WELCOME AND INTRODUCTION

Welcome to the first edition of our Gynaecology Update newsletter. In this edition we will focus on Female Incontinence.

The science and practice of gynaecology has made remarkable advances in the last decade. There is a growing awareness of common issues like bladder control problems. Fortunately there are more treatment options than ever before.

Our practice specialises in helping your patients improve their quality of life, through the very best in medical care and information. With this issue of our Gynaecology Update newsletter, we invite you to learn more about solutions for incontinence. There are a number of excellent options available that can restore bladder control for women who suffer from stress urinary incontinence.

To find out more about the treatments available to your patients, questions about incontinence or any other Gynaecological condition, please do not hesitate to contact me on 1300 698 699 or 07 3831 0519

FROM DR PHILIP HALL

MB BS MRMed FRANZCOG, FRCOG, FACRRM

Dr Hall practices the breadth of Gynaecology and has over 30 years’ extensive experience in treating:

- Female incontinence
- Pelvic organ prolapse & Vaginal surgery

Dr Hall is a Director of the Pelvic Medicine Centre at St Andrews War Memorial Hospital, Brisbane — the first private multidisciplinary clinic that aims to provide ‘whole of patient care’ for both men and women experiencing a wide range of pelvic conditions; including incontinence and prolapse.

www.thepelvicmedicinecentre.com.au
THE FACTS
- Between 19.3-37% of Australian women suffer from Urinary Incontinence
- Females represent two thirds of people likely to experience severe incontinence

STRESS URINARY INCONTINENCE (SUI)
Urine loss during exercise, coughing, sneezing, laughing, or any body movement which puts pressure on the bladder. The treatment options aim to strengthen or aide the pelvic muscles that have been damaged, the different types are:
- Pelvic floor exercises
- Pessary devices
- Bulking agents
- Surgery

The gold standard surgical treatment for Stress Incontinence is the placement of a mid urethral sling (MUS) which include three types of sling access.
Retropubic, Trans-obturator and Single Incision Slings which provide a stable platform under the mid urethra.

FIRST STEPS IN DIAGNOSIS
CONTINENCE QUESTIONNAIRE
Many patients will not raise the subject of incontinence. Having a questionnaire available in the waiting room can start the initial conversation.

BLADDER DIARY
This tool provides invaluable evidence on drinking and voiding habits.

URODYNAMICS
This test is designed to provide volume and pressure information about bladder dysfunction.

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ULTRASOUND
Ultrasound can assist in diagnosing movement of the pelvic floor muscles during valsalva. Weak support of the tissue surrounding the urethra is very visible upon scanning.
MINIMALLY INVASIVE SINGLE INCISION SLING

Advantages:
- LESS Mesh
- LESS Pain
- LESS Anaesthetic
- LESS Incision
- LESS Recovery time

This mid urethral sling inserted through a 1.5cm incision in the vaginal wall. It is designed to be minimally invasive and therefore reduce the risk of tissue trauma and bleeding. It features the same proven mesh used in over 750,000 procedures and employs one slim 2.3mm needle designed to minimize tissue trauma and help promote less dissection.

This sling uses only 8.5cms of mesh as apposed to other obturator slings which require up to 14cms.

Small, integrated self-fixating tips provide significant holding force into the obturator muscle without pain and helps prevent migration during initial tissue fixation and ingrowth.

Known Risks Of Surgical Procedures For The Treatment Of Urinary Incontinence Include:
- Pain/Discomfort/Irritation
- Inflammation (redness, heat, pain, or swelling resulting from surgery)
- Infection
- Mesh erosion (presence of suture or mesh materials within the organs surround the vagina)
- Mesh extrusion (presence of suture or mesh material within the vagina)
- Fistula formation (a hole/passage that develops between organs or anatomic structures that is repaired by surgery)
- Foreign body (allergic) reaction to mesh implant
- Adhesion formation (scar tissue)
- Urinary incontinence (involuntary leaking of urine)

Urge Urinary Incontinence

Patients experience the overwhelming need to urinate, even if your patient just went and/or being unable to hold it long enough to reach a bathroom. It is often called ‘Keyhole Incontinence’.

Treatment includes:
- Lifestyle Changes
- Behaviour Modifications
- Medications
- Neural Stimulation
SURGICAL TREATMENT FOR URGE INCONTINENCE

SACRAL NEUROMODULATION THERAPY

When medication therapy, targeting the muscular component of Overactive Bladder (OAB), is unable to achieve the desired symptomatic results, other options must be considered. One such option is Sacral Neuromodulation Therapy (SNM), which targets the nerve miscommunication between the bladder/bowel and the brain.

SNM Therapy has treated over 150,000 patients worldwide. It is indicated for use in patients suffering from urgency-frequency, urgency-incontinence, incomplete emptying and retention, as well as faecal incontinence (FI).

A unique characteristic of SNM is that the therapy offers the ability to test each patient with either a Basic or Advanced Evaluation. SNM works on regulating the signals in the bladder/bowel and brain communication pathways. The test can help determine if a nerve miscommunication is the culprit behind the bladder or bowel issues a patient may be experiencing.

SNM testing options and the therapy are all minimally invasive and fully reversible. Long-term results have been demonstrated in clinical trials, and vary by patient.\(^5\)

BOTULINUM TOXIN A BLADDER INJECTIONS

Botulinum Toxin A treatment has been found to be effective in treating the urgency associated with OAB (Overactive Bladder) and most importantly for sufferers — the urge incontinence episodes. In a recent clinical study, people who were suffering with an average of 5.5 incontinence episodes per day at the start of the trial — approx. 25% of people became totally dry after one treatment.

This effect can last up to six months or longer.

Furthermore from the TGA recognising Botulinum Toxin as being effective — the PBS as of November 1 will cover the cost for OAB, for patients who have trialled two anticholinergics.

Botulinum A injections are given through a cystoscope into the wall of the bladder.

REFERENCES

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