

Combo Approach Eases Pelvic Floor Dysfunction

BY HEIDI SPLETE
Senior Writer

WASHINGTON — Brooke Gurland, M.D., realized that, despite her training as a colorectal surgeon, she didn't have a complete perspective on pelvic floor dysfunction.

Fellows in colorectal surgery "weren't even trained to know the anatomy of the other organs, much less how to work with other pelvic specialists in the hospital system," said Dr. Gurland, a colorectal surgeon at Maimonides Hospital in New York. A multidisciplinary approach to women's pelvic floor disorders is important, because multiple pelvic floor defects often exist in the absence of patient complaints, she said at the annual meeting of the Gerontological Society of America.

Older women tend to underreport pelvic floor problems, especially those associated with fecal incontinence or defecation problems, because they don't feel comfortable raising the subject with their doctors, or because they find ways to compensate, such as using an enema or finger to complete their defecation. "However, these problems have tremendous psychosocial implications for older women," Dr. Gurland said. And failure to identify pelvic floor pathology can lead to treatment failure and frustration for both doctors and patients.

Research in pelvic floor symptomatology is limited, and many physicians don't know that different treatment options exist for pelvic floor dysfunction, said Dr. Gurland, who is spearheading a pelvic

floor task force at Maimonides. The main objectives are to establish a center to evaluate the pelvic floor compartments as a functional unit, to educate health professionals and the community about pelvic floor disorders, to create a database, and to coordinate studies of multicompartment pelvic floor disorders to improve knowledge in this area.

To help finance these efforts, Dr. Gurland received a career development grant totaling \$200,000 over 2 years from the American Geriatrics Society to establish the Maimonides Center for Pelvic Floor Dysfunction and Reconstructive Surgery.

The first step was to identify a pelvic floor task force that includes physicians, nurse practitioners, continence specialists, physician assistants, and pain specialists from fields such as urology, gynecology, colorectal surgery, and geriatrics.

Plans so far have included a nurses' public health symposium and a fellowship program in which an ob.gyn. would work with Dr. Gurland and a colleague in urogynecology. The staff conducted community outreach by placing ads in local newspapers to encourage women with pelvic floor complaints to visit the center.

"We are getting patients who would not have approached their primary doctors, but are seeking us out specifically," Dr. Gurland noted.

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The designated support staff has made all the difference in establishing the center and creating a multidisciplinary treatment protocol, she said. "I have two physician assistants and two medical assistants who coordinate care between subspecialists. They coordinate surgeries and are trained to do pelvic floor rehabilitation and biofeedback, and provide emotional support to the patients."

In addition, Dr. Gurland combines office hours with a urogynecologist, which minimizes patient visits and eases the travel burden for elderly patients. "Once we make a decision on how to care for a patient, I can sit down with the urogynecologist and create a plan," Dr. Gurland said. "We can also see the postops together and see how people are responding to treatment."

Dr. Gurland and her colleagues list the symptoms of fecal dysfunction on their database for tracking patients and conducting research. They use the Wexner fecal incontinence score, which ranges from 0 to 20 (no incontinence to complete fecal incontinence) and includes incontinence to flatus, liquid, and solid stool. The frequency of accidents and its effect on lifestyle also are included. In addition, the Rome criteria are used to define obstructive defecation, such as a feeling of anal blockage 25% of the time and the need for an enema or other help to fully evacuate.

Dr. Gurland reported results from the first 70 patients treated at the center. The women enrolled in the database had symptoms of urinary dysfunction and prolapse and either fecal incontinence or difficult evacuation. The average age was 66 years, with an average parity of 3. Seventeen had undergone hysterectomies.

Although urinary incontinence was the most common symptom, 38 patients had fecal incontinence, 28 had obstructive defecation, and 22 reported rectal pressure. Of those with fecal incontinence, 89% had urinary incontinence, 61% had pelvic pressure or a bulge, and 3% had pelvic pain.

An overwhelming majority, 82%, of those with obstructed defecation had rectal pressure, 43% had pelvic pressure or bulge, and 25% had pelvic pain. And of those with rectal pressure, 73% had urinary incontinence, 68% had pelvic pressure, and 18% had pelvic pain.

Rectocele was the most common physical finding in the entire group (60% of patients), followed by cystocele, enterocele, rectal prolapse, and anal sphincter defects diagnosed by endorectal ultrasound.

As for the outcomes, 35% had surgery, 25% are undergoing biofeedback treatment, and approximately 28% are considering surgical or nonsurgical treatment. An additional 10% decided they were satisfied with their quality of life and declined treatment.

"There's no rush. This is a quality of life issue, and it has to be scheduled at the patient's convenience," Dr. Gurland said, adding that a combined approach to pelvic floor dysfunction improves patient care. ■

Resistant Enterococci Behind Elders' Urinary Tract Infections

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — The culprit behind most noncomplicated urinary tract infections in outpatients—*Escherichia coli*—plays less of a role as patients age, a study of 2,751 urine cultures showed.

Other pathogens, particularly enterococcus, played a greater role in urinary tract infections (UTIs) in older patients, and the rates of antibiotic-resistant enterococcus increased in older patients, David J. Blehar, M.D., said at the annual meeting of the American College of Emergency Physicians.

The prospective study of serial cases from 80 outpatient offices and four emergency departments divided adult patients into five age groups and looked at the pathogens responsible for UTIs and their susceptibility to antibiotic treatment.

In the youngest group, 18- to 40-year-olds, *E. coli* caused more than 75% of UTIs, a finding similar to previous estimates that *E. coli* causes 75%-90% of UTIs overall. The role of *E. coli* fell with increasing age, however, with a proportional increase in other pathogens. In patients older than 80 years, *E. coli* accounted for fewer than half

of UTIs, but enterococcus caused up to 20% of UTIs, said Dr. Blehar of the University of Massachusetts, Worcester.

The study looked at rates of resistance to four antibiotic therapies. Although trimethoprim/sulfamethoxazole (TMP/SMX) is the formal first-line drug therapy for noncomplicated UTI, guidelines suggest substituting a fluoroquinolone in areas where rates of *E. coli* resistance to TMP/SMX exceed 10%-20%. Dr. Blehar's institution and others have adopted levofloxacin as first-line therapy for noncomplicated UTIs. The study also looked at ceftriaxone and ampicillin resistance.

E. coli generally maintained susceptibility to the various antibiotics across age groups, except for a statistically nonsignificant trend toward greater resistance to TMP/SMX with increasing age. Pathogen resistance to ceftriaxone or ampicillin also held steady across age groups.

While *E. coli* resistance rates to levofloxacin remained low across age groups, enterococcus resistance rates climbed with age. In patients aged 70 years or older, 22% of enterococci were resistant to levofloxacin, and 38% of enterococci showed resistance to levofloxacin in patients aged 80 years and older. ■

New Drug for Overactive Bladder Lacks Cognitive Side Effects

BY BRUCE JANCIN
Denver Bureau

ORLANDO, FLA. — Darifenacin, a selective muscarinic M3 receptor antagonist being developed for treatment of overactive bladder, doesn't affect cognition in the elderly at clinically effective doses, Richard B. Lipton, M.D., reported at Wonca 2004, the conference of the World Organization of Family Doctors.

Darifenacin thus stands in marked contrast to traditional antimuscarinic agents, which are effective for overactive bladder but have a high rate of limiting cognitive side effects due to their broad spectrum of action. Older antimuscarinic drugs lack selectivity for the M3 receptor, which regulates detrusor muscle function, and often cause collateral blockade of central muscarinic M1 receptors, with resultant cognitive impairment and sleepiness, explained Dr. Lipton, professor and vice chair of neurology and professor of psychiatry at Albert Einstein College of Medicine, New York.

He presented a Novartis-sponsored randomized controlled trial of darifenacin that focused on the drug's cognitive impact rather than on clinical efficacy, which has already been established in nu-

merous clinical trials totaling more than 10,000 subjects. He reported on 129 subjects aged 65-84 years who participated in a randomized, double-blind, placebo-controlled crossover study in which they received 2-week courses of three of four regimens: darifenacin at 3.75, 7.5, or 15 mg once daily, or placebo.

The primary study end points consisted of scores on a battery of cognitive function tests assessing memory scanning sensitivity, speed-of-choice reaction time, and delayed word recognition sensitivity. There was no change from baseline in mean scores on any of the cognitive tests over the course of 14 days of darifenacin at any of the studied dosages. Nor were test scores while on darifenacin significantly different than with placebo.

The most common darifenacin-related adverse events were mild to moderate non-treatment-limiting constipation and dry mouth, each of which was reported in 4%-12% of patients on various dosages. There were no ECG abnormalities, which can occur with blockade of the muscarinic M2 receptor.

Darifenacin (Enablex) was approved for the treatment of overactive bladder by the Food and Drug Administration at the end of last year. ■