Dr Eva Fong

Urologist

Auckland

Holding Your Pelvic Floor Tight - Nurses Programme

Saturday, 22 June 2013 Start 11:00am Duration: 30mins Sportsdrome

Hold on Tight:
Pelvic floor disorders

GPCME 2013

Eva Fong

Urologist

What are pelvic floor disorders?

- Bladder problems
- Bowel problems
- Pelvic organ prolapse

*“ Pelvic floor disorders **are not** considered a normal part of aging that you just have to live with. They are medical conditions that can be successfully treated.”*

(American Urogynaecologic Society)

Tip of the iceberg

What percentage of incontinent women seek medical help?

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

Hannestad et al: Scand J Primary care 2002

Facts

- 30% of women with overactive bladder or urinary incontinence also have loss of bowel control
- More than 50% of women age 55 and older suffer one or more of the problems caused by pelvic floor disorders.

Take the opportunity….

- Many women don’t mention these symptoms because of embarrassment
- Screen if you have the chance
  - Cervical smears
  - Mothers of young children
- Presentation is often delayed

Bladder problems

- Frequency/urgency of urination
- Urinary incontinence
- Urinary tract infections

Frequency/urgency of urination

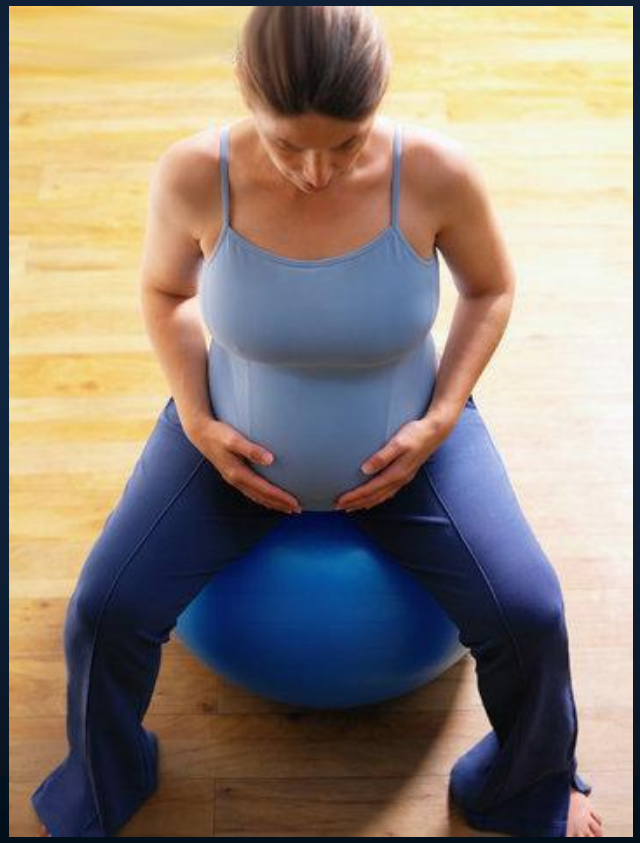
- Symptoms
  - > 7 x/ day and >1/night (bother)
  - Feeling like they have to go suddenly and can't make it to the toilet in time
  - Part of "Overactive bladder"
- Treatment
  - Reducing caffeinated drinks
  - Managing constipation
  - Pelvic floor exercises
  - Timed voiding

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

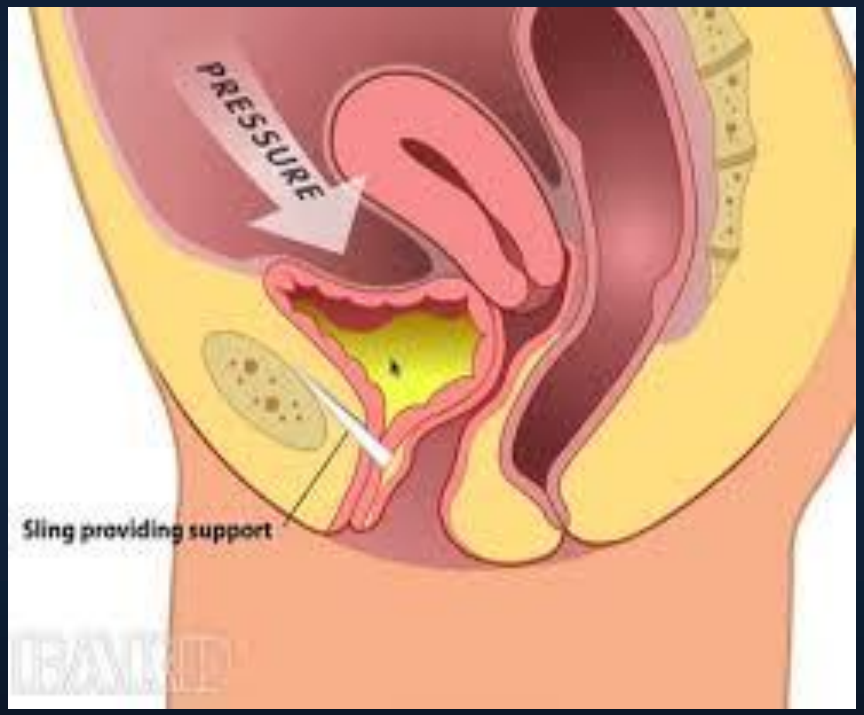
- Post menopausal women
- 0.5mg oestriol/ applicator

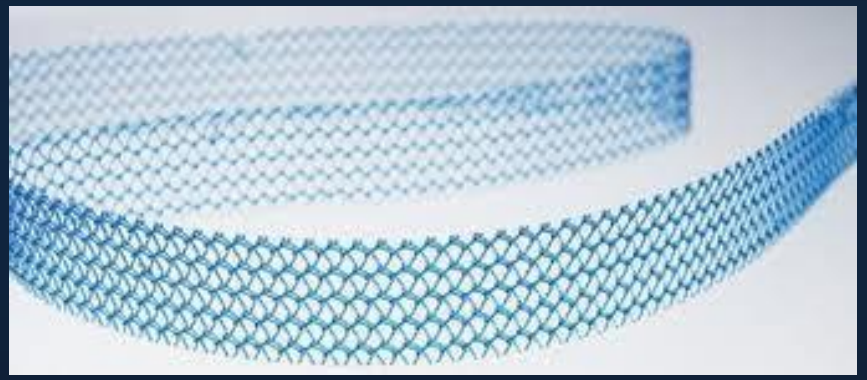
Treating urge incontinence: Anticholinergic medications

Who needs to see a specialist?

- Bothersome incontinence affecting quality of life
- Or
- Complicated incontinence
  - Nocturnal or continuous
  - Previous prolapse/ incontinence surgery
  - Previous pelvic radiation
  - Neurogenic bladder

Surgical treatment: Stress incontinence





90% effective

Surgical treatment: Urge incontinence

70% effective

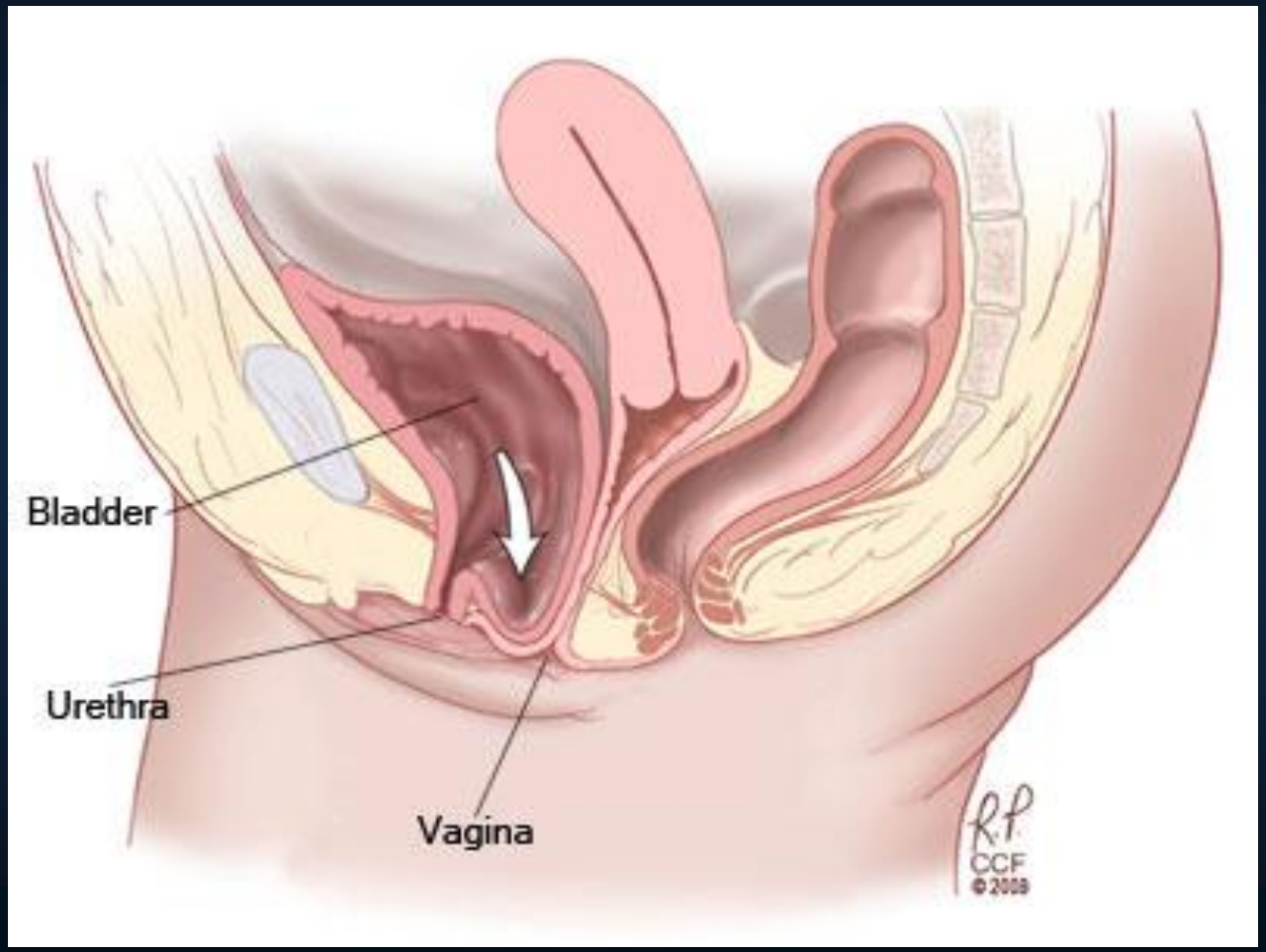
Urinary tract infections

- Advice to give
  - Wipe front to back
  - Void after sex
  - Cranberry (d-mannose) tablets
  - Probiotics
- Recurrent UTIs
  - Refer early to a specialist – frustrated/upset pts

What is pelvic organ prolapse (POP)

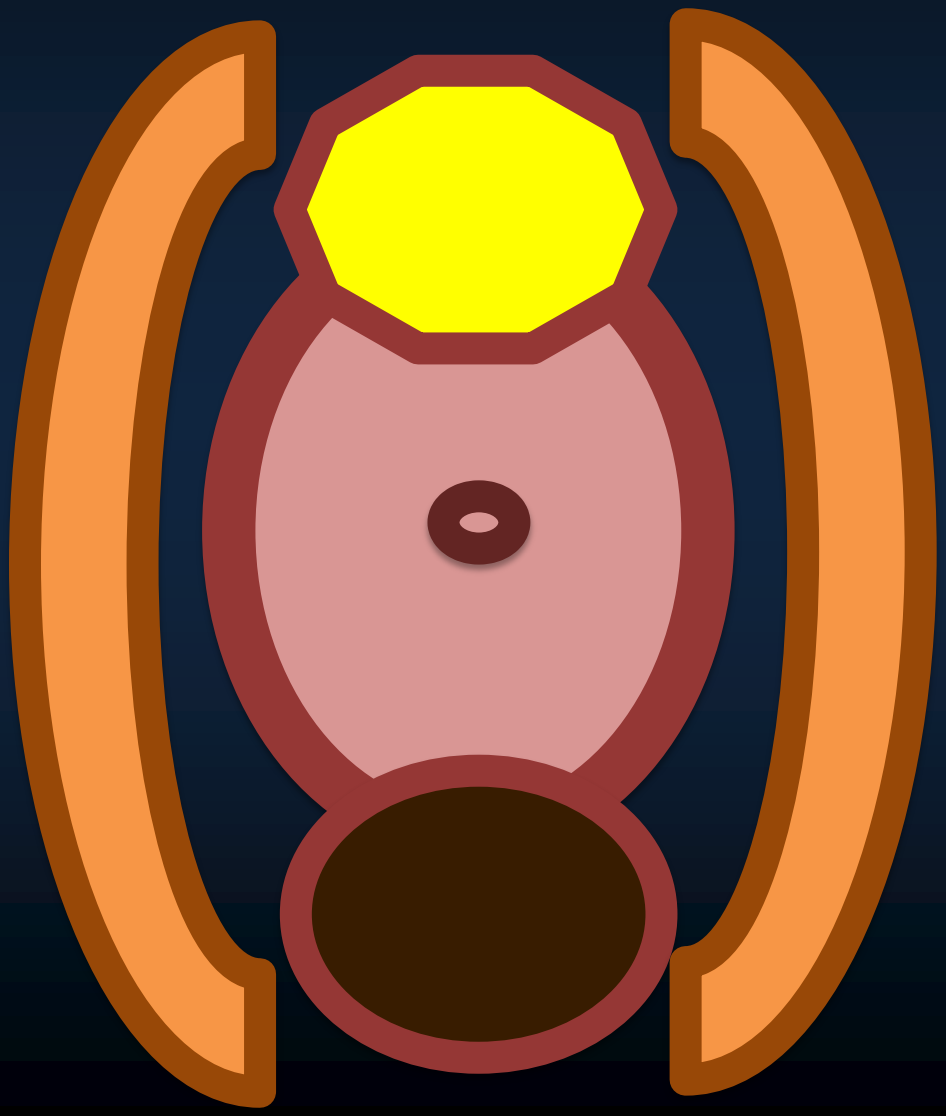
- Weakness in the supporting structures of the pelvic region
- Bladder, rectal, or uterine tissue may bulge into the vagina

Bladder prolapse: Cystocoele

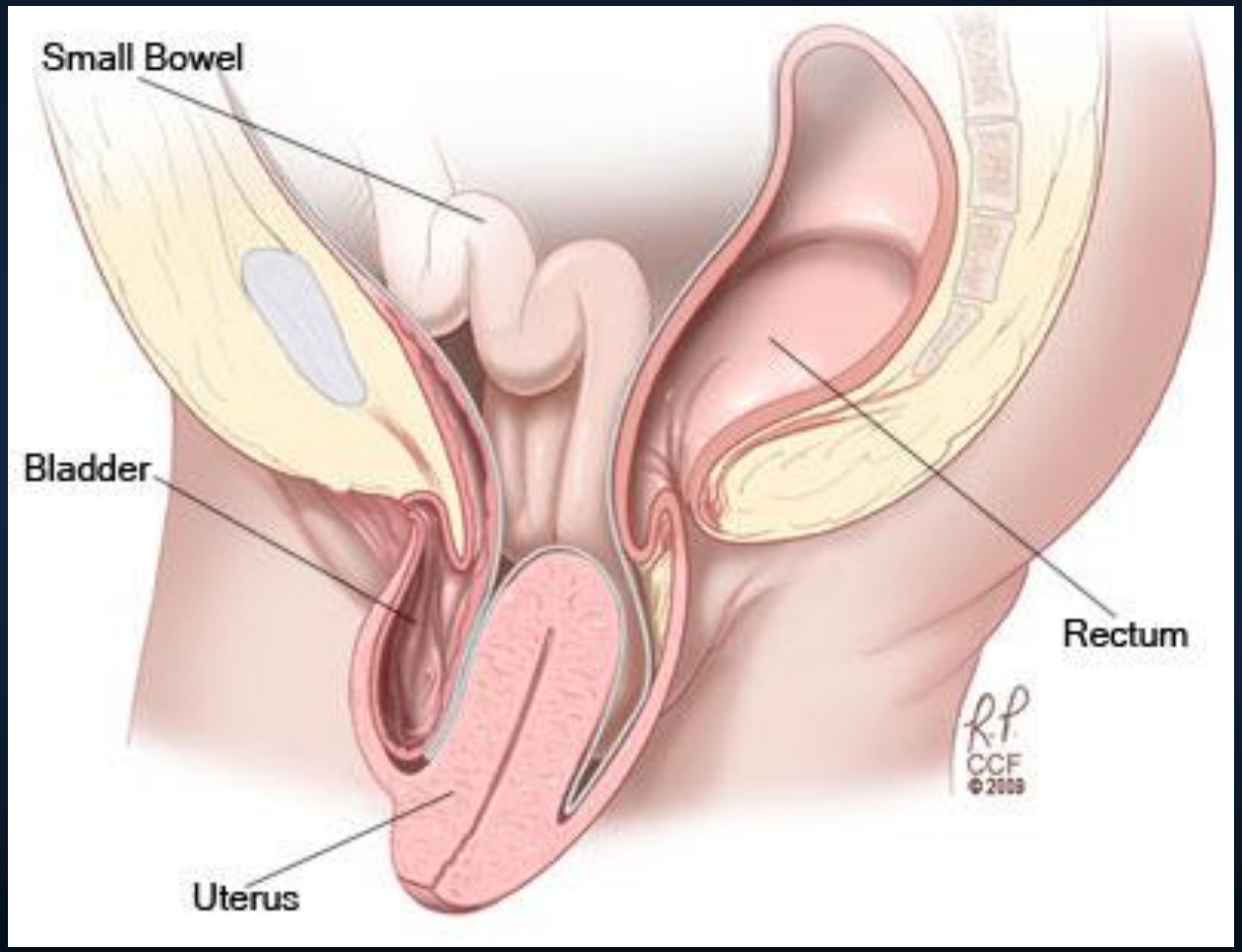


From Cleveland clinic website

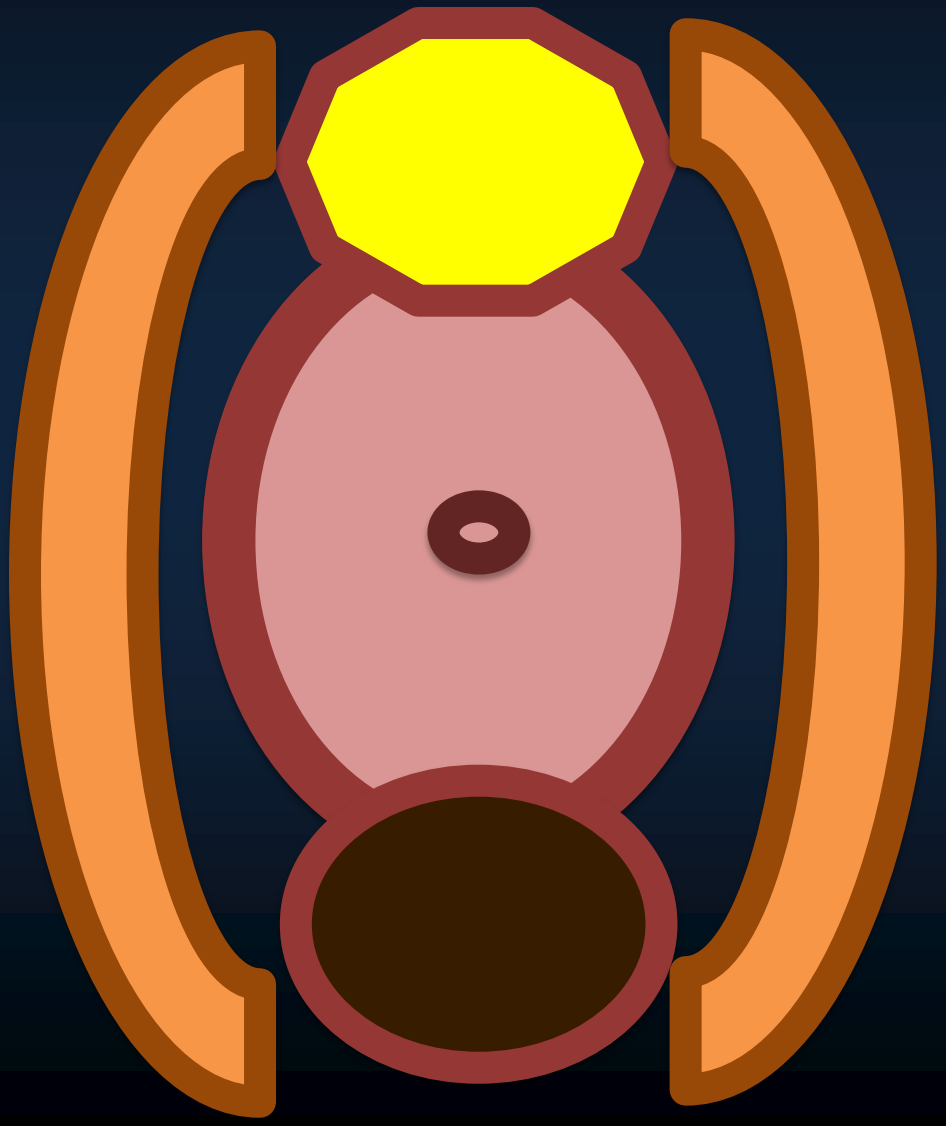
Bladder prolapse: Cystocoele



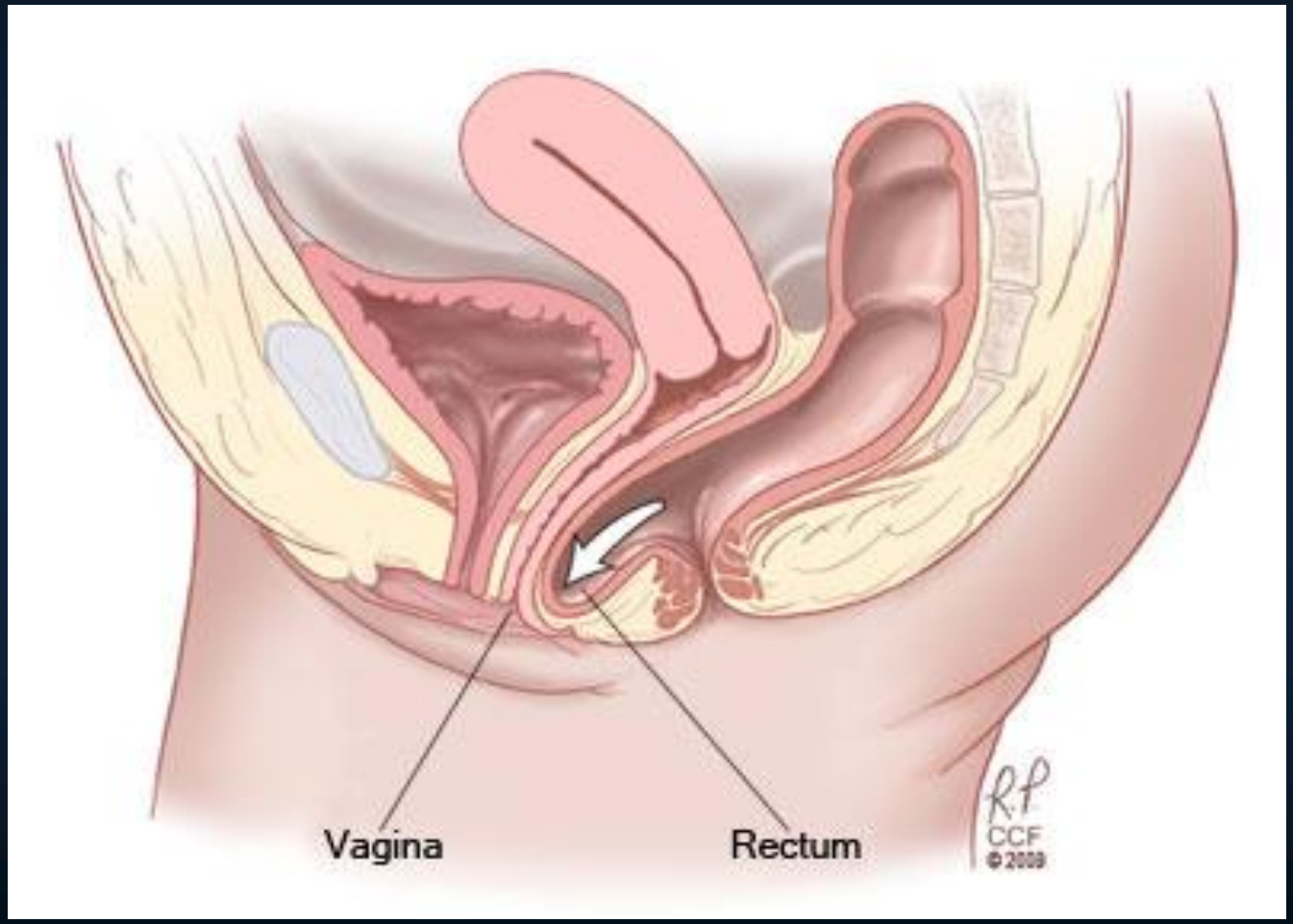
Uterine (Apical) prolapse



Uterine (Apical) prolapse



Rectal prolapse: Rectocoele



Rectal prolapse: Rectocoele

How to advise about preventing progression…

- Lose weight
- Do regular pelvic floor exercises
  - See a pelvic floor physio if possible
- Manage constipation
- Quit smoking
- Void regularly, but not preventatively
- Try reducing caffeinated drinks
- Oestrogen cream if post-menopausal

Who should be treated for prolapse?

- No symptoms
  - No treatment – can't make them any better
- Bothersome symptoms
  - Refer for assessment and treatment

Treating prolapse

- Non-surgical
  - Pessary

Treating prolapse

- Surgical
  - Vaginal repair +/- mesh
  - Abdominal repair
- Most important to get a good functional result

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

Mesh

- Why is it used?
  - Vaginal repair with native tissue has 30% recurrence
  - Used in other hernias successfully and safely
- Why have problems arisen?
  - Introduced too quickly to many undertrained users
  - Leading to high complication rate
  - Same users often could not remove mesh if problems

Mesh complications
Symptoms your patient might have:

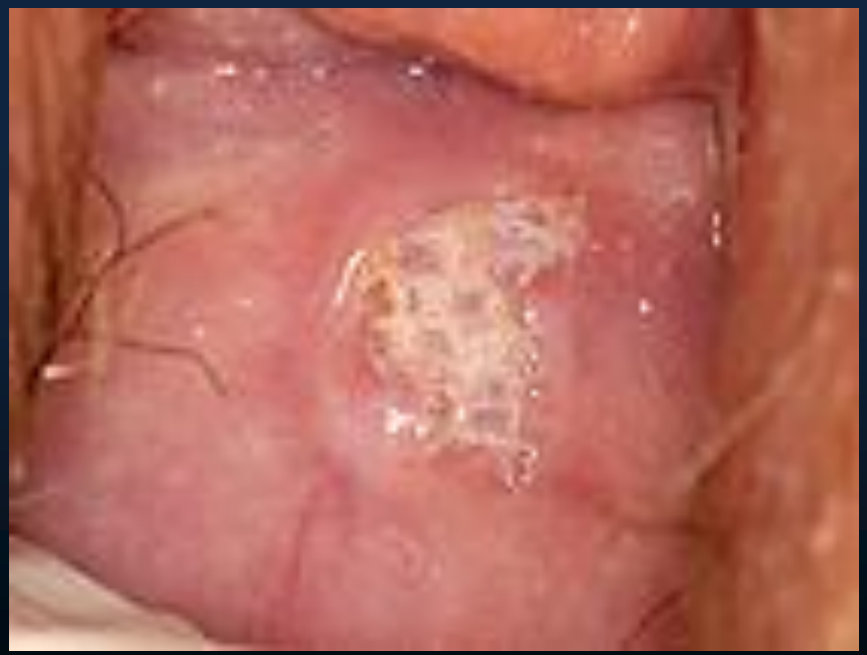
- Pain
  - Buttock, legs, vaginal, pelvic, dyspareunia

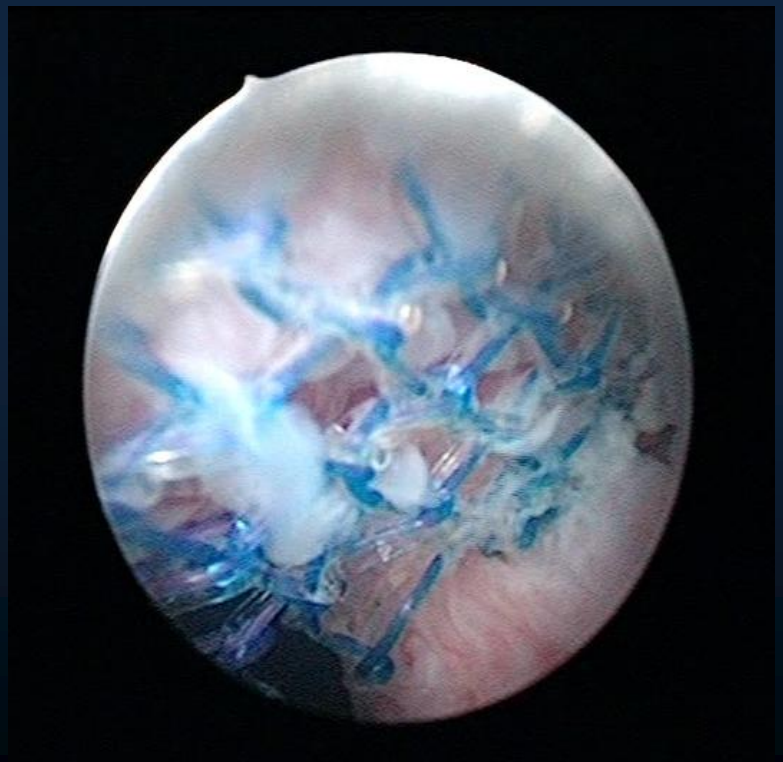
Mesh complications
Symptoms your patient might have:

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

What you see on exam:

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





Managing mesh complications

- Prompt recognition
- Treatment/ mesh removal (if necessary) should be early
    - Not all symptoms reversible if left for long time
- If in doubt….
  - Refer to specialist experienced with mesh complications

Case study: Ms N

- Failed prolapse repair 6 months prior
  - Ongoing uncomfortable bulge/ pressure
  - Victim of sexual assault
    - Very fearful about gynaecologic exams
    - Unable to see male doctor
- Very despondent about ongoing prolapse
- Referred for second opinion from gynaecology department

- Discussed her case with Clinical nurse specialist
- She contacted patient by phone
  - discussed her concerns about examination
  - Concerns about treatment
  - Reassured her she would feel safe with us

- Saw her in clinic
  - Upset, tearful about failed prolapse repair
  - Fearful about further surgeries
    - Risk of failure
    - Had been offered mesh
    - Possible contact with male staff/ patients
- Examination under anaesthetic to remove her pessary

- Performed second prolapse repair
  - Requested side room
  - Female anaesthetist and staff
- From immediately post-operatively
  - Easier physical recovery (in the patient's opinion)
  - Positive hospital experience
- Followup
  - Prolapse successfully repaired
  - A woman transformed…

Conclusion

- Underdiagnosed problem
  - You can help by asking your patients
- Significant physical and emotional burden
- Women should not be advised to just “put up with it”
- Effective help is available