Dr Rebecca Young

How can female stress urinary incontinence be treated?

Stress urinary incontinence is leakage of urine when there is an increase in intra-abdominal pressure e.g. during cough/sneeze or exercise. It affects at least 10-20% of women and can have a significant impact on a patient's quality of life.

How is it diagnosed?

- Careful history and examination.
- Postvoid residual to exclude voiding dysfunction.
- A bladder diary: particularly helpful if the history is not clear or there is a picture of mixed incontinence.
- Urodynamic testing.

What management options are available?

- Pelvic floor exercises and pelvic floor physiotherapy.
- Weight loss.
- Avoidance of constipation and heavy lifting.
- Treatment and prevention of chronic cough if present.
- Topical oestrogen in postmenopausal women.
- A tampon can be placed in the vagina to support sub-urethrally during exercise/activity.
- Continence pessaries e.g. contiform, a continence dish, a ring pessary with a knob.
- Surgery.

What surgeries are available for treatment?

- **Retropubic mid-urethral sling (polypropylene mesh) i.e. TVT:**
  - Despite complications that can occur with the mesh TVT this is still the recommended surgical treatment as per the Australian Commission on Safety and Quality in Healthcare as it has a high success rate and is minimally invasive.
  - Most patients can be discharged the day of the procedure or the following day after ensuring normal voiding.
  - It does involve placement of a permanent mesh with a 1-2% risk of mesh complications (mesh extrusion, chronic pain) so may not be suitable for all patients.
- **Laparoscopic burch colposuspension:**
  - Involves laparoscopic dissection of the retropubic space and placement of permanent sutures which elevate the mid urethra and anterior vaginal wall.
  - Has a lower success rate long-term than sling procedures but still has a 70-80% success rate (based on meta-analysis).
  - Has a short recovery with most patients able to be discharged 1-2 days post procedure and minimal pain due to the use of laparoscopy.
- **Pubovaginal (autologous) sling:**
  - Similar high long-term success to the mesh TVT but uses the patients own tissue to create the sling.
  - Tissue can be harvested from the rectus sheath or fascia lata of the thigh and smaller incisions can be used if a patient is suitable for a 'sling on a string', where the length of the fascia is approximately 8cm.
  - Avoids mesh and is a robust operation, good for patients with recurrent or severe SUI.
  - There is a small risk for future hernia, an increased recovery time and a higher risk for long-term voiding dysfunction compared to other continence surgeries.
- **Urethral bulking agents (e.g. bulkamid or macroplastique):**
  - Involves injecting a bulking agent around the urethra to narrow the lumen and reduce leakage.
  - Is most often used in patients with recurrent SUI after prior surgery or in those not fit for major surgery as it has a lower success rate compared to other continence surgery (approximately 50%), though it can be used as a primary procedure in other circumstances.
  - Can be repeated if the effect wears off with time.

Should my patient have surgery?

- The decision to have surgery is very personal and will depend on the degree of bother, the aim is to significantly improve quality of life.
- Surgery should be considered following trialling conservative treatments if symptoms are ongoing.
- The Australian Commission on Safety and Quality in Healthcare provides helpful information for women with stress urinary incontinence regarding their options which can be accessed at: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/treatment-options-stress-urinary-incontinence-sui

MR0046067 NSPH Dr Rebecca Young – Stress incontinence GP info sheet

Dr Rebecca Young
Obstetrician and Gynaecologist – Urogynaecology

Suite 104, Level 1
172 Fox Valley Road
Wahroonga NSW 2076

P: 02 9094 3313
F: 02 9066 5757

E: info@drrebeccayoung.com.au
www.drrebeccayoung.com.au