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Urologist
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Managing UTIs, Incontinence and Prolapse - Main Session (Workshop options scheduled)
Friday, 21 June 2013
Start 2:55pm
Duration: 20mins
Baytrust
Managing UTIs, incontinence and prolapse

GPCME 2013

Dr. Eva Fong
Urologist
Overview

Urinary incontinence

Pelvic organ prolapse

LUTS

Dysuria/ bladder pain

UTIs
Overview

- Urinary incontinence
- UTIs
- Pelvic organ prolapse
- LUTS
Tip of the iceberg

What percentage of incontinent women seek medical help?

1. 5%
2. 25%
3. 50%
4. 75%
Urinary incontinence

• How to assess in primary care
• How to treat in primary care
• When to refer
• Surgical treatment options
How to assess

• Type
• Severity
  – Absolute
  – Quality of life and “bother”
Stress incontinence
Urge incontinence
Severity and bother
What percentage of incontinent women “bear down” (valsalva) when asked to do a pelvic floor contraction?

1. 10%
2. 30%
3. 50%
4. 100%

Easy?
Treating urge incontinence: Managing fluids
Treating urge incontinence: Managing constipation
Treating urge incontinence: Timed voiding

- Voiding every 3-4 hours even if no sensation to go
Treatment of urge incontinence: Vaginal oestrogen cream

- Post menopausal women
- 0.5mg oestriol/applicator
Treating urge incontinence: Anticholinergic medications
Dry mouth

• What percentage of patients get dry mouth with oxybutynin (ditropan)?

1. 20%
2. 40%
3. 60%
4. 80%

3. 60%
When to refer?

• According to patient’s bother
  – If significantly restricts activities
• Mixed incontinence
• Early referral:
  – Previous incontinence/prolapse surgery
  – Pelvic irradiation
  – Neurogenic bladder
  – Nocturnal or continuous incontinence
Surgical treatment:
Stress incontinence

90% effective
Surgical treatment: Urge incontinence

70% effective
Overview

Urinary incontinence

Pelvic organ prolapse

UTIs

LUTS
POP: Cystocele
POP: Cystocele
POP: Apical prolapse
POP: Apical prolapse
POP: Rectocele
POP: Rectocele
Examination
Split speculum exam
Primary care interventions

• Things to do
  – Manage constipation
    • Psyllium husks (metamucil), Kiwicrush, fluid, exercise
  – Lose weight
  – Stop smoking/ manage asthma
  – Pelvic floor exercises/ physiotherapy
  – Vaginal estrogen cream

• Things to avoid
  – Heavy lifting
Treatment

- According to symptoms
- No symptoms
  - We can’t make them any better
Treatment of prolapse: Non Surgical

• Ring pessary
Treatment of prolapse: Surgical options and goals

• Options
  – Vaginal
    • Native tissue
    • Mesh
  – Abdominal
    • Open, laparoscopic, robotic

• Goals of treatment
  – Traditional: anatomical result
  – Modern: functional result
What does the patient want?

- Feel better (prolapse reduced)
- Bladder and bowels to work well
- Good sexual function
- Avoid complications
- Minimise recurrence
What about mesh?

Surgical mesh costs millions

By Chloe Johnson
6:30 AM Sunday Sep 30, 2012

A surgical mesh that is the subject of international lawsuits and health warnings is still being implanted in hundreds of New Zealanders.

The mesh is often used for hernia repairs and prolapsed pelvic organs and muscles, despite ACC paying $3.1 million in treatment and compensation to people with post-surgical complications.

Heather Anderson has been in pain for eight years since the mesh was implanted in her lower abdomen.

She said it was like a cheese grater cutting through her internal organs.

In the US thousands of women complained of severe pain, infections, excessive bleeding and organ erosions, eight years since the mesh was implanted.
Why use mesh?

• 30% recurrence with traditional repairs
• Mesh used as standard in other hernia repairs
• Mesh reduces recurrence to 10-15% for cystocele
Where did mesh go wrong?

"Nurse, get on the internet, go to SURGERY.COM, scroll down and click on the 'Are you totally lost?' icon."
Mesh kit
Direct placement
Complications: symptoms & signs

• Pain
  – Buttock, legs, vaginal, pelvic, dyspareunia
Complications: symptoms & signs

• Bladder
  – Haematuria, UTIs, dysuria, urgency, difficulty voiding

• Bowel
  – Bleeding
Complications: symptoms & signs

• Examination
  – Palpable/visible mesh in vagina, pain on examination
Managing mesh complications

• Prompt recognition
• Treatment and mesh removal (if necessary) should be early
  • Not all symptoms reversible if left for long time
• Refer to specialist experienced with mesh complications
Lessons learned

• Specific indications for mesh use in high risk/recurrent cases
  – Informed consent: risks and alternatives

• High level training required to place mesh safely (and remove for complications)
  – Complication rates lower in surgeons highly trained in pelvic surgery
Overview

Urinary incontinence

Pelvic organ prolapse

UTIs

Dysuria/bladder pain

LUTS
Uncomplicated UTI

• Definition:
  – Women < 55
  – No other comorbidities
  – Not post-menopausal, pregnant, no recent UTI, no vaginitis symptoms
  – Typical symptoms of urinary frequency and dysuria

• First-line
  – Co-trimoxazole/trimethoprim
  – Norfloxacin
Urinary tract infection

• Uncomplicated
  – Cystitis
    Treatment aimed at symptom resolution
  – Reasonable to treat empirically
    • 3 day course effective in >90%
Recurrent UTI

• Definition
  – >3 episodes of symptomatic uncomplicated UTI (>1 documented culture) in 12 months
  – 3-5% of UTI
  – Relapse
    • Same organism as previous UTI
  – Re-infection (25-50%)
    • Successful treatment, symptoms recur OR 2\textsuperscript{nd} infection with 2\textsuperscript{nd} organism
Age-based evaluation

• Adolescent and pre-menopausal women
  – Relation to sexual activity

• Post-menopausal
  – Tumours, obstruction, atrophic vaginitis, prolapse, incontinence

• Investigations:
  – Renal tract ultrasound +/- cystoscopy
Treatment

• Prophylactic antibiotics
  – Reduced daily dose
  – Post-coital antibiotics
  – 3 x/week for 6 month

• Patient-initiated treatment at early symptom stage
Treatment

• Food additive prophylaxis
  – Cranberry juice/tablets
  – Lactobacilli probiotics

• Local hormonal treatment in post-menopausal women
UTI in men

• Most complicated by prostate pathology
• Low risk
  – <45, no prostatitis/urethritis, no obstructive symptoms or haematuria
• Urological evaluation
  – Adolescent
  – Febrile UTI
  – Recurrent infections
  – Suspected complicating factors (BPH)
Treatment

- 7 day (If febrile - 2 week) course fluoroquinolones
- Culture recommended in all men
Summary - LUTS

• Screen for incontinence and pelvic organ prolapse symptoms
• Many women are too embarrassed to volunteer information
• Effect on quality of life determines need for treatment
• Reassure patients that help is available and effective
It’s the simple things...

“Been sneezing all morning and NOT leaking!
I can’t believe it just so happy...Life changing”