

PENINSULA UROLOGY CENTER, INC NEWSLETTER

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TOPIC OF THE MONTH:

Stress Urinary Incontinence

Urinary incontinence affects more than 33 million Americans and only a small percentage of those patients undergo an appropriate work up and management. 80% of women with incontinence go untreated primarily because of a lack of knowledge about treatment options, embarrassment, or the thought that they are suppose to live with this condition because it is a normal part of aging. In this newsletter we will discuss this disease process.

There are a number of categories for urinary incontinence: stress, urge, mixed, overflow, post void dribble, nocturnal enuresis, extra-urethral, continuous leakage, and neurogenic (functional) incontinence. Although they all result in embarrassing loss of bladder control, the causes and management for each is very different.

Stress incontinence occurs when a patient coughs, sneezes or exercises with an associated loss of urine. Our focus in this issue will be on stress incontinence and will save the other forms of incontinence for future news letters.

Stress urinary incontinence (SUI) is the most prominent type of incontinence among middle age women. 50% of women with incontinence are classified as having SUI. The condition has peak prevalence around the time of menopause. There are two forms of stress incontinence; urethral hypermobility and intrinsic sphincteric deficiency.

The evaluation of stress incontinence involves a detailed history. The patient should describe whether SUI occurs during walking, bending, sneezing, or exercise. Patients should describe how many pads they use and whether they soak their pads or change them once a small amount of urine is leaked. Mild to moderate incontinence with provocative maneuvers

suggest hypermobility which is often associated with pelvic prolapse. More severe incontinence is usually associated with Intrinsic Sphincteric Dysfunction (ISD). Historic risk factors for ISD are failed bladder neck suspension, pelvic radiation therapy, history of radical pelvic surgery and pelvic trauma.

Voiding diaries are helpful in determining overall voiding patterns, frequency, the magnitude of incontinence and an estimated functional bladder capacity. The Pad weight test has been described as the only true measure of SUI magnitude.

The physical exam is an important part of the SUI evaluation. The abdominal exam should screen for prior surgical scars, obesity and a distended bladder. The pelvic exam should exclude signs of a cystocele, rectocele, or enterocele. The position of the cervix or vaginal cuff should be noted; a gynecologist should assess cervical descent. The vaginal epithelium should be checked for atrophic changes. Urethral bladder descent greater than 35 degrees is usually indicative of urethral hypermobility. A neurological exam is important to rule out any deficits that could have an impact on detrusor function.

Cystoscopy is not usually performed unless there is a history of hematuria or other urologic concerns unrelated to the stress incontinence.

Urodynamics is not required prior to SUI surgical management; however most large practices and academic institutions incorporate urodynamics as a necessary part of the SUI work up prior to any surgical management. Multi-channel urodynamics should evaluate several variables. Functional bladder capacity (300cc-600cc). Compliance which can be decreased in patients with neurogenic bladders. Sensation and stability. The all important valsalva leak point pressure (VLPP), if the leak occurs at less than 60cm H₂O then intrinsic sphincter dysfunction is diagnosed. VLLP >100cm H₂O usually indicates

urethral hypermobility.

Treatment for SUI has changed dramatically over the last five years. Open surgical procedures with hospital stays and long post operative courses are no longer the norm. Non surgical management with fluid and dietary modification, bladder retraining and pelvic floor therapy has been met with mixed success depending on the severity of the SUI. Behavioral therapy is usually a safe first line therapy for patients who aren't ready for invasive procedures. Success rates are mixed.

Minimally invasive procedures like urethral bulking and HIFU are done in the office setting with local anesthesia. Urethral bulking agents are suited only for patients with ISD. There are a number of agents used. Success rates range anywhere from 46% to 77%. Perioperative complications include urinary retention in 20% to 25% of patients. Irritative voiding symptoms occur in 15% of patients, and multiple injections are often required to achieve success.

The Renessa procedure is a thermotherapy procedure (HIFU) that is indicated for type III hypermobility. The procedure takes 10 minutes in the office with minimal side effects. 59% of patients will see a fifty percent reduction in SUI, and 58% percent of patients in a recent study were able to eliminate their need for pads. While the overall cure rate is only 35% this procedure offers patients who aren't surgical candidates or don't want surgery an option for improvement.

The surgical treatment for SUI has changed dramatically of the last 5 years. No longer are abdominal procedures with suprapubic tubes and prolonged hospital stays and recovery periods indicated. The mid urethral procedures are performed in less than 30 minutes as out patient surgery. It's performed primarily within the vagina with no scars and minimal postoperative pain. Success rates range from 84%-90%. Complications include irritative voiding symptoms, urinary retention, and erosion of the sling, bladder calculus, and persistent stress incontinence.

CENTER FOR CONTINENCE

Our Center for Continence in conjunction with Dr. Bruno is now offering treatment for men with incontinence after prostatectomy, as well as Interstim treatment for men and women with overactive bladder and non-obstructive urinary retention.

We are the only locally recognized facility to offer the Renessa treatment and continue to offer pelvic floor muscle training for urinary incontinence and pelvic pain.

EMERGING TREATMENTS

Our office is currently enrolling patients in two clinical trials. One trial involves a 6 month formulation of GnRH for the treatment of prostate cancer in patients > 18 years of age. This trial will last 14 months. The other trial involves medication for OAB in both males and females > 18 years of age experiencing frequency and urgency with or without incontinence for > 3 months. If you have any patients you think would be good candidates have them call Linda at 650-306-0750.

UPCOMING TOPICS

1. Erectile Dysfunction
2. Kidney Stones
3. Incontinence
4. Hematuria
5. Renal, Bladder, Prostate, Testicular Cancer
6. Male Menopause
7. Interstitial Cystitis
8. Treatment Advances for UPJ Obstruction
9. Recurrent UTI's
10. Infertility

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