

The Female Patient[®]

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New Options for Stress Urinary Incontinence

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Stress urinary incontinence (SUI), or the involuntary loss of urine resulting from an increase in abdominal pressure (physical stress on the bladder), is a problem plaguing many female patients. Despite recent advances in understanding this condition and new surgical options, the limited therapeutic choices in between conservative treatment and surgical intervention for SUI cause frustration for both patient and clinician. Approximately 20 million adult women suffer from SUI, yet only about a quarter of these seek help from a health care professional for this condition.¹ Patient fear and embarrassment, and clinician hesitance to inquire about the condition, contribute to this low number. Despite these limitations, health care professionals have a responsibility to inform patients about the variety of treatment options that exist and to help them understand the potential benefits and risks of each.

Current treatment options for SUI include observation, pelvic muscle exercise (PME, also known as Kegel exercises) with or without assistance from a pelvic floor physical therapist, medication, vaginal pessary, urethral bulking agents, radiofrequency collagen denaturation (Renessa[®]), and surgery (retropubic urethropexy or

Radiofrequency collagen denaturation offers a nonsurgical office treatment that can reduce or eliminate SUI symptoms for women with urethral hypermobility.

midurethral sling [MUS]). These options offer a range of results, from no effect, to improvement, to near total improvement, or absolute cure. Women with SUI may be more satisfied with an improvement in bladder control, rather than absolute cure, if the treatment is safe and convenient and has minimal risk of adverse events. For example, only 17% of women presenting to one urogynecology clinic expected a complete cure.² In addition, only 38% of women in this population found it accept-

able to undergo minor surgery for SUI that promised an 85% chance of cure but carried a 2% risk of long-term self-catheterization. By contrast, 57% of women would accept a clinic procedure with a 60% improvement and no long-term risk.²

Kegel Exercises

A recent study found that most women presenting to a suburban urogynecology practice had heard of PME, but less than half had been instructed by a clinician to perform these exercises. Examination of these patients revealed that only 23% could contract their pelvic floor muscles to any degree.³ Women opting for PME should work with a pelvic floor physical therapist or undergo bimanual assessment by a clinician to confirm proper performance. Unfortunately, as with most exercise programs, the number of women who continue performing PME on a long-term basis is less than optimal.

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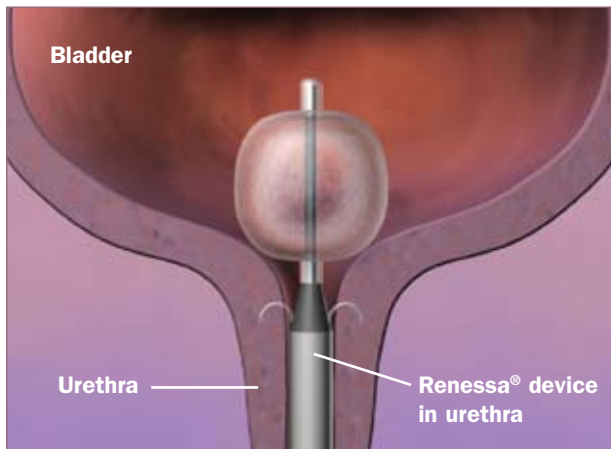


FIGURE. Renessa® device situated at bladder neck. The needle tips gently heat the subepithelial tissue at the bladder neck using radiofrequency energy.

Nonsurgical Treatment

Currently, there are no FDA-approved medications for the treatment of SUI. Vaginal pessaries and incontinence rings in particular may alleviate symptoms of SUI in women willing to wear a vaginal device. Associated discharge, odor, and interference with sexual activity decrease acceptance of this option, especially in young, sexually active women.

Injection of periurethral bulking agents can be performed under local anesthesia in an office setting. Multiple injections are frequently required to achieve and maintain continence, and efficacy tends to diminish over time. Injectables are currently FDA approved for use in women with a severe form of SUI known as intrinsic sphincteric deficiency, but they have been used in women with urethral hypermobility because of lack of suitable surgical or nonsurgical choices.

Radiofrequency Collagen Denaturation

Most recently, radiofrequency collagen denaturation offers a nonsurgical office treatment that can reduce or eliminate SUI symptoms for women with urethral hypermobility (lax ligamentous support of the urethra). Marketed in the United States as Renessa®, this 30-minute treatment is performed under local anesthesia in an office setting (Figure). No incisions are required, and minimal recovery allows patients to return to their normal daily activities in 24 to 48 hours. The results at 12 months posttreatment of a 3-year prospective multicenter trial involving 136 women who underwent radiofrequency collagen denaturation showed that half the women reported a 50% reduction in the number of weekly incontinence episodes.⁴ Almost 70% of the women had a 50% reduction in amount of urine lost on a standardized in-office pad test, and 45%

of the women were dry on pad testing (ie, where a pre-weighed pad is re-weighed after a standard set of exercises). The majority of adverse events were mild and transitory. The most common at 3 days posttreatment were dysuria, retention, postprocedural pain, and urinary tract infection (UTI). No serious adverse events were reported.

Midurethral Sling

Synthetic MUS has surpassed retropubic urethropexy (Burch or MMK) as the gold standard for the surgical treatment of SUI. Last year, 300,000 synthetic slings were performed in the United States alone. The MUS is commonly performed as an outpatient procedure under local, regional, or general anesthesia. Although surgeons like to believe that this procedure is >90% curative in all patients, the true dry rates are likely lower. In a Dutch study of 809 women undergoing MUS by 54 different surgeons, only 66% of women reported absolute cure at 2 years.⁵ However, this cure rate does not necessarily reflect the number of women improved or satisfied with the results. Risks of surgery include anesthesia, bleeding, infection, organ injury, mesh erosion, new onset or worsening of existing urge, recurrent urinary tract infection, and urinary retention. Recommended recovery time varies by surgeon but involves time off work and limitations on physical activity, typically for a period of weeks.

Conclusion

A number of options exist for women with SUI. Exploring a woman's goals for treatment, tolerance for persistent leakage, and procedure-related risk will help clinicians to best counsel patients with SUI. Many women will choose safety and convenience for an improvement in their condition over a procedure that promises a higher chance of cure but involves greater risks.

References

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