Urinary incontinence and Prolapse:

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What is urinary incontinence?

It is the involuntary loss of urine which occurs either when sneezing, running, jumping, laughing (referred to as stress urinary incontinence –*SUI)*; when standing from a sitting position (intrinsic sphincter deficiency-*ISD*); or continuous leakage (maybe a fistula).While these are most commonly described symptoms, there are other presentations. Sometimes the leakage is accompanied by a sudden desire to urinate which is important information for your doctor, as this might suggest another problem called overactive bladder (OAB).

This is a syndrome which includes urinary frequency (passing urine more than 8 times per 24hours), urgency and nocturia (when you are awoken from your sleep to pass urine). The treatment for each is different and therefore when you consult the doctor will take a detailed history from you. Sometimes a combination of stress and urgency symptoms occur and this combination is the called mixed urinary incontinence –MUI.

How is urinary incontinence evaluated?

After a detailed history and clinical examination the clinician will determine the investigations that are required. To begin with, simple tests are requested such as:

- screening for a urinary tract infection and diabetes
- post void residual-the amount of urine left in the bladder after urination
- 3 day bladder diary- which will document the time, amount of fluids taken in and amount you urinate, the type of fluid as well and any associated wet episode

After these results further specialised tests maybe requested such as:

- pad test
- transperineal ultrasound- to look at the thickness of the bladder wall
- urodynamic tests-which evaluates the bladder function
- cystoscopy-looking at the bladder with a scope

What are the different types of treatment available?

In cases of mild SUI pelvic floor exercises (Kegel exercises) is first-line treatment. This is voluntary contraction of the pelvic floor muscle, initially done by lying down. Your doctor will teach this exercise to you during the consultation by pointing out which muscle to contract and also check that you are activating the correct muscle. You will need to do 10 contractions 3 times a day. In some cases the exercised are done in conjunction with electrical stimulation to improve the functioning of the pelvic floor muscle.

Behavioural therapy is also sometimes suggested based on the bladder diary. This includes timed voiding, that means emptying your bladder at certain time intervals to avoid over-filling of the bladder. The length between emptying will be gradually lengthened. Avoidance or reducing the amount of caffeine and fizzy drinks will also be suggested as these are bladder irritants.

For OAB drug treatment is usually prescribed together with the above. These drugs are called anticholinergics since they work on the nerves of the bladder. They have been shown to decrease the amount of incontinent and urgency episodes, thereby improving quality of life. However, many patients will discontinue this treatment due the side effects such as drowsiness, constipation, blurred vision, flushing and a faster heart rate. If you do not respond to oral treatment (usually after 6 weeks), other modalities are explored such as neuromodulation and botox. This should be discussed with your specialist.

Surgery is done for moderate to severe cases of SUI. These are called sling procedures (mid-urethral) and are done under general anaesthesia most times. It involves the

placement of a tape beneath the urethra. There are different types of sling procedures such as the retropubic (behind the pubic bone), transobturator and mini-slings-more information can be obtained from your treating specialist.

Conclusion: After a diagnosis discuss the treatment plan with your doctor. This will be dependent on your medical condition, treatment preferences and the surgeon's experience. Urinary incontinence can be distressing and debilitation condition for patients, family members as well as care-givers. It is a common condition in women, and embarrassing but treatment is available.

What is prolapse and what are the common complaints?

Prolapse is described according to the part that comes down the vagina. This can either be the bladder (cystocoele), uterus, rectum (rectocoele), urethra and in some cases bowel (entercoele). The severity is usually graded from 1-4, grade 1 being mild and 4 most severe.

In most cases the commonest complaint is feeling 'bulge in the vagina, or something coming down'; and also lower abdominal pain. After an examination your doctor will inform you what is coming down and discuss further treatment options. Note that prolapse is not cancer and is not life-threatening.

What treatment options are available?

Surgery as well as treatment with a vaginal pessary is available options.

Vaginal pessaries involve the insertion of a silicone ring into the vagina to lift the prolapse. There are different types of pessaries. The commonest used worldwide is the ring pessary. It can stay in for 3-6 months after which you will need to reconsult the doctor who inserted it-this is important as the vaginal can become irritated with prolong usage. In some the use of a pessary is indicated, such as: declining surgical treatment, unsuitable for surgery, awaiting surgery, females who still desire to have babies.

Surgery for bladder prolapse is called an anterior repair, for rectocoele, a posterior repair. This involves opening the vaginal skin and stitching the tissue together. For uterine prolapse, there are various options such –either vaginal or an abdominal procedure. The type of procedure again is dependent on the surgeon's experience and patient preference. In cases where you have no uterus, and the top part of the vaginal comes down, this is called vault prolapse. The operation to correct this is called a sacrocolpopexy, which is an abdominal procedure.

For further information on these topics please visit www.sa-urogyne.org.