Dr Eva Fong

Urologist

Auckland

Managing UTIs, Incontinence and Prolapse - Main Session (Workshop options scheduled)

Friday, 21 June 2013 Start 2:55pm Duration: 20mins Baytrust

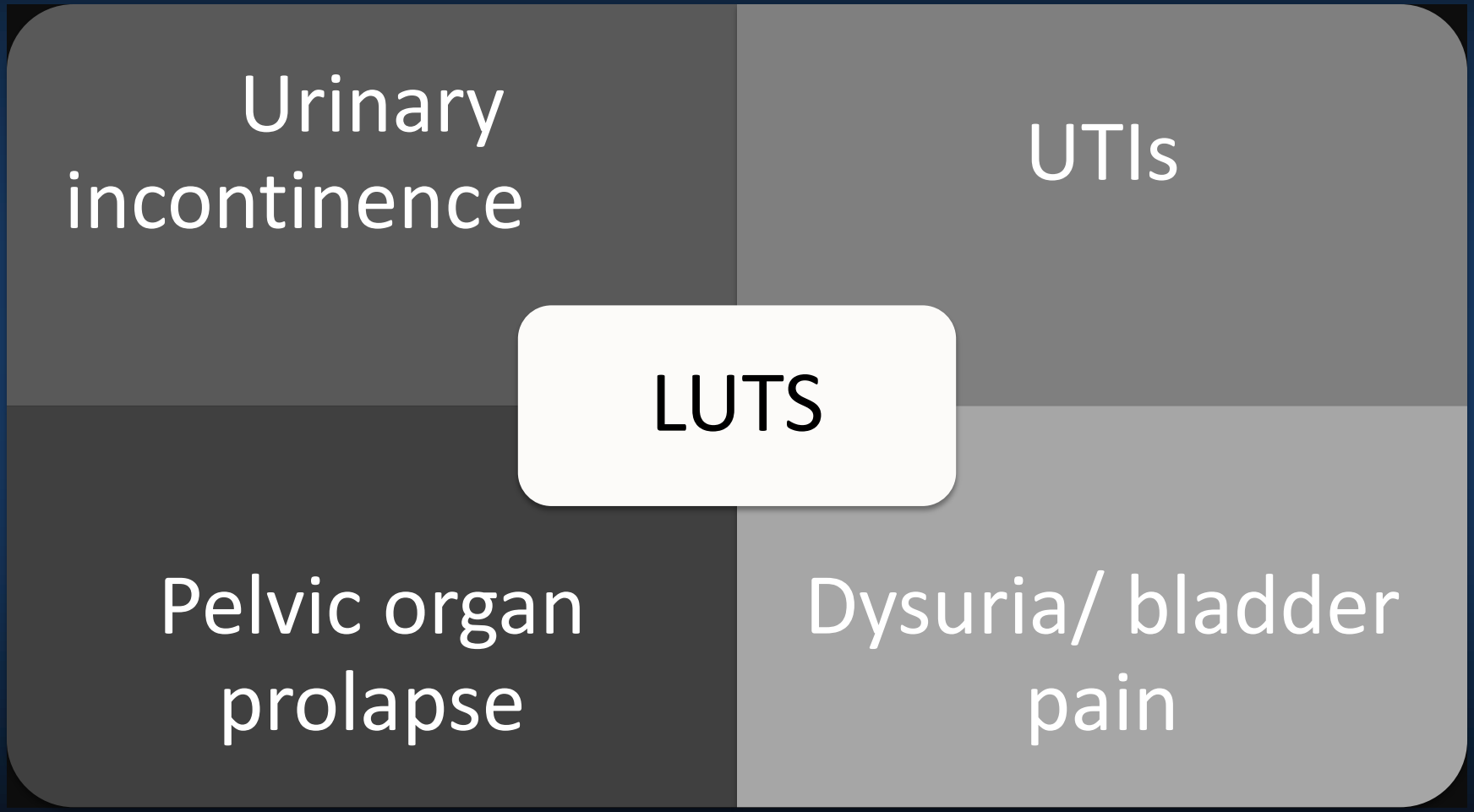
Managing UTIs, incontinence and prolapse

GPCME 2013

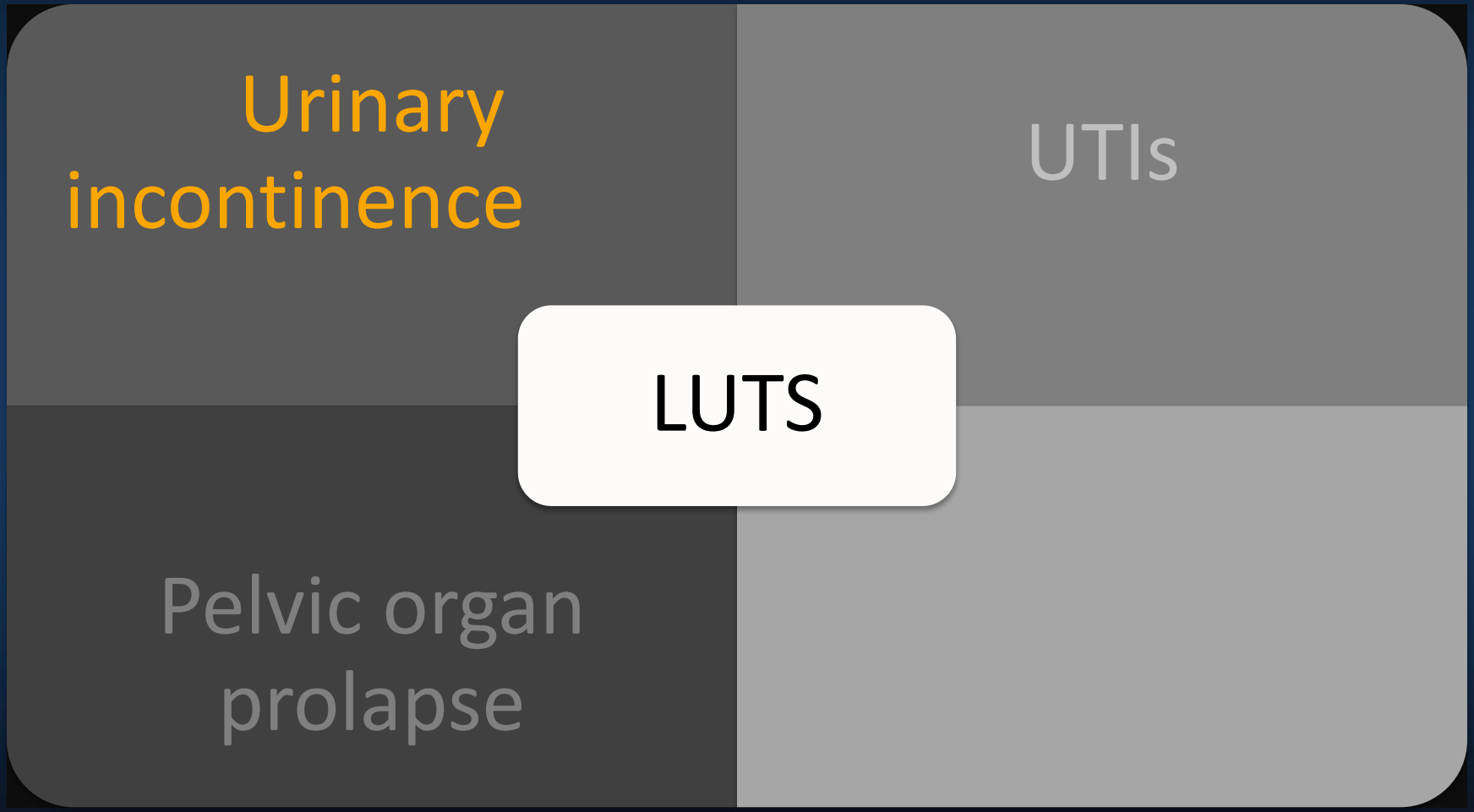
Dr. Eva Fong

Urologist

Overview


Urinary incontinence
UTIs
LUTS
Pelvic organ prolapse
Dysuria/ bladder pain

Overview



Tip of the iceberg

What percentage of incontinent women seek medical help?

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

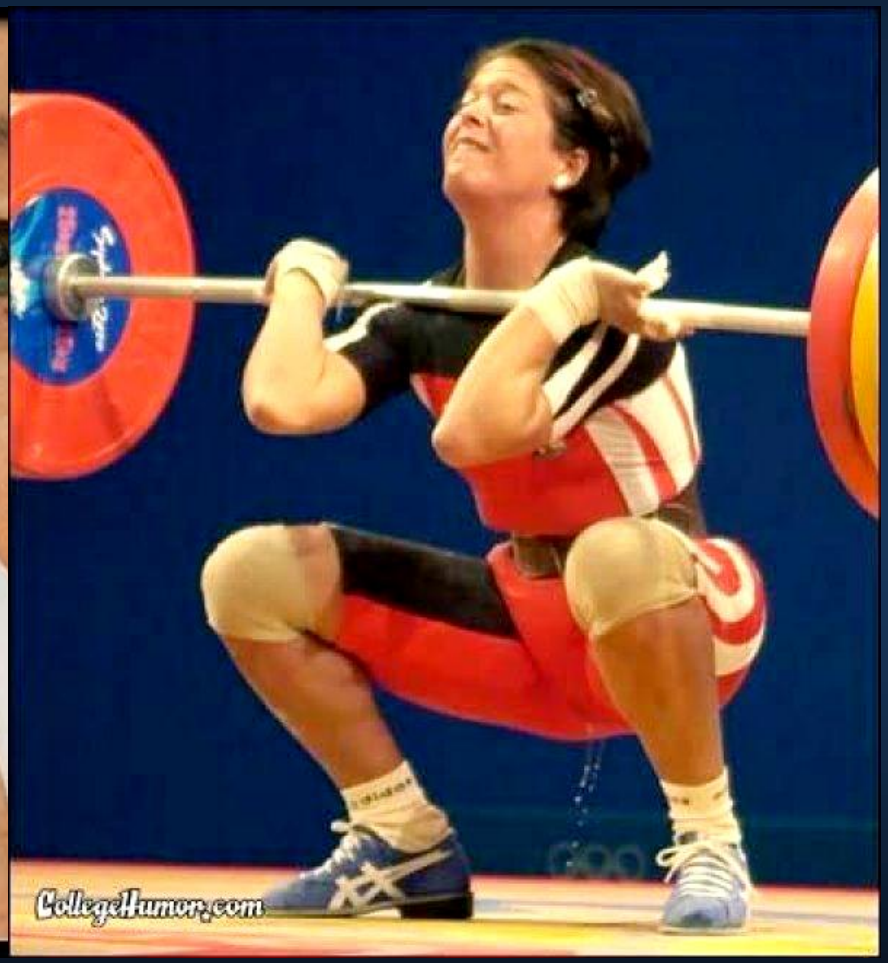
Urinary incontinence

- 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”

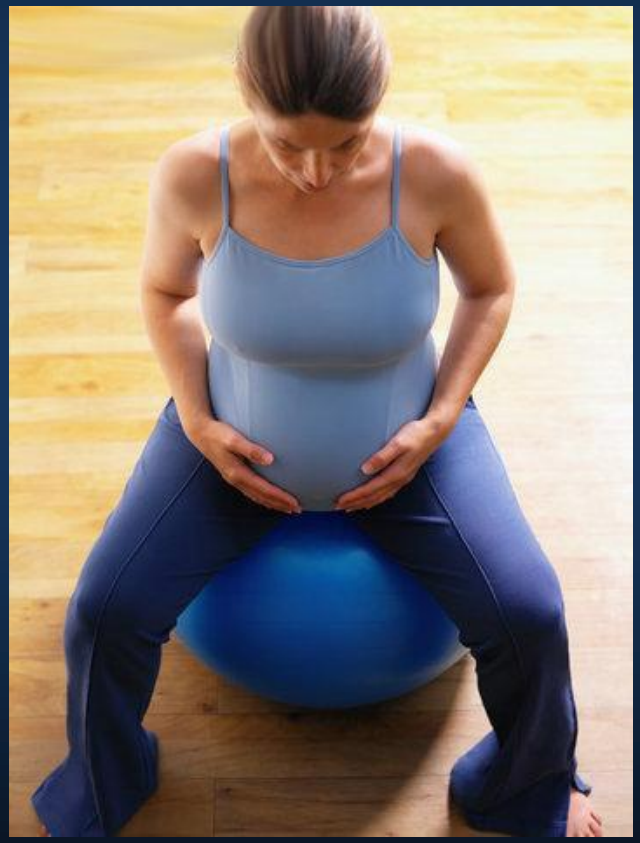
Stress incontinence



Urge incontinence

Severity and bother

Treating stress incontinence



Easy?

- What percentage of incontinent women “bear down” (valsalva) when asked to do a pelvic floor contraction?

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

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

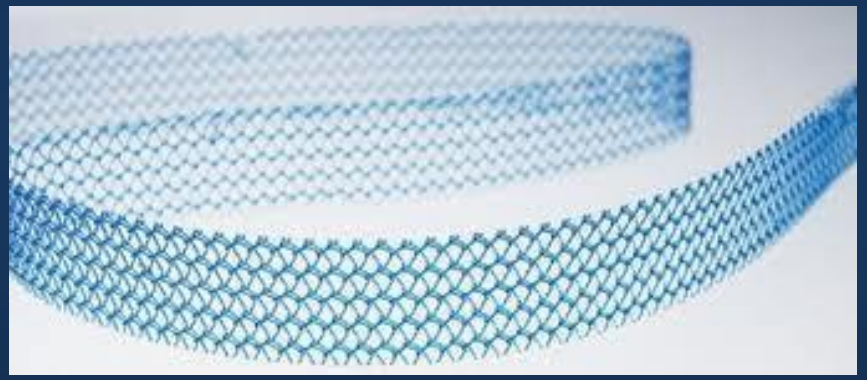
- What percentage of patients get dry mouth with oxybutynin (ditropan)?

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

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

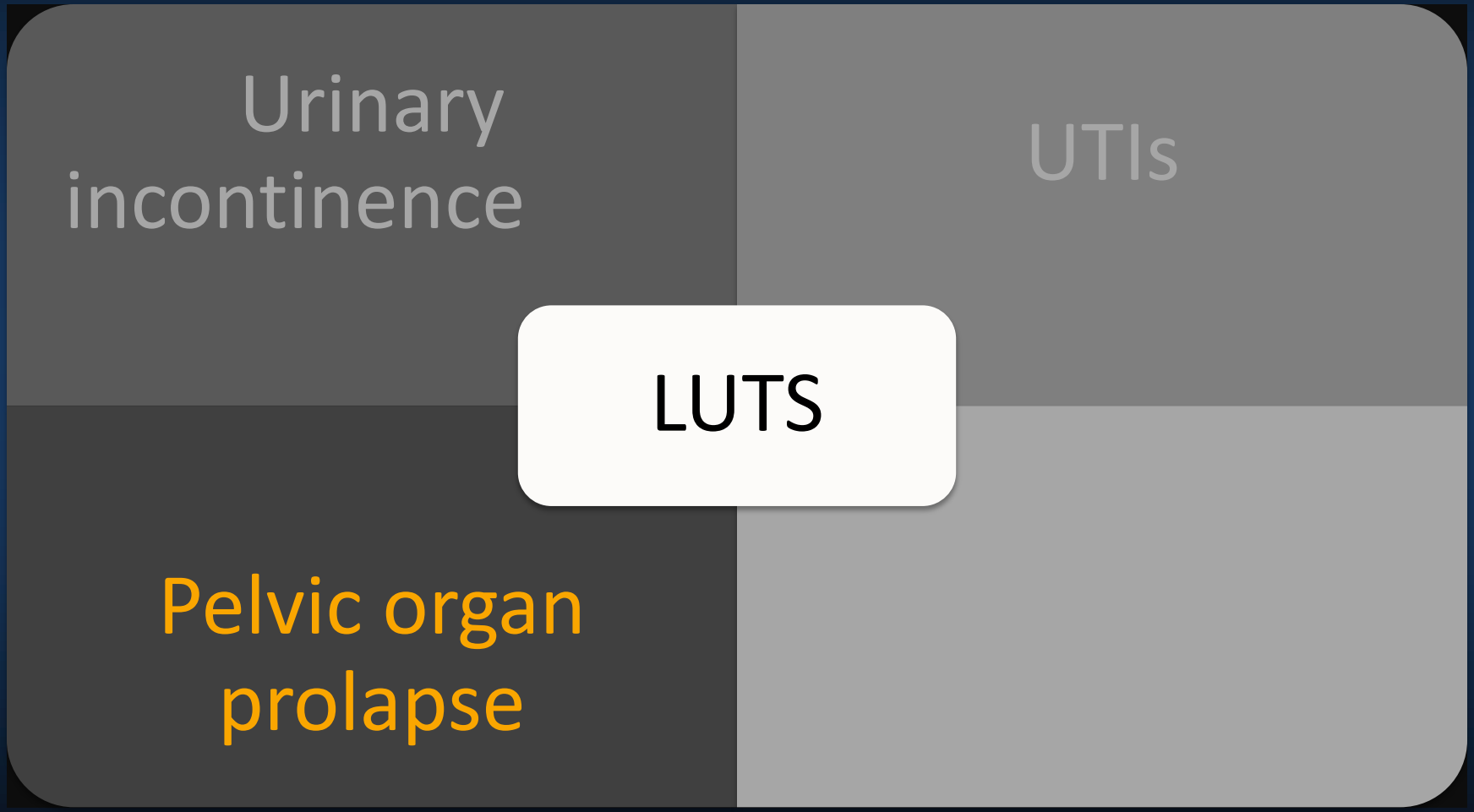


90% effective

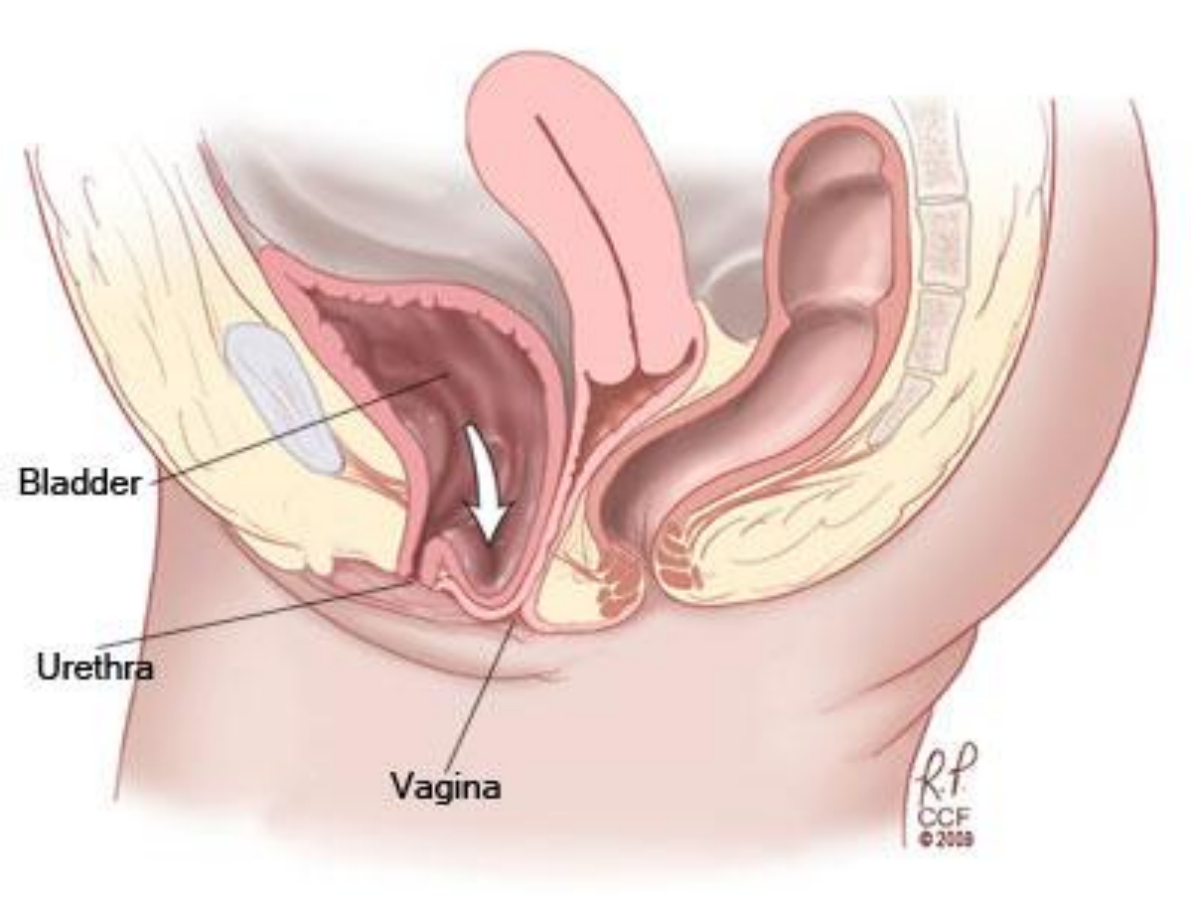
Surgical treatment: Urge incontinence

70% effective

Overview



POP: Cystocoele



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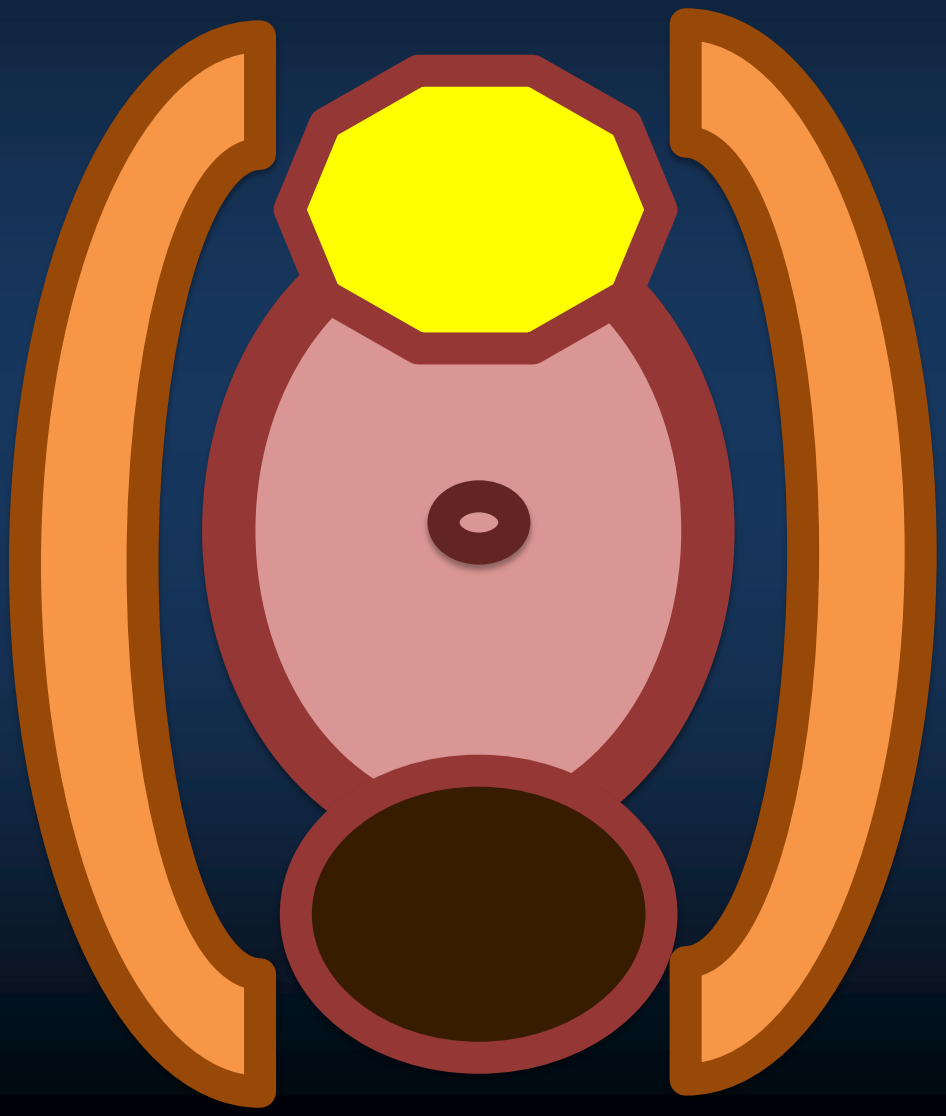
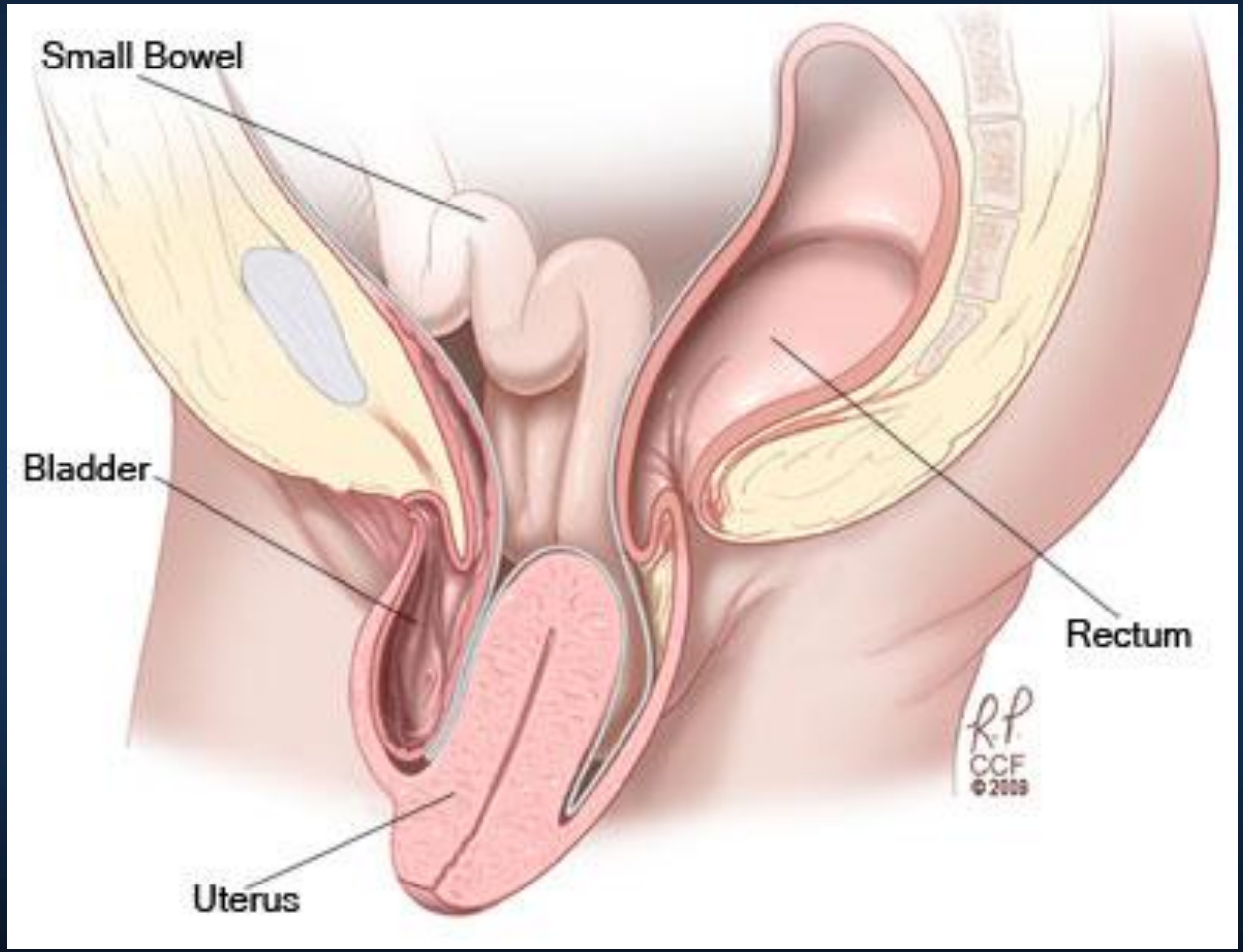
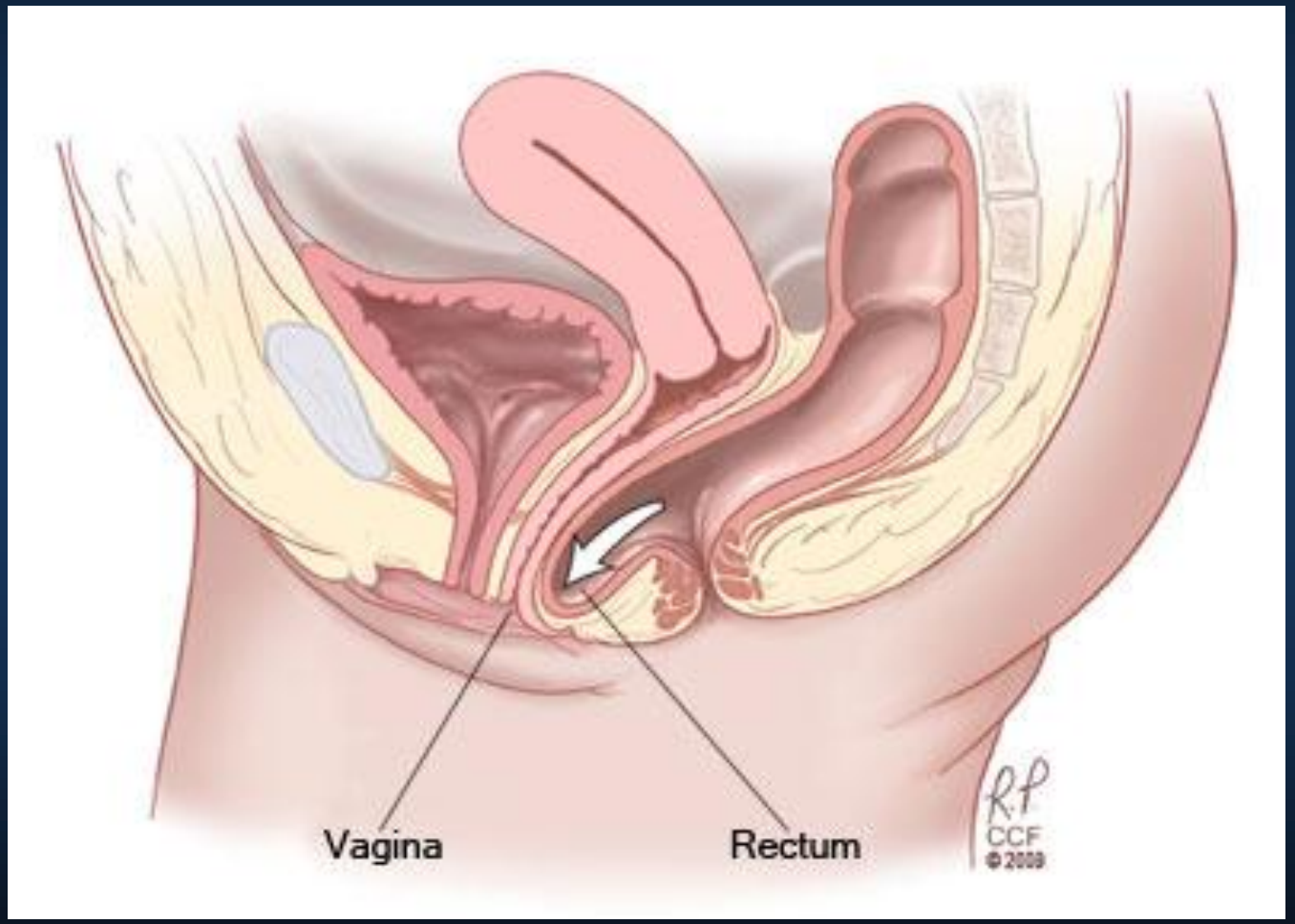


POP: Apical prolapse



POP: Apical prolapse

POP: Rectocoele



POP: Rectocoele

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?

The New Zealand Herald

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 severe pain for years after surgical mesh was implanted in her abdomen. Photo / Kellie Blizard

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

Why use mesh?

- 30% recurrence with traditional repairs
- Mesh used as standard in other hernia repairs
- Mesh reduces recurrence to 10-15% for cystocoeles

Where did mesh go wrong?

Mesh kit

Direct placement

Complications: symptoms & signs

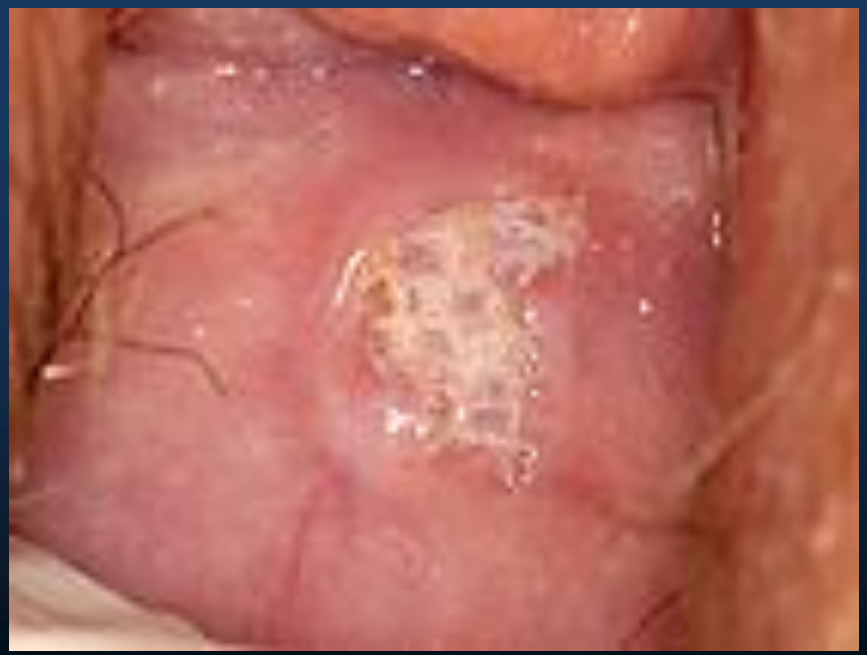
- Pain
  - Buttock, legs, vaginal, pelvic, dyspareunia

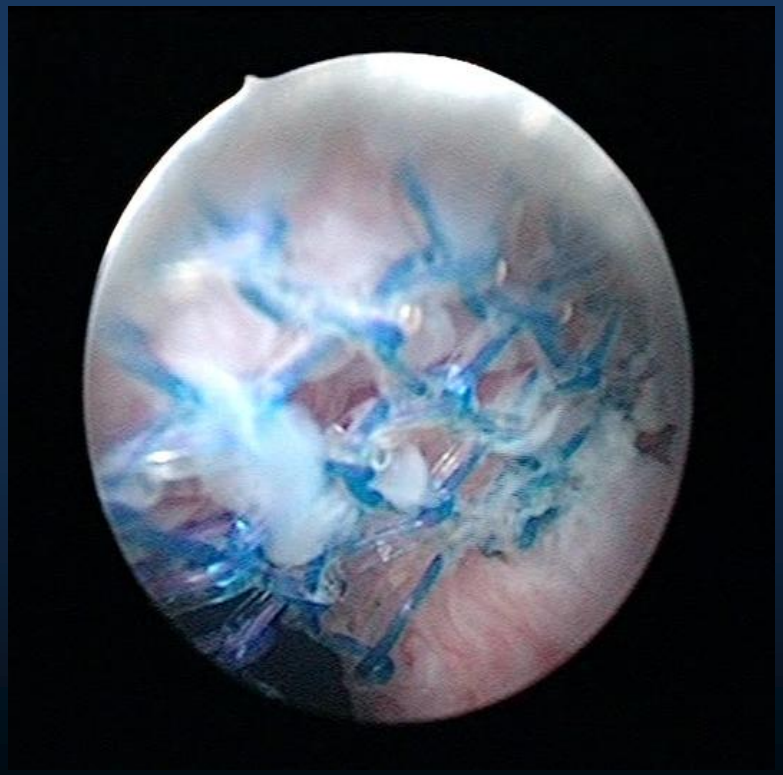
Complications: symptoms & signs

- Bladder
  - Haematuria, UTIs, dysuria, urgency, difficulty voiding
- Bowel
  - Bleeding

Complications: symptoms & signs

- Examination
  - Palpable/visible mesh in vagina, pain on examination





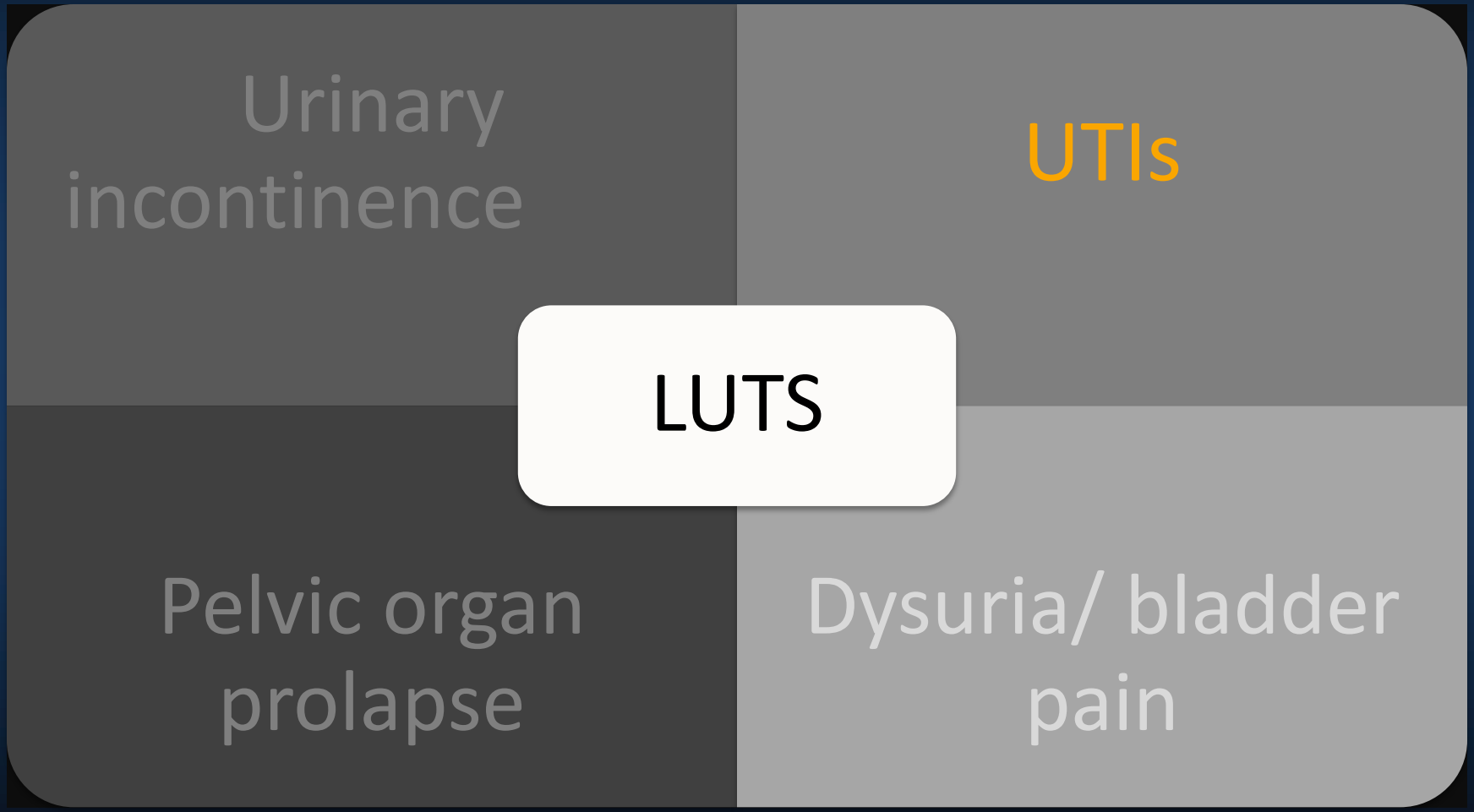
Managing mesh complications

- 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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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 2nd infection with 2nd 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”