



WOMEN'S MEDICAL GROUP
OBSTETRICS – GYNECOLOGY – INFERTILITY

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Urinary Incontinence

Incontinence is the involuntary loss of urine. Low estrogen levels can decrease muscle tone and result in decreased urinary control in the bladder and urethra. Many types of urinary incontinence are possible. The two most common types, genuine stress incontinence and urge incontinence, will be discussed here.

Stress incontinence is most likely to occur in women who have had one or more children. With childbirth the tissue of the vagina is stretched and the underlying elastic tissue is broken. Prior to menopause the muscles of the vagina can be exercised to increase the tone and decrease the amount of urine loss. After menopause, atrophy, or thinning of the estrogen sensitive tissues results in reduced sphincter control. Other changes with menopause include a decrease in the support of the pelvic organs. When stress is put on the bladder due to coughing, sneezing, laughing or jogging a momentary loss of control can result in a small amount of leakage.

Urge incontinence can also be a problem for some women. It is usually described by women as a feeling of a sudden and uncontrollable need to urinate. It often occurs within an hour of having emptied the bladder. Women often urinate frequently during both the day and night due to the irritability of the bladder.

Kegel exercises, named after the doctor who first described them, help to strengthen the pelvic floor. The exercises are often effective for those who perform them diligently. The exercises can be done anywhere, without anyone being aware that they are being performed. To perform Kegel exercises correctly, you must first relax your abdomen, thighs and buttocks. Then contract the muscles of the pelvic floor by squeezing them inward and upward as if trying to control a strong urge to urinate. Hold the contraction for up to ten seconds then release. Do ten long squeezes three times a day. It usually takes one to two months to notice an improvement. Do not do the Kegels while urinating. It's possible to figure out which muscles are the correct ones by stopping the urine flow but continued exercise this way can lead to problems with urinary retention and can also be frustrating.

Other aides to increasing muscle tone include using vaginal cones, biofeedback and electrical stimulation devices. Vaginal cones are weights that fit into the vagina and help women by accelerating the effects of the Kegels. Dacomed Corporation makes a set of five cones ranging in size from half an ounce to more than three ounces. It can be ordered at most medical supply stores with a prescription.

Biofeedback is taught by some physicians and some physical therapists. A computer is used to monitor a probe which is inserted into the patient's vagina, allowing her to watch the computer monitor and view the strength of the Kegel exercises. Instant feedback is the advantage of this system. When the patient squeezes correctly, the computer graphs an increase in pressure. When the Kegels are done incorrectly, the graph remains flat.

Artificial electrical stimulation devices such as the Enovid system produce low levels of electric current to the pelvic floor muscles, causing them to contract automatically and increase the muscles strength. All of the methods can be used to increase the muscular control in the vagina and reduce genuine stress incontinence.

If the Kegels do not improve bladder control significantly, surgery is another option. Many different procedures have been developed to control stress incontinence. Traditionally, gynecologists have performed an anterior vaginal repair or cystocele operation to help with incontinence. Long term studies, however, have shown the success rate to be approximately 50 percent of women without leakage at five years.

Recently it has become standard to perform a urethral suspension. This can be performed abdominally or vaginally depending on the patients' age, anatomy and tissue strength. The surgeons training and comfort with each procedure is important in determining the long-term cure rate. It is wise to investigate your gynecologists or urologists training in uro-gynecology. Most procedures approach an 85% cure rate at 5 years. Women who are obese, smoke, use the medication prednisone, lift heavy objects, or have chronic lung disease are more likely to have recurrent symptoms.

Urge incontinence does not improve with surgery. It most often is the result of bladder or detrusor muscle instability. The bladder has spontaneous contractions. Women can retrain the bladder using a timed voiding schedule. To "train" the bladder, void at a timed interval slightly more frequent than normal. After this becomes a comfortable habit, gradually increase the voiding interval by 15-30 minutes every 10 days in an attempt to suppress the urgency associated with incontinence. Avoid caffeine, carbonated beverages and alcohol in your diet as these can increase the bladder spasms. Estrogen supplementation, orally or vaginally can help with bladder control. Antispasmodic medications can also help with urge incontinence. Dry mouth and constipation are a side effect with the medications.

To determine what type of incontinence you may have, a complete history and physical exam should be performed by your gynecologist. Your doctor may also ask for a diary of your urinary patterns which includes caffeine and alcohol consumption as well as medication usage. Further evaluation may include urinalysis, urine culture and urodynamic testing. Urodynamic testing evaluates the bladder volume, function and voiding pattern. Cystoscopy, or looking inside the bladder, is also performed when appropriate.