

Sharpen Interview Skills to Detect Incontinence

Many women will not volunteer the fact that they leak urine.

BY BETSY BATES
Los Angeles Bureau

SAN FRANCISCO — An office evaluation for incontinence and overactive bladder can begin with one simple screening question, and then a follow-up if the answer is yes, said Dr. Michael Moen, director of the division of urogynecology at Advocate Lutheran General Hospital in Park Ridge, Ill.

The first question is, “Do you have bladder problems that are troublesome, or do you ever leak urine?”

If the patient answers in the affirmative, rule out a urinary tract infection and perform a focused history and physical examination.

But don't forget to include one more key inquiry before you move on.

That question is whether she has nocturia, which points strongly in the direction of overactive bladder rather than stress incontinence.

“If you have overactive bladder, it doesn't take the evening off,” said Dr. Moen at Perspectives in Women's Health sponsored by OB.GYN. NEWS.

In contrast, urodynamic stress urinary incontinence is triggered by activity, not rest.

Many women will not volunteer the fact that they leak urine when they exercise, laugh, or cough, or that they rise four times a night to urinate—unless they're asked.

“They think it's part of aging or part of having children,” he said.

Although symptomatic pelvic organ prolapse may propel a woman to make an appointment, it may take significant lifestyle disruption or a profoundly embarrassing public episode of leakage to make women seek care for urinary incontinence, which affects 20%-55% of American women.

Dr. Moen targets four important areas in a review of pelvic symptoms:

► **Anatomic function.** Is there a bulge? A mass? Pressure?

► **Urinary function.** Does she void at intervals of less than 3 hours? Experience urgency? Rise more than twice a night to urinate? Leak with urge? Leak with laughing, coughing, or sneezing? Leak with exercise? Does she have difficulty voiding? Does she need to wear pads?

► **Bowel function.** Does she experience leakage? Constipation?

► **Sexual function.** Does she have pain with intercourse? Anatomic issues? Embarrassment or avoidance due to urinary issues?

Constipation is a surprisingly frequent concurrent issue, said Dr. Moen, occurring in at least 30% of patients he sees for any pelvic floor disorder. It is uncertain whether constipation causes or is caused by pelvic floor dysfunction, but it needs to be addressed.

“Some people think it is more normal to push and strain their insides out than to take fiber every day,” he said.

He frames the issue within the context of modern life and the American diet.

“I tell women it is virtually impossible to get enough usable fiber in their diet without consuming too many calories,” he said.

He suggests that supplements are the answer, not a medicine.

Before conducting an examination, Dr. Moen also brings up the possibility that a woman's quality of life may have been affected by her problems with incontinence or overactive bladder. Perhaps she has restricted her exercise, social activities, and travel. In line with several studies on an association with incontinence, she may be suffering from clinical depression.

The visual and physical examination are aimed at detecting urogenital atrophy, “one of the most overlooked and easily treated conditions in women,” and/or pelvic organ prolapse, he said.

A simple cough stress test approaches a 95%-98% sensitivity and specificity in identifying incontinence.

Neuromuscular function should be assessed by eliciting perineal sensations with a light touch near the anus and an assessment of pelvic muscle strength, facilitated by asking the patient to isolate and squeeze pelvic floor muscles while one of the physicians' fingers is inserted 3-4 cm into the vaginal canal.

In an examination of young, asymptomatic women, Dr. Moen and associates found that 20%-30% were unable to properly contract their pelvic floor muscles, with 10% “actually perform[ing] a Valsalva” maneuver and believing they were doing a Kegel contraction, said Dr. Moen.

“This is critical, because even if you don't suggest to them that they do these types of exercises, they're reading about them in Elle, Self, and Good Housekeeping.”

Doing Kegel exercises improperly can actually exacerbate pelvic floor weakness. On the other hand, proper use of the exercise as few as 30 times, 3 times a week, can be effective in preventing or improving symptoms of stress and urge incontinence.

If simple instruction does not work, physical therapy, perhaps including biofeedback, electrical stimulation, and electromagnetic therapy, may be very helpful in strengthening pelvic floor muscles.

Other potentially important therapeutic options for incontinence and/or overactive bladder may include medications, pessaries, and in 25% or fewer cases, eventual surgery if other measures fail.

The most important intervention, according to Dr. Moen, is bladder retraining.

“If you do nothing else, tell patients to go to the bathroom on schedule. They will get better,” he said.

If a woman estimates she is urinating every hour, he begins with that target, telling her to urinate each time the clock sweeps 12.

Next, the patient is instructed to begin to “outsmart her bladder,” by stretching the intervals to 2 hours, then 3 hours. ■

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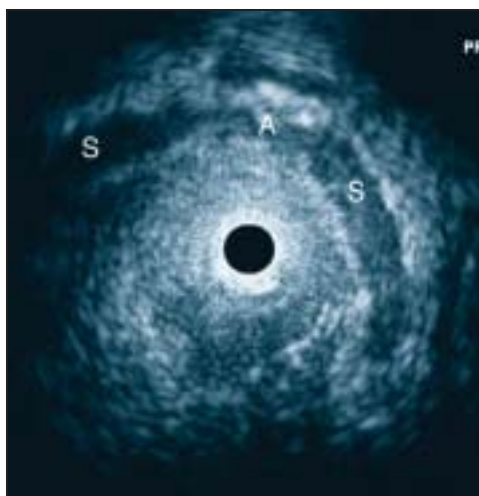
Stem Cell Injection Beats Collagen for Urinary Incontinence

BY PATRICE WENDLING
Chicago Bureau

CHICAGO — Injection of adult autologous stem cells shows an excellent success rate for the treatment of urinary stress incontinence, compared with collagen injections, Dr. Matthias Schurich said at the annual meeting of the Radiological Society of North America.

In the study of both women and men, 50 (79%) of the 63 patients randomized to transurethral ultrasound-guided injection of adult stem cells were completely continent after follow-up lasting 6-30 months, compared with only 2 (7%) of the 28 patients treated with endoscopic injection of collagen after 6-12 months, he reported on behalf of principal investigator Dr. Ferdinand Frauscher and his colleagues at the Medical University Innsbruck (Austria).

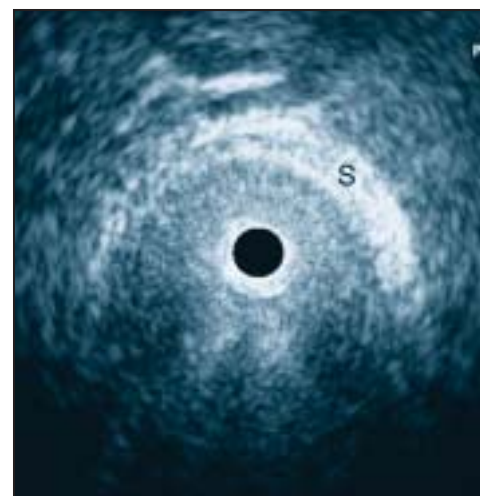
The long, successful follow-up period for the stem cell injections is noteworthy because endoscopic collagen injections work well initially, but the effect is known to wear off relatively quickly, Dr. Schurich said in an interview.



Urethral submucosa shows thinning of the rhabdosphincter (S) with atrophy (A).

The success rate for stem cell injections was significantly higher for women than for men, with 39 (93%) of 42 women continent and 11 (52%) of 21 men continent at follow-up.

This could be because most of the men had undergone radical prostatectomy with resulting scarring and little or no sphincter muscle remaining to be bulked up by the stem cells, explained Dr. Schurich, who is also with the university.



After injection of stem cells, the sphincter appears hyperechoic (S).

The autologous stem cells were obtained from skeletal muscle biopsies of the patient's arm and were cultured to yield roughly 50 million fibroblasts and 50 million myoblasts.

The fibroblasts were injected into the urethral submucosa, whereas the myoblasts were implanted into the rhabdosphincter.

Overall, the 63 patients (aged 36-84 years) were treated with autologous stem

cells between September 2002 and February 2005.

During the same period, 21 women and 7 men (aged 31-84 years) also diagnosed with urinary stress incontinence were treated with standard transurethral endoscopic injections of collagen.

Patients were randomly assigned to the groups according to capacity in the cell culture laboratory.

Compared with baseline, the stem cell-treated patients demonstrated significant improvements in incontinence scores (5.95 vs. 0.44), thickness of the urethra (3.75 mm vs. 5.3 mm) and rhabdosphincter (2.10 mm vs. 3.30 mm), contractility of the rhabdosphincter (0.56 mm vs. 1.46 mm), and quality-of-life scores (51.3 vs. 104.0) at follow-up.

In addition to the 50 patients whose incontinence was cured, 6 had substantial improvement in symptoms and 7 experienced no improvement.

Incontinence scores and quality-of-life scores improved significantly among collagen-treated patients, but the improvements were “clinically irrelevant for the majority of patients,” Dr. Schurich said. ■

PHOTOS COURTESY DR. FERDINAND FRAUSCHER