THE PELVIC MEDICINE CENTRE

ST ANDREW'S WAR MEMORIAL HOSPITAL

First class treatment. World class results.

FEMALE URINARY INCONTINENCE

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WELCOME AND INTRODUCTION

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

'Less than 50% of women with urinary incontinence discuss their symptoms with their Doctor.'[1]

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

Dr Philip Hall, Pelvic Medicine Centre, St Andrews War Memorial Hospital, Brisbane.

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

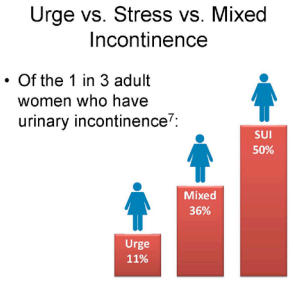
Dr Hall is a Director of the Pelvic Medicine Centre at St Andrews War Memorial Hospital, Brisbane — the first private multidisciplinary clinic that aims to provide 'whole of patient care' for both men and women experiencing a wide range of pelvic conditions; including incontinence and prolapse.

www.thepelvicmedicinecentre.com.au

In this issue: **URGE v STRESS urinary incontinence • Conservative treatments • Surgical options**

THE FACTS

- Between 19.3-37%[2] of Australian women suffer from Urinary Incontinence
- Females represent two thirds of people[2] likely to experience severe incontinence



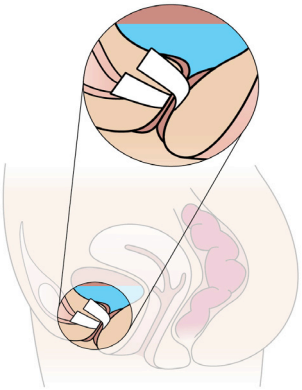
STRESS URINARY INCONTINENCE (SUI)

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[3] are:

- Pelvic floor exercises
- Pessary devices
- Bulking agents
- Surgery

The gold standard surgical treatment for **Stress Incontinence is the placement of a mid urtheral 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.



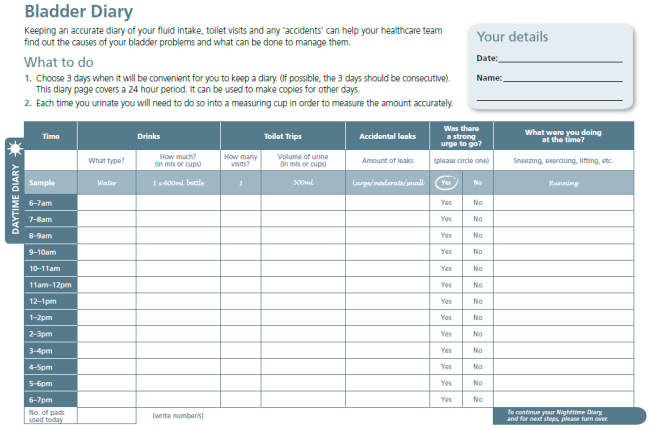
FIRST STEPS IN DIAGNOSIS

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.



Bladder Diary

Keeping an accurate diary of your fluid intake, toilet visits and any 'accidents' can help your healthcare team find out the causes of your bladder problems and what can be done to manage them.

What to do

1. Choose 3 days when it will be convenient for you to keep a diary. (If possible, the 3 days should be consecutive). This diary page covers a 24 hour period. It can be used to make copies for other days.
2. Each time you urinate you will need to do so into a measuring cup in order to measure the amount accurately.

Your details

Date:_____

Name:_____

DAYTIME DIARY

Time	Drinks		Toilet Trips		Accidental leaks	Was there a strong urge to go?		What were you doing at the time?
	What type?	How much? (in mls or cups)	How many visits?	Volume of urine (in mls or cups)	Amount of leaks	(please circle one)		Sneezing, exercising, lifting, etc.
Sample	Water	1 x 600ml bottle	1	500ml	Large/moderate/small	Yes	No	Running
6–7am						Yes	No	
7–8am						Yes	No	
8–9am						Yes	No	
9–10am						Yes	No	
10–11am						Yes	No	
11am–12pm						Yes	No	
12–1pm						Yes	No	
1–2pm						Yes	No	
2–3pm						Yes	No	
3–4pm						Yes	No	
4–5pm						Yes	No	
5–6pm						Yes	No	
6–7pm						Yes	No	
No. of pads used today		(write number/s)						To continue your Nighttime Diary, and for next steps, please turn over.

URODYNAMICS

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

Investigation	Symptoms	Possible diagnosis
Uroflow	Frequency, nocturia, poor flow	Bladder outlet obstruction
Pressure flow	Frequency, nocturia, poor flow	Bladder outlet obstruction
Cystometry	Frequency, urgency	Detrusor instability
Urethral closure pressure	Incontinence	Genuine stress incontinence

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

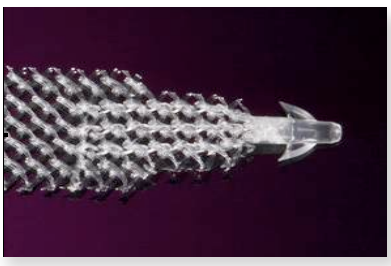
Advantages:

- **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.



Single Incision Sling

- Minimally invasive for enhanced patient recovery
- Ambulatory day procedure
- Now is often performed with local anesthesia
- Single incision offers potential for less post-operative pain
- Most patients can resume normal activities within 1-2 weeks of the procedure[4]

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

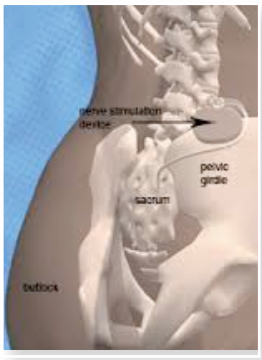
SURGICAL TREATMENT FOR URGE INCONTINENCE

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.



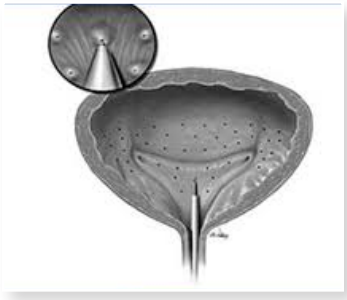
SNM testing options and the therapy are all minimally invasive and fully reversible. Long-term results have been demonstrated in clinical trials, and vary by patient.[5]

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.

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THE PELVIC MEDICINE CENTRE

CONTACT US: Dr Philip Hall
The Pelvic Medicine Centre
St Andrew's War Memorial Hospital
457 Wickham Terrace Spring Hill Qld 4001
p: 07 3831 0519 / 1300 698699 / f: 07 3831 9717
e: reception@drphilbne.com.au
w: thepelvicmedicinecentre.com.au