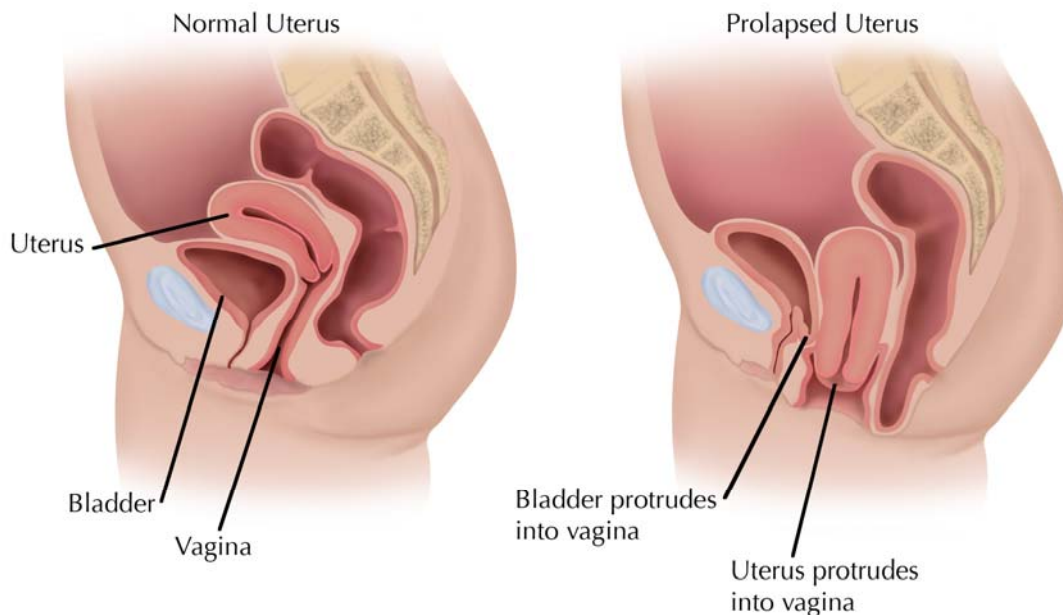


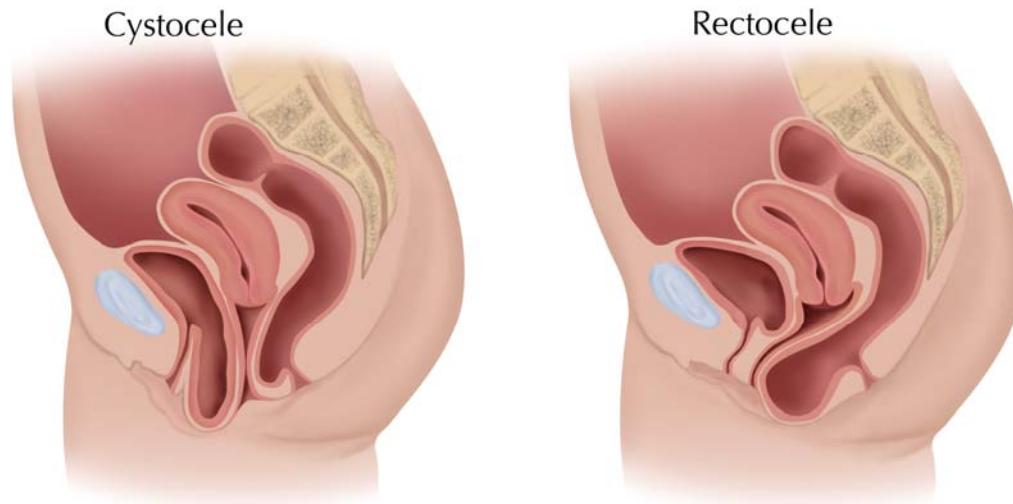
TREATMENT OF URINARY INCONTINENCE AND PELVIC PROLAPSE

“Silent epidemic” has been used to describe the increasing prevalence of women with urinary incontinence and pelvic prolapse as a large segment of our population passes through the childbearing years. The prevalence increases further with active lifestyles and with the loss of estrogen after menopause. Many are reluctant to discuss these problems at least in part because traditional therapies such as “bladder tacks” have at best mixed results. However, advanced therapies are now highly effective with minimal impact on lifestyle.

The vaginal tube is both simple and elegant in design. Thin sheets of strong support tissue called *fascia* form the roof and floor of the tube preventing the bladder from collapsing through the roof and the rectum from bulging through the floor of the vagina. These sheets of fascia plus cords of fascia support the uterus while thin fibers of fascia loop beneath the bladder outlet preventing loss of urine with sneezing, coughing, laughing and exercise (*stress incontinence*). Vaginal fascia requires estrogen and good nutrition to remain healthy and strong.

Prolapse occurs when the supporting fascia weakens and tears with stresses such as repeated heavy lifting and childbirth allowing the bladder, rectum and uterus (see figures) to either separately or together collapse into or out of the vagina. *Stress incontinence* develops following damage to the support fibers beneath the bladder outlet. The impact on quality of life and on overall health from prolapse and incontinence can be significant.





Traditional therapies have included *pessaries* (objects placed in the vaginal tube) and surgeries ranging from “bladder tacks” to larger surgeries requiring abdominal incisions to surgeries that completely obliterate the vagina. These traditional repairs did not restore the original anatomy and in some women created additional problems. However, surgical therapies have rapidly improved with current technology providing much greater cure rates of both prolapse and stress incontinence while restoring original anatomy and function.

The greatest advance to date has been the development of a material that augments the original fascia. While earlier attempts at artificial material had unacceptable failure and complication rates, a thin, light mesh has evolved with large studies showing high success and low complication rates. The surgeries used for mesh placement are now minimally invasive requiring only small vaginal incisions and subsequently more rapid return to normal activity.

Urinary incontinence may occur for reasons other than a weakened outlet. The most common cause is spasm of the muscle forming the bladder wall (*urge incontinence*). Combined urge and stress incontinence is common.

Both types of incontinence may improve with simple changes in lifestyle and voiding habits and by doing Kegel exercises. This requires lifelong commitment. Urge incontinence not responding to lifestyle changes may improve with medicines that relax the bladder muscle and in extreme cases by surgically implanting electrodes near nerves that control the bladder.

Women with prolapse and incontinence should take comfort in knowing that many others have the same problem and that when needed highly effective, minimally invasive treatments are available. There is no need to remain silent.

Article by Dr Keith Merritt, MD