UROGYNAECOLOGY Urinary incontinence

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- Urinary incontinence is defined as the involuntary leakage of urine. It is said to a ff ect approximately 30% of women, with a higher prevalence seen in older age groups. It can have a significant impact on quality of life. oman Incontinence can be classified into: /uni25CF - stress urinary incontinence (SUI) (involuntary leakage of urine secondary to increased intra-abdominal pressure, e.g. coughing, sneezing); /uni25CF - overactive bladder (OAB); urinary urgency , usually with urinary frequency and nocturia, with or without urinary incontinence; /uni25CF mixed urinary incontinence (combination of both OAB and SUI). It can result from both functional and anatomical causes, including: /uni25CF multiparity; - /uni25CF childbirth complications and vaginal delivery; /uni25CF risng female age - menopause; /uni25CF fistulae; y of /uni25CF urethral diverticulum/congenital anomalies, e.g. ectopic ureters; /uni25CF immobility , constipation or urinary tract infection; /uni25CF chronic medical conditions, e.g. congestive heart failure, diabetes mellitus, multiple sclerosis; /uni25CF medications, e.g. loop diuretics; /uni25CF secondary to pelvic masses; /uni25CF obesity and weight gain. Common symptoms and complaints include: /uni25CF storage symptoms: /uni25CF frequency (increased frequency of more than eight times during the day) /uni25CF urgency /uni25CF nocturia (increased frequency of voiding more than once a night) /uni25CF emptying symptoms: /uni25CF hesitancy /uni25CF slow stream /uni25CF incomplete emptying /uni25CF straining to urinate /uni25CF urinary leakage with exertion/coughing gations should be performed to rule out malignancy). Investigations include: /uni25CF urinary incontinence-specific symptom and quality of life questionnaire, including a bladder diary; /uni25CF digital examination; /uni25CF urine analysis and a midstream urine sample for micro scopy , culture and sensitivity; /uni25CF urodynamics, including an assessment of postvoid residual volumes – if conservative measures have failed, the type of incontinence is unclear or there is a recurrence of symp toms following surgical intervention; /uni25CF ultrasound of the kidneys, ureters and bladder in patients with recurrent urinary tract infections/haematuria; /uni25CF cystoscopy if pathology is suspected. Management can be divided into conservative methods, medical therapy or surgical intervention (Tables 87.9–87.11 The treatment of choice is dependent on the under lying cause. Treatments can be combined and are individualised for the patient. Should initial therapy be unsuccessful or repeat pr ocedures be required, then the patients should be discussed within a multidisciplinary team (MDT) setting. /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF β /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF Edvard Laurits Ehlers , 1863–1937, dermatologist, Copenhagen, Denmark. Henri-Alexandre Danlos , 1844–1912, dermatologist, Paris, France. Antoine Bernard-Jean Marfan ,

1858–1942, paediatrician, Paris, France. /uni25CF /uni25CF /uni25CF - /uni25CF - /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF). /uni25CF /uni25CF /uni25CF /uni25CF

TABLE 87.9 Management options for overactive bladder (OAB). Lifestyle changes (i.e. limit /f_l uid intake, avoid Conservative diuretics such as tea/coffee, weight loss) Behavioural modi /f_i cation (e.g. bladder drills) for a minimum of 6 weeks Review of coexistent medications (e.g. diuretics) Pelvic /f_l oor training (physiotherapy) for at least 3 months, comprising at least eight contractions three times per day Bladder catheterisation-intermittent self catheterisation if increased post void residuals Medical Anticholinergics (e.g. oxybutynin [avoid therapy in elderly frail women at risk of cognitive impairment], tolterodine); side effects include a dry mouth and constipation Selective -adrenoreceptor agonist (e.g. 3 mirabegron) for the management of urge incontinence Desmopressin speci /f_i cally used to treat symptoms of nocturia Surgical Intravesical botulinum toxin A Neuromodulation (tibial nerve stimulation or sacral neuromodulation) Bladder reconstruction (augmentation cystoplasty – risks include bowel disturbance, metabolic acidosis, mucus production and/or retention in the bladder, urinary tract infection, urinary retention and malignancy) Urinary diversion only when non-surgical management has failed and if botulinum toxin type A, percutaneous sacral nerve stimulation and augmentation cystoplasty are not appropriate or are unacceptable incontinence (SUI). Conservative Pelvic /f_l oor training (physiotherapy) for at least 3 months, comprising at least eight contractions three times per day Management of a persistent cough Bladder catheterisation-intermittent self catheterisation if increased post void residuals Medical Serotonin and noradrenaline (norepinephrine) therapy reuptake inhibitors (e.g. duloxetine) (can be used when conservative measures have failed and surgical treatment is contraindicated or declined) Surgical Colposuspension (bladder neck suspension) Autologous rectus fascial sling procedures and retropubic midurethral mesh slings Periurethral bulking agents Arti /f_i cial urinary sphincter Do not offer: anterior colporrhaphy; needle suspension; paravaginal defect repair; porcine dermis sling; the Marshall–Marchetti–Krantz procedure TABLE 87.11 Management options for speci /f_i c conditions causing urinary incontinence. Pelvic masses Surgical approach, e.g. myomectomy or hysterectomy Recurrent Antibiotics – treatment, low dose urinary tract prophylaxis, rescue course infections 3 month course of vaginal oestrogen in post menopausal women Fistulae or Surgical correction ectopic ureters

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