence
- Duration of symptoms
- Frequency of symptoms
- Provoking factors
- Associated symptoms
- co-existing medical problems
- medications
- social stuff, inc bother and fluid intake

- Urinary symptoms may be a sign of another disease process

“Bother”

- social interactions/relationships
- isolation
- hygeine
- self esteem

- etc, etc

Types of incontinence

- Stress Incontinence
- Urge Incontinence (+ overactive bladder)
- Mixed Incontinence

- Urgency
- Frequency
- Nocturia *

- healthpathways

Urinary Incontinence

- remember the basics
- take a good history
- remember underlying medical problems
- simple examination

Clinical examination

- demonstrate incontinence
- abdo-pelvic mass
- vaginal atrophy
- prolapse
- basic neurology
- weight / BMI

Urinary Incontinence

- remember the basics
- take a good history
- remember underlying medical problems
- simple examination
- PADS

PADS

- post-void residual
- analyse urine
- diary
- stress test

- (consider order- SAPD or DSAP!)

Figure 1. Fluid volume chart

Date:_____ Name:_____

TIME	AMOUNT VOIDED	LEAKAGE? (YES OR NO)	LIQUID INTAKE	COMMENTS
6-8 AM				
8-10 AM				
10-12 AM				
12-2 PM				
2-4 PM				
4-6 PM				
6-8 PM				
8-10 PM				
10-12 PM				
Overnight*				
Total in 24 hours	No. of voids	No. of wet pads	Fluid intake	

*Just make a check mark for nighttime voids; no need to measure.

Assessment

- remember the basics
- take a good history
- remember underlying medical problems
- simple examination
- PADS

management

- Goals ?
- Patient-centred

management

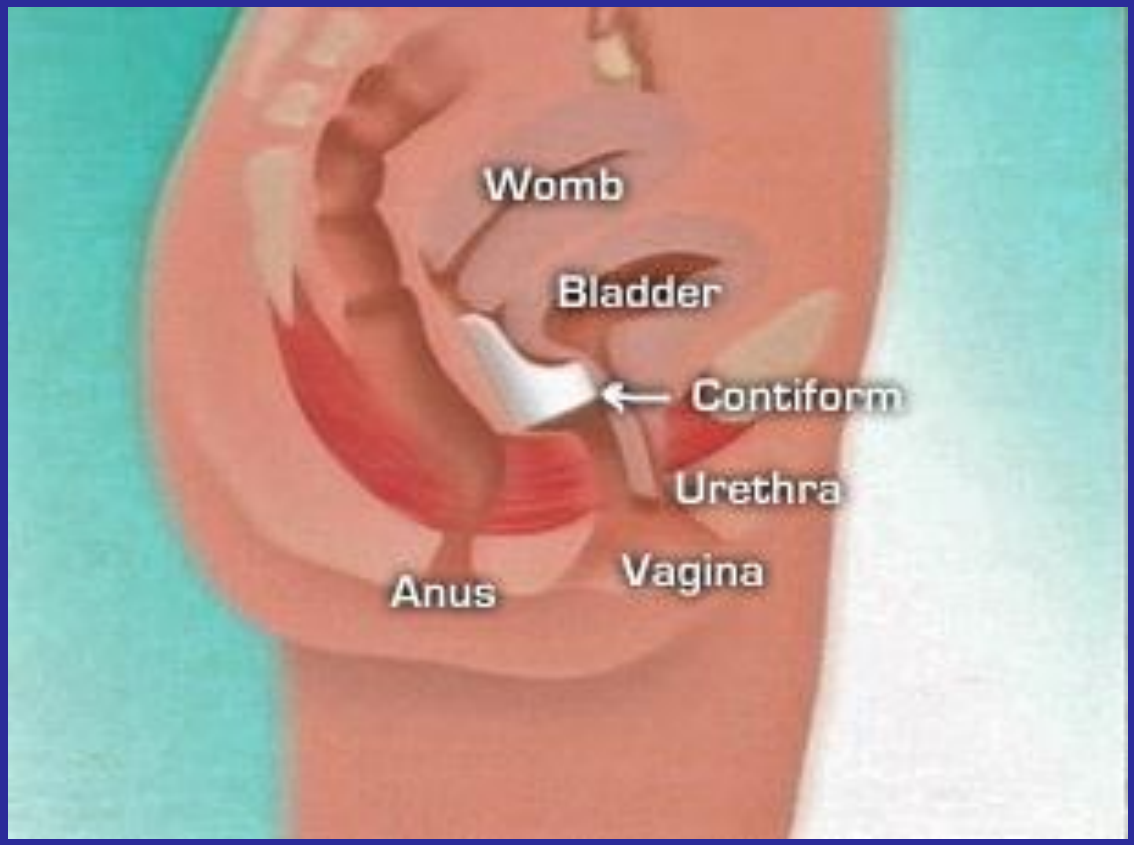
- Treat UTI
- Treat significant prolapse
- Vaginal oestrogen
- Lifestyle interventions
- Continence products

Lifestyle interventions

- Weight reduction (*)
- Relieving constipation
- Cessation of smoking/treatment of chronic cough.
- Bladder irritants
- fluid management
- Reduction of physical forces (exercise, work)

(*doesn’t help with prolapse)


Contiform
Contiform


Womb
Bladder
Contiform
Urethra
Vagina
Anus

Stress Incontinence

- Pelvic floor exercises
- 33% of women cannot do from pamphlet alone
- Pelvic floor assessment vital


Global
HD

patient selection

- >2 leakages/day
- Psychotropics
- Symptoms >5yrs
- +ve stress test (first attempt)
- >2pads/day
- Significant (untreated) prolapse

- (urodynamic data)

PHYSIO

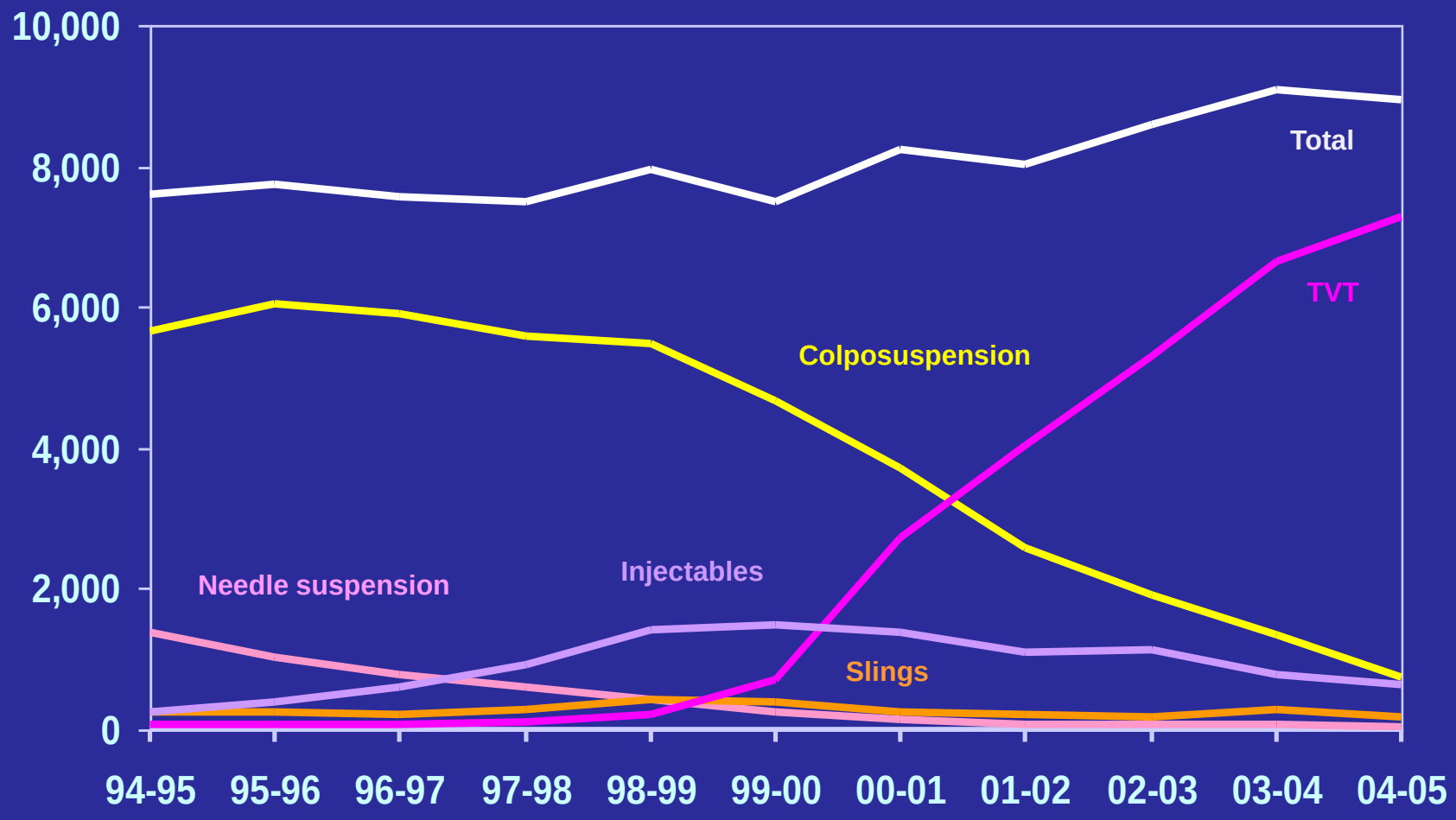
- 50% significant improvement
- 25% mild improvement
- Age/BMI not predictors

- 4 M’s

- Patient choice

Surgery

Hospital episode statistics 1994-2005



- Success not guaranteed
- Overall 80-90%, using QOL

- Failure RFs-
  - OBESITY
  - DIABETES
  - URGENCY
  - PREV SURGERY
  - UNTREATED PROLAPSE
  - SPHINCTER DEFICIENCY

Urge incontinence/OAB

- treat prolapse
- treat vaginal atrophy
- fluid management
- bladder retraining
- pharmacotherapy

- synergistic effect of above

mixed incontinence

- identify most bothersome aspect and treat first

Pelvic Organ Prolpase

- Assessment

prolapse assessment

Anatomy

POP-Q Stage	Nulliparous (n=30)	CS only (n=14)	CS & SVD (n=15)	SVD (n=84)	AVD (n=51)
0	13 (43.3%)	2 (14.3%)	1 (6.7%)		
1	15 (50.0%)	9 (64.3%)	6 (40.0%)	31 (36.9%)	12 (23.5%)
2a (above the hymen)	2 (6.7%)	3 (21.4%)	6 (40.0%)	34 (40.5%)	23 (45.1%)
2b (at or below the hymen)			2 (13.3%)	19 (22.6%)	13 (25.5%)
3					3 (5.9%)

POP Symptoms

- General
- Bladder
- Bowel
- Sexual

POP Symptoms

- General
  - Bulge

POP Symptoms

- Bladder
  - voiding issues
  - overactive bladder/urge incontinence
  - stress incontinence may worsen after treatment

POP Symptoms

- Bowel
  - Obstructive defaecation

POP Symptoms

- Sexual
  - physical
  - emotional

prolapse and ageing

- deterioration is NOT inevitable
- atrophic tissue stiffer
- prolapse often longstanding and symptoms may relate to E2 deficiency

treatment of prolapse

- Symptomatic
- Anatomical

treatment of prolapse

- Symptomatic
  - Oestrogen
  - Physiotherapy
  - fibre, laxatives
  - catheterisation

treatment of prolapse

- Symptomatic

- Anatomical
  - Physiotherapy
  - Pessaries
  - Surgery

problems

- ‘standard’ physio will only treat mild prolapse.
- to treat moderate to severe prolapse it needs to be extremely intensive.
- pessaries not appealing at face value.
- surgery has disappointing long term results and potential complications.

Pessaries

- useful for anterior and central compartments
- less effective for posterior compartment

- At 1 year similar improvement in urinary, bowel, sexual and QOL measures when compared to surgery

- median duration of use 2 yrs

Reasons for discontinuation

- Inconvenient
- Inadequate relief of symptoms
- Uncomfortable
- Elected for surgery
- Unable to remain in place
- Difficulty urinating (or bowels)
- Incontinence increased

- (different sizes or shapes may help)


A
B
C
D
E
F
G
H
I
J
K
L
M
N
O
P
Q
R
S

Surgery

- designed to correct anatomy
- traditional surgery success at 5 years
  - 40%
  - worse for repeat surgery

developments

- ‘mesh’
- better anatomical results
- greater complications
- lack of long term data

re-evaluation

- consider symptoms and functional outcomes
- consider anatomical significance
- consider re-operation rates

- mesh marginally better for anatomy
- no difference for symptoms/function
- re-operation rates almost identical
- more complications with mesh

- multiple studies looking at ‘mesh’ vs ‘no mesh’
- all at primary repairs or all repairs
- 2 case series on mesh for repeat repair only

patient selection

- mesh for repeat repair
- mesh for ‘high risk’ primary repair (?!)
- role of imaging ?

Ring Pessaries

Mrs M

A lady with incontinence

Presenting Complaint

Urinary incontinence with associated recurrent UTIs.

- HPC:
  - Experienced urinary incontinence for years which has recently worsened, becoming more frequent and increasingly urgent.
  - Elements of both stress and urge incontinence, urgency is her biggest concern.
  - Frequency during the day, 2-3 episodes of nocturia per night.
  - Requires incontinence pads.
  - Only urine, never faeces.
  - Some sensation of a prolapse – vague.
  - Occasional dysuria – not currently.

HPC continued..

- Long standing recurrent UTIs
  - Most recent in April 2011 – heavy growth of alpha haemolytic streptococcus, treated with amoxycillin, resolved.
- Drinks 3-4 teas/day
- No ETOH intake
- Obstetric hx: 3 live births, biggest 7lb 2 oz
- Important negatives:
  - No flow problems or sensation of incomplete emptying.
  - No haematuria or bladder pain.
  - No bowel symptoms.

Past Medical History

Extensive past medical history.

- IHD
- Heart Failure
- Mitral valve prolapse → severe MR
- Pulmonary Interstitial Fibrosis
- Paroxymal AF
- Laparotomy for non-malignant ovarian cystadenoma removal (2007)
- Hysterectomy - ? Indication, ?year

Medications

- Oxybutinin 5mg OD
- Frusemide 80mg bd po

•Morphine sulfate 20mg po bd •Warfarin as per INR •Amiodarone 200mg mane po •Prednisone 5mg od po •Paracetamol 1g qid po •Metoprolol 95mg mane po •Omeprazole 40mg mane po •Slow K 600mg bd po	•Levothyroxine 100mcg mane po •Laxol 2 tabs nocte po •Isosorbide mononitrate 30mg mane •Triazolam 187.5mg nocte po •Ferrous sulphate 325mg mane po •Vitamin B complex 2 tabs od po •Calcium Carbonate 2.5g nocte po •Cholecalciferol 1.25mg monthly po

- Allergy - Voltaren

Social History

- Resident at a retirement home
- Limited mobility with a frame
- Widowed, children live rurally around Christchurch
- Ex-smoker – quit 20 years ago
- Very embarrassed about this issue. Feels “like a wuss to wet yourself all the time” and is distressed at the thought of losing control.

On Examination…

- Height: 155cm, Weight: 68kg, BMI: 28
- Vitals:
  - BP 104/60
  - HR 53bpm
  - Sats 95% RA
- Abdomen SNT, bladder not palpable or percussible.
- No vaginal prolapse seen.
- Urinary incontinence demonstrated on bearing down and coughing

Differentials

- Stress incontinence
- Urge incontinence – detrusor overactivity.
  - Can be associated with impaired detrusor contractility (DHIC) – high PVR.
- Mixed incontinence
- Incomplete emptying – overflow incontinence due to detruser underactivity

Investigations

- FBC, U&Es
  - All within normal parameters
- Vitamin B12
  - 28/6/11 – 212pmol/L (170-600)
- Urine MSU
  - 28/6/11 test clear
- Bladder scan
  - 400ml postvoid residual volume
- Urodynamics
  - Awaiting

Management

- Reassure and normalize
- Reduce tea consumption
- Stop Oxybutinin
- Intermittent catheterisation – decreasing bladder volume.
- Physiotherapy – pelvic floor muscle retraining.

Prognosis

- Optimal management of Mrs M's incontinence may improve her emotional wellbeing and therefore her qualilty of life.
- Normalizing the condition may improve embarrasement and isolation over the situation which will also improve her wellbeing.
- Urge incontinence increases an elderly person's risk of falls as they attempt to get to the toilet on time. Night pads or accessible bed pans may help.