Pessaries Key to Stress Incontinence Management

BY CHRISTINE KILGORE

EXPERT ANALYSIS FROM THE ANNUAL MEETING OF THE AMERICAN UROLOGICAL ASSOCIATION

WASHINGTON – Trials of vaginal and urinary inserts are worthwhile for managing stress urinary incontinence in women who are young, women with episodic leakage related to certain activities, or in women who – for various reasons – are not yet ready for a surgical repair or are at high risk from any invasive procedure, Dr. Deborah J. Lightner said.

"It's unfortunate, but many women currently manage their incontinence with pads," said Dr. Lightner during a discussion of office-based management of stress urinary incontinence (SUI) at the meeting.

The mainstay of SUI management is still active pelvic floor muscle training that's taught and done correctly. But when this is unsuccessful, and when no neurologic abnormalities are detected, pessaries and other inserts – in some cases, a simple tampon – deserve consideration, she said. Research has shown that many women buy pads and tampons for the purposes of helping with urinary leakage and that three-quarters of women who use a tampon or other vaginal insert for mild SUI will be dry with that insert. "Many women know about tampons [for this purpose], but if not, you can offer them a very simple management strategy," she said.

A tampon may be the best option, for instance, for a 24-year-old woman who leaks when playing soccer and only rarely at other times, especially if pelvic floor management training has provided no relief and if she is planning to have children. "This is an incredibly common scenario. [Urinary leakage] is a real barrier to women's participation in high-impact activities and sports," said Dr. Lightner, a professor of urology at the Mayo Clinic in Rochester, Minn.

Pessaries are widely available and mainly used for prolapse, but there are a variety of "highly effective" incontinence rings and dishes that provide external compression of the bladder neck, Dr. Lightner said.

'Women will decide early on if this is the right option for them. And if it's not, they can move on to other therapies.' If well tolerated, 'there's very high long-term success.'

Early discontinuation of pessaries and other inserts "can be expected in about one-third of patients [who try them], but when [the inserts] are well tolerated, there's very high long-term success," she said.

Among women who were randomized to use an intravaginal pessary in the Ambulatory Treatments for Leakage Associated With Stress Incontinence (ATLAS) trial, 63% were satisfied at 3 months, 33% had no bothersome SUI, and more than 50% had a greater than 75% reduction in their urinary leakage, she said. Results of the ATLAS trial were reported last year (Obstet. Gynecol. 2010;115:609-17).

Refitting of pessaries is not uncommon, she noted. (In the ATLAS trial, 47% of the patients assigned to the pessary group needing a refitting, and 92% were ultimately properly fitted.) Minor complications can also occur. In one retrospective study of 273 women fitted with a ring pessary, the rate of minor complications (vaginal bleeding, extrusion, severe vaginal discharge, pain, and constipation, in decreasing order) was a surprisingly high 56% (BJOG 2009;116:1715-21).

"Women will decide early on if this is the right option for them," Dr. Lightner said. "And if it's not, they can move on to other therapies."

Clinical experience over the past 2 decades with urethral inserts has been "somewhat challenging," she said. Colonization and symptomatic urinary tract infections can occur with frequent or long-term use. Calcification and erosion also can occur, but "mainly with indwelling inserts, and not with episodic use."

The reported continence rate with use of the FemSoft urethral insert – the only one currently available in the United States – is 93% at 48 months. Early discontinuation occurs in up to 40% of users, and UTIs occur in about one-third of patients. Still, with this "excellent" continence rate, the urethral insert may have a role for women who wish to postpone or avoid surgery, she said.

Pelvic floor muscle training – the first-line management option for SUI – is often inadequately taught to women, she emphasized. "It can't be effective it's not done correctly, so I'd have that as part of my physical exam … find out, what can she do with her pelvic floor?"

Dr. Lightner reported that she had no disclosures. ■

Drop in Oophorectomies at the Time of Benign Hysterectomy

BY NASEEM S. MILLER

FROM THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

VITALS

Major Finding: There was an 8% absolute decrease in the performance of benign oophorectomy at the time of benign hysterectomy, between 2001 and 2006.

Data Source: A cross-sectional analysis of the New York State Department of Health database of 146,494 women aged 18 years or older who had undergone benign hysterectomy.

Disclosures: Dr. Novetsky said he had no relevant financial disclosures.

WASHINGTON – The rate of bilateral oophorectomies in women under age 55 significantly decreased from 2001 to 2005, according to a study based on a cross-sectional analysis of the New York State Department of Health database.

The study results presented at the meeting also showed that age, route of hysterectomy, and associated gynecological diagnoses influenced the rate of oophorectomy.

"Recent studies on complications of HRT [hormone replacement therapy] and prophylactic bilateral oophorectomy may have influenced patients' and physicians' decision-making, leading to lower rates," according to the researchers (ACOG 2011, A.P. Novetsky et al., abstract).

Dr. Akiva P. Novetsky, lead researcher and chief resident at New York University Langone Medical Center, said that although hysterectomy is among the most common operations performed in U.S. women, prophylactic oophorectomy has remained controversial.

Among the studies that have argued for the preservation of ovaries is the landmark 2005 study by Dr. W.H. Parker, which concluded that "ovarian conservation until at least age 65 benefits long-term survival for women at average risk of ovarian cancer when undergoing hysterectomy for benign disease" (Obstet. Gynecol. 2005;106:-26).

Meanwhile, the results of a 2011 study based on data from the Women's Health Initiative showed that bilateral salpingo-oophorectomy "may not have an adverse effect on cardiovascular health, hip fracture, cancer, or total mortality compared with hysterectomy and ovarian conservation" (Arch. Intern. Med. 2011;171:760-8).

Roughly 90% of women who get ovarian cancer are older than 40 years of age, and the greatest number includes women aged 55 years or older, according to statistics from the Centers for Disease Control and Prevention.

Ovarian cancer is the second most common and deadliest gynecologic cancer.

What prompted the study was the team's observation of a trend in ovarian retention in the past decade, Dr. Novetsky said in an interview.

The analysis included 146,494 women aged 18 years or older who had undergone benign hysterectomy. The results showed an 8% absolute decrease in the performance of benign oophorectomy at the time of benign hysterectomy, between 2001 and 2006.

The findings, "didn't come as a huge shock to us," said Dr. Novetsky. "What was interesting to us was the temporal relationship to the decline in HRT use, although we can't make an argument for a cause and effect relationship."

Nearly half (47%) of hysterectomies in the database included oophorectomy. Race and insurance status were associated with performance of oophorectomy.

The results also showed that women who underwent oophorectomy were older; more likely to have a family history of breast/ovarian cancer; and more likely to have a personal history of breast cancer, ovarian cancer, or endometriosis.

Women were less likely to have an oophorectomy if they underwent vaginal or laparoscopic hysterectomy, or had uterine prolapse.

"We didn't see a decline [in oophorectomy] in women over age 55," said Dr. Novetsky.

Although the study was based on a New York State database, he predicted that the trend toward fewer oophorectomies at the time of benign hysterectomy is prevalent nationwide, and "will continue to increase among premenopausal women."

The study had some limitations, including the accuracy of the database and the fact that risk factors for the performance of oophorectomy may not have been adequately recorded.

Dr. Novetsky said while oophorectomy at the time of benign hysterectomy might not have been as much in question a decade ago, "a lot more patient counseling and research go into it now. … It's become a lot more personalized." ■