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PopQuiz

A publication on

Pelvic Organ Prolapse

and Continence from
The Center of Pelvic Reconstructive Surgery, Medicine, and Continence.
J. Kyle Mathews, MD

WELCOME to POP QUIZ,
A periodic publication to provide the practicing physician with concise, up to date, information in Female Pelvic Medicine, Restorative Pelvic Surgery, Urogynecology, and Incontinence.

NEWS

Look for the new website in February. The new site will not only have patient information, it will also contain a physicians section with up to date information regarding current trends in women's health. *www.drjkm.com*

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MYTHS, MISTRUTHS, AND MISINFORMATION

A patient that is nulliparous, or has an enlarged uterus (fibroids), or had a cesarean section will require an abdominal hysterectomy if she needs her uterus removed. FALSE.

While it is true that 75% of the 590,000 hysterectomies each year performed in the U.S. used the abdominal approach, multiple studies and the American College of Obstetrics and Gynecology state that the majority of hysterectomies should be performed by the vaginal approach. These same studies have shown that the decision to perform a hysterectomy abdominally or vaginally has more to do with the training and experience of the surgeon than the condition for which the procedure is being performed. American College of Obstetrics & Gynecology (ACOG) Committee Opinion #311 April 2005.

Suturing the skin for closure gives better cosmetic results than staples in patients undergoing Cesarean Section.

This issue continues to be debated in the Obstetrical literature but according to a recent study by Rousseau in the Am J Obstetics & Gynecology. 2009;200:2065, the use of staples for skin closure during cesarean delivery produced less pain, shorter operative time, and cosmesis comparable to sutures.

Supracervical hysterectomy (LASH) is advantageous in preserving sexual desire, preventing urinary incontinence, increasing the quality and frequency of sex, and improved body image. FALSE.

While is has been used as a good marketing campaign, numerous studies have shown that there is NO advantage of supracervical technique in terms of postoperative outcomes such as urinary incontinence, quality and frequency of sex, sexual desire and body image. Furthermore, studies to date have shown that supracervical hysterectomy may increase the risk of future problems with retained cervix that may lead to further surgery being required. American College of Obstetrics & Gynecology (ACOG) Committee Opinion # 388 2007.

URINARY INCONTINENCE CAUSED BY URGENCY AND FREQUENCY

For 33 million Americans, bladder control is a problem. In the United States, Overactive Bladder (OAB), defined as frequent urination with urgency and sometimes incontinence along with Painful Bladder Syndromes (Interstitial Cystitis), defined as a chronic inflammatory condition of the bladder without bacterial infection, is more common than adult onset Diabetes.

Idiopathic Detrusor Overactivity (IDO), the most common diagnosis for OAB, is characterized by urinary urgency, frequency, and urge incontinence without a neurological disorder as the etiology. Studies have shown that less than 50% of women will seek professional evaluation and those that do, have had symptoms for an average of 6 years before presenting for evaluation. In an attempt to address these facts, there are multiple Questionnaires available. MESA, Incontinence Impact Questionnaire, Urinary Distress Inventory, and others have been studies with the MESA questionnaire proving to be an effective screening tool. A simple, quick, and noninvasive test with acceptable accuracy for use in a primary care setting is simply to ask the following questions.

During the last three months, have you leaked urine (even a small amount)? If no, you need not proceed any further. If yes, the following questions can be asked:
During the last three months, did you leak urine (check all that apply):

1. *When you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?*
2. *When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?*
3. *Without physical activity and without a sense of urgency?*

During the last three months, did you leak urine most often (check only one):

1. *When you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?*
2. *When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?*
3. *Without physical activity and without a sense of urgency?*
4. *About equally as often with physical activity as with a sense of urgency?*

The patient's type of urinary incontinence is defined by the third question on the quiz. Here is the answer sheet:

1. *Most often with physical activity: stress-only or stress-predominant urinary incontinence.*
2. *Most often with the urge to empty the bladder: urge-only or urge-predominant urinary incontinence.*
3. *Without physical activity or sense of urgency: incontinence due to other causes.*
4. *About equally with physical activity and sense of urgency: a mix of incontinence types.*

The mainstays of treatment for IDO OAB have been bladder retraining and anti-cholinergic medication. The anticholinergics are the most frequent prescribed drug for treatment and may be classified as pure anticholinergic, mixed anticholinergic with anti-muscarinic effects, and trycyclic antidepressants. Their mechanism of action is to inhibit bladder spasm, increase bladder capacity, diminish frequency of involuntary bladder contractions, and delay initial urge to void. They however, do not increase warning times for patients with IDO OAB disease.

Pure anticholinergic medications have limited use in treating IDO OAB. One drug however, Hyoscyamine (Levsin) has been shown to be helpful in patients whom present with recurrent UTI symptoms without evidence of bacterial etiology. These patients often have cyclic over active bladder symptoms and may benefit from oral or sublingual Hyoscynamine . (Sublingual 0.125 mg seems to work better)

Mixed anticholinergics are the most common medications prescribed. Drugs such as Ditropan, Detrol, Detrol LA, Enablex, Sanctura, Vseicare and others all have additional affects on the muscarinic receptors of which there are 5. It has been shown that the third muscarinic receptor, M3, is the most important for the treatment of IDO OAB and many of the newer medications are attempting to be more selective for the M3 receptor. Of the newer drugs, Vesicare is a competitive muscarinic receptor antagonist and Enablex is a selective M3 muscarinic receptor antagonist. The effectiveness of these drugs as a class is a source of much discussion and opinion. As a class, it is safe to say that all have a high rate of discontinuation because of side effects such as dry mouth, constipation, fatigue, and weight gain. It is also, my experience that none of them are as effective as advertisements to the public have suggested. One tip with regard to prescribing these drugs is to give them at night where the most common side affect, dry mouth may be less of an issue.

Tricyclic antidepressants have a limited use in treating bladder dysfunction and generally are used for nocturnal enuresis. Care must be taken when prescribing these drugs in that they may be cardiotoxic and potentially fatal if overdosed.

Bladder Training or Pelvic Floor Rehabilitation can be used to treat IDO OAB and some studies have shown treatment to have benefit in greater than 50% of patients participating in them. Outcomes, however, were highly dependent on interaction of Nurse Practitioner with the patient during the therapy session, patient motivation, and follow up.

In patients who fail to respond to diet modifications, decreasing caffeine and alcohol consumption, bladder training, biofeedback, and medications, Sacral Nerve Stimulation, InterStim Therapy, may be effective. InterStim Therapy is a well-studied, minimally invasive, FDA approved therapy for the treatment of urinary retention, and overactive bladder, including urge incontinence and significant symptoms of urgency-frequency in patients who have failed or could not tolerate the above mentioned treatments. The true benefit of this therapy is the ability for the patient to try the therapy without having a permanent stimulation lead or battery placed. The initial test phase of the therapy consists of a small thin electrode placed in the back near the tailbone. The lead is attached to a small stimulator, about the size of a pager, which can be adjusted and controlled. During the test stimulation, the patient is asked to keep a diary to document her urinary symptoms. If therapy proves to be beneficial, long term InterStim Therapy can be initiated. This consists of a short surgery to implant a small neurostimulator in the upper buttocks under the skin along with a permanent stimulator lead. The device is controlled by the patient with a programmer and may be adjusted and turned off at any time. I have found this therapy to be very beneficial in patients who have failed medications.

Of note, studies using Botox to treat IDO OAB are underway and several have reported improvement in symptoms and number of incontinent episodes. This therapy shows great promise at present and studies are on going.

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UPDATE IN THE TREATMENT OF CANDIDA VULVOVAGINITIS

Candida albicans accounts for 80 to 92% of episodes of vulvovaginal candidiasis; Candida glabrata is the next most common species and is resistant to the common treatments with azoles in about 50% of the infections. Candida sp. Are a member of the normal endogenous vaginal flora in 5 to 20% of women and the goal of treatment should be resolution of symptoms and not eradication. It should be noted that Candida is not considered a sexually transmitted infection but sexual transmission can occur. It is, however, not recommended to treat an asymptomatic sexual partner routinely. Women with recurrent infection may represent an instant where the treating physician may consider deviating from this recommendation.

Uncomplicated infections may be treated with oral or topical antifungal and clinical cure rates are in excess of 80%. For women who have recurrent or persistent infections, I suggest culture with identification of species. Candida albicans can be treated with Diflucan 150 mg orally in two sequential doses given three days apart followed by once a month at the time of menses for 6 months. Non albicans species such as glabrata may require treatment with intravaginal Boric Acid Suppositories, 600 mg once daily at night for two weeks followed by Diflucan 150 mg orally weekly for 6 weeks. Boric Acid Suppositories can be made by a compounding pharmacy.

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