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Stress urinary incontinence: What qualities do women seek in treatment?

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Clinicians face significant challenges in the management of stress urinary incontinence (SUI). Nearly 20 million adult women in the United States experience SUI, yet only half discuss it with a physician, and only 20% of those who do speak up actually pursue treatment. Patients may believe that SUI is a normal consequence of aging or that few treatment options are available.¹

It is imperative that the physician clearly understands a woman's expectations for treatment. Does she seek sufficient improvement in bladder control to allow a return to normal activities? Or is she expecting to be completely dry? What is her tolerance for risk of adverse events (AEs)? Can she comply with the recommended postoperative restrictions, which may include taking time off from work or avoiding physical activities? Will she desire a treatment that offers an improvement in symptoms and quality of life, but carries minimal risk for AEs and minimal recovery time? Or a treatment that may offer a complete cure, but may pose more significant risks and require several weeks of recovery?²

Current treatment options

NONSURGICAL TREATMENTS. Pelvic muscle exercises (PME) may be appropriate for select patients; however, one study demonstrated that only 23.4% of patients can perform pelvic muscle contractions.³ Exercises must be continued indefinitely to maintain improved bladder control.

Pessaries, incontinence rings, or nonmenstrual use of vaginal tampons may alleviate symptoms but may be associated with discharge and odor, and may interfere with sexual activity.

Periurethral bulking agents (including collagen and several synthetic materials) can be injected in-office under local anesthesia, and typically require cystoscopy. Multiple injections may be needed. All urethral bulking agents are indicated

for the treatment of intrinsic sphincteric deficiency (ISD). ISD is present in only approximately 15% of SUI patients.

Transurethral collagen denaturation in the bladder neck and proximal urethral (Renessa[®]) is an in-office, 30-minute treatment (the office visit lasts 45 to 60 minutes) that can reduce or eliminate SUI symptoms in women who have urethral hypermobility. The procedure is performed under local anesthesia, requires no incisions, and allows return to normal daily activities in 24 to 48 hours.

Clinical effectiveness of Renessa has been demonstrated. A 3-year prospective multicenter trial (n=136) showed that at 12 months post-treatment, half of the participants reported at least a 50% reduction in weekly incontinence episodes. Almost 70% had >50% less urine loss (using a standardized in-office pad test), and 45% were dry on pad testing (i.e., where a preweighed pad is reweighed after a standard set of exercises).⁴ The most common AEs at 3 days post-treatment were dysuria, retention, postprocedural pain, and urinary tract infection (UTI). All were transient and managed with medication. No serious AEs were reported in this or any Renessa clinical trial.⁴

SURGICAL INTERVENTION. The midurethral sling (MUS), performed on approximately 300,000 patients in the United States annually, has surpassed retropubic urethropexy as the surgical gold standard. It is commonly performed on an outpatient basis under local, regional, or general anesthesia. Surgeons may believe that MUS provides a >90% cure/dry rate; however, the true dry rates may be lower. A follow up of 809 patients at 2 years demonstrated a 66% absolute cure/dry rate, although a greater percentage of women were satisfied with their outcomes.⁵ In addition to the risks of any surgical procedure (anesthesia, bleeding, infection), risks of MUS include organ injury, mesh erosion, new onset or worsening of existing urge, recurrent UTI, retention, and possible need to return to the OR for sling revision. Recommended recovery time varies by surgeon, but involves time off from work and limitations on physical activity, typically for a period of weeks.

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Conclusion

Various options exist for women with SUI. Clinicians should discuss with their patients their expectations for treatment, recovery limitations, and tolerance for procedure-related risk. Many women will choose a treatment that offers an improvement in their condition but is safe and convenient, rather than a procedure that promises a higher chance of cure, but involves greater risks and recovery time. The Renessa treatment offers women and their physicians a safe and effective nonsurgical option that may improve symptoms and quality of life with minimal risk and recovery limitations.

References

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CASE STUDIES

Case 1

PRESENTATION AND HISTORY. A 41-year-old woman presents with SUI. She experiences leakage episodes 3 to 4 times per day that require use of incontinence pads. She has performed daily Kegels since the birth of her last child 8 years ago. She desires a sling procedure, noting that a friend had one and is very pleased with the results.

She works as a cashier at a large grocery store and must lift large items. She is wary about requesting 4 weeks off. In addition, she has been divorced for 5 years and has recently become engaged to a man several years her junior. She does not want to reveal the extent of her incontinence to him, because it makes her feel too old. She is also reluctant to discuss the need to avoid intercourse for 4 weeks. They also hope to have a child together; slings are recommended for women who have completed childbearing.

Case 2

PRESENTATION AND HISTORY. A 61-year-old woman presents with SUI, leaking an average of 3 times per day. She has performed Kegels with no improvement. She works as a receptionist, but is physically active, requiring incontinence pads when she plays tennis. She frequently babysits her young grandchildren and leaks when chasing them around the playground. She is not sexually active.

Case 1 and Case 2 Physical examination and diagnosis

Pelvic exams demonstrate urethral hypermobility and excellent pelvic floor contraction. Postvoid residuals are negligible. Cough stress tests are positive. Each patient underwent urodynamic testing, which confirmed the diagnosis of urodynamic stress incontinence. There was no evidence of detrusor overactivity in either patient.

Case Discussions

Treatment options are carefully reviewed with each patient. PME demands time and effort. Insurance coverage of physical therapy for Patient 1 is an issue. However, neither patient is interested in this option, especially since each has already tried Kegels. Patient 1 does not use tampons for menstruation and does not want to try a tampon or incontinence pessary during activities. Removing and replacing a device is unappealing as is the possibility of vaginal irritation or discharge. Patient 2 also finds this a less-than-acceptable solution.

In discussing available procedures, expectations, risks, and benefits of each option are discussed with the patient. Renessa focuses on improvement in incontinence; studies demonstrate that approximately 75% of patients experience an improvement in their symptoms. More than half the women having this procedure have

experienced a 50% or greater improvement with close to 45% of those becoming dry. About 10% of women describe a worsening of incontinence, the majority of whom experience transient urgency symptoms which are commonly managed with medication and resolve within a few weeks.

Renessa is performed in the office under local anesthesia with no incision. Return to normal activity occurs within 24 to 48 hours. The common risks are UTI, transient dysuria and/or urgency, and hematuria. No problems have been reported in women who have insufficient response to Renessa and then have a sling performed.

The goal of MUS is total cure/dryness, achieved by approximately two-thirds of patients who receive this procedure. It is performed as an outpatient procedure in the hospital or ambulatory surgicenter. (Our practice exclusively uses local anesthesia with “twilight” sedation, although other centers routinely employ general or spinal anesthesia.)

The risks of surgery in general are bleeding, infection, and anesthetic risk. Risks of a sling include organ injury, particularly bladder perforation. A risk of transient urinary retention could necessitate the use of an indwelling catheter or clean intermittent self-catheterization (CISC) for a period of days to weeks. Sling revision in the OR may be necessary because of obstruction or mesh exposure.

No standard recommendations for activity restriction after MUS exist. We ask women who work outside the home to stay home for 4 to 5 days post procedure. We recommend a 4-week period of restrictions that include avoiding lifting >8 pounds, sexual intercourse, and constipation. We believe that activity restriction adds to an ideal result. Patient counseling requires that we accurately educate patients on the risks and restrictions.

Treatment Choices

Each patient has to weigh the burden of the treatment against the promise of efficacy. Some women will want to avoid surgery at all costs and will devote time and energy to exercise and device use. Others want this “broken” body part fixed and are more interested in a one-time procedure or surgery that offers significant improvement or cure. Most surgeons who treat incontinence consider MUS to be a minor procedure (particularly those of us who have extensive experience with Marshall Marchetti Krantz [MMK] or Burch procedures).

Patient 1 has little flexibility in her life, due to her economic and social situation. For this reason, she is most interested in the Renessa procedure. She is also reassured to learn that if this treatment choice does not provide sufficient symptom relief, MUS remains an option.

Patient 2 prefers a definitive solution, with the potential for a total cure. She selects MUS.