Oxford Clinic
Women's Health

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

gynaecology in family medicine

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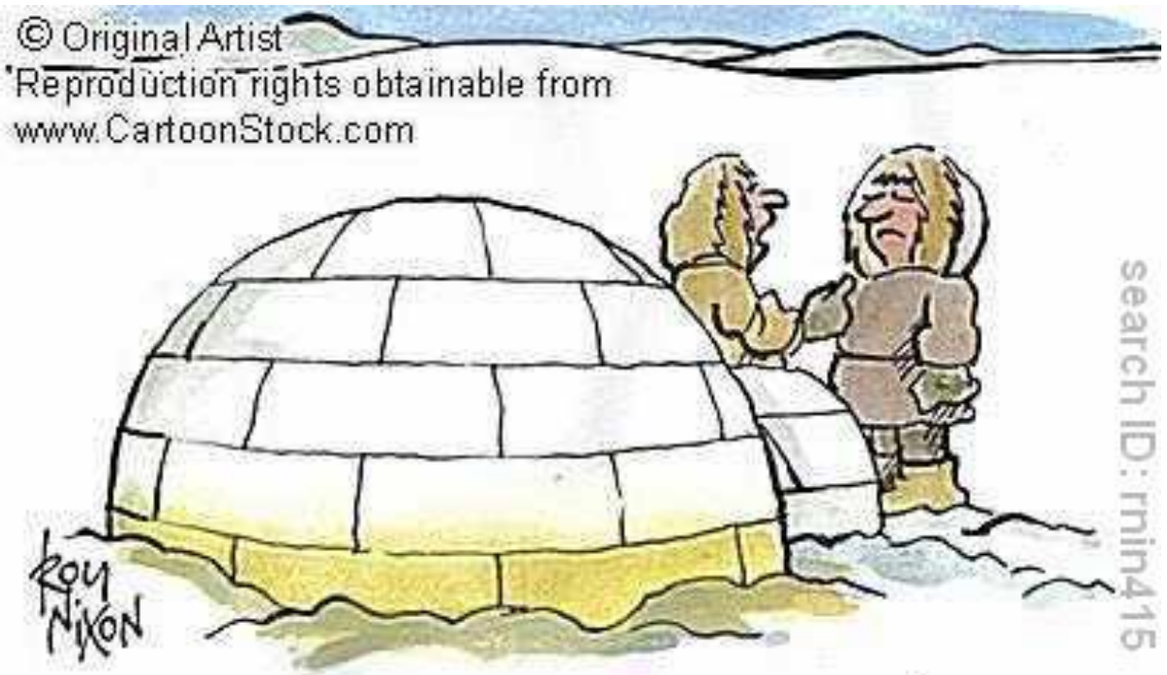
“What’s going on down there?”

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



"YOU CAN DENY IT TILL YOU'RE BLUE IN THE FACE BUT YOU'RE DEFINITELY INCONTINENT!"

"We need something for his verbal incontinence. He has a blather control problem."

" It says here that you'd prefer someone with regular bowel movements..Does it matter if they're involuntary ? "

urinary incontinence

- involuntary leakage of urine
- stress
- urgency
- mixed

- 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

- Bladder Pressure vs Urethral Pressure

- Bladder pressure = detrusor pressure + abdominal pressure

- Urethral pressure = urethral sphincter + pelvic floor

- Mental function
- Mobility
- Motivation
- Manual dexterity

- categorise incontinence
- identify modifiable factors
- consider underlying medical problems and medications
- remember quality of life

Clinical examination

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

PADS

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

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	

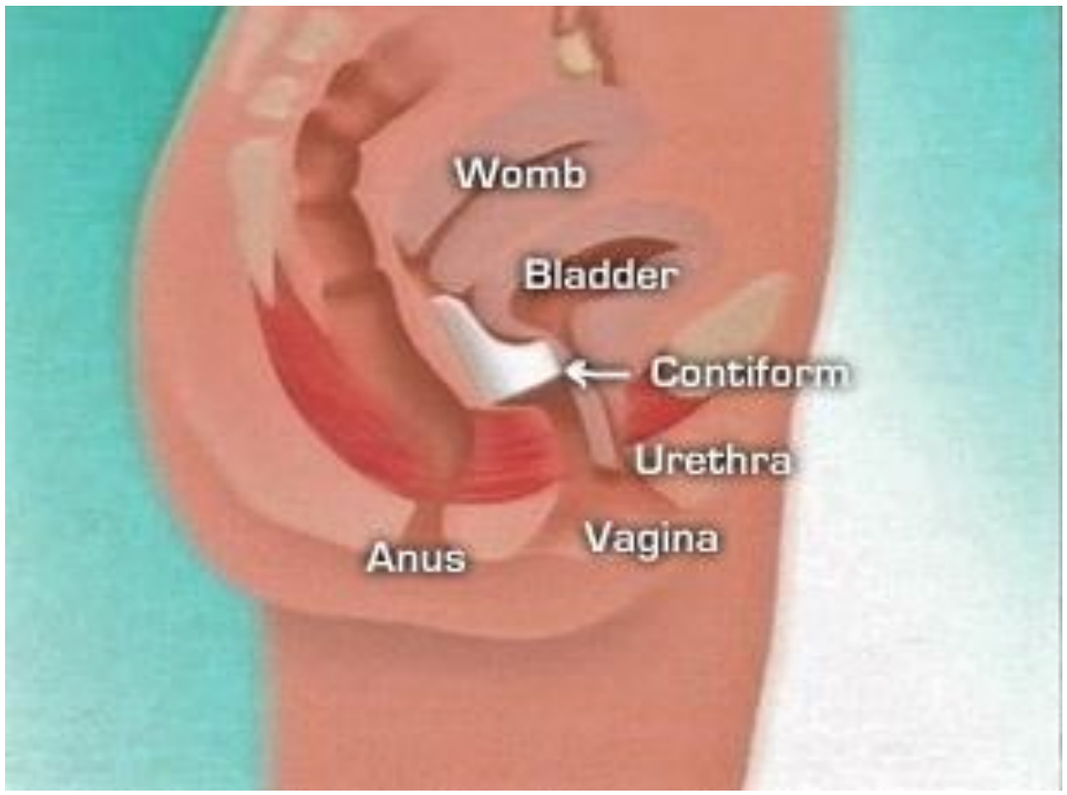
*Just make a check mark for nighttime voids; no need to measure.

- 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)


Contiform
Contiform


Womb
Bladder
Contiform
Urethra
Vagina
Anus

- Pelvic floor exercises

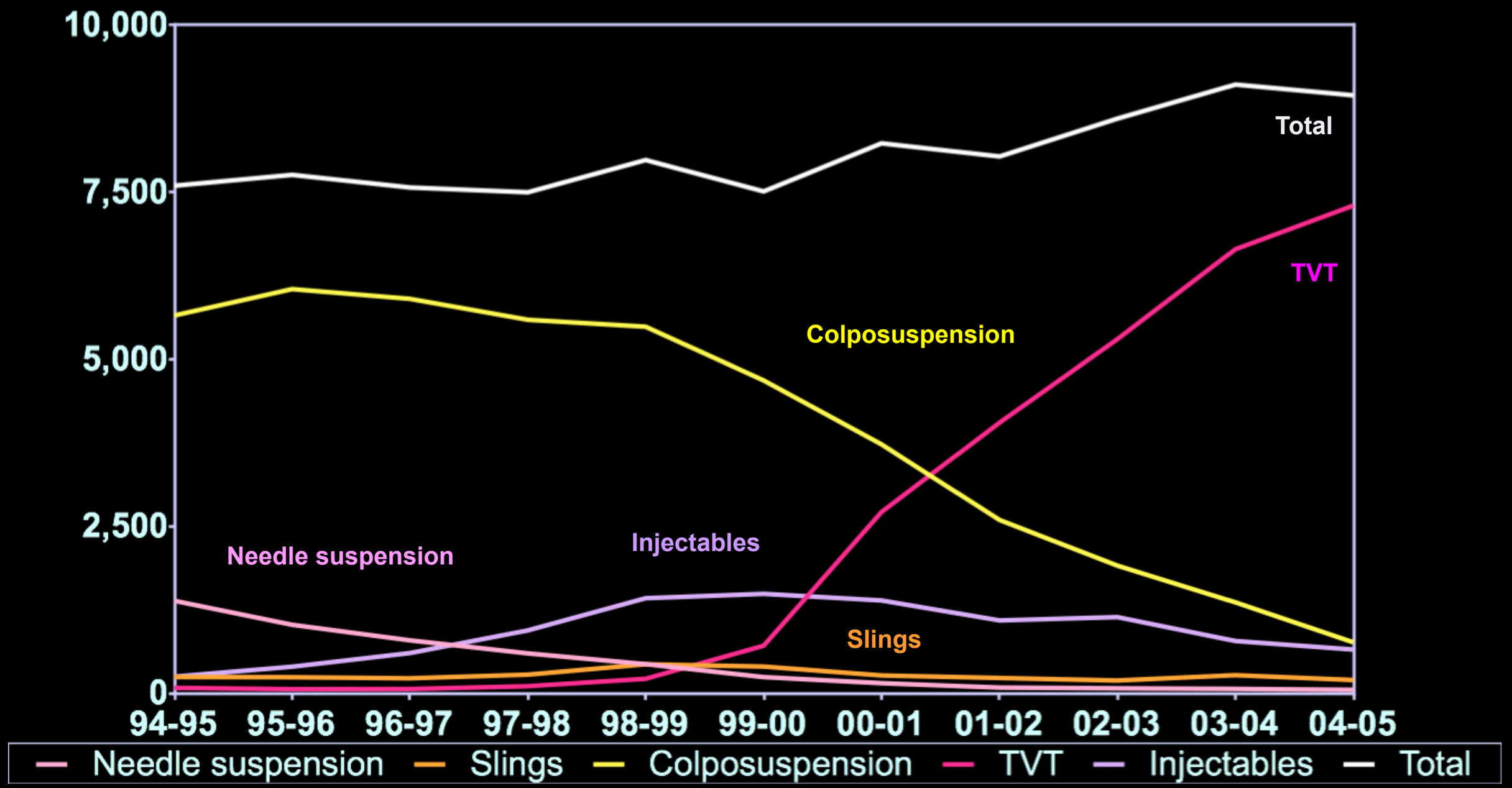
- 33% of women cannot do from pamphlet alone

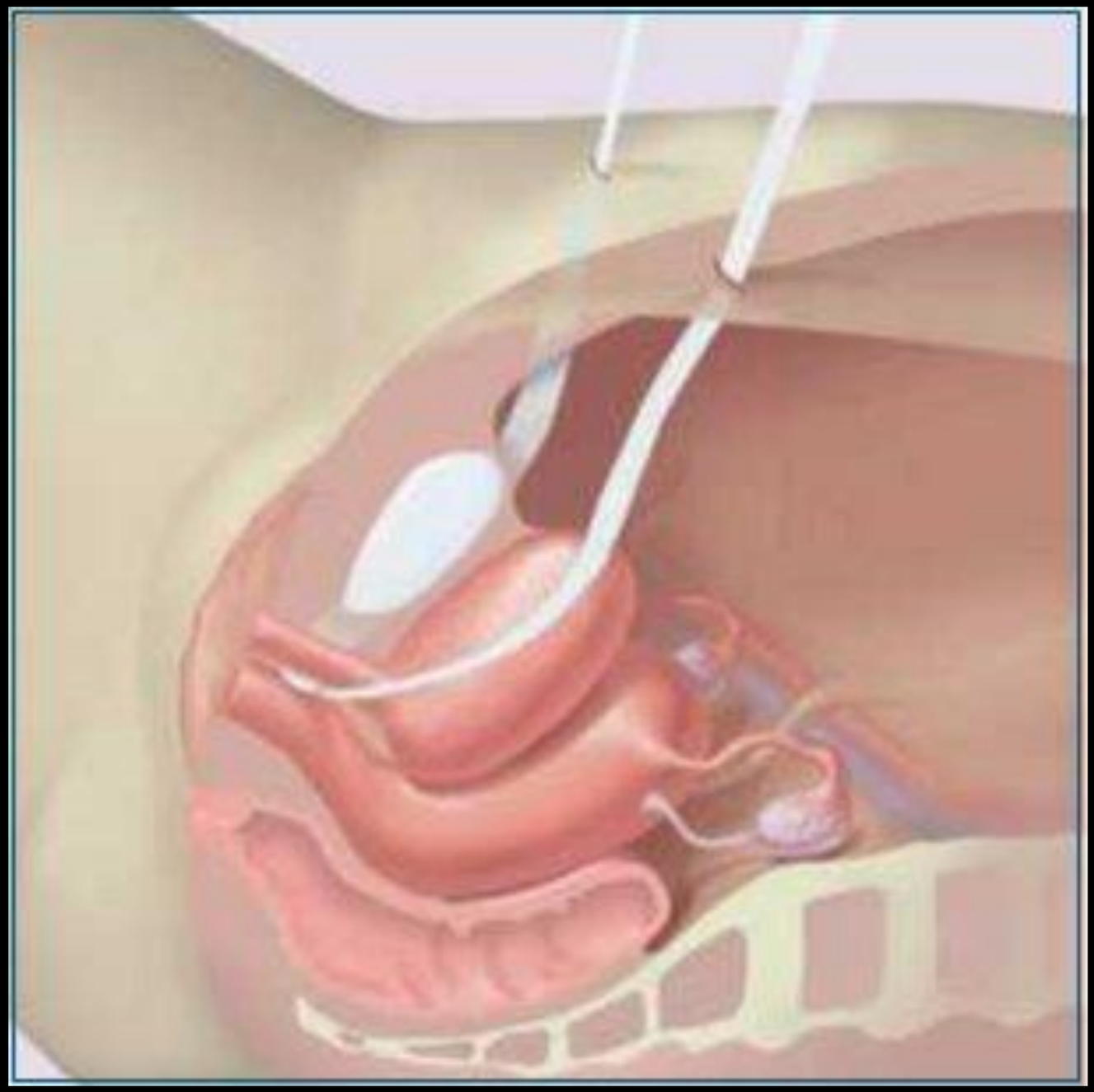
- Pelvic floor assessment vital

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

- 50% significant improvement
- 25% mild improvement
- Age/BMI not predictors
- 4 M’s
- Patient choice

Hospital episode statistics 1994-2005





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

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

complications

- bleeding
- infection
- injury
- voiding issues
- pain
- mesh erosion

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

Summary

- Basic science is quite basic
- categorise incontinence
- assess QOL
- consider other morbidities
- lifestyle measures
- simple treatments
- surgery

Continence care resources

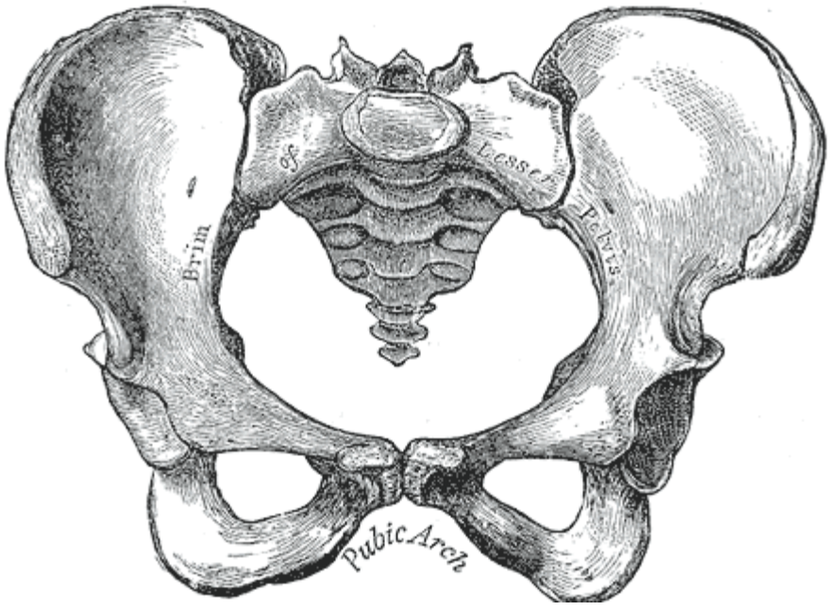
- Courses: Email ruth.helms@otago.ac.nz

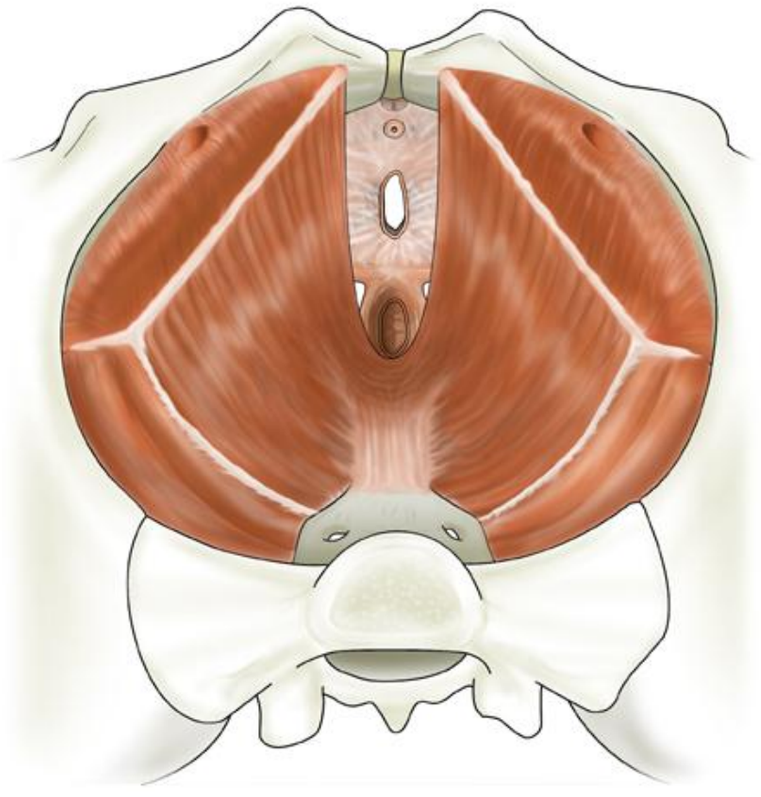
- *NZCA: www.**continence**.org.**nz***

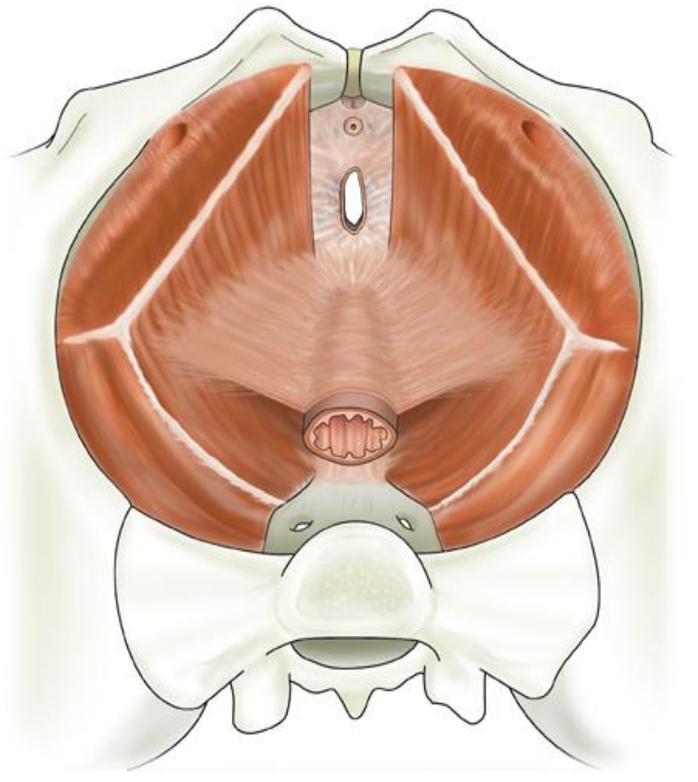
pelvic organ prolapse

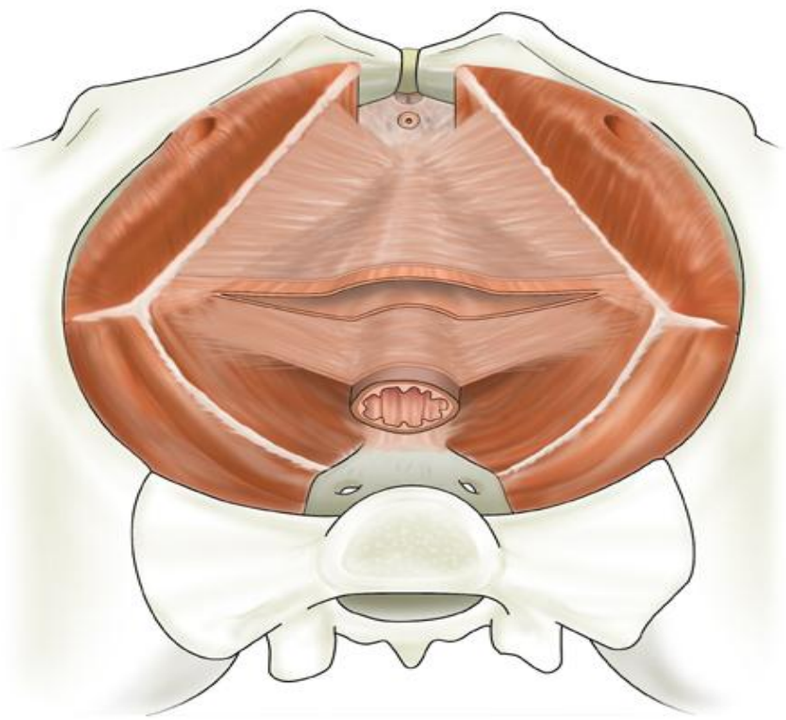
- pelvic organs - uterus, bladder, rectum
- prolapse - displacement of viscus through an orifice
- orifice - vagina (and anus)

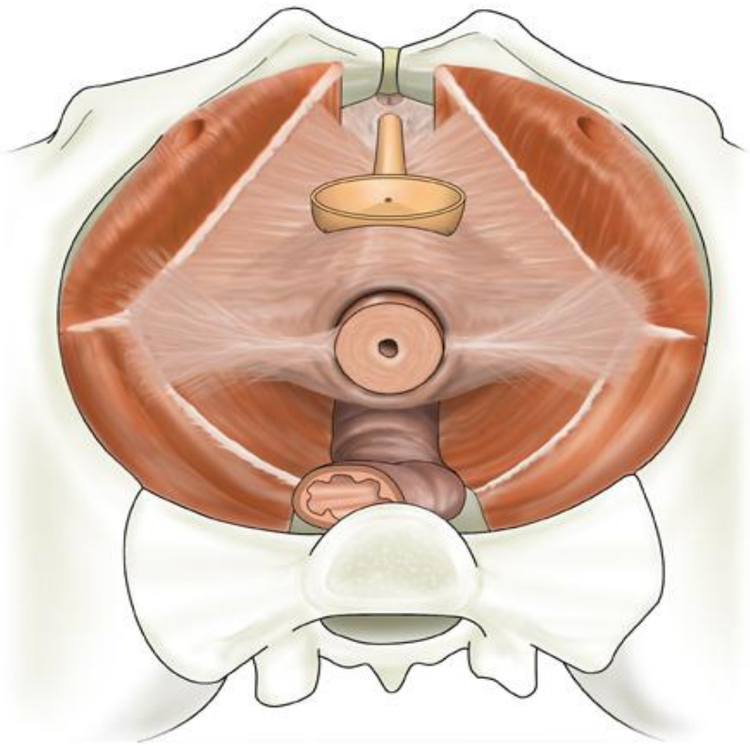
- Internal structures that support the pelvic organs are weak, stretched or damaged such that the organs drop from their normal position and bulge into the vagina

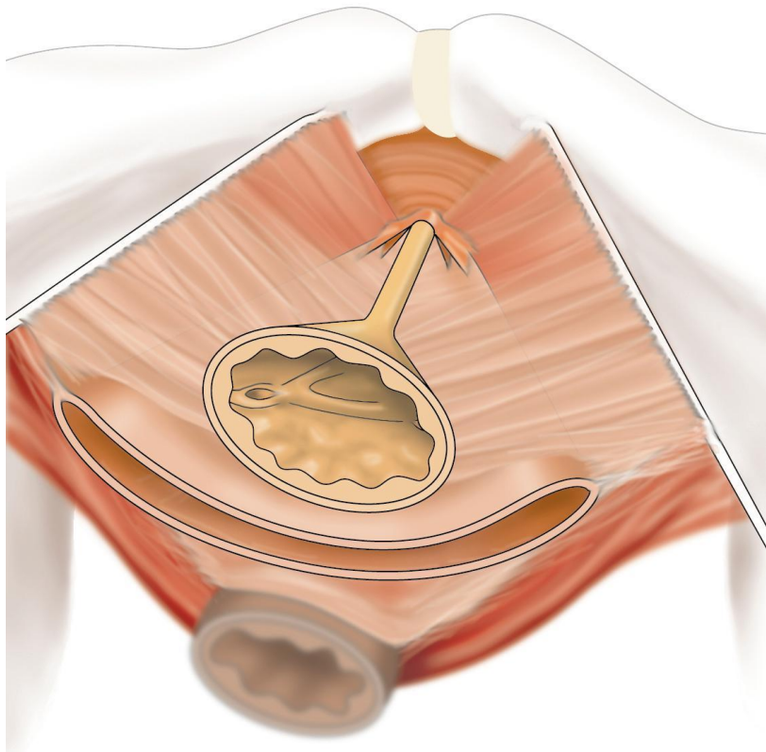

Brim
of
Lesser
Pelvis
Pubic Arch

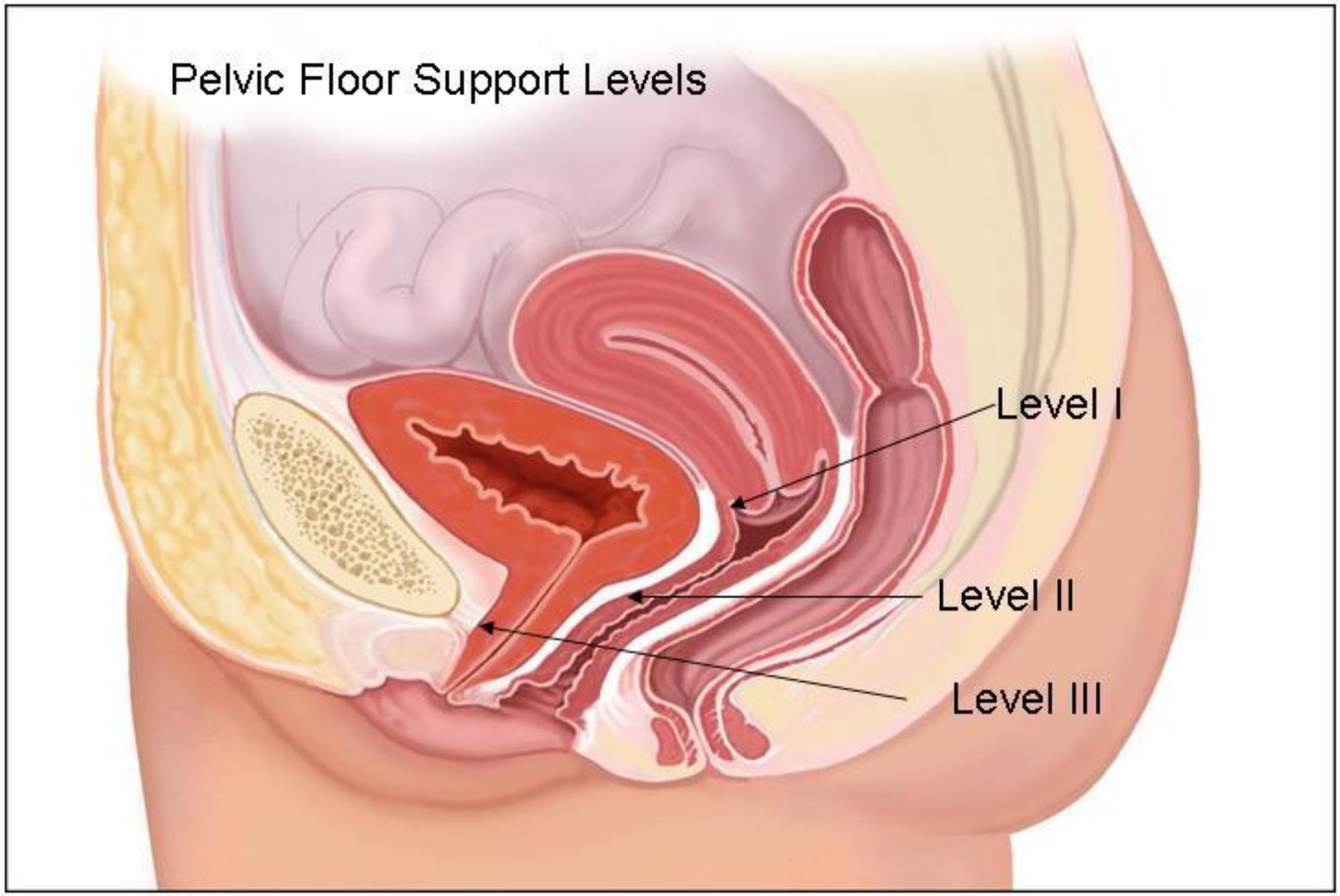




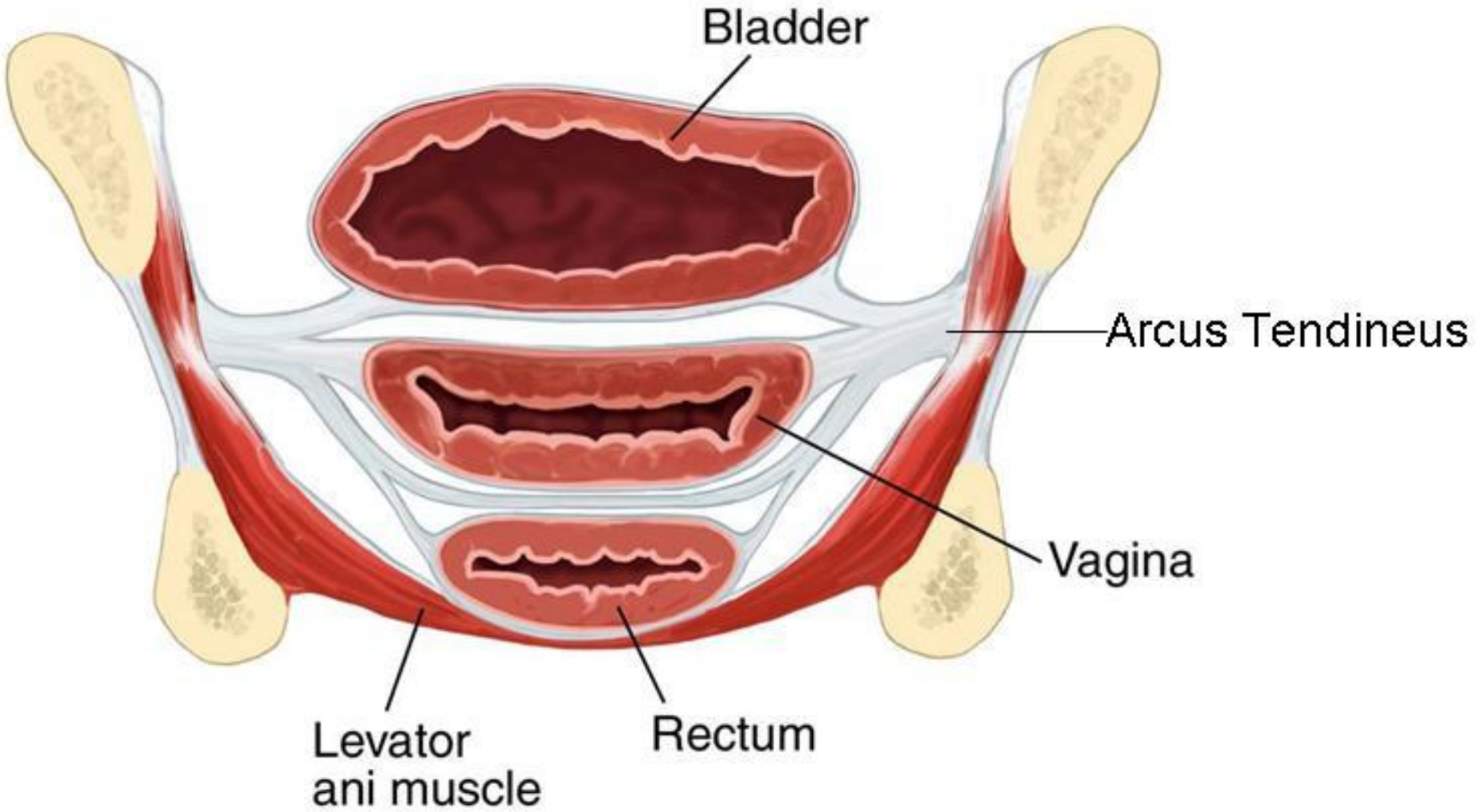







Pelvic Floor Support Levels
Level I
Level II
Level III

Normal Pelvic Floor Fascia Structures



aetiology

- genetics
- pelvic floor injury, eg childbirth
- chronic increased abdo pressure, eg obesity, constipation, coughing, pregnancy

symptoms

- often asymptomatic
- bulge
- bladder- overactivity, voiding issues
- bowel- obstructive defaecation
- sexual- physical and/or emotional

prolapse assessment

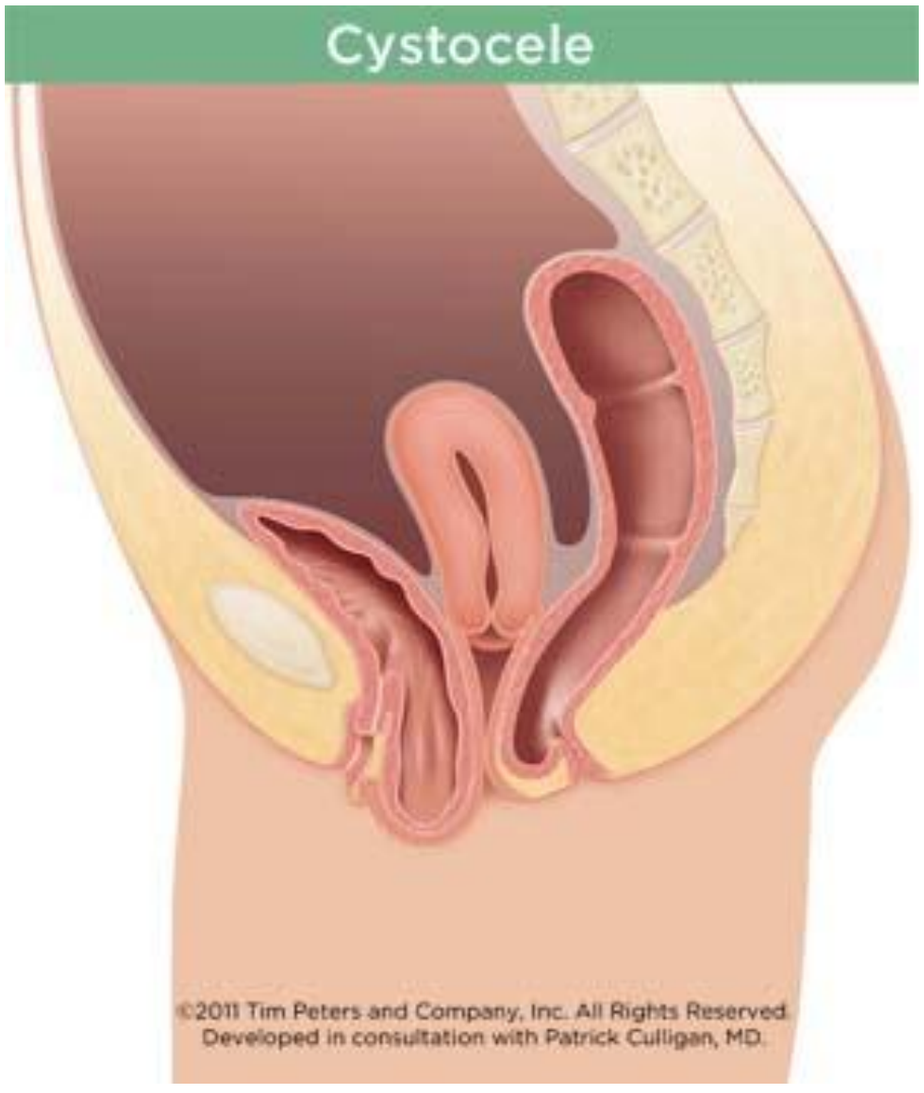
http://www.bardmedical.com/pop-q/swf/pop-q.swf

assessment

- aspect of vagina involved
  - anterior, posterior, apical
- organ prolapsing
  - bladder (cystocoele), rectum (rectocoele), small bowel (enterocoele), uterus (hysterocoele)

grading

- grade 0- normally sited
- grade 1- halfway to hymen
- grade 2- reaches hymen
- grade 3- halfway outside hymen
- grade 4- complete descent


Cystocele
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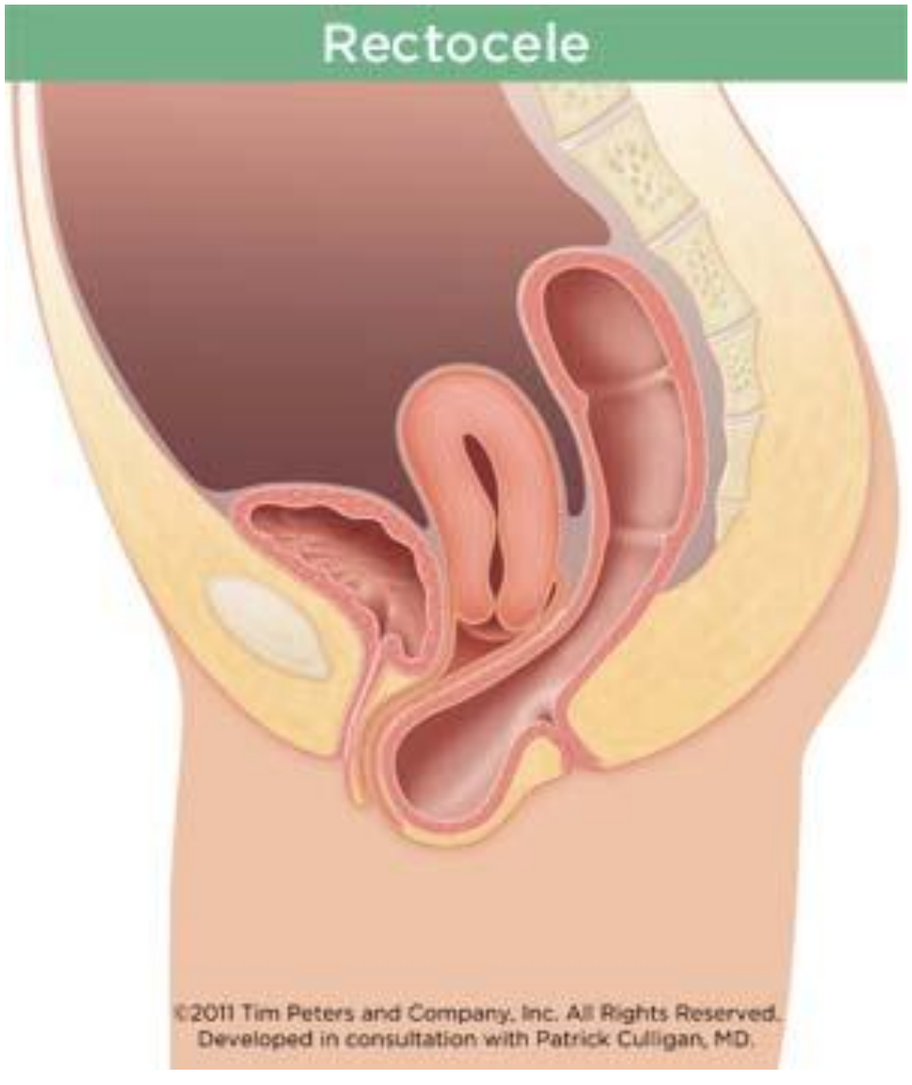
Developed in consultation with Patrick Culligan, MD.


Rectocele
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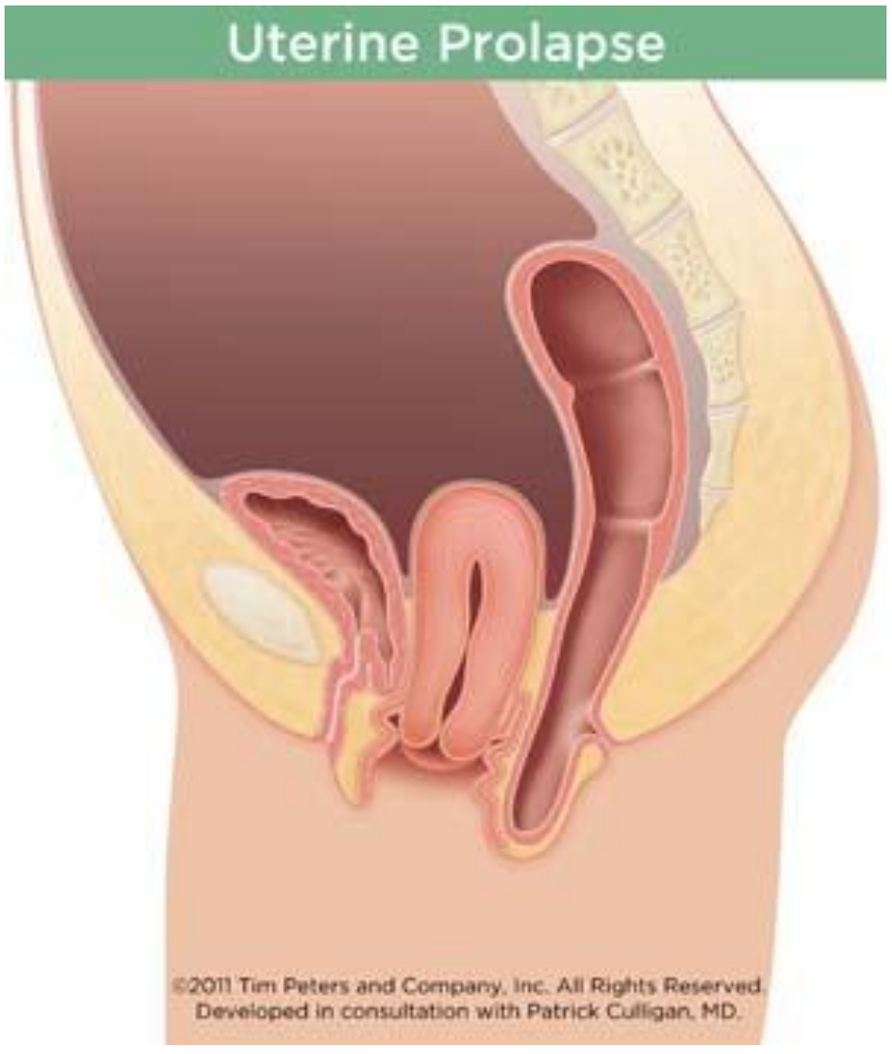
Uterine Prolapse
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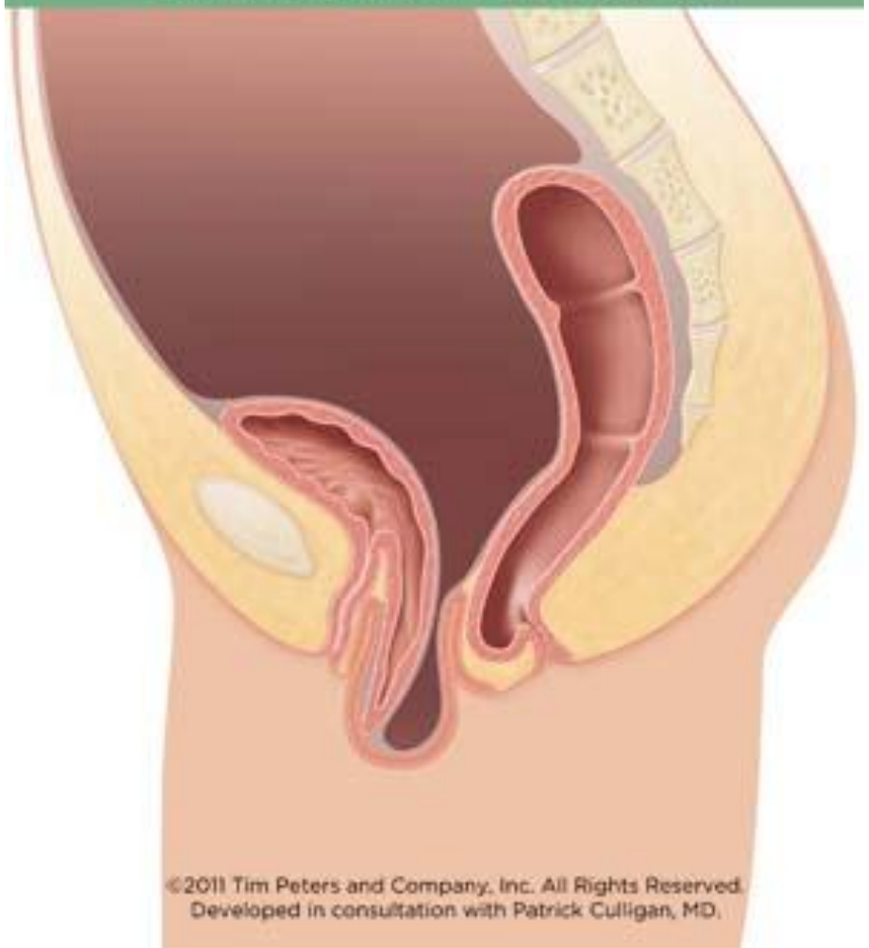
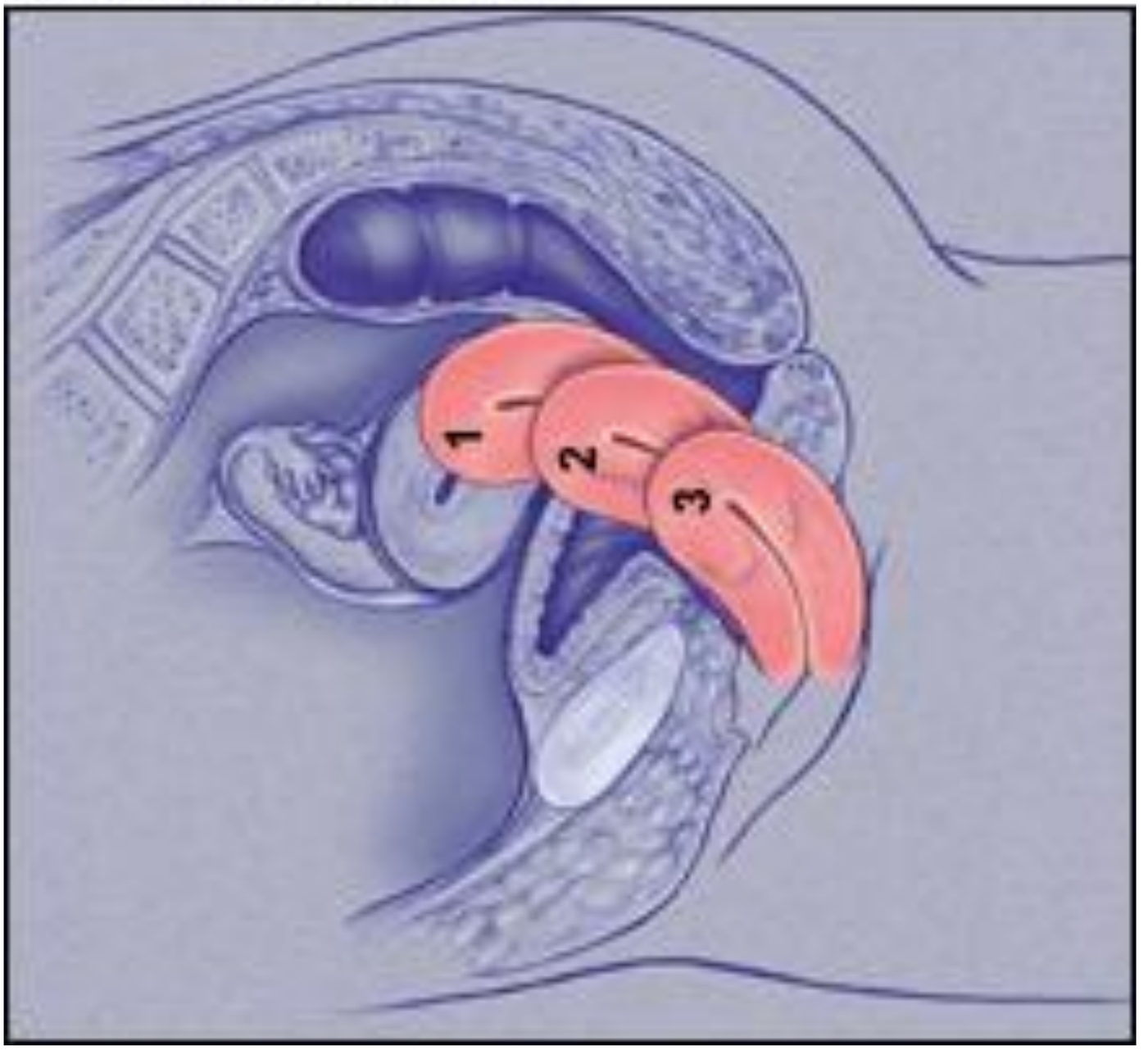
Vaginal Vault Prolapse





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%)

natural history

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

treatment of prolapse

- Symptomatic
- Anatomical

treatment of prolapse

- Symptomatic
  - Oestrogen
  - Physiotherapy
  - fibre, laxatives
  - catheterisation
  - weight loss unhelpful

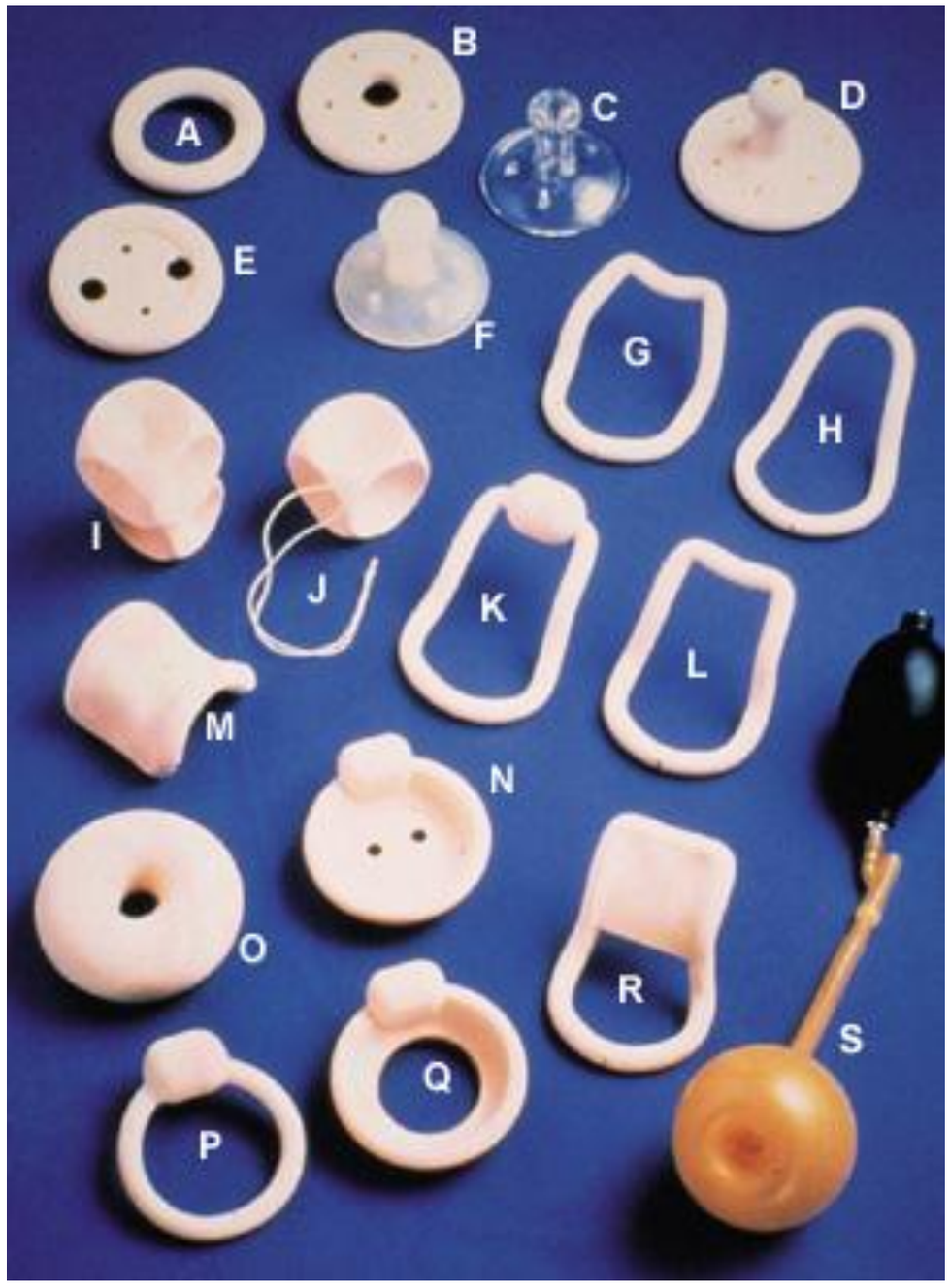
treatment of prolapse

- 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



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

- possible to avoid surgery

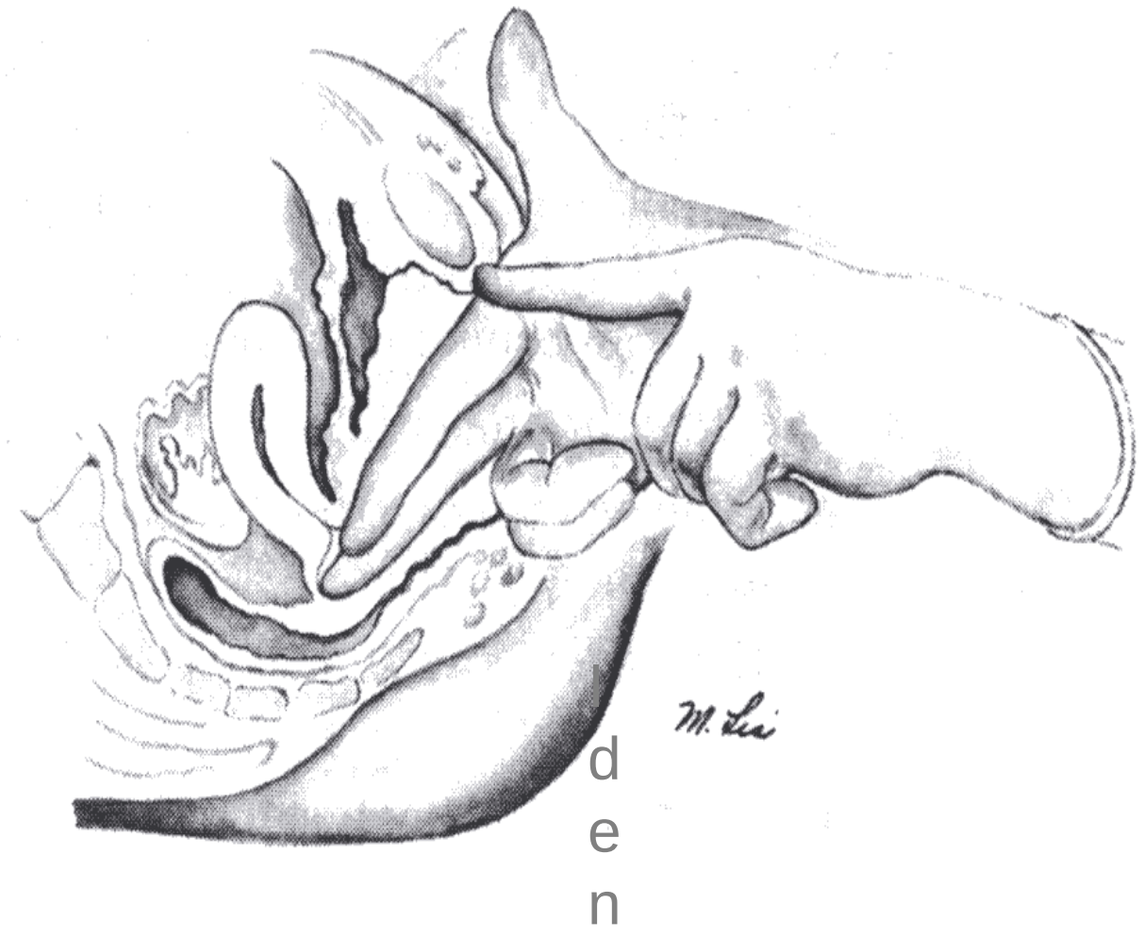
Reasons for discontinuation

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

- (different sizes or shapes may help)

Sizing up ring pessaries

- insert fingers deep into the posterior fornix
- Make note of where the hand comes into contact with the pubic bone
- Compare to pessary.



d
e
n

- regular oestrogen
- annual review

operations

- Standard repairs
- Vaginal hysterectomy
- Sacrospinous fixation
- colpocleisis
- mesh repairs

tradition operations

- done vaginally
- eg anterior and posterior repair
- repair fascia (level 2)

- results often disappointing

- ? tissue beyond repair

vaginal hysterectomy

- uterus is innocent bystander
- bulk may cause symptoms
- hysterectomy allows access to level 1 supports
- apical repair can the be performed
- shortening / re-approximation of para-cervical and uterosacral ligaments

sacrospinous fixation

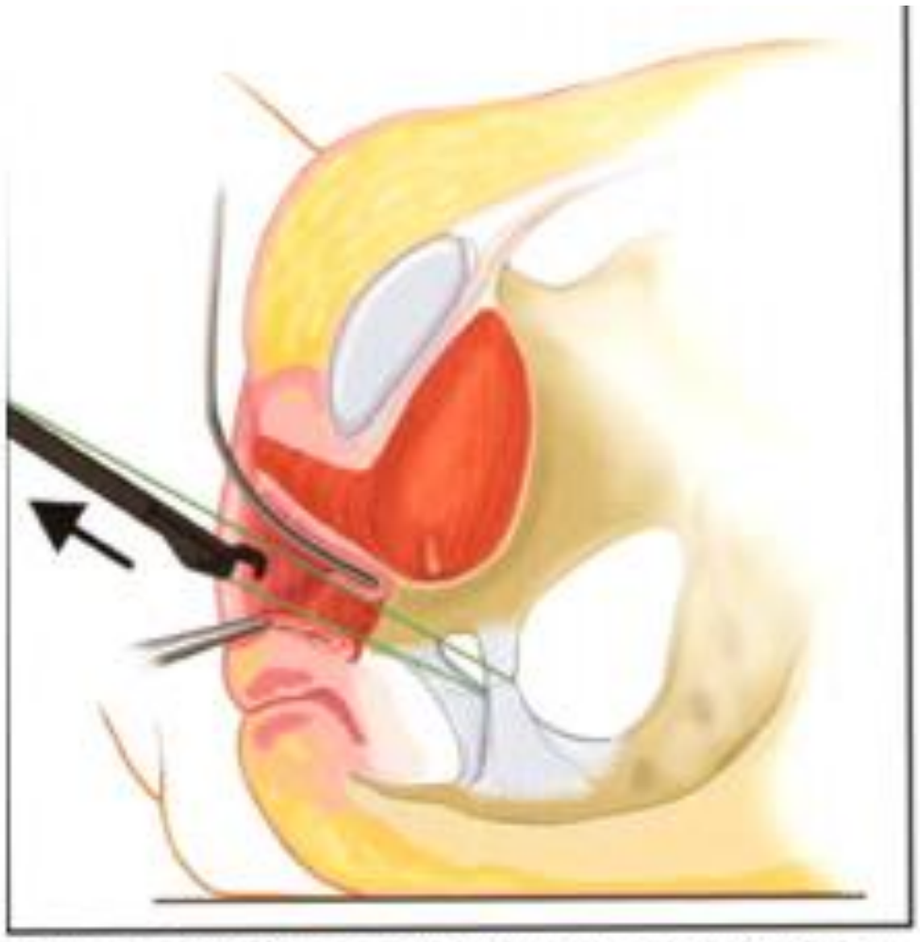


***Figure 6**: Once suturing is confirmed, the Capio device is carefully withdrawn and reloaded*

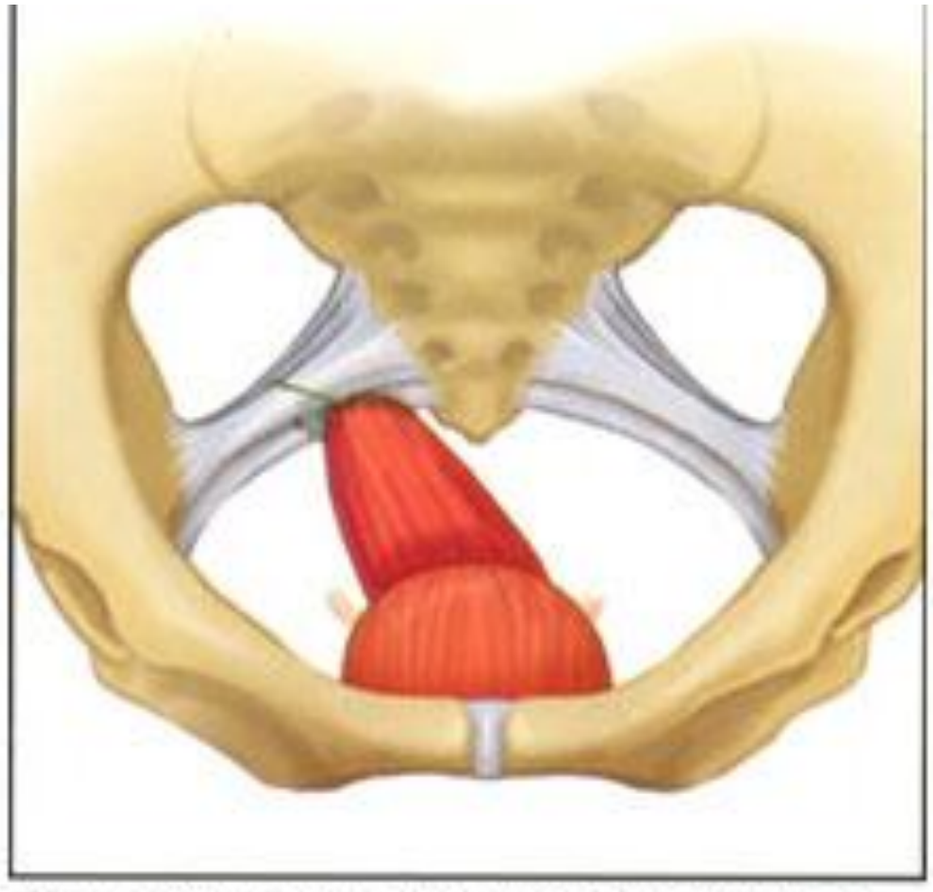
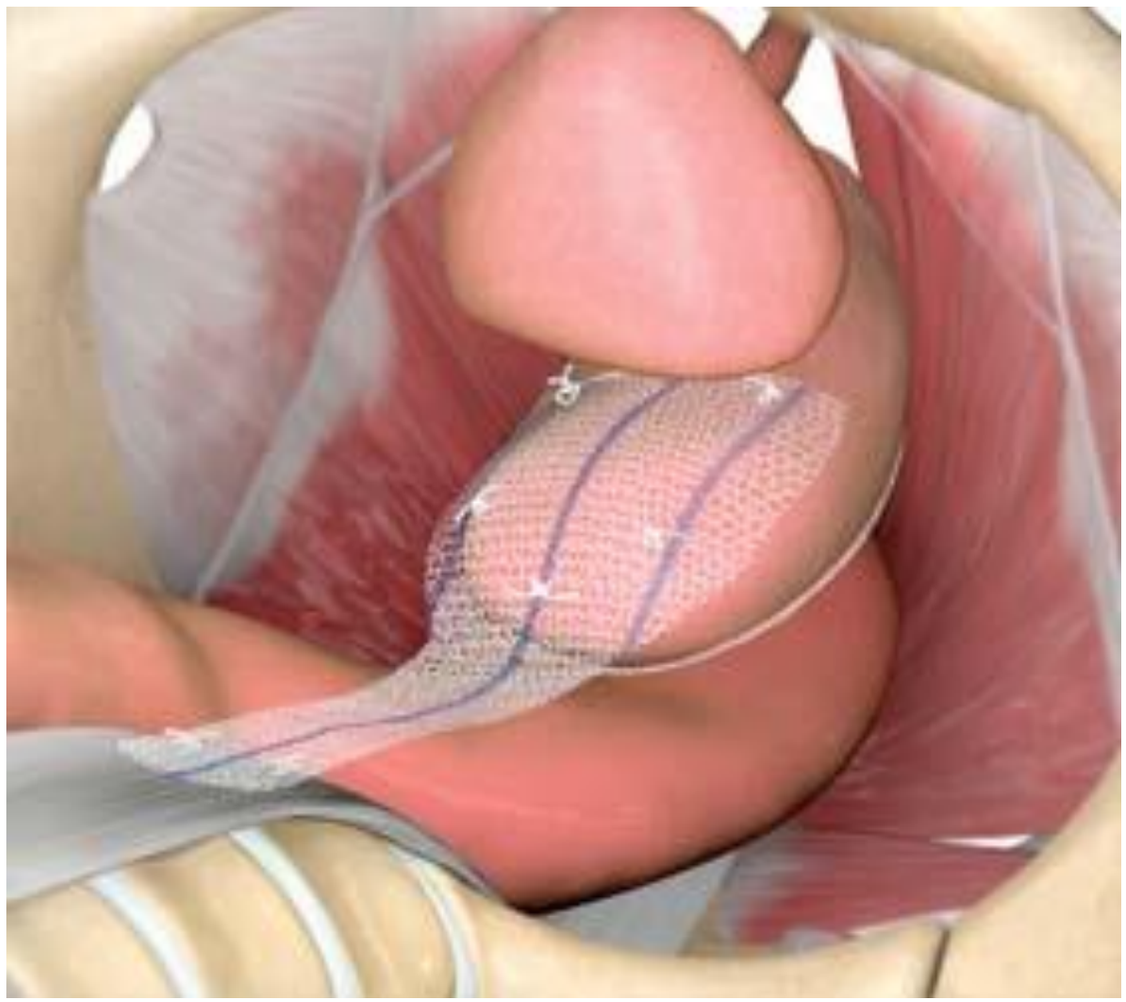


***Figure 8**: The upper vaginal vault is secured to the sacrospinous ligament, restoring vaginal wall support and correcting prolapse*

sacrocolpopexy
sacrohysteropexy



colpocleisis

- closure of vaginal orifice

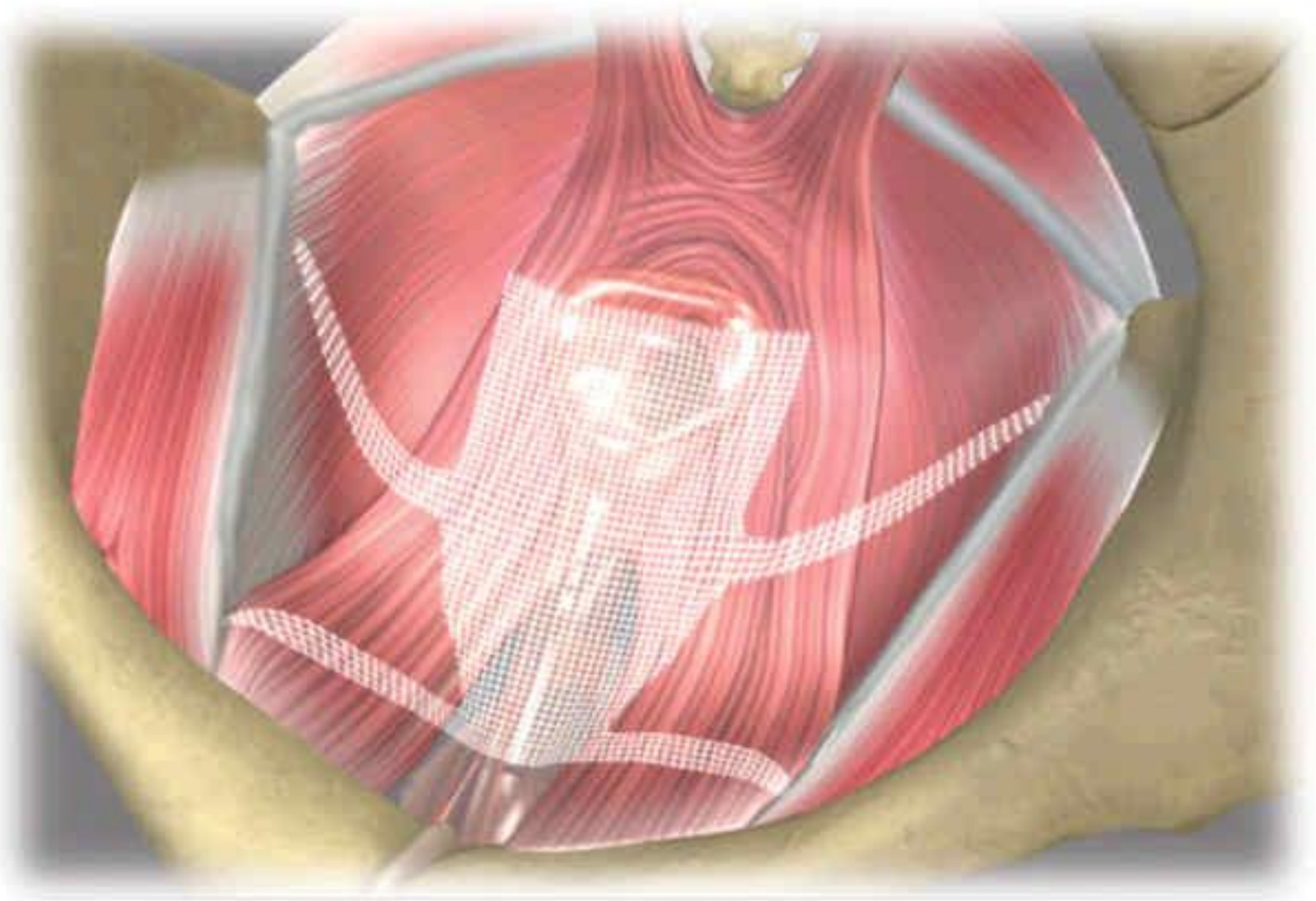
- ‘the only problem left unsolved by the gynaecologist of the past century is that of permanent cure of Cystocoele’

- “if only it were possible to artificially produce tissue of density and toughness of fascia and tendon, the secret of the radical cure of hernia would be discovered”

mesh repair

- Proposed for transvaginal repair of vaginal prolapse 1990s.
- Disappointing results of traditional surgery
- 2001 RCT – success of anterior repair at 40% (Sand et al), 30% (Weber et al)

- replaces (instead of repairs) level 2 (?level1) supports / fascia
- greater anatomical success than traditional surgery
- no difference in subjective outcomes



Complications

- Higher with mesh
  - ‘erosion’
  - pain
  - infection
  - bleeding
  - dysparuenia
  - organ injury
  - urinary/bowel problems

Re-evaluation

- Weber et al 2001:
- anatomical success- 30%
  (based on grade 0)

- Based on grade 2a or less success 90%

- Based on symptoms success 95%

- Mesh success 81% - 95.1%
- No mesh success 65% - 88.7%

mesh

no mesh

Enthusiasts

Sceptics

“Early uptakers”

“Laggards”

Mesh for all

Mesh for some

Mesh for none

summary

- POP common
- often asymptomatic
- some degree normal
- quality of life issues
- surgical or non surgical treatment
- subjective vs objective outcome measures

Contraceptive Update

- Side Effects
- Improving efficacy
- New products
- Eligibility criteria
- IUDs/implants

Contraception saves lives

- 50 million pregnancies terminated worldwide per year
- 50,000 women die as a result
- Up to 50,000 more deaths may be prevented
- Other health/societal benefits

Serious risks

- CVA and MI RR 1.5-2.0
- Ring and patch 2.5-3.0
- POP no increase
- However, overall risk v low (1-2 extra events per 10,000 women)
- Smoking, BP, other RFs important

Side Effects

- Long lists, based on postmarketing surveys, not clinical evidence
- Real danger of misinformation leading to discontinuation of contraception and unwanted pregnancy

COCP vs Placebo

- No difference:
  - Headache
  - Nausea and vomiting
  - Breast pain
  - Decreased libido
  - Weight gain

Difference:

- PV spotting for first 3 months (more with COCP)

POP

- Regular bleeding 40%
- Irregular bleeding 40%
- No bleeding 20%

- No evidence: weight gain, depression, CVS changes, breast cancer

- No evidence based treatment for bleeding patterns

depo

- No evidence:
  - Headache
  - Mood/libido issues
- No concerns re bone mineral density
- Routine testing not recommended

Mirena

- Alopecia in 1%

Improving pill efficacy

- OCs and DMPA “very effective”
  - Use-continuation rate 50%
- IUDs and Implants “most effective”
  - Use-continuation rate 80%

Continuous use supported

>8 continuous pills need to be missed to risk pregnancy

Eliminates hormone withdrawal effects

New products

- Qlaira- reduced heavy menstrual bleeding
- Zoely- theoretical impact on haemostasis and lipids
- Depo-subQ- self administered DMPA, sub-cut not IM
- Nuva-ring- improved cycle control
- Yaz Flex- pill alarm reminder

Eligibility criteria

- 1. use in any circumstances
- 2. generally use the method. Benefits outweigh risks
- 3. use not usually recommended unless other methods not acceptable. Proven risks outweigh benefits
- 4. Do not use. Risk is unacceptable

- COCP category 3 if BMI>35, category 2 if BMI 30-34

- COCP category 2 for migraine without aura, category 3 if migraine related to use (1 & 2 for POP)

- GTD, everything category 1, except IUD- cat 4 in cases of elevated HCG or malignancy

- IUDs category 1 for PID and ectopic pregnancy
- (no longer remove in presence of chlamydia)

Concomitant meds

- No additional precautions for OCs and enzyme-inducing antibiotics
- COCP not recommended for women on lamotrigine

IUDS/implants

- LARCs most effective, esp on adolescents
- Better post TOP
- IUDs do not ‘cause’ infections. Pre-placement swaps important
- Jadelle not effective with enzyme-inducers
- Insertion issues in thin women

- IUD better postcoital contraception around ovulation and if BMI>30

resources

- www.familyplanning.org.nz
- www.fsrh.org
- http://whqlibdoc.who.int/publications/2010/9789241563888_eng.pdf