Incontinence

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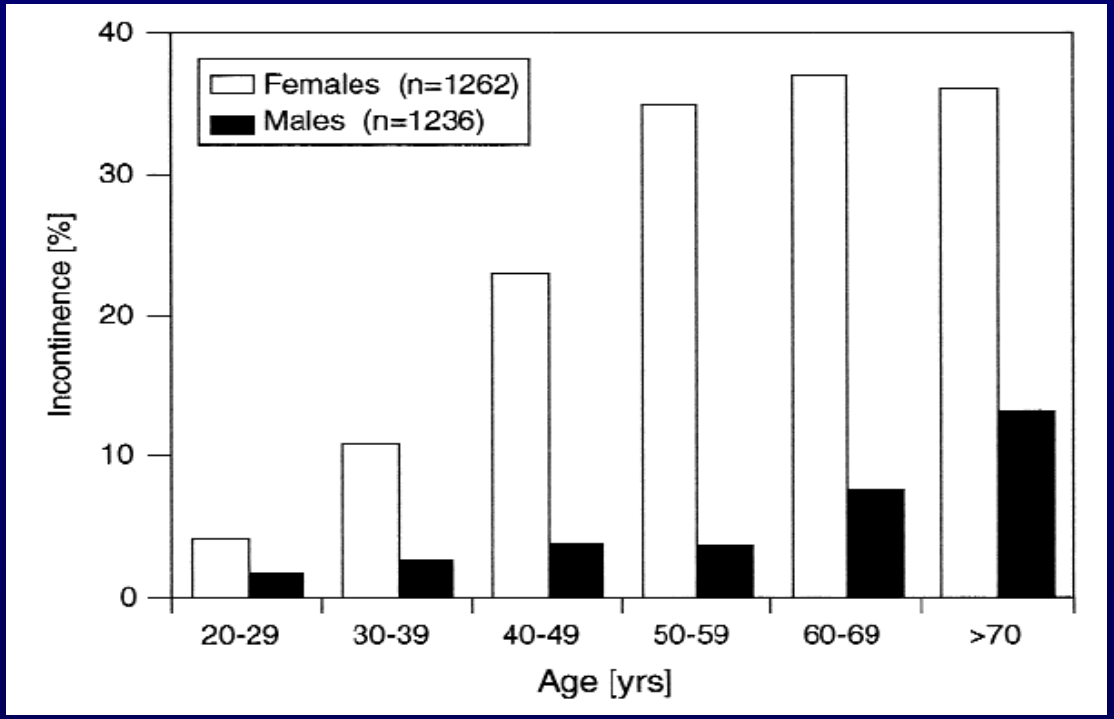
Training Course in Reproductive Health Research – Geneva 2008

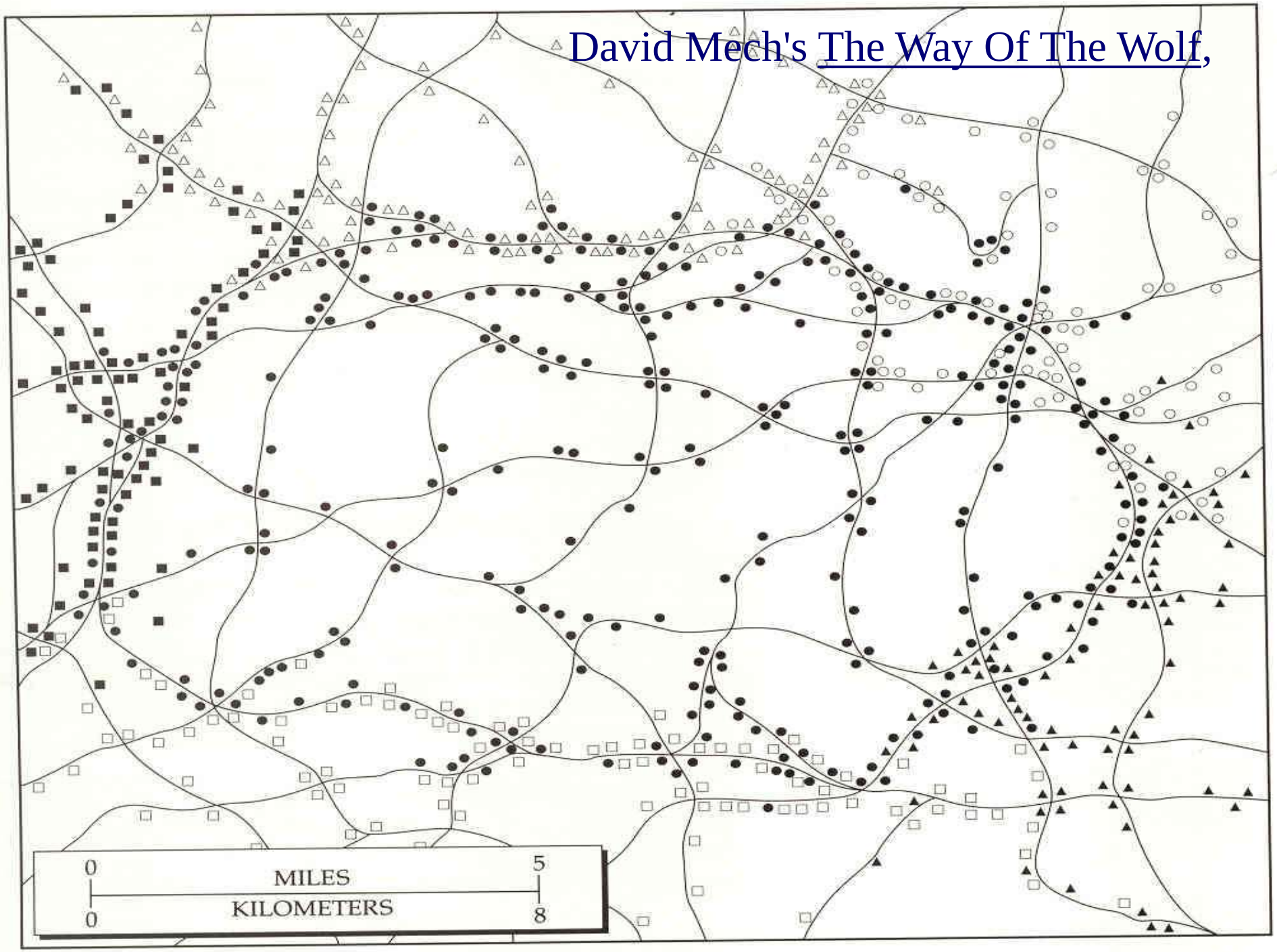
ICS definition of incontinence

Urinary incontinence is the complaint of any involuntary loss of urine

Prevalence



Temml et al Neurourol Urodyn 2000


David Mech's The Way Of The Wolf,
0
MILES
5
0
KILOMETERS
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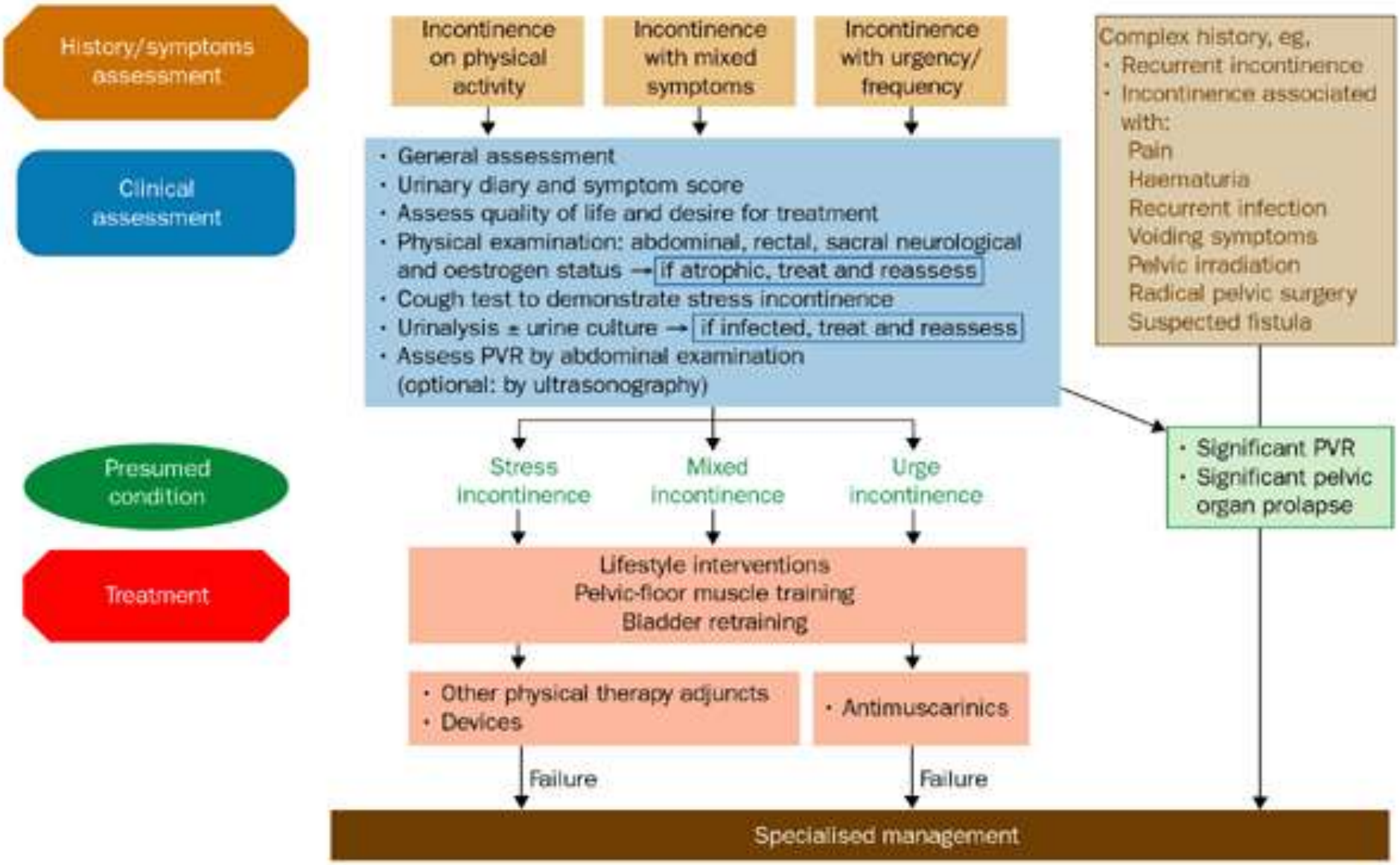
Assessment and Treatment of Urinary Incontinence :

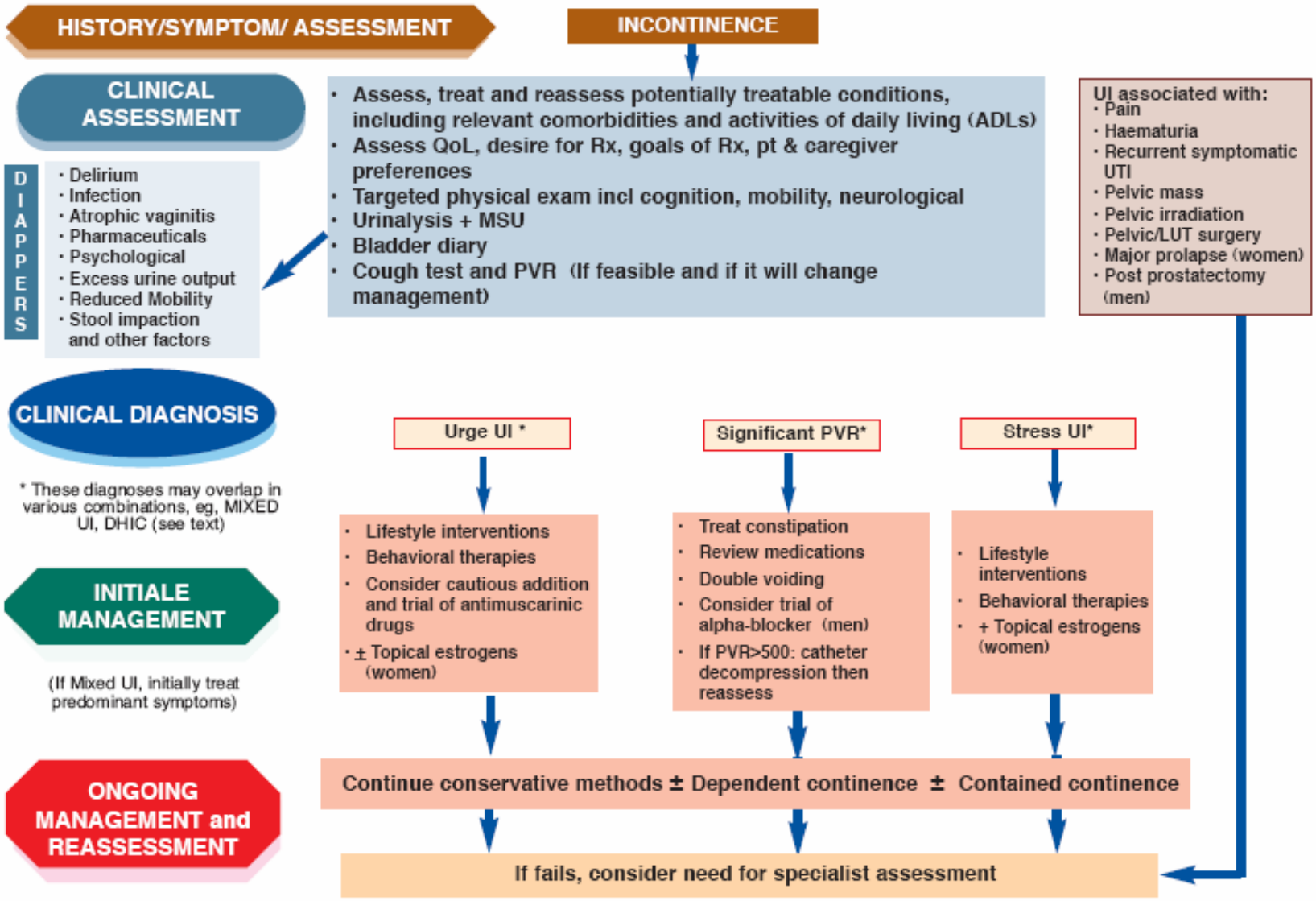
Scientific Committee of the First International Consultation on Incontinence

The Lancet 2000;355: 2153-58

Initial management of urinary incontinence in women

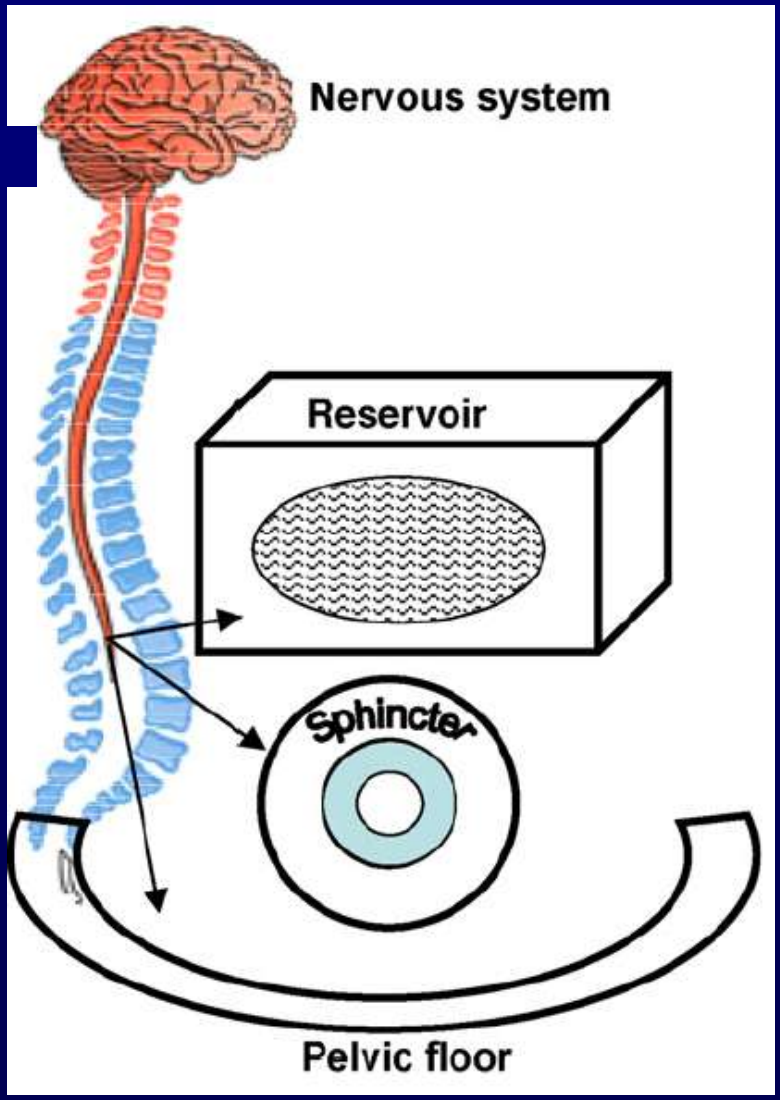


MANAGEMENT OF URINARY INCONTINENCE IN FRAIL OLDER PERSONS

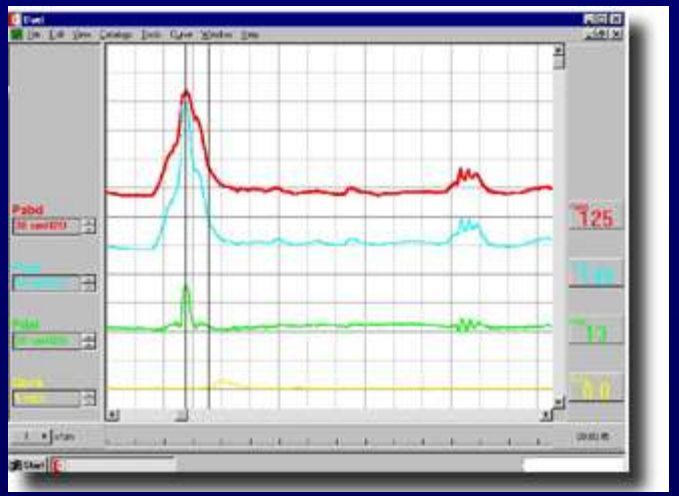


Think function

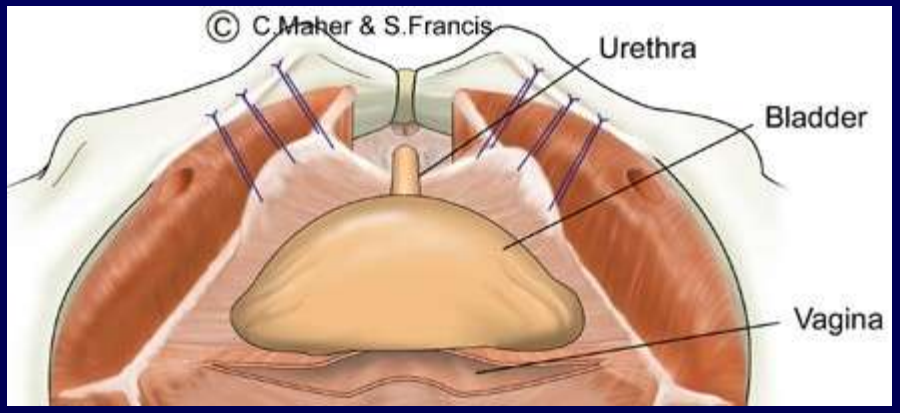
Urinary
Reproductive
Anorectal



Urodynamics

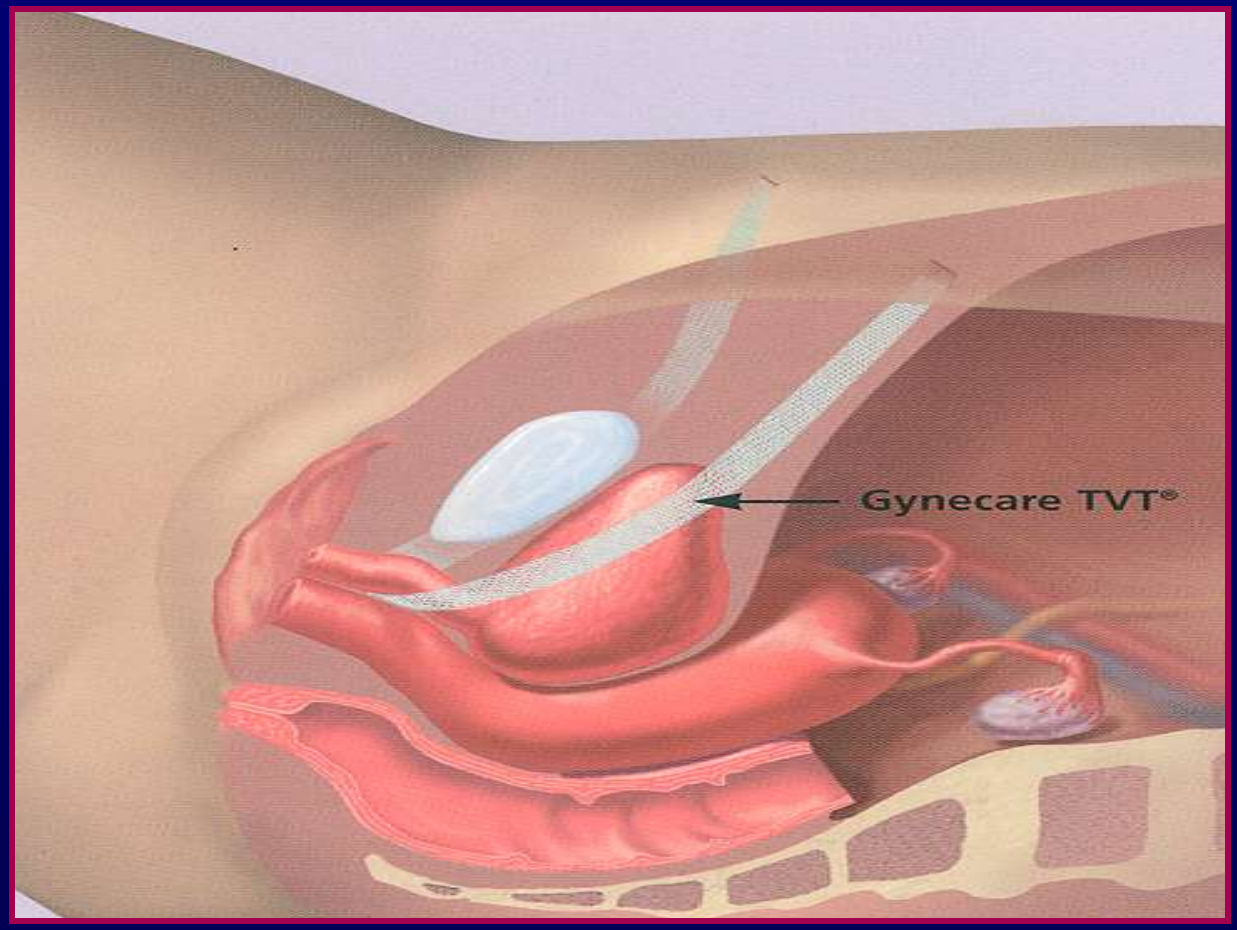


Burch colposuspension

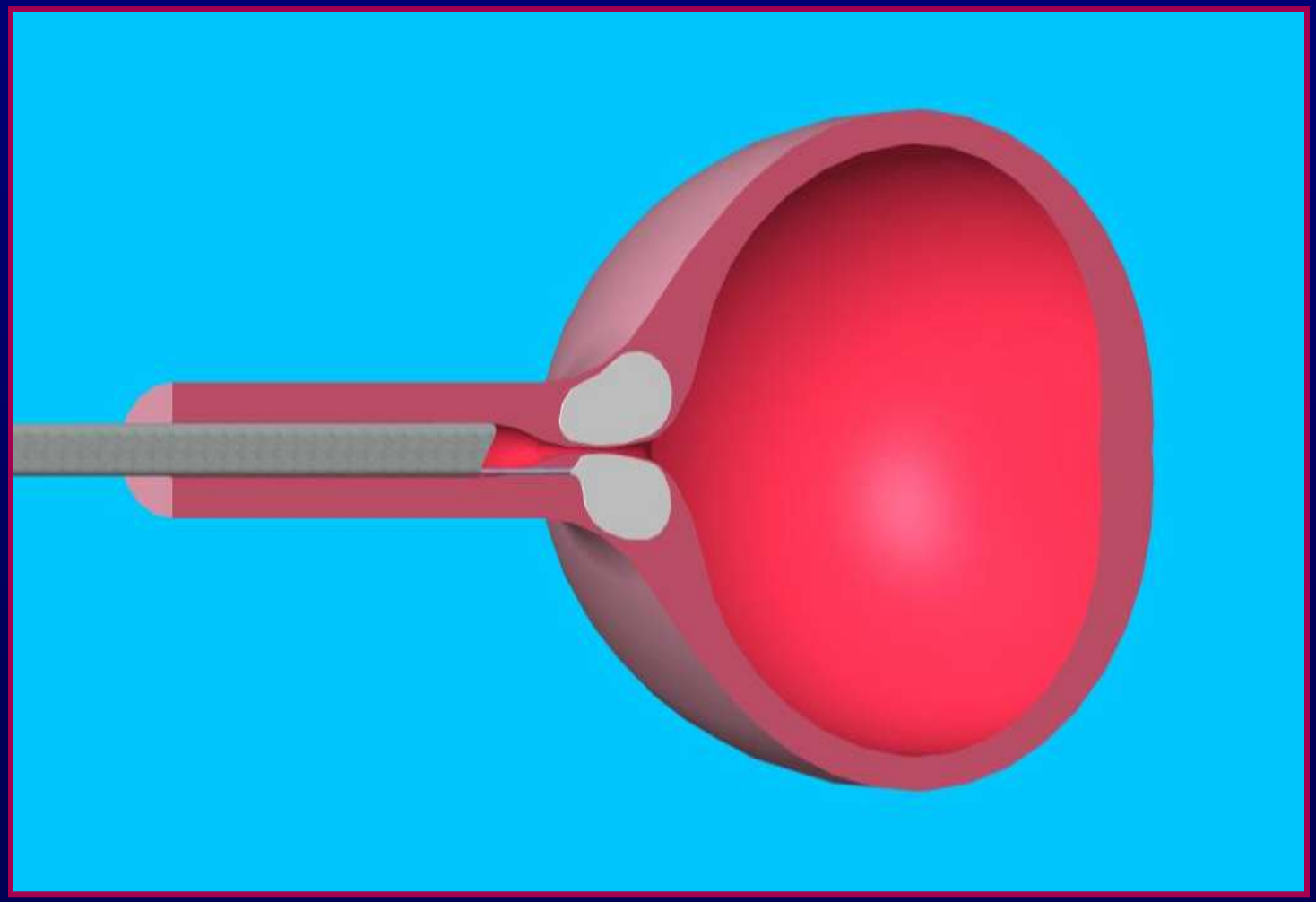


TVT

(tension free vaginal tape)



Bulking agents



Intraurethral bulking agents for urinary incontinence

Incontinence surgery: what is evidence-based ?

"Evidence based medicine is the integration of best research evidence with clinical expertise and patient values"

EBM Sackett et al 2000

How to find the current best evidence ?

1. Burn your (traditional) textbooks
2. Try "modern" textbooks
   - Frequently revised
   - Heavily referenced
   - Explicit selection
3. Invest in evidence databases

EBM Sackett et al 2000

Surgical treatment of stress urinary incontinence in women

George Flesh, MD

UpToDate performs a continuous review of over 330 journals and other resources. Updates are added as important new information is published. The literature review for version 12.3 is current through August 2004; this topic was last changed on September 10, 2004. The next version of UpToDate (13.1) will be released in February 2005.

- Surgery is the gold standard for treatment of SUI

- The goals of surgical treatment are to:
  - Stabilize the bladder neck to prevent descent with increased intra-abdominal pressure
  - Create a stable fascial layer for urethral compression

- However, surgery does not make all women continent and some procedures that are intitially successful can eventually fail.

- Unfortunately, comparing the different surgical procedures is difficult due to variations in patient selection, experience of the surgeon, diagnostic methods, techniques, outcome criteria, and length of follow-up

  Hilton 2002

- A systematic review of 11 randomized controlled trials, 20 nonrandomized trials/prospective cohort studies, and 45 retrospective cohort studies concluded that recommendations as to the best clinical practice could not be based upon scientific evidence

  Black 1996

Key points:

- Accurate diagnosis is the first requirement
- The goal of surgery is to stabilize the bladder neck and to create a stable fascial layer for urethral compression.
- Excessive tension must be avoided.
- Open Burch and sling procedures are the techniques with the best documentation of long-term success.
- All patients with stress incontinence have some degree of intrinsic sphincter deficiency (ISD).
- Periurethral bulking agents are useful for ISD without hypermobility and SUI with high surgical risk, but long-term outcome is poor without repeated injections.

American Journal of Obstetrics and Gynecology (2004) **190**, 324–31

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GENERAL OBSTETRICS AND GYNECOLOGY: GYNECOLOGY

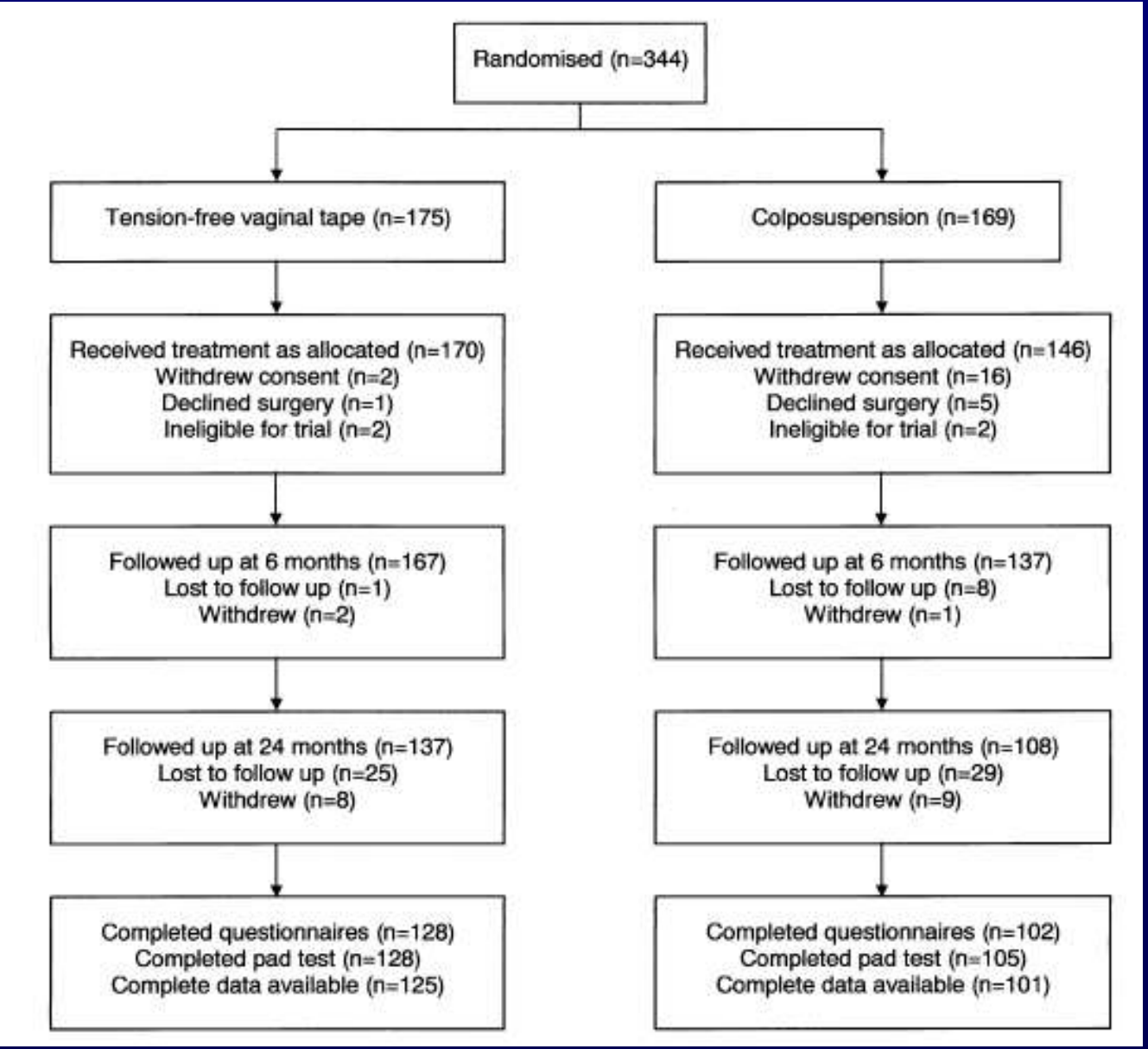
A prospective multicenter randomized trial of tension-free vaginal tape and colposuspension for primary urodynamic stress incontinence: Two-year follow-up

Karen L. Ward, MRCOG, Paul Hilton, MD, FRCOG,* on behalf of the UK & Ireland TVT Trial Group

Department of Obstetrics and Gynaecology, University of Newcastle upon Tyne, and Directorate of Women's Services, Royal Victoria Infirmary, Newcastle upon Tyne, United Kingdom

Received for publication May 24, 2003; revised July 27, 2003; accepted July 29, 2003

Participants flow



Results

Table I Analysis of pad test results at 2 years, using different assumptions about outcome for patients with missing data

	TVT	%	Colposuspension	%	Odds ratio	95% CI	*P* value*
Assumption							
Women with data available at 24 mo	111/137	81	86/108	80	1.09	0.59-2.06	.87
Assuming all withdrawals are failures	111/175	63	86/169	51	1.67	1.09-2.58	.02
Assuming all withdrawals are cured	149/175	85	147/169	87	0.86	0.47-1.58	.64
Last observed result carried forward	136/175	78	115/169	68	1.64	1.01-2.65	.052
Assuming presurgery withdrawals are cured and last postoperative result carried forward	141/175	81	138/169	82	0.93	0.54-1.60	.89

* Fisher exact test.

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Abdominal Sacrocolpopexy with Burch Colposuspension to Reduce Urinary Stress Incontinence

Linda Brubaker, M.D., Geoffrey W. Cundiff, M.D., Paul Fine, M.D., Ingrid Nygaard, M.D., Holly E. Richter, M.D., Ph.D., Anthony G. Visco, M.D., Halina Zyczynski, M.D., Morton B. Brown, Ph.D., and Anne M. Weber, M.D., for the Pelvic Floor Disorders Network*

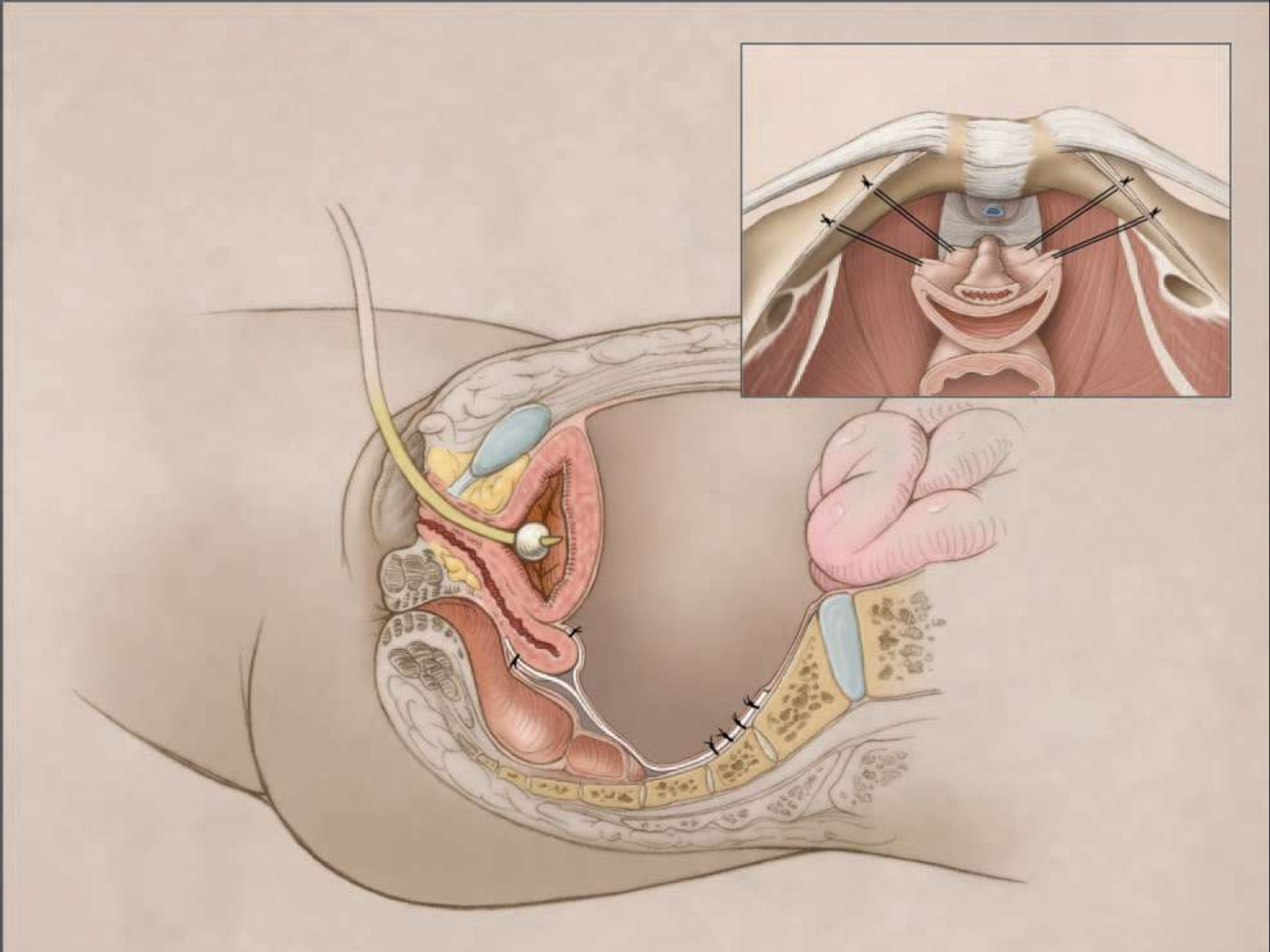

Table 3. Urinary Evaluation at Three Months after Surgery.

Variable	Burch Group (N=157)	Control Group (N=165)	P Value
Stress incontinence outcome — no./tota	35/147 (23.8)	67/152 (44.1)	<0.001
According to symptoms†	29/153 (19.0)	60/151 (39.7)	<0.001
According to stress testing‡	7/148 (4.7)	14/162 (8.6)	0.14
According to treatment	8/157 (5.1)	19/165 (11.5)	0.05
Other measures of stress incontinence			
Bothersome stress incontinence — r	9/147 (6.1)	37/151 (24.5)	<0.001
MESA score for stress incontinence¶	13.3±19.0	23.3±24.7	<0.001

Table 3. Urinary Evaluation at Three Months after Surgery.*

Variable	Burch Group (N=157)	Control Group (N=165)	P Value
Urge outcome — no./total no. (%)	50/153 (32.7)	58/151 (38.4)	0.48
Serious adverse events to 3 mo — no./total no. (%)			
All events	23/157 (14.6)	24/165 (14.5)	0.79
Urologic and gynecologic events	5/157 (3.2)	5/165 (3.0)	0.70
Plausibly related events	7/157 (4.5)	5/165 (3.0)	0.24

Autologous myoblasts and fibroblasts versus collagen for treatment of stress urinary incontinence in women: a randomised controlled trial

Hannes Strasser, Rainer Marksteiner, Eva Margreiter, Germar Michael Pinggera, Michael Mitterberger, Ferdinand Frauscher, Hanno Ulmer, Martin Fussenegger, Kurt Kofler, Georg Bartsch

Summary

Background Preclinical studies have suggested that transurethral injections of autologous myoblasts can aid in

Lancet 2007; 369: 2179–86

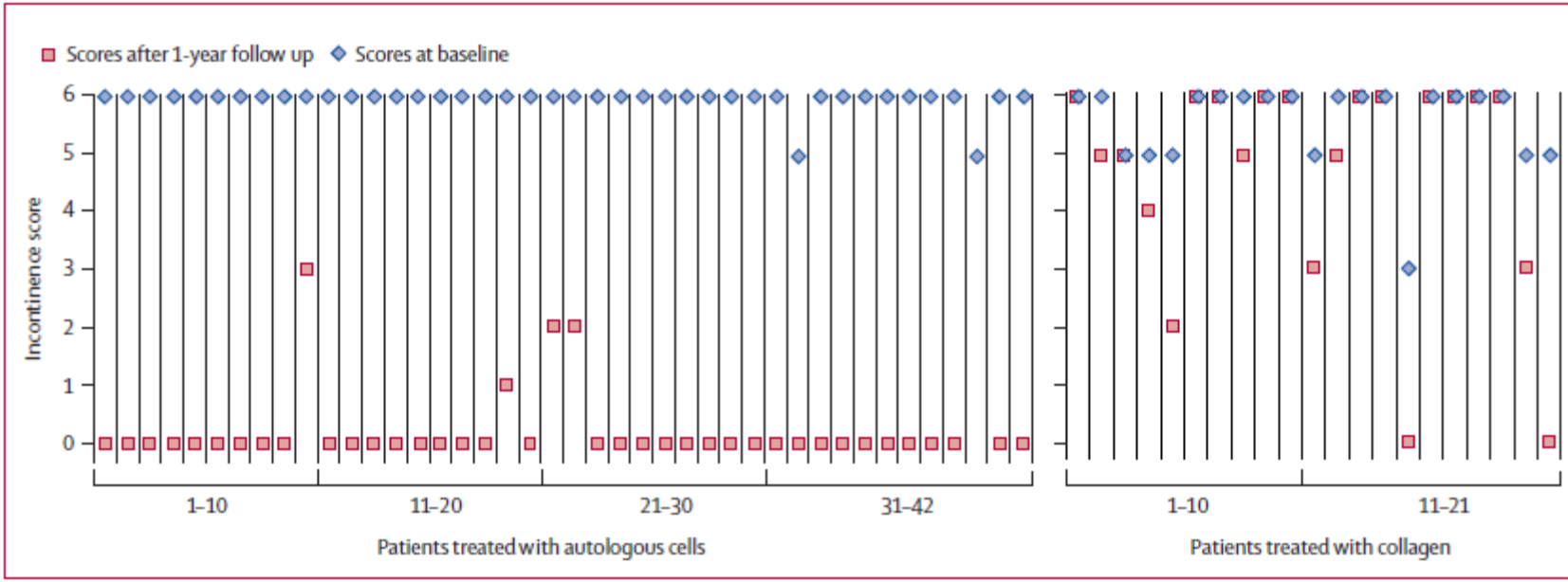

Figure 5: **Incontinence score before and after treatment**
Blue marks represent baseline scores and pink marks are scores after 1 year of follow-up.

Incontinence: sharing the expertise

- Local-international
- Multidisciplinary
- Public awareness
- Professional teaching
- Expertise availability-dissemination

Incontinence

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