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Treatment Options for Urinary Incontinence - Concurrent Workshop Repeated

Saturday, 22 June 2013	Start 8:30am	Duration: 55mins	Works
	Start 9:35am	Duration: 55mins	Works

Urinary incontinence: Treatment options

GPCME 2013

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Healthy Living

One in three women share something in common

Can we talk about something? The real reason we are here is that we all share this issue. Light Bladder Leakage or LBL. One in three women experience it and there are all kinds of triggers: sneezing, laughing, pregnancy and even exercise. There's nothing to be ashamed of and it's something we should be talking about.

What is LBL?

It stands for Light Bladder Leakage, and 1 out of every 3 women experience it. Little leaks happen, and then we get on with our lives. Fortunately, leaks can be easily and discreetly managed, so you can continue to be yourself and go about your day.

Millions of women rely on Poise®

Urinary incontinence

- Is not normal part of aging or childbearing
- We *can* make it better

Urinary incontinence: Overview

- Types
- How to take a history
- When to refer
- Investigation
- Treatment
- Case studies

Types
Stress incontinence

Types
Urgency incontinence

Other types

- Mixed incontinence
- Coital incontinence
- Unaware incontinence
- Overflow
- Nocturnal enuresis

History

- Aim is to establish
  - Type
  - Severity/ bother
  - Features for early referral

Typing incontinence

- Is it stress:
  - Does it occur when you cough, sneeze, move suddenly, go from sitting to standing, run?
- Is it urge:
  - Do you feel like you can't make it to the toilet in time? When you get to your front door?
  - Do you feel like you need to wee often to avoid an accident?

Severity and bother

- Need for treatment is based on patient's bother
- Does it stop you doing things?
  - Going out (in case you can't find a toilet)
  - Exercising/ running
- Absolute severity
  - Drops vs pads

Other relevant history

- Is patient postmenopausal
- Constipation
- Glaucoma
- Breast cancer
- Fluid intake
  - Caffeinated beverages

Indications for early referral

- Haematuria
- Night time wetting
- Difficulty with slow flow of urine, start stop stream or feeling of poor emptying
- Previous prolapse or incontinence surgery
- Continuous incontinence
- Previous pelvic radiation

Investigations in primary care

- MSU – to look for reversible causes
  - Diabetes
  - Infection

Treating stress incontinence

- Pelvic floor exercises
  - Refer to pelvic floor physio
- Weight loss
  - Trial comparing 6 month intense weight loss program (8kg lost) versus control (info only 1kg lost)
  - 47% reduction in weekly incontinence episodes vs 28%

Treating urge incontinence

- Fluid management
  - Assess total volume and timing of drinks
  - Assess caffeinated beverages and reduce
- Manage constipation
  - Kiwicrush, psyllium husks
- Timed voiding
  - Go every 3-4 hours
- Pelvic floor exercises/ physio
- Losing weight

Medications for urge incontinence

- Post menopausal women
  - Vaginal oestrogen
    - Ovestin cream 1mg
    - Use with applicator
    - Daily for 2 weeks and then twice weekly for maintenance
    - CI: breast/ endometrial cancer

Medications for urge incontinence

- Anticholinergic
  - Oxybutynin
    - Give 5mg up to three times a day
  - Solifenacin
    - 5mg or 10mg once daily
    - Special authority after trying oxybutynin
- Contraindicated
  - Narrow angle glaucoma

Medications for urge incontinence

- Compliance limited by side effects
  - Drymouth up to 60%
  - Constipation
  - Confusion in elderly
  - Reflux

Practically

- 1 -2 week trial of oxybutynin
  - If ineffective or effective but has side effects
- Special authority for solifenacin

Next generation

- 7% dry mouth
- Once daily gel
- Not available in NZ

What next????

Specialist investigations

- Bladder scan for post void residual
- Urinary flow test (flow rate)
- 3 day bladder diary
- Urodynamics

What is urodynamics?

- 20 min test of how the bladder functions
- Measures
  - How much the bladder can store
  - Definitively if stress and/or urge incontinence present
  - How strong the detrusor muscle is and how well it empties

What is urodynamics?

- Using
  - 6 Fr urethral catheter
  - small rectal catheter

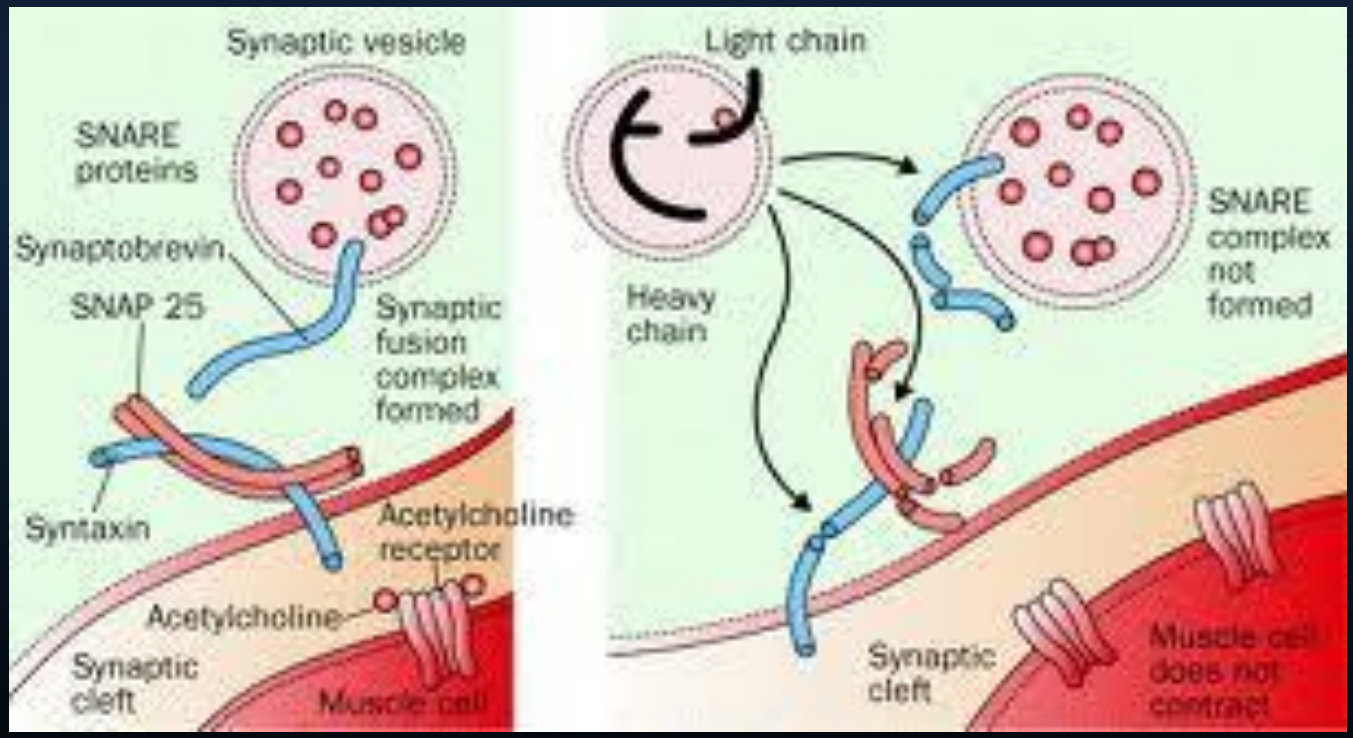
- Specialist should be present for the test
  - Dynamic study, adapted to each patient's symptoms
  - Information derived is operator dependent

Specialist treatment for urge incontinence

- Botulinum toxin
- Sacral neuromodulation

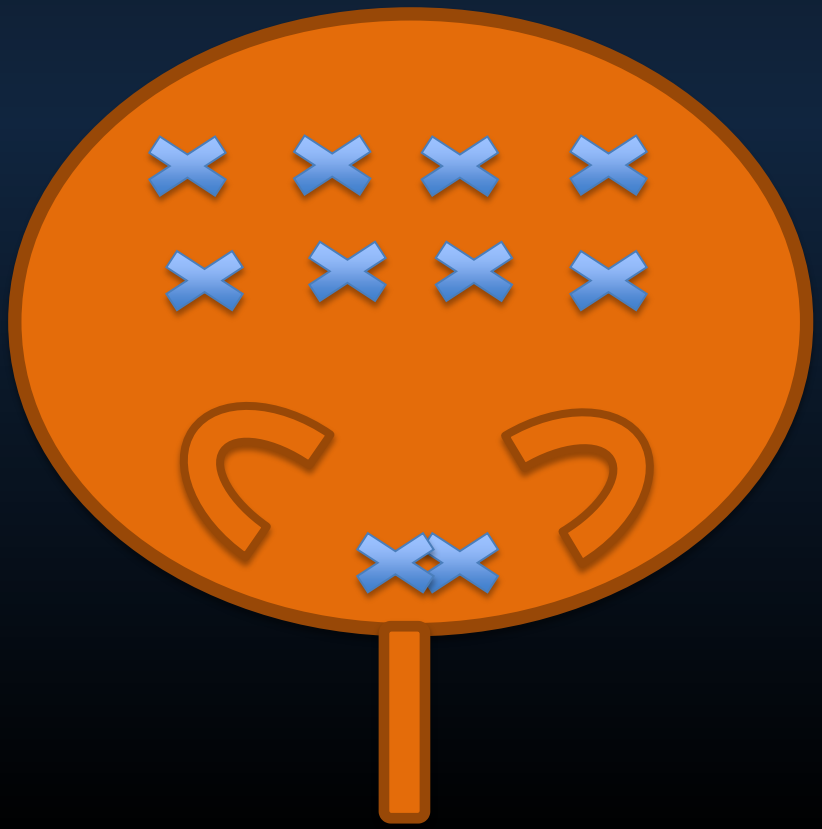
Intravesical botulinum toxin

- Mechanism of action



How botox is performed

- Cystoscopy (GA or LA)
- Inject into detrusor muscle



Intravesical botulinum toxin

- Pros:
  - Continence 70%
  - Daystay case or under local
- Cons:
  - Not permanent – 9 months
  - Risk of urinary retention

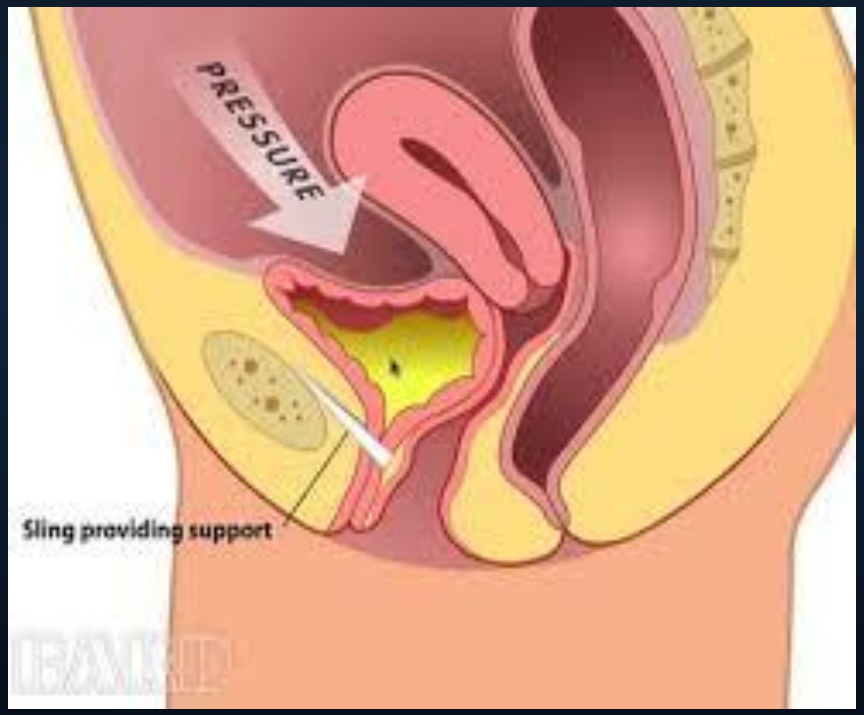
Sacral neuromodulation

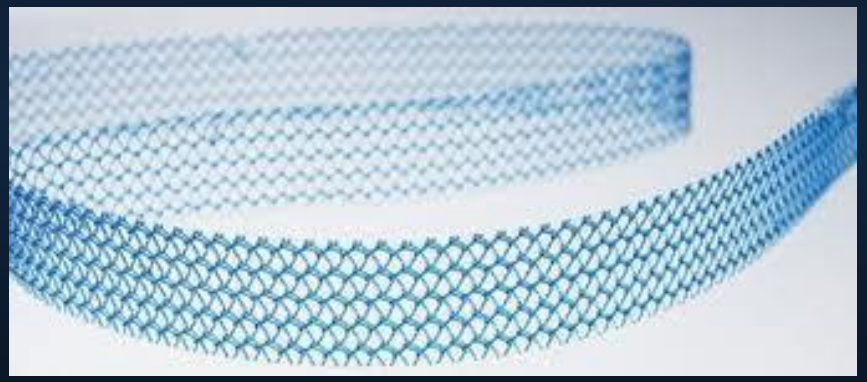
- 70% success

Sacral neuromodulation

- Pros:
  - Day surgery
  - Permanent implant
- Cons:
  - Battery needs changing 5 yearly
  - May not be able to have MRI scans
  - Not currently available in most of NZ

Treatment for stress incontinence
Mid-urethral sling





All about sling surgery

- Who should have it?
  - Someone with stress incontinence who has tried pelvic floor exercises
  - Not designed to fix urgency/ urge incontinence

All about sling surgery

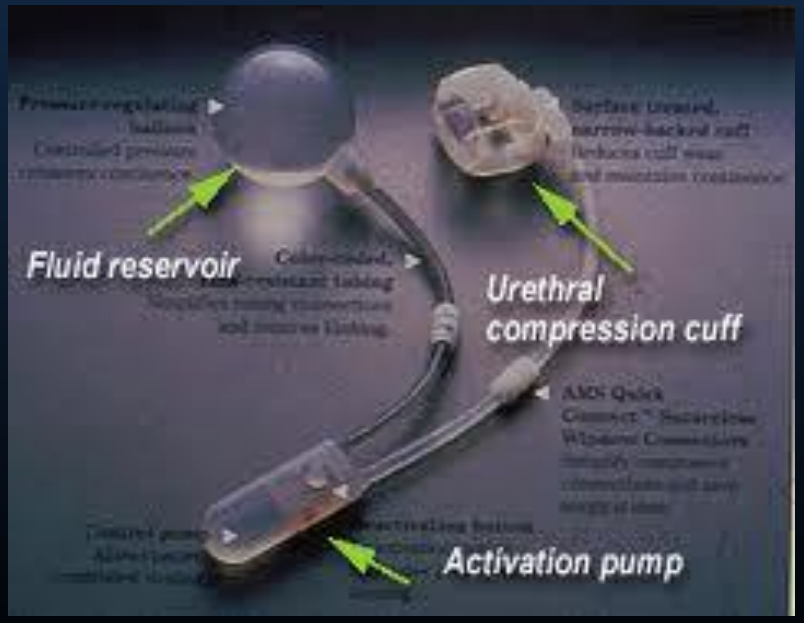
- How it works
  - Placed through 1cm vaginal incision
  - Sits like a hammock supporting urethra
- Short surgical time
  - Under GA or spinal
- Rapid return to normal activities
  - 4 week break from high impact exercise and sex

All about sling surgery

- Successful in >90% of patients
  - Durable
- Side effects
  - Uncommon
  - Rare (but severe)
    - Bleeding from vessels
    - Damage to bowel
    - Erosion into bladder, urethra, vagina

Male incontinence

- Causes
  - Post radical prostatectomy
  - Pelvic radiation
- Investigations
  - MSU, pad weight tests
- Treatments
  - Male sling
  - Artificial urinary sphincter



Incontinence and prolapse

- 60% of women with prolapse also have incontinence
- However prolapse not always cause of incontinence
- Incontinence after prolapse surgery
  - 16% improved
  - 10% de novo
  - 22% deteriorated after prolapse surgery

- *Urodynamics and good patient counselling prior to prolapse surgery is key to good outcomes*

Special types of incontinence

- Coital
  - Particularly distressing
  - Occurs more often in younger > older women
  - Usually stress type (can be urge if during orgasm)
- Overflow
- Continuous
  - Need to refer to exclude fistula

Mrs K, 70 yo

- What brings you here today?
  - I have been having bladder problems for a long time
- What kind of problems?
  - I have to pee often and I feel like I can't hold on, when I have to go I have to run and sometimes I don't make it
- Do you have an accident most days?
  - Yes about once a day but I am always worried. I know every toilet and I am nervous about going on holiday.

Mrs K, 70 yo

- Do you leak when you cough or sneeze?
  - Yes
- Does that happen every time?
  - No, only occassionally.
- Does that type of leakage bother you?
  - No, not really

Mrs K, 70 yo

- Do you leak at night?
  - No but I wake up and go twice and it feels urgent
- Do you have any blood in your urine?
  - No
- Do you get bladder infections?
  - No
- Do you have any difficulty starting to pee or feeling like you don't empty?
  - No

Mrs K, 70 yo

- Have you ever been treated for this?
  - No I saw another urologist 10 yrs ago and he told me I had a prolapse and should have a prolapse repair to treat my bladder symptoms
  - I decided not to go ahead with this for a number of reasons
- Do you have a feeling of a bulge between your legs?
  - No
- What about pelvic pressure or a dragging feeling?
  - No

Mrs K, 70 yo

- Brief gynaecologic history
  - How many pregnancies and how many children do you have?
  - Have you had any operations on your uterus or ovaries? Or abnormal smears
  - When did you stop having your periods?
  - Did you use HRT?
  - Are you sexually active? Do you have any vaginal dryness or bleeding?

Mrs K, 70 yo

- Do you get constipation? No
- Do you have accidents with your bowels? No
- Do you have any other medical problems? Just high blood pressure, I take tablets for it
- Do you have glaucoma? Yes
- What type? I am not sure
- Have you ever smoked? No

Mrs K, 70 yo

Examination findings:

- Bladder scan 100mls
- Pale vulva – atrophic vaginitis
- Asked her to cough
  - No leakage
  - Small prolapse seen
- Bimanual : no masses felt
- Split speculum exam: stage 2 anterior prolapse(cystocoele), no apical or posterior prolapse.

Mrs K, 70 yo

- Clinical diagnosis
  - Overactive bladder (with urge incontinence)
  - Stage 2 bladder prolapse

Mrs K, 70 yo

- Urodynamics
  - Overactive bladder with urgency
  - No improvement with prolapse reduced (with pessary)

Mrs K, 70 yo

- Next step
  - Anticholinergic - Oxybutynin (dry mouth after 1 week)
  - Switched to solifenacin
- 2 week follow-up
  - Urgency and urge incontinence cured
  - Tolerable dry mouth

Ms C, 16 yo

- History
  - Incontinence several times/ week
  - Laughing, sport, rushing to bathroom
  - No significant medical history
  - No bowel problems
- O/e
  - Normal urethra and normal sensation in perianal area
  - Leakage seen with cough

Ms C, 16 yo

- MSU – clear
- Lumbar plain radiograph – normal

- Treatment
  - Advised about caffeinated drinks and overall fluid intake
  - Pelvic floor physiotherapy

Ms C, 16 yo

- F/u
  - 90% better after 3 months of pelvic floor physio
    - Was unable to identify pelvic floor muscles
    - Performed valsava instead of contraction
  - Advised about timing of fluid

Mrs L, 64 yo

- History
  - Recent prolapse repair (sacrocolpopexy and hysterectomy) 6 weeks prior
  - Now presents with new onset, severe incontinence
  - Stress type symptoms (Coughing, moving)
  - Also has slow flow and ? Incomplete emptying
  - Referred by gynaecologist to help with ?sling surgery

Mrs L, 64 yo

- Urodynamics had shown ? Obstruction of flow
  - ? Secondary to prolapse
- O/e:
  - Leakage with cough
  - Moderate anterior wall prolapse

Mrs L, 64 yo

- Unlikely to be enough to cause obstruction
- Repeat urodynamics
  - Stress incontinence
  - Slow flow due to slightly underactive bladder
  - No obstruction due to prolapse
- Advised to proceed with sling surgery and might need to self catheterise if unable to void initially

Mrs L, 64 yo

- Treatment
  - Mid urethral sling, anterior repair
  - Difficult procedure due to previous scarring
- F/u:
  - Able to void
  - Resolution of stress incontinence

Ms M, 34 yo

- History
  - Lifelong frequency and urgency incontinence
  - Voids ½ hourly, incontinent 2x day
  - Nocturia x4
  - Otherwise fit and well
- O/e:
  - Unremarkable

Case study: Ms M

- Investigations: Urodynamics
  - Involuntary bladder contraction at 30mls, unable to hold more than 60mls
  - Severe overactive bladder
- Treatment
  - Tried vesicare but unable to tolerate dry mouth
  - Treated with 100 units of botox intravesically
- F/u:
  - At 2 weeks, improved bladder capacity and no further incontinence

Ms H, 15 yo

- History
  - 8 month history of bladder pain
  - Tried analgesics, had renal US, oxybutynin with no improvement
  - Previous history of ureteric reimplant surgery age 7
  - Very occasional incontinence
  - Not associated with urgency or exertion
  - No significant gynae history
  - Couldn’t be sure if pain was associated with incontinence

Ms H, 15 yo

- O/e:
  - Normal except lower abdominal tenderness
- Investigation
  - MSU
  - Bladder diary
  - Pelvic US - Normal
  - Cystoscopy - Normal
  - Mag-3 - No obstruction at previous reimplant site; No reflux

Ms H, 15 yo

- Tried solifenacin – no improvement
- Urodynamics
  - Overactive bladder at 150mls
  - Desperate to pee
  - Significant after contraction and reproduced pain

Ms H, 15 yo

- Diagnosis: Overactive bladder
- Treatment
  - Intravesical botulinum toxin
    - 100 units
  - Severe pain after treatment
    - Concerned wasn't emptying
    - Bladder scan day 1 post-op – emptying completely
  - Pain for 2 weeks post-operatively
  - Resolution of pain and incontinence for 9 months
  - Recent repeat treatment, good effect

Conclusion

- Challenging to get patients to present with this problem
- History taking can usually establish type
- Initiate lifestyle, medications and pelvic floor physiotherapy in primary care
- Refer to a specialist if incontinence is having impact on their quality of life