

Ask About Bladder, Bowel Pain With Vulvar Disease

BY MARY ANN MOON
Contributing Writer

WASHINGTON — Women who have vulvar disease should be asked specifically about bladder and bowel pain, and these symptoms also must be addressed, Colleen M. Kennedy, M.D., of the University of Iowa, Iowa City, advised.

Women with vulvar disease are twice as likely as are general gynecology patients to have bladder pain and bowel pain. “We hypothesize that certain vulvar or vaginal diseases are not isolated clinical entities, but rather represent symptoms of a global or generalized pelvic floor disorder—a pelvic floor pain disorder,” she said at the annual meeting of the Central Association of Obstetricians and Gynecologists.

Dr. Kennedy and her associates assessed the rates of painful bladder syndrome (interstitial cystitis) and irritable bowel syndrome in 324 women who were being treated at a vulvar disease clinic, and compared them with the rates among 321 control subjects attending a general gynecology clinic.

Of the women with vulvar disease, 12% reported bladder pain, compared with only 6% of control subjects. Similarly, 23% of those with vulvar disease were found to have bowel pain, com-

pared with only 11% of control subjects.

Looked at another way, the data showed that women who reported bladder pain were 2.18 times more likely than were those who did not report bladder pain to have been treated for vulvar disease. Women with vulvar disease had a mean score of 20.3 on the Urinary Distress Inventory’s pain subscale, compared with a mean score of 5.3 for women without vulvar disease.

Likewise, women with functional bow-

el disorders were 2.13 times more likely than were those who did not have bowel disorders to have been treated for vulvar disease.

The higher prevalence of painful bladder and painful bowel syndromes in women with vulvar disease may reflect a common etiology for all these disorders. The design of this study, however, didn’t allow the researchers to tease out whether there is a common etiology “or whether treatments for one disorder may

exacerbate or cause the other disorders.

“From a clinical point of view, it is clear that women with vulvar disease should be queried about bladder and bowel pain, and treated accordingly,” Dr. Kennedy said.

She added that the study also showed that women with vulvar disease had nearly a fourfold higher risk of undergoing hysterectomy than did the general gynecology patients. “To our knowledge, ours is the first large clinic comparison to report this association,” she said. ■

Metronidazole For BV-Associated Organisms in PID

Bacterial vaginosis-associated organisms found frequently in women with pelvic inflammatory disease also were strongly associated with endometritis, Catherine L. Haggerty, Ph.D., of the University of Pittsburgh and her colleagues reported.

They looked at the associations between endometritis and *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, anaerobic bacteria, facultative bacteria, lactobacilli, and bacterial vaginosis (BV) in 278 women from the PID Evaluation and Clinical Health Study. Those with acute endometritis were more likely to be infected in the endometrium with *C. trachomatis* (odds ratio [OR] 16.2), *N. gonorrhoeae* (OR 11.6), diphtheroids (OR 5.0), black-pigmented gram-negative rods (OR 3.1), and anaerobic gram-positive cocci (OR 2.1), the investigators found (Clin. Infect. Dis. 2004;39:990-5).

The associations between acute endometritis and black-pigmented gram-negative rods, anaerobic gram-positive cocci, and BV remained significant after excluding the 41% of women infected with *N. gonorrhoeae* and/or *C. trachomatis*.

Treatment in most PID patients is targeted at *N. gonorrhoeae* and *C. trachomatis*, but these account for fewer than half of all cases. The frequency of BV-associated organisms in PID patients suggests that a treatment regimen containing metronidazole to improve anaerobic coverage is warranted, the researchers said.

—Sharon Worcester

The difference between Stress and Urge Urinary Incontinence

It’s the *difference* between insufficient urethral closure in Stress Urinary Incontinence (SUI) and uncontrolled bladder contractions in urge urinary incontinence

It’s the difference in symptoms, causes, and receptors

Stress Urinary Incontinence (SUI) is defined as any complaint of involuntary loss of urine during activities such as sneezing, coughing, laughing, lifting, or exercising.¹⁻³ It occurs when bladder pressure exceeds resistance of the urethral sphincter in the absence of a bladder contraction.¹ The cause of Stress Urinary Incontinence (SUI) is insufficient urethral closure.¹ Emerging science suggests that both serotonin (5-HT) and norepinephrine (NE) act centrally and play a key role in regulating contractions of the urethral sphincter to help maintain sufficient urethral pressure.⁴

In contrast, individuals with urge urinary incontinence have an involuntary loss of urine preceded by a strong desire to empty the bladder.² This sensation occurs as a result of uncontrolled bladder contractions.² Cholinergic muscarinic receptors act peripherally and play a key role in regulating bladder smooth muscle function.⁴ Anticholinergic agents are not indicated for Stress Urinary Incontinence (SUI).

It’s the difference in prevalence

There are 2 major types of urinary incontinence—Stress Urinary Incontinence (SUI) and urge urinary incontinence. Both are characterized by embarrassing wetting accidents that patients cannot control. Stress Urinary Incontinence (SUI) is the most prevalent type of urinary incontinence in women: an estimated 49% of patients with incontinence have Stress Urinary Incontinence (SUI) compared with 22% with urge urinary incontinence, and 29% have both stress and urge symptoms.²

	STRESS URINARY INCONTINENCE (SUI)	URGE URINARY INCONTINENCE
SYMPTOMS	Involuntary loss of urine associated with sneezing, coughing, laughing, lifting, exercising ¹⁻³	Involuntary loss of urine preceded by a strong desire to empty the bladder ²
CAUSES	Insufficient urethral closure ¹	Uncontrolled bladder contractions ²
RECEPTORS	Serotonin (5-HT) and norepinephrine (NE) receptors ⁴	Cholinergic muscarinic receptors ⁴

