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**SPECIAL EXERCISES** such as Kegel exercises have a low success rate in treating stress incontinence when performed without the involvement of a physical therapist with unique training in pelvic floor biofeedback therapy.



## Stress Urinary Incontinence 'Detrusor Overactivity' affects many women

**S**tress incontinence is a type of urinary incontinence caused by increases in abdominal pressure. Women with stress incontinence typically have leakage of urine with activities such as swinging a golf club, playing tennis, jumping, bending, coughing, laughing, yelling, or brisk walking.

The real trick in diagnosing and treating stress incontinence is not confusing it with urge incontinence, a type of incontinence caused by bladder spasms. Some of the same activities that cause stress incontinence can cause a bladder spasm (urge incontinence). Therefore, if a patient is complaining of loss of urine with some of these activities, it is critically important to make sure that she is not having bladder spasms. If she is having bladder spasms, treatments for stress incontinence will not stop the leakage of urine, but could make it worse. An urogynecologist utilizes urodynamic testing to sort this out.

### The Scientific Mumbo Jumbo

Stress Urinary Incontinence is defined by complaints of involuntary leakage of urine on effort or exertion, or on sneezing or coughing. Urodynamic stress incontinence is defined as involuntary leakage of urine caused

by increases in intrabdominal pressure in the absence of bladder contractions. Urodynamic testing is used to evaluate uri-

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nary incontinence. This test utilizes a computer, which can measure both muscle activity (EMG) and pressure changes of the bladder and urethra as it is filled with water. Many patients with stress incontinence symptoms will not have urodynamic stress incontinence.

### Treatment Techniques

#### Surgical Options

■ **Mid-Urethral Slings:** Around 2002, mid-urethral slings became the gold standard in the surgical treatment of stress incontinence. As the name suggests, in this surgery, the surgeon places a sling under the urethra. The most common material used is a synthetic non-absorbable material called polypropylene mesh. Some surgeons use natural materials such as pig dermis. However, these natural slings seem to have a higher failure rate. Slings are named for the route the surgeon uses to insert them. Examples include Transobturator (TO) and Retropubic (RP). In the hands of an experienced and skilled surgeon, success rates are similar. Sling surgeries are completed in 15 to 30 minutes, and patients are discharged home the same day. It is a good idea to choose a surgeon who performs at least 50 successful sling surgeries each year.

■ **Burch and MMK Procedures:** Prior to the introduction of mid-urethral slings, Burch and MMK procedures were considered the best method in the treatment of stress incontinence. However, lower success rates and higher complication rates associated with these procedures caused these procedures to fall out of favor. Unlike sling procedures, which require no abdominal incisions, Burch and MMK procedures are typically performed through a small incision just over the pubic bone. Most patients

are admitted to the hospital and do not go home the same day. These procedures are also associated with a higher rate of urinary retention and overactive bladder symptoms. Based on the lower success rates, higher complication rates and more invasive nature of these procedures, these procedures are considered inferior to mid-urethra slings.

#### Non-Surgical Options

■ **Urethral Injections:** Urethral injections are material injected into the wall of the urethra in order to "tighten" or partially close it. The increase in bladder pressure associated with a voluntary urination is sufficient to push open the urethra. However, when injected appropriately, activities such as exercise, coughing, sneezing, or laughing do not push open the urethra and cause incontinence.

The trick to appropriate injection is not just in the technique: It involves choosing the correct patient. Most patients with stress incontinence have both a weak urethra (one that does not stay closed) and a poorly supported urethra (one that falls into the vagina). Urethral injections work poorly in patients who have a poorly supported vagina. However, subsets of patients with incontinence, 10-20 percent, have a urethra that is weak, but well supported. It is this group of patients that have the highest chance at cure via urethral injection. Urethral injections are extremely well tolerated in the office setting, typically last six months to two years and can be repeated as needed. The average time to complete this procedure is just three minutes.

■ **Pessaries:** Pessaries are rubber or silicon rings, squares, or unique shapes which may be worn inside

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the vagina. Although they are most commonly used to treat women with pelvic organ prolapse who do not want surgery, they can also be used to treat stress incontinence. For those women whose stress incontinence is caused predominantly by movement of the urethra into the vagina, pessaries will sometimes decrease stress incontinence symptoms. Unfortunately, success rates are low, and pessaries do cause substantial vaginal discharge.

■ **Pelvic Floor Physiotherapy:** Strengthening specific muscles of the pelvic floor, such as the pubococcygeus muscle, can prevent movement of the urethra. This may lead to a significant decrease in stress incontinence symptoms. Physical therapists with unique training in pelvic floor biofeedback therapy (using computers to help women strengthen their pelvic muscles) and other specialized methods offer the best chance at improvement. Special exercises such as Kegel exercises have low success rates when performed without the involvement of a physical therapist.

More severe grades of stress incontinence do not benefit from physiotherapy. Urodynamic testing is often utilized to identify those patients most likely to improve with physiotherapy.

■ **Electrical Stimulation Therapy:** Gentle, painless levels of electrical stimulation applied to the muscles of the pelvis causes those muscles to contract. These contractions may lead to strengthening. The electrical stimulation is

administered through a thumb-sized probe that is placed in the vagina for fifteen minutes twice a day. Although many believe E-Stim's success rates are exaggerated, due to its minimal side effects, it is still widely available.

■ **Drug Therapy:** Certain medications increase the tone of the urethral sphincter. Hence, these medications may decrease stress incontinence symptoms. Examples of such medicines include Pseudoephed\* and Imipramine. There is also some preliminary evidence that the antidepressant Cymbalta\* may have an effect on the urethra.

Unfortunately, these medications only help the mildest cases of stress incontinence and have associated side effects. Additionally, the patients that improve with drug therapy are the same patients that have the best chance of improvement with physiotherapy.

Many women suffer silently for years with stress incontinence issues. There is no substitute for experience, and the first step in any stress incontinence treatment plan should be finding a qualified urogynecologist. With the wide variety of treatment options available, there is no excuse to continue suffering. ■

Dr. Ralph Zipper is a national leader in the field of urogynecology and vaginal surgery. Zipper Urogynecology Associates is one of the nation's top centers for the treatment of pelvic floor dysfunction, overactive bladder and urinary incontinence and vaginal rejuvenation. For details, please visit the newly launched educational web site [www.zipperurogyn.com](http://www.zipperurogyn.com) or call 321-674-2114. Jennifer Lang P.A.C. is one of the nation's most experienced urogynecology PAs. Zipper Urogynecology Associates accepts most major insurances including Medicare and Health First. Call 321-674-2114 for an appointment or e-mail request to [frontdesk@zipperurogyn.com](mailto:frontdesk@zipperurogyn.com)

