## Incontinence

### Daniel Faltin

Dianuro – Centre de périnéologie 54b rte des Acacias 1227 Carouge/Genève 022 3093300 www.dianuro.ch

daniel.faltin@dianuro.ch

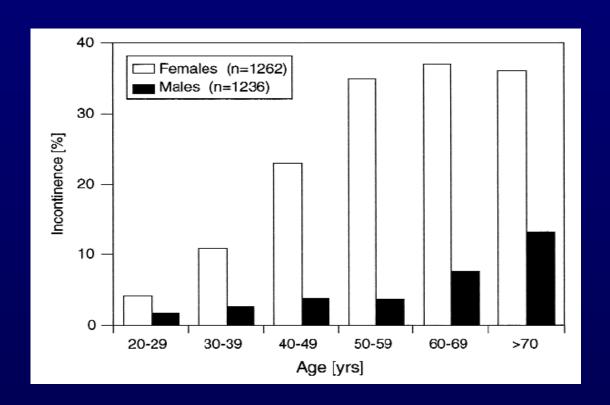


Training Course in Reproductive Health Research – Geneva 2008

### ICS definition of incontinence

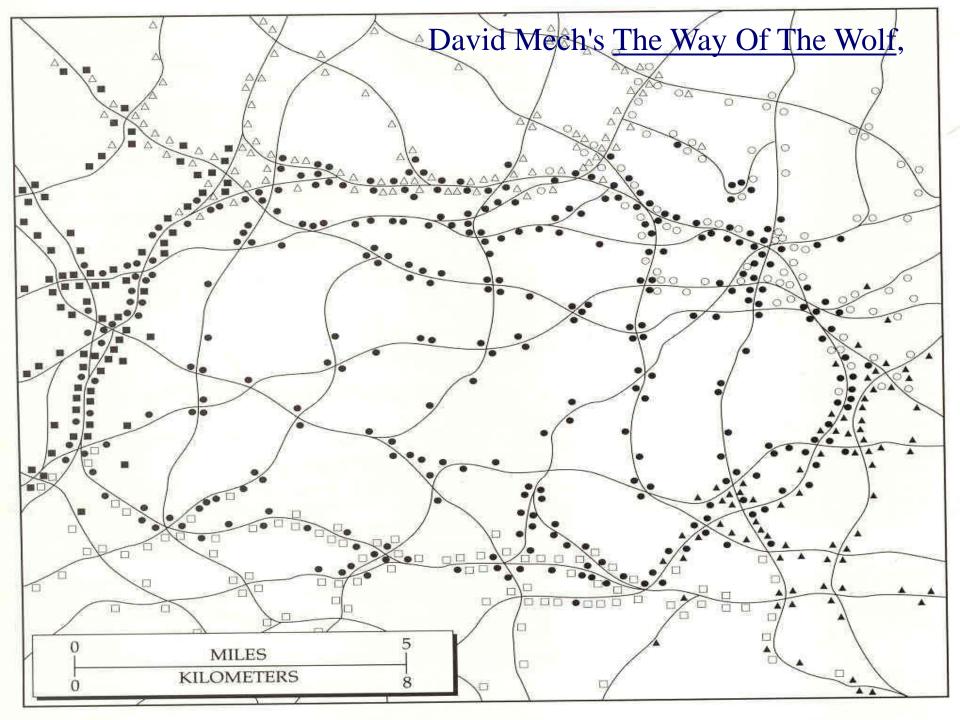
Urinary incontinence is the complaint of any involuntary loss of urine

### Prevalence













# 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

Incontinence Incontinence Incontinence Complex history, eg. History/symptoms on physical with mixed with urgency/ Recurrent incontinence assessment activity symptoms frequency. Incontinence associated with: Pain General assessment Haematuria Urinary diary and symptom score Clinical Recurrent infection Assess quality of life and desire for treatment assessment Voiding symptoms Physical examination: abdominal, rectal, sacral neurological Pelvic irradiation and oestrogen status → if atrophic, treat and reassess Radical pelvic surgery Cough test to demonstrate stress incontinence Suspected fistula Urinalysis ± urine culture → if infected, treat and reassess Assess PVR by abdominal examination (optional: by ultrasonography) · Significant PVR Presumed Stress Mixed Urge Significant pelvic condition incontinence incontinence incontinence organ prolapse Lifestyle interventions Pelvic-floor muscle training Treatment. Bladder retraining

Antimuscarinics

Specialised management

Failure

· Other physical therapy adjuncts

Failure

· Devices

#### MANAGEMENT OF URINARY INCONTINENCE IN FRAIL OLDER PERSONS

#### HISTORY/SYMPTOM/ ASSESSMENT

#### INCONTINENCE

#### CLINICAL ASSESSMENT

 Delirium Infection

- · Atrophic vaginitis Pharmaceuticals
- Psychological
- Excess urine output
- · Reduced Mobility
- · Stool impaction and other factors

- Assess, treat and reassess potentially treatable conditions, including relevant comorbidities and activities of daily living (ADLs)
- Assess QoL, desire for Rx, goals of Rx, pt & caregiver preferences
- Targeted physical exam incl cognition, mobility, neurological
- Urinalysis + MSU
- Bladder diary
- Cough test and PVR (If feasible and if it will change management)

#### UI associated with:

- Pain
- Haematuria
- · Recurrent symptomatic UTI
- Pelvic mass
- Pelvic irradiation
- Pelvic/LUT surgery
- Major prolapse (women)
- Post prostatectomy (men)

#### **CLINICAL DIAGNOSIS**

\* These diagnoses may overlap in various combinations, eq. MIXED UI, DHIC (see text)

#### INITIALE MANAGEMENT

(If Mixed UI, initially treat predominant symptoms)

ONGOING MANAGEMENT and REASSESSMENT



Urge UI \*

- Lifestyle interventions
- Behavioral therapies
- Consider cautious addition and trial of antimuscarinic drugs
- ± Topical estrogens (women)

#### Significant PVR\*

- Treat constipation
- Review medications
- Double voiding
- Consider trial of alpha-blocker (men)
- If PVR>500: catheter decompression then reassess

#### Stress UI\*

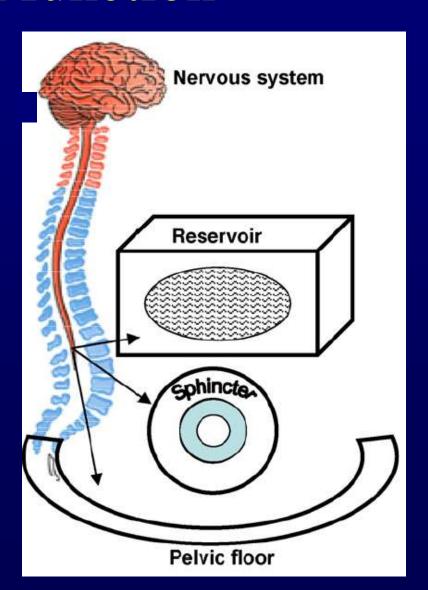
- Lifestyle interventions
- Behavioral therapies
- + Topical estrogens (women)

Continue conservative methods ± Dependent continence ± Contained continence

If fails, consider need for specialist assessment

## Think function

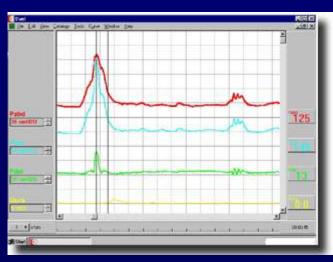
Urinary Reproductive Anorectal



## Urodynamics



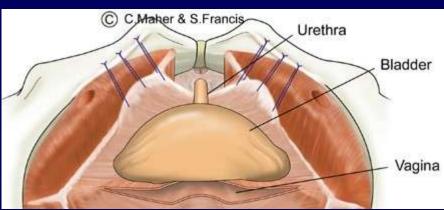






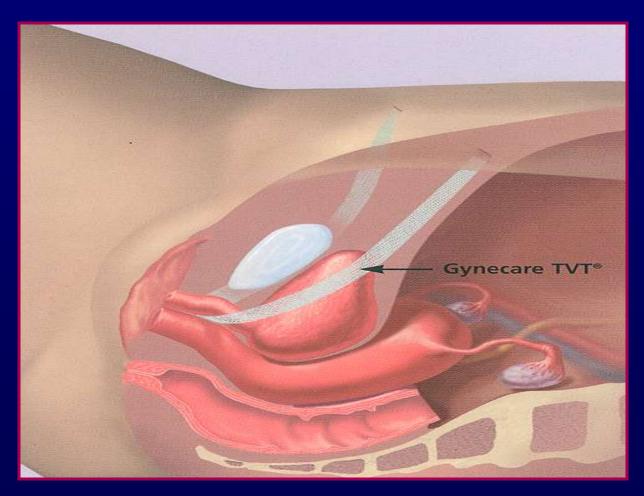
## Burch colposuspension



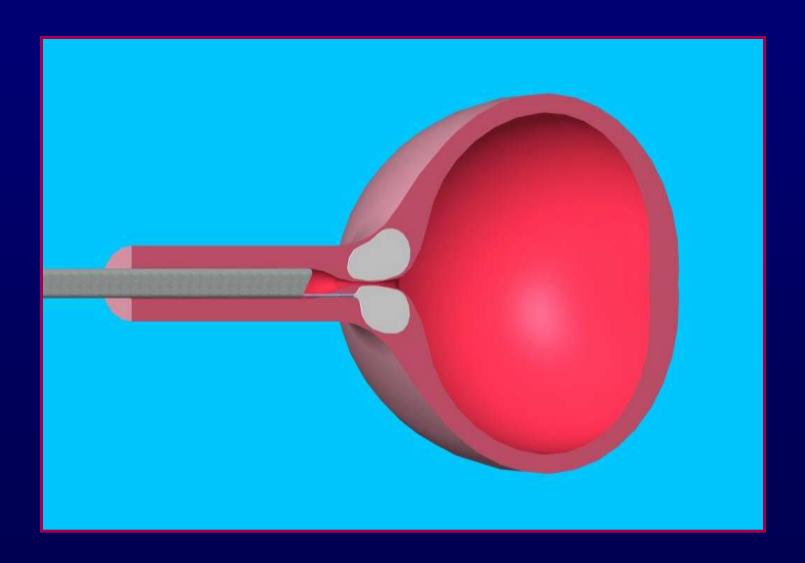


## TVT

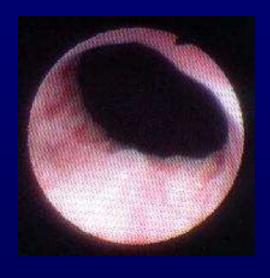
(tension free vaginal tape)



## 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"

# 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



©2004 UpToDate®

New Search

Table of Contents

<u>Feedback</u>

Help

Official reprint from UpToDate® http://www.uptodate.com/

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

## 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





www.elsevier.com/locate/ajog

GENERAL OBSTETRICS AND GYNECOLOGY: GYNECOLOGY

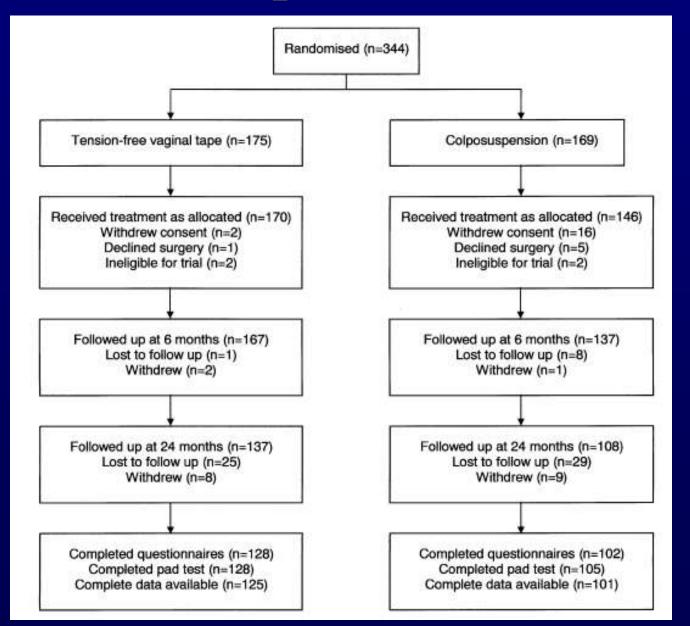
A prospective multicenter randomized trial of tension-free vaginal tape and colposuspension for primary urodynamic stress incontinence: Two-year follow-up

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

Ward and Hilton

	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	141/175	81	138/169	82	0.93	0.54-1.60	.89
and last postoperative result carried forward			·				

<sup>\*</sup> Fisher exact test.

# The NEW ENGLAND JOURNAL of MEDICINE

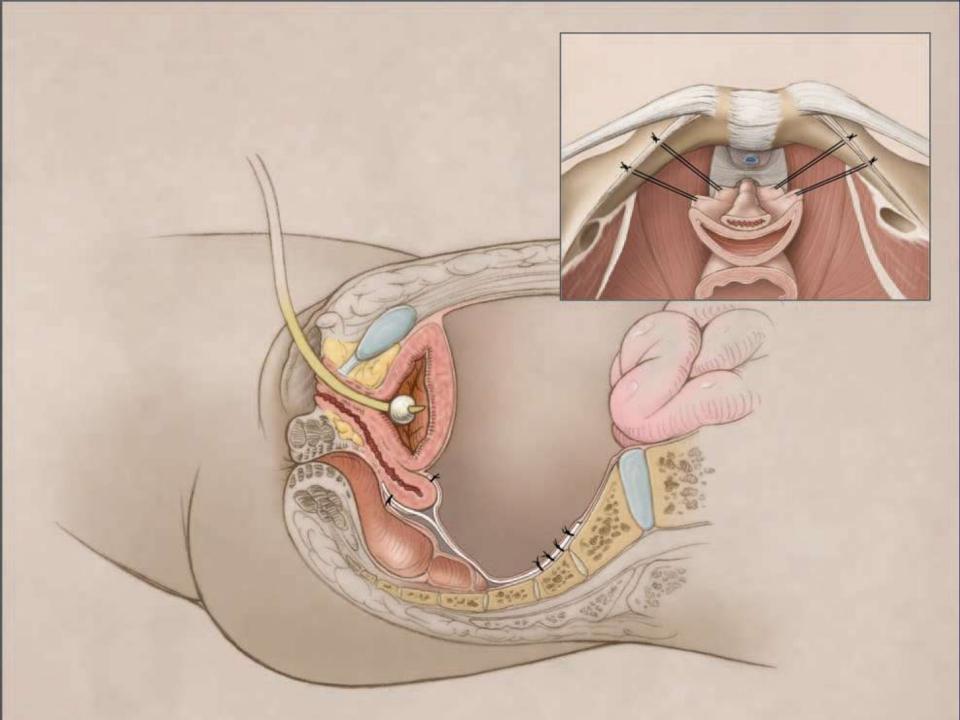
ESTABLISHED IN 1812

APRIL 13, 2006

VOL. 354 NO. 15

## 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\*



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	

13.3±19.0

23.3±24.7

< 0.001

MESA score for stress incontinence

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

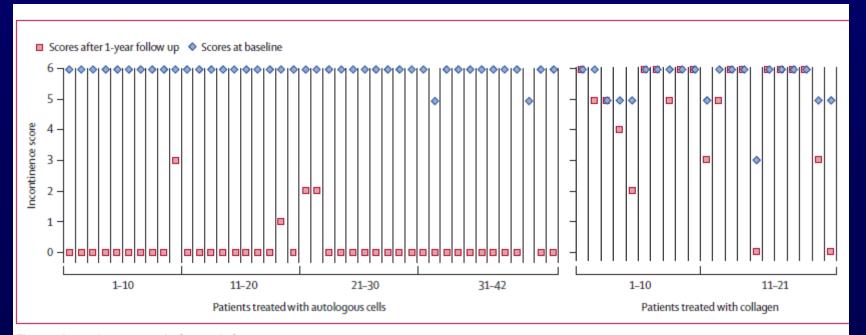


Figure 5: Incontinence score before and after treatment

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

### Daniel Faltin

Dianuro – Centre de périnéologie 54b rte des Acacias 1227 Carouge/Genève 022 3093300 www.dianuro.ch

daniel.faltin@dianuro.ch



Training Course in Reproductive Health Research – Geneva 2008