

reatment options

- ▶ Modify fluid intake
- ▶ Weight loss
- ▶ Pelvic floor exercises
- ▶ Treat any exacerbating factors – cough, asthma, OSA

Pelvic Floor exercises

How to locate the pelvic floor muscles

- ▶ Squeeze the area of the rectum to tighten the anus as if trying not to pass gas. Feel the sensation of the muscles pulling inward and upward.

Or:

- ▶ Women: Insert a finger into your vagina and contract the vaginal muscles. Feeling a squeeze confirms that you're using the correct muscles.
- ▶ Men: Stop urinating midstream. When you contract your pelvic muscles correctly, you should see a slight lifting of the penis.

TREATMENT OPTIONS FOR
**Stress Urinary
Incontinence**



What is stress urinary incontinence?

Stress Urinary Incontinence (SUI) is the leaking of urine during activities that increase pressure inside the abdomen and push down on the bladder, such as coughing, sneezing, running, or heavy lifting.

There are several causes of SUI including pregnancy, childbirth (particularly where forceps were needed), weight gain, and chronic straining or coughing.

Types of incontinence

Incontinence is any accidental or involuntary loss of urine from the bladder – urinary incontinence – or bowel motion, faeces or wind from the bowel – faecal or bowel incontinence.

There are different types of urinary incontinence, each with different causes and treatments, which include:

- Stress incontinence – this type of incontinence is the focus of this information resource
- Urge incontinence – urinary incontinence preceded by a sudden and strong need to urinate
- Incontinence associated with chronic retention – when the bladder is unable to empty properly and frequent leakage of small amounts of urine occurs as a result
- Functional incontinence – due to medications or health problems that make it difficult to reach the bathroom in time
- Continuous incontinence – where your bladder cannot store any urine at all, resulting in either passing large amounts of urine constantly, or passing urine occasionally with frequent leaking.

Sometimes women have more than one type of incontinence. Specialised tests will help diagnose the type of incontinence you have and which treatment options are right for you. These tests may include a urodynamic study or a cystoscopy.

What are my treatment options?

Stress urinary incontinence can be embarrassing and distressing. Your treatment really depends on how much it affects you and what you feel you can cope with, as well as your general health. Your options fall into three categories:

1 Do nothing

Manage your symptoms with continence aids

2 Non-surgical treatments

Lifestyle changes, pelvic floor exercises, continence pessaries

3 Surgical treatments

Pubovaginal sling, colposuspension, retropubic mid-urethral sling, transobdurator mid-urethral sling, urethral bulking agents.

Each of these options is explained in more detail on the following pages.

The decision you make about which treatment option is best for you will depend on a number of things:

-
- why you are seeking treatment

 - how severe or troublesome your symptoms are

 - how well you understand the treatment options

 - your lifestyle and values.

After considering the less-invasive, non-surgical options, it is your decision if you wish to proceed with surgical treatment.

Some surgical options use transvaginal mesh in a mid-urethral sling. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommends mid-urethral sling surgery for SUI in routine cases. The Royal Australasian College of Surgeons also recommends that you understand your options before proceeding with treatment.

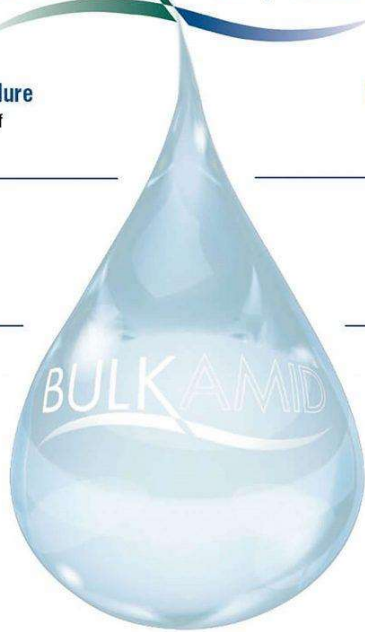
BULKAMID®

Minimally invasive procedure

No incisions are made, just a series of small injections.

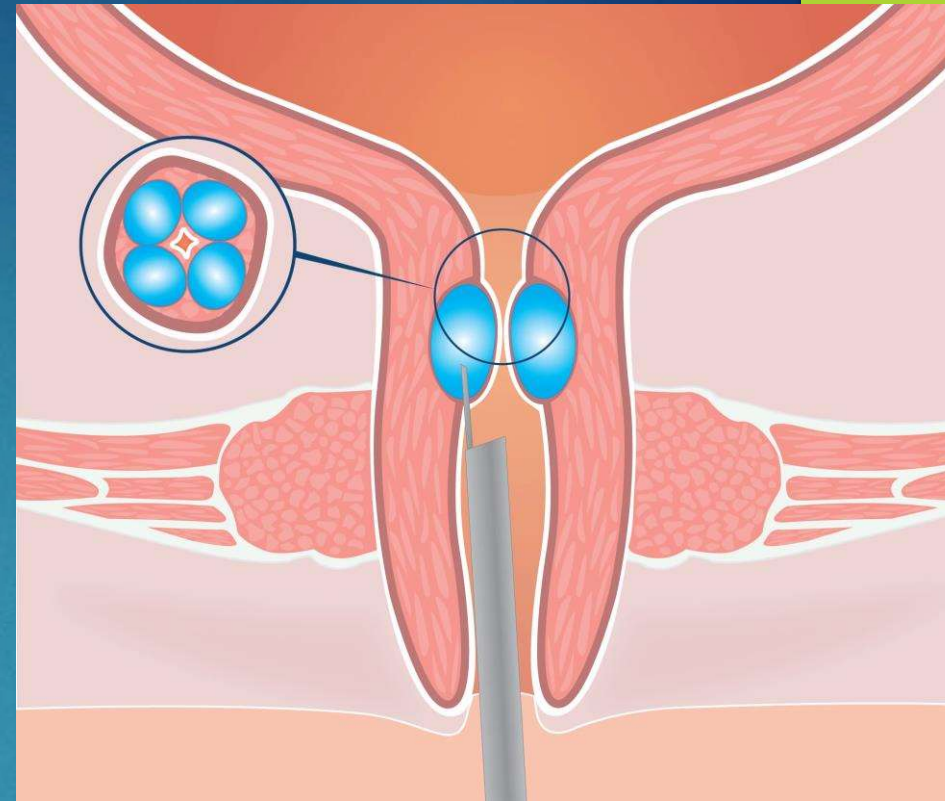
More than 70,000 patients
have been treated with Bulkamid.

3 out of 4 women
report that their stress urinary
incontinence was cured or
improved after treatment
with Bulkamid.



No reported long term complications*

Short term side effects normally
resolve within a couple of days.



Urethral bulking agents

A useful option for recurrent SUI with a well-supported urethra and for women who wish to delay consideration of other types of surgery

This is usually offered as a day procedure or as a 24-hour stay and some clinicians offer this under local anaesthetic

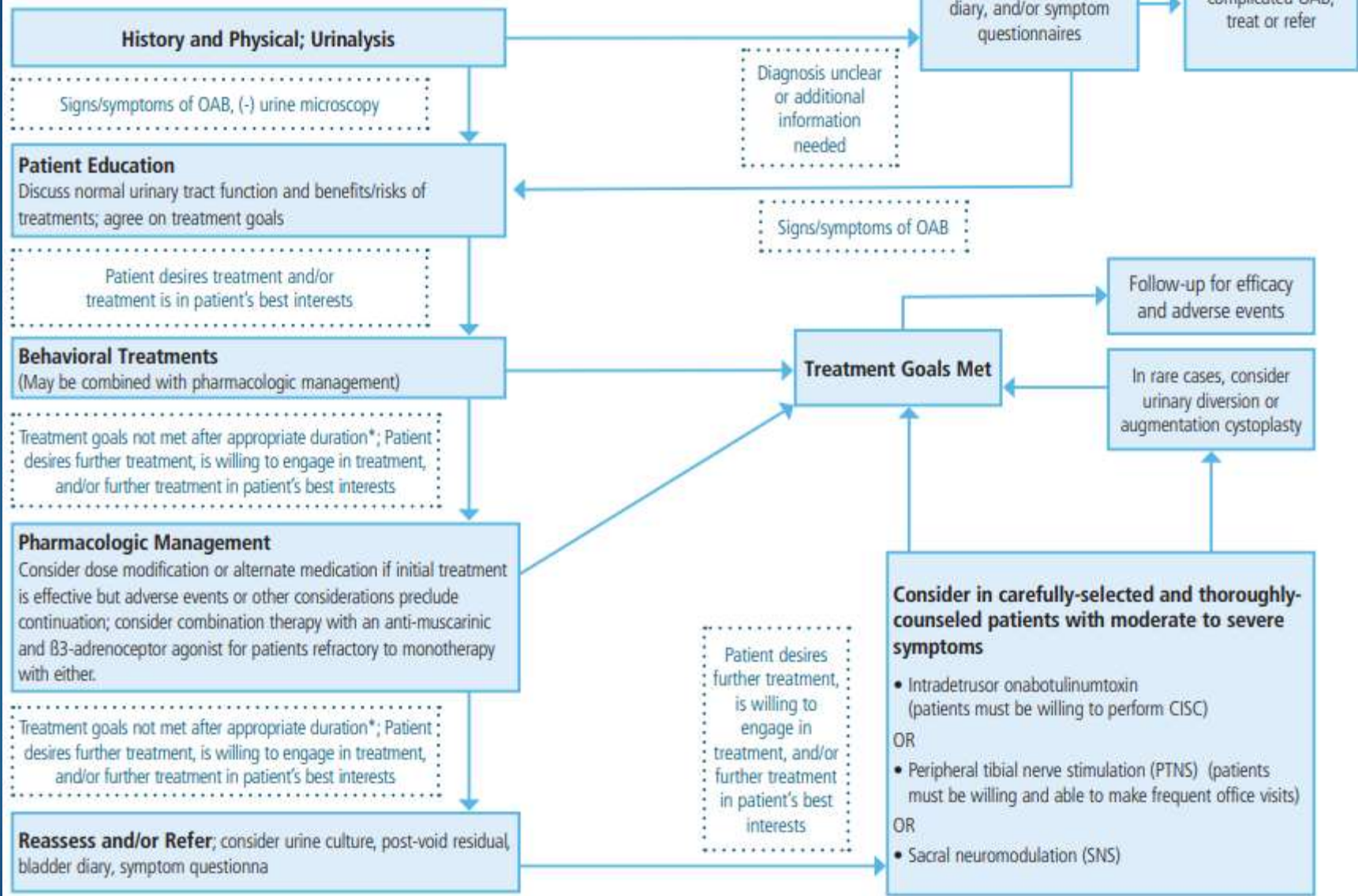
Recovery time is short and the risk of complications is low

Low risk of difficulty with bladder emptying compared to other surgical procedures

- Urethral bulking is not generally used as a first-line treatment for SUI
- Success rate is around 4 in 10 to 5 in 10 after two years. Success is better with well supported urethra and satisfactory urethral closure function
- Rarely, a localised infection (abscess) can form in the urethral wall where the bulking agent was injected
- There may be temporary difficulty emptying the bladder after the procedure
- May require repeat injections for some patients
- Serious complications are rare

	Potential benefits	Considerations
<p>Vaginal or sling</p>	<p>Uses your own fascial tissue from your abdomen</p> <p>May be used for all forms of SUI including complex reconstruction after other procedures have failed</p> <p>Long-term success rate of 85%</p>	<ul style="list-style-type: none"> • Comparable risk of recurrent stress incontinence is 1 in 10 compared with other surgical treatments • Involves a combination of vaginal and abdominal surgery Only some specialised surgeons perform this type of surgery. • Involves a longer operation, post-operative hospital stay (2-3 days) and recovery period than mid-urethral sling. • Complications include: wound related (such as infection and risk of hernia where the fascia was removed from) and difficulty emptying the bladder which may require self-catheterisation or re-operation • Serious complications are rare
<p>Suspension</p>	<p>Uses your own tissue and sutures (stitches) to re-support the bladder outlet and suspend the vagina from ligaments on the pubic bone</p> <p>Long-term success rate of at least 70%</p>	<ul style="list-style-type: none"> • May be performed by either abdominal or laparoscopic surgery • A range between 1 in 10 and 3 in 10 risk of developing urinary incontinence after the operation • Involves a longer operation, post-operative hospital stay (2-3 days) and recovery period than mid-urethral sling • Complications include: wound related (such as infection), difficulty emptying the bladder which may require self-catheterisation or re-operation and may be difficult to correct • Higher risk of vaginal prolapse compared to MUS in long term • Serious complications are rare
<p>Mid-urethral sling polypropylene repair</p>	<p>Mid-urethral sling is the recommended surgical treatment for SUI, and is highly effective in the short and medium term</p> <p>Minimally invasive procedure</p> <p>Large, long-term studies show women are satisfied in the long-term with this operation and the improvement in their SUI symptoms</p> <p>More data about this than any native tissue repair</p> <p>Rarely associated with major abdominal organ or major blood vessel damage</p> <p>Decreased operating time, inpatient time (mostly performed as a day procedure), recovery time and lower rates of urinary retention and post-operative complications compared with surgery where mesh is not used</p>	<ul style="list-style-type: none"> • Mesh is intended to remain in the body permanently • Comparable risk of recurrent stress incontinence is 1 in 10 compared with other surgical treatments • Difficulty with bladder emptying may require reoperation • Rarely associated with major abdominal organ or major blood vessel damage • Discomfort with intercourse may occur, sometimes with other pelvic pain syndromes, following mesh repair • Removal of part, or all, of the sling may be necessary in the case of a complication such as the mesh affecting the vaginal wall and becoming exposed or eroding into the bladder or urethra. Complete removal may be difficult or impossible and multiple surgeries may be needed • Long-term pain can be difficult to treat • Women who have severe complications may experience significant personal and mental wellbeing effects. Higher rate of bladder perforation, major blood vessel injury, blood loss and longer hospital stay compared to transobturator surgery (see below) • Bladder emptying difficulty may occur and require an adjustment after the operation • Rarely associated with major abdominal organ or major blood vessel damage • Discomfort with intercourse may occur, sometimes with other pelvic pain syndromes, following mesh repair • Serious complications are rare

Guideline on Non-Neurogenic Overactive Bladder in Adults



ladder retraining exercise

- ▶ The goals are to increase the amount of time between emptying your bladder and the amount of fluids your bladder can hold.

Further investigations?

- ▶ Inability to demonstrate SUI
- ▶ Neurogenic LUTS
- ▶ Haematuria/pyuria
- ▶ Urgency predominant mixed incontinence
- ▶ High PVR
- ▶ POPs

