No Laughing Matter

Urinary incontinence has many running for the bathroom but wishing for another alternative

Bladder control problems pose a major health issue for more than 33 million adults in the United States. And sadly about one-third of those affected seek medical treatment. This is unfortunate, because significant strides have been made in recent years in treatment.

Bladder control problems, or urinary incontinence, can be broadly classified in two forms. Urge incontinence pertains to the lack of control that exists with the sudden urge to go to the bathroom ("got to go, got to go, got to go, go, go," as the TV commercial says). These urges can occur at any time. Often the sound of running water or the ingestion of small amounts of liquid will trigger such events. Urinary stress incontinence refers to the leakage that occurs with coughing, sneezing, laughing, lifting, jogging, etc., anything that causes sudden contraction of the abdominal muscles. Often, patients will have both types of incontinence, which is called mixed incontinence. Overflow incontinence occurs when the bladder doesn't empty properly, causing it to spill over. Weak bladder muscles or a blocked urethra can cause this type of incontinence. Overflow is rare in women.

Most of the patients urologists see with urinary incontinence are women, but the disorder can occur in men, as well. In the case of stress incontinence, this occurs in men primarily after radical prostate surgery.

When a patient presents with urinary incontinence, often a history and brief physical exam alone will suffice in directing treatment. It helps to know how well the patient is emptying his or her bladder, and this can be determined in the office with a simple, noninvasive bladder scan. If there is a problem with mixed incontinence, the patient will often be

advised to have urodynamic studies — this involves checking muscle and nerve function of the bladder and pelvic floor, or sphincter muscles. This test can be informative.

In urinary urge incontinence, simple changes in diet (avoiding caffeine, spicy foods, alcohol, etc.) can often be helpful. Pelvic floor exercises — or Kegels, as they are commonly called — may also help. Biofeedback helps in identifying the muscle groups involved in these exercises.

Many medications for overactive bladder have come out in recent years. Most of these are taken only once or, at the most, twice weekly.

In urge incontinence as well as the urgency-frequency syndrome, when medications, dietary changes, etc. do not result in significant improvement, patients may be candidates for sacral nerve modulation, or InterStim. Approved in the United States 10 years ago, tens of thousands of patients have undergone this therapy with significant benefit. The therapy involves placement of a small wire electrode next to the nerve that goes to the bladder and then connection of this electrode to a pulse generator implanted in the upper part of the buttock. For want of a better term, this serves as a "pacemaker" for the bladder. One of the attractive features of this therapy is that a test stimulation procedure can be done, usually in the office, before the procedure. A temporary electrode is implanted through the skin, and the patient wears a small portable pulse generator (like a TENS unit) on his or her belt or waistband for a week or two. If the symptoms of urge incontinence or urinary urgency and frequency are improved, the implant is performed as outpatient surgery.

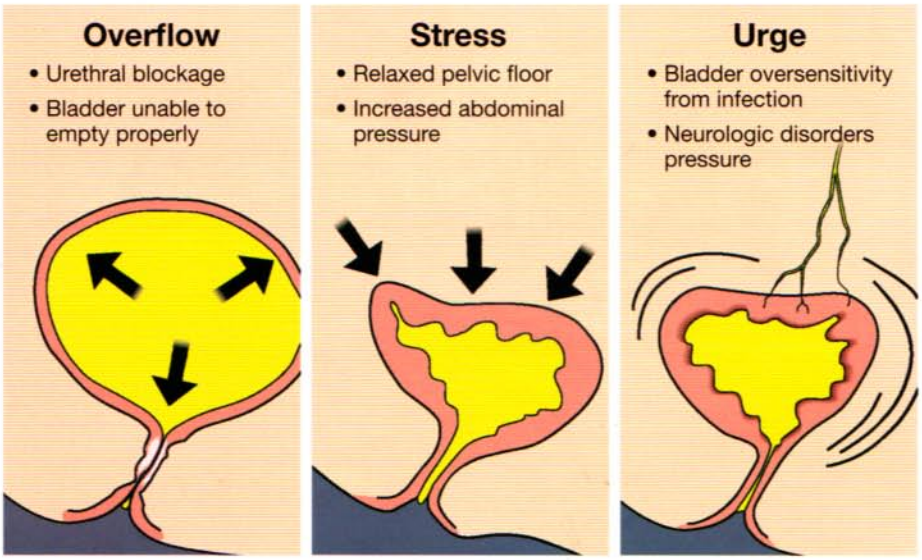
In urinary stress incontinence (again, that which occurs with coughing, sneezing, laughing, etc.), major strides have been made. Treatment usually involves surgery, but the type of surgery performed today is much less involved than that which was offered only a few years ago. The pubovaginal sling became popular a decade ago. Now, in most cases, a midurethral sling is recommended. This outpatient procedure is associated with little or no postoperative pain, and the patient usually leaves the hospital or ambulatory surgery center without a catheter. This operation constitutes the major development in the past three decades in urinary stress incontinence treatment.

As mentioned earlier, stress incontinence can also occur in men, usually after prostate surgery. The implantation of an artificial sphincter has been an option for more than 20 years in these patients. This device has stood the test of time and has been a godsend for many men. For those cases of less severe incontinence after prostate surgery (one or two small pads per day), new sling procedures have been developed and appear attractive.

Urinary incontinence is a major quality of life issue for many adults. In recent years, there have been significant advances in the evaluation and treatment of all forms of incontinence.

*incontinence***breakdown**

THE THREE TYPES OF INCONTINENCE



TREATMENT OPTIONS

Diet modification
Avoid bladder stimulants such as caffeine, alcohol, and spicy food

Pelvic floor exercises
Also known as Kegels, the exercises consist of the regular clenching and unclenching of the muscles which form part of the pelvic floor

Biofeeback
Electromyogram (EMG) is the most common form of biofeedback measurement used for incontinence.

EMG uses electrodes or other types of sensors to measure muscle tension

Allow patients to learn how to recognize the feeling of muscle tension to help to try and control it.

Medication
Some drugs inhibit contractions of an overactive bladder

Others relax muscles, leading to more complete bladder emptying during urination.

Some drugs tighten muscles at the bladder neck and urethra, preventing leakage.

Some, especially hormones such as estrogen, are believed to cause muscles involved in urination to function normally.

Surgery
Usually suggested only after other treatments have been tried

Many surgical options have high rates of success

InterStim
Also known as sacral nerve modulation

Therapy involved placing small electrode next to the nerve that goes to the bladder

Electrode acts like a bladder pacemaker

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