URINARY INCONTINENCE

URINARY INCONTINENCE IS DEFINED by the International Continence Society (ICS) as the involuntary loss of urine that represents a hygienic or social problem to the individual. It should be thought of as a symptom, not a disease, as the causes are many and often multifactorial. Urinary incontinence affects man and woman differently through the various age groups. This article will cover incontinence affecting women in the reproductive age group and beyond. This symptom in women is not a recent medical and social phenomenon.

The three common types of incontinence affecting women are stress urinary incontinence (SUI), urge incontinence and a combination of both. SUI is characterized by the leakage of urine associated with increased intra-abdominal pressure from coughing, sneezing, laughing, exercises, and in extreme cases, even on walking. Urge incontinence is the involuntary leakage accompanied by or immediately preceding the urge to urinate. The anatomical defect in SUI in women is hypermobility of the urethra (the urine outlet) secondary to poor pelvic support.Pregnancy is arguably the most common cause of SUI. It can occur even during pregnancy as a result of pressure of the enlarging gravid uterus on the bladder coupled with the softening of the supports of the bladder (and uterus) due to increase hormonal production. Reassurance of the patient is all that's required. The majority will recover soon after delivery or after two to three months.

Vaginal delivery, be it normal or instrumental, leads to stretching and often tearing of the supports of the bladder and uterus. Prolong and difficult instrumental deliveries are especially harmful. Prevention is the key to the management of SUI in women after childbirth. Difficult instrumental delivery should be avoided. Precise repair of vaginal and perineal tears and lacerations, proper bladder regime in the pueperium, and diligent pelvic floor exercises are the more important preventive measures.

Other important causes of urethral hypermobility are menopause, surgery (especially hysterectomy), pelvic trauma, obesity, chronic constipation, chronic cough from smoking or other respiratory disease.

Urge incontinence is commonly due to urinary tract infection, in which instance, it is accompanied by frequency and painful urination. The overactive bladder (OAB) as a cause of urge incontinence is now seen more frequently in practice. In this condition, the detrusor (muscle of the bladder wall) is hypersensitive. The aetiology of this hypersensitive state, though often unknown, may be attributed to excessive coffee consumption, smoking, and excessive water intake. Atrophic vaginitis in the postmenopausal women, and chronic medical conditions (eg diabetes) are common causes.

The management of urinary incontinence in this age group of patients is complex. Good history taking to determine the extent of the problem, clinical and pelvic ultrasound examination, followed by counselling and medical treatment should form the basis of management in the first instance. Even if surgery is the definitive treatment, adjunctive medical treatment will be helpful.

- The approach to management is keyed to the type of incontinence.
- Stress Urinary Incontinence: Surgery, pelvic floor exercise, medication
- Urge Incontinence: Changes in diet, behavioral modification, pelvic floor exercise, medications.
- Mixed Incontinence: Medicine and surgery.

The first choice of treatment should ideally be the least invasive one. However, in specific situations, minimally invasive surgery may be the most effective modality in the management of urinary incontinence. Of all the surgical procedures available for the treatment of urinary incontinence, none has been more researched and documented than the Tension-Free Vaginal Tape (TVT,) in the surgical management of stress urinary incontinence in women. The tape is non-absorbable, and the cure rate, depending on patient profile, varies between 80-90 percent after 10 years. ■

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