



INCONTINENCE

URINARY INCONTINENCE TREATMENTS

DOES YOUR BLADDER CONTROL YOUR LIFE?

Laughing, coughing, sneezing, exercising, a simple trip to the supermarket... to a woman with incontinence, these things signify insecurity, fear, embarrassment and humiliation.

If you suffer from urinary incontinence you are not alone. At least one in four women suffer from this affliction, and for many, this is a side of life that they keep hidden from their closest friends and even their doctor, through fear of embarrassment.

Urinary incontinence is not normal and is always a symptom or sign of an underlying problem which can be treated.

WHAT IS URINARY INCONTINENCE?

Urinary incontinence is the involuntary loss of urine at a time that is neither convenient nor socially acceptable. Incontinence is a symptom, not a disease or inevitable part of growing older. Basically, anyone can suffer from urinary incontinence, regardless of age. At best, it is an uncomfortable nuisance, at worst, a devastating condition, causing tremendous embarrassment and withdrawal from public life.

Although millions of women allow incontinence to restrict their lives, the good news is that it can be successfully treated at any age.

There are several different types of urinary incontinence. The most common cause is Stress Incontinence, which is the leaking of urine when pressure is put on the bladder, such as when you cough, sneeze, exercise, laugh or when you lift heavy objects or even change body positions, such as getting up from a chair. Weakness of the ligaments supporting the urethra is the most common cause of stress incontinence.

The second most common cause of urinary incontinence is Urge Incontinence, which is when the urge to urinate is so strong that it is not possible to reach the toilet in time.

This overwhelming desire to go may occur frequently during the day, as well as several times at night. It may be due to external pressure on the bladder, such as a vaginal prolapse, or it may be due to an inherent overactivity of the bladder muscle. Restricting fluids and constant preventative trips to the toilet only make matters worse.

OUR SERVICE

Our Centre (Gold Coast Gynaecology) is located at 140 Queen Street, Southport, 4215. (www.goldcoastgynaecology.com.au).

We have a long history of extensive research and innovation in Pelvic Floor Re-education, Injection (bulking) therapy and minimal surgical techniques (see publications). We are committed to providing high quality evaluation and compassionate treatment for all types of incontinence. Our Service offers assessment, pelvic floor rehabilitation and simple minimally invasive surgery to treat incontinence.

We understand that incontinence has an affect on your quality of life. Our goal is to provide you with the highest standard of treatment to return you to good health with the minimum of disruption. The Gold Coast Gynaecology Centre is one of a number of Centres in Australia specializing in the management of urinary incontinence and prolapse problems in women. We are members of the International Urogynaecological Association (IUGA) and the British Society of Urogynaecological Surgeons (BSUGS).

Many women affected with this condition do not seek relief. They are either unaware that help is available or too embarrassed to ask. The problem in most cases can be cured or significantly improved.

OUR FACILITIES AND EQUIPMENT

The Director the Gold Coast Gynaecology Centre (Associate Professor Dr. Samir Henalla), has been specially trained in the various non surgical and surgical techniques to treat urinary incontinence. He has pioneered the outpatient injection therapy in 1996 and is an accredited trainer of other gynaecologists in the same techniques.

In addition, our caring and sympathetic staff will provide you with a friendly and comfortable environment during your treatment programme.

WHAT DOES THE SERVICE INVOLVE?

You will need a referral from your General Practitioner. When you phone the Centre to make your first appointment, the initial consultation will include an assessment, which will include a general medical history, a detailed questionnaire regarding your bladder symptoms and a gynaecological examination. A full diagnosis will usually involve Urodynamic Study including an Ultrasound Scan. This does not involve harmful radiation, as used in other methods.

Treatment options include a Pelvic Floor Rehabilitation programme, medication or a minimally invasive surgical technique. Simple Surgical techniques are performed as day cases such as TVT (Tension free Vaginal Tape) (Figure 2) or a simple injection of Macroplastique material to treat stress incontinence (see our own publications, articles 3, 4 and figure 1).

We also use Botox injection to help overcome bladder overactivity.



Figure 1

Your treatment options will be discussed to enable you to make an informed decision regarding your care.

PELVIC FLOOR REHABILITATION

Traditional pelvic floor exercises, pulling up, alone are not effective. Our techniques involve strengthening of the individual muscles and ligaments that have been weakened by pregnancy and the menopause. In mild cases, with only slight leakage problems, the techniques are simple and offer relief in 70-80% (see our own publications, articles 1 and 2).

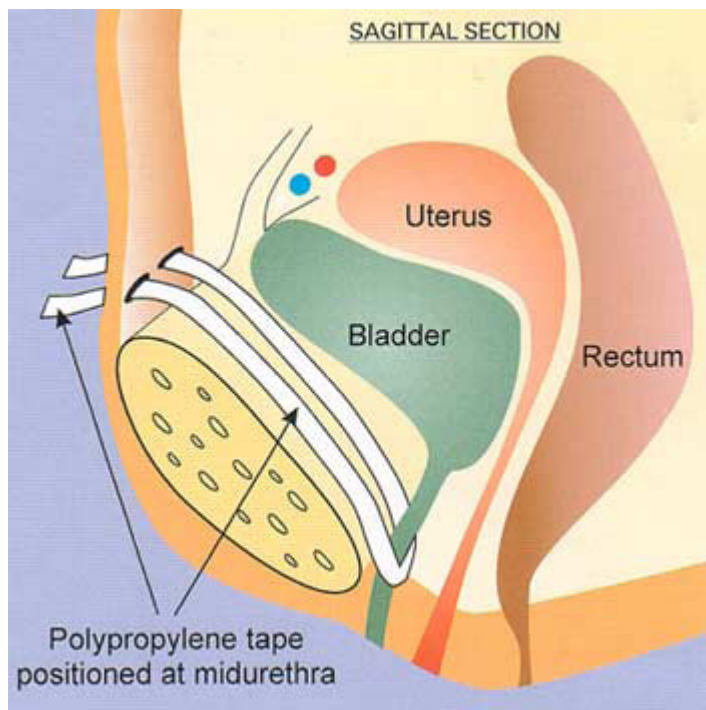


Figure 2 - Anterior intra-vaginal sling placement for genuine stress incontinence

THE SURGICAL TECHNIQUE

Traditional surgical techniques were based on an inaccurate understanding of the anatomy and physiology of the female pelvis, and often led to complications such as urge incontinence or prolonged retention of urine, requiring long term catheterisation. Long term results were poor.

It is now realised that what keeps a woman dry is mainly a ligament arising from the pubic bone, which is attached to the mid-point of the urethra. When you cough, the pelvic muscles pull the upper part of the urethra backwards and downwards, thus kinking and closing the urethra. If this ligament is weakened, the urethra cannot close properly and leakage occurs.

The TVT operation involves passing a special tape under the midpoint of the urethra to strengthen, support and replace the weakened ligament. Collagen grows into the tape, creating a new ligament. By restoring the anatomy, post-operative retention of urine and other problems are usually avoided and a catheter is not normally necessary.

The technique has undergone modification since it was introduced in 1998, and currently in excess of 95% are completely and permanently cured.

Important legal notice: This information is to be taken as a guide only and is not intended as an alternative to advice from your doctor. The Gold Coast Gynaecology legal disclaimer and waiver of liability applies to this document for more information please see <http://www.goldcoastgynaecology.com.au/100048.php>. This document was written by Dr David S. Browne 2003 and subsequently modified by Dr Samir M. Henalla 2010.