OBSTETRICS & GYNAECOLOGY

The urge to pee

Women suffering from urinary incontinence suffer more than just embarrassment when such moments occur. Learn what preventive measures you can take, and what options you have should the condition arise.

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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 men and women 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.

Types of urinary incontinence

The three common types of incontinence affecting women are stress urinary incontinence (SUI), urge incontinence, and a combination of both.

SUI is characterised by the leakage of urine associated with increased intra-abdominal pressure from coughing, sneezing, laughing, exercising and, in extreme cases, 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 comon 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 increased hormone production. Reassurance of such patients is all that's required — the majority of them will recover soon after delivery or after two to three months.

Vaginal delivery leads to stretching and, often, tearing of the supports of the bladder and uterus. Prolonged and difficult instrumental deliveries are especially harmful and should be avoided where possible. Prevention is key to the management of SUI in women after childbirth. 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, and chronic cough from smoking or other respiratory disease.

Urge incontinence is commonly due to urinary tract infection, which causes painful urination. The overactive bladder (OAB) as a cause of urge incontinence is now seen more frequently in practice. In this condition, the detusor (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 post-menopausal women and chronic medical conditions (e.g. diabetes) are common causes.

The management of urinary incontinence in this 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 treament, adjunctive medical treatment will be helpful.

Managing urinary incontinence

The approach to management is key to the type of incontinence:

- Stress Urinary Incontinence — surgery, pelvic floor exercise, medication
- Urge Incontinence — changes in diet, behavioural modification, pelvic floor exercise, medication
- 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 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 and 90% even after 10 years.