Hello, today we’re talking with Dr. Fleischman about urinary incontinence. This is Roberta Speyer of ObGyn.net, and I have the pleasure today to be talking to a specialist who deals with urinary incontinence in America.

Roberta Speyer: “Hello, today we’re talking with Dr. Fleischman about urinary incontinence. This is Roberta Speyer of ObGyn.net, and I have the pleasure today to be talking to a specialist who deals with urinary incontinence in America. Dr. Fleischman could you tell us a little about yourself and your practice?”

Steve Fleischman, MD: “Sure. I’m currently in private practice in New Haven, Connecticut with Gynaecology and Infertility and I’m a Clinical Instructor of Obstetrics and Gynaecology at the Yale University School of Medicine.”

Roberta Speyer: “What about urinary incontinence in America? What’s the landscape? Why has your practice chosen to diagnose and treat urinary incontinence? Is this something new or is this something that’s not new but something we are hearing more about?”

Steve Fleischman, MD: “I think it’s definitely not new. It’s something we’re certainly hearing a lot more about these days. I think when you look back on the statistics of it; it’s fairly poorly documented in terms of how prevalent this disorder is. We know it’s somewhere, depending on which study you’re looking at, it’s about 10-50% of women will report urinary incontinence. Certainly something that increases with increasing age and when you get up to women over 64 it can be as high as 40 to 50% of the population of the community. When you look at nursing homes it’s even greater than that, about 50% of women who are living in nursing homes will leak urine.”

Roberta Speyer: “Is this more prevalent in women than in men?”

Steve Fleischman, MD: “It certainly is more prevalent in women than in men. It is a problem in men but not nearly as common.”

Roberta Speyer: “What are the contributing factors to that?”

Steve Fleischman, MD: “Well there are several factors. One, we certainly know that childbirth can have an impact on it. About 50% of women who have had vaginal deliveries will experience some form of prolapse at some point in their future. Unfortunately we know from most of the data that’s out there that a small portion of those women will actually seek care. There are other issues related to estrogen levels. There’s issues related to age and general atrophy of the vaginal mucosa. I think the other big issue, at least in our society today, is that the largest segment of the aging population is the over 85 group. So when you’re dealing with a largely increasing elderly population you’re seeing this as becoming a more prevalent disorder.”

Roberta Speyer: “It would be interesting I think for the woman listening to this interview, and certainly for the clinicians, if you could explain to us a little bit about the typical work up for urinary incontinence? And also include in that, I believe as a layperson, I’ve heard that there are different types of urinary incontinence. Urinary incontinence isn’t one specific problem but may be urge or stress. So if you could fill us in a little bit on what the different types are and how you do a work up to decide how to treat, I think that would be very helpful to our audience.”

Steve Fleischman, MD: “Sure. I think the first thing to realize about urinary incontinence is yes, there are different types. There’s what we refer to, and I will go into detail a little on each of these, as genuine stress incontinence, which typically the symptoms are leaking of urine when you laugh,
cough, sneeze, you do something with heavy lifting and it’s an involuntary loss of urine. The second type that’s fairly common is what we call urge incontinence or what’s also known as detrusor instability or overactive bladder. This is more related to not as much of a structural problem where the bladder is falling or there’s a change in the angle, but with the muscle of the bladder.”

Roberta Speyer: “The first type would be more of a structural problem?”

Steve Fleischman, MD: “Correct, and the second, the urge incontinence is more related to what we call overactive bladder where the muscle in the bladder is actually contracting on its own when you don’t want it to. So an involuntary contraction of that bladder, which gives people a sense of urgency where they feel like they have to go to the bathroom immediately. They can’t wait, they get to a point and they say they need to be in a bathroom right now, and sometimes they will leak from that.”

Roberta Speyer: “What causes that?”

Steve Fleischman, MD: “There are various receptors on the bladder which are either stimulated to cause the bladder to relax or stimulated to cause the bladder to contract and we’re not sure exactly why but in certain people they develop an over activity of that muscle where it begins to contract on its own. There are various reasons some can be medication. A lot of women who are put on medications for other medical problems, such as blood pressure medication, sometimes medications for depression can actually stimulate the bladder or relax the bladder and cause some of these urgency symptoms. We know that women who have severe vaginitis, if you actually have a really bad yeast infection or bacterial infection of the vagina, that inflammation in the vagina can actually cause some irritation of the underside of the bladder and cause women to have urgency and frequency symptoms at that time. So, having the symptoms, per se, doesn’t necessarily mean it is an overactive bladder there can be other things. That is traditionally treated with more of a medication.”

Roberta Speyer: “I, Dr. Fleischman, actually had that problem and that’s why I can appreciate what you’re saying about women going with these problems for a number of years. I probably had that problem for four or five years and just thought that was because I had had children and that’s the way it was and then I actually explained it to my physician and was treated with a pill for a three month period of time and after that, cured. What’s happening during that cure, is it just you are re-educating your brain?”

Steve Fleischman, MD: “It’s hard to say exactly why people don’t seek help for this. I don’t know if it’s a generational thing. It’s the most common complaint when I speak to most patients. I make sure in my initial work up that in the general routine physical exam I ask them about their urinary symptoms and the most frequent thing they respond to me is ‘Well, yes of course, but that’s just the way it is.’ And it’s not until you really tell them that ‘Well, it doesn’t have to be that way and those are not necessarily normal symptoms and we can do something about it’, that women really want to do anything.”

Roberta Speyer: “So is that part of when you’re doing a work up for urinary incontinence, first of all they have to identify that indeed they have a problem?”

Steve Fleischman, MD: “Right, and I would say for me in a general ObGyn practice the way I picked up most of my incontinence work ups actually started with a routine physical exam. Some women come in for their routine pap smear, who, during my review of symptoms, when I ask them what’s going on, I always make sure I talk about general symptoms, whether it’s vaginal pressure, whether its prolapse symptoms, but specifically I make sure I address urinary issues. Do they leak when they laugh, cough or sneeze, do you ever feel like you have to go to the bathroom and when you go there’s not much there, are you getting up in the middle of the night more than three or four times to go to the bathroom, those sorts of symptoms. In that initial review, if any of those things are positive, then we move on to what would be more of a clinical work up for incontinence.

And when I talk about the clinical work up it’s very important to start out with any time you’re talking about incontinence you want to get into a history and figure out exactly what their history is. How
long have these symptoms been present? Is this something that just started this year, is it something that has been going on for three years and it’s gotten progressively worse, or is this something that happened last week? I’ve had patients, elderly women, who suddenly developed urinary incontinence out of nowhere. It turns out that it’s just a bladder infection but they didn’t get the typical symptoms they had when they were 25 or 30 with their bladder infections, rather incontinence was their presenting symptom. You treat the infection and they don’t leak anymore. You want to make sure what brings on the incontinence, what makes it better, is there anything that makes it better. You want to make sure you get into a good history of their drug medications that they’re on, you want to get into childbirth history, and you want to get into neurologic findings. There are women who had neurologic impairment secondary to either things such as multiple sclerosis and diabetes where they actually have some nerve damage which could entail abnormal bladder function.”

Roberta Speyer: “So tell us a little bit about something that’s fairly new and we don’t hear very much about, urodynamics. Is this something that you could share with us? How does that fit into your treatment decisions? What are urodynamics?”

Steve Fleischman, MD: “I will tell you what, let me step back a second just to get into this. Before I’m going to do any work deciding about urodynamics I really want to make sure I do a thorough physical exam and that’s important any time anyone is evaluating someone for urinary incontinence. You want to make sure that there either is or is not pelvic prolapse associated with the incontinence because if you are going to get into repairs at some point, and we’ll talk about that a little later, you want to make sure that you know what other issues are going on in the vaginal area. If they have prolapse you often have to need to fix that at the same time you’re going to fix their incontinence, if it’s something that can be surgically repaired. We want to check a urinalysis and culture always to make sure that there is no evidence of bladder infection and you typically will check what’s called a post-void residual. You have the patient empty their bladder and then you want to see whether or not they do a good job emptying their bladder when they voided. A lot of women will have what’s called over-flow incontinence where they actually think they empty their bladder and they still might have 200ccs in there, so they clearly have a problem with the bladder actually emptying.”

Roberta Speyer: “If you were using a measuring cup, what are 200ccs – maybe a tablespoon a teaspoon?”

Steve Fleischman, MD: “Oh, no, no, no, 200ccs would be more than a cupful.”

Roberta Speyer: “Oh my goodness! And they still have that much?”

Steve Fleischman, MD: “There are some women that will have that type of symptom, but that typically, if I’m going to see that, that tends to be in women that are significantly older. I rarely see that in my 40 to 50 year-old group but more like those 70 years of age.”

Roberta Speyer: “So what do you see in your 40 to 50 year-old group which is a large portion of the folks on the Internet that are using OBGYN.net.”

Steve Fleischman, MD: “I would say in the 40-50 year-old group we’re talking primarily about overactive bladder and genuine stress incontinence. Those are the two major things.”

Roberta Speyer: “So what can we do now with these two problems?”

Steve Fleischman, MD: “When a patient comes in and has these things, the next thing we talk about is, again, how do we know what the right diagnosis is? If someone comes in to me the first time and really just has traditional urgency symptoms, ‘I can’t make it to the bathroom, I feel like I always have to go’ and, you know, ‘I’m constantly running there, I get up in the middle of the night, multiple times a night’, that really tells me they have more symptoms than overactive bladder.”

Roberta Speyer: “So it is the urge, the urge incontinence?”

Steve Fleischman, MD: “With some people you have to understand it’s not always urge
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incontinence, meaning that they might not leak but it’s still something that impacts their quality of life. If you have an overactive bladder but if you have a very good functioning sphincter, ural sphincter, your bladder is functioning well, you could have those symptoms and not actually leak yet. So if you leave it alone, at some point it might develop into a leakage issue and most patients will say, ‘Well I have the urgency frequency but it’s rare, but occasionally, maybe once every two, three weeks, I might leak a little bit.’

Roberta Speyer: “My feeling was the closer you got to a toilet, the more the urge came on. So my problem was by the time I got there it was right at the end.”

Steve Fleischman, MD: “The first kind of symptoms really go along with more than overactive bladder. If someone comes in to me with strictly overactive bladder symptoms and doesn’t really leak except when they are very close to the toilet I’m going to start them out on a medication to treat overactive bladder before I consider urodynamics. When you are talking about urodynamics, what urodynamics are, just to define them, urodynamics are actually a physiologic exam that looks at the functioning of your entire lower urinary tract system. What that means is that typically there are catheters, one that normally goes into the bladder and one that goes into the vagina. What you do is, you are trying to look at the function of the bladder and the urethra during a sort of physiologic state. In other words I’m going to fill the bladder with saline or with water, sterile water, add a catheter that is measuring pressures in the bladder and the urethra. At the same time I have a catheter in the vagina which measures pressures in the abdomen because, again, when someone leaks urine the reason that they leak is because there is an increase in pressure in the abdominal cavity such as coughing, laughing, sneezing or bearing down that overcomes the ability of the bladder to prevent it from leaking. So you want to measure what your pressure in the bladder is and what your pressure in the vagina is and this way you can figure out what pressures make someone leak. Going back to urge incontinence, I’m going to put that off the table for now, because I generally, in someone who just has urge incontinence, I will try to treat them medically.”

Roberta Speyer: “No, of course, if you can treat something easily you’re going to do that but in a lot of cases this problem is probably multifaceted and you have to really get in there and figure out what the problem is.”

Steve Fleischman, MD: “So the goal of your urodynamics is really to objectively reproduce the affects of the bladder function so you can figure out what exactly you want to do.”

Roberta Speyer: “Am I correct, you’re now able to look at what’s going on and get some types of measurements so that you can maybe take apart the problem and reconstruct it and understand what exactly the problem is?”

Steve Fleischman, MD: “Right. Rather than taking a shotgun approach and just throwing out all these different treatments to try to fix it, you try to objectively determine where the exact problem lies and then come up with a treatment plan that will deal with that individual problem rather than just trying to fix everything and hope you get the right thing.”

Roberta Speyer: “Some of these fixes include surgery correct?”

Steve Fleischman, MD: “Exactly.”

Roberta Speyer: “So you don’t want to be doing surgery that you don’t need to do or that isn’t the correct surgery.”

Steve Fleischman, MD: “Exactly. What you are looking at is what we call multi-channel cystometry or urodynamics. Really, there are several indications; I’ll briefly go through some of them why you would do it. I do it in patients who have a really complicated history. Something that’s not just as straightforward ‘I leak or I don’t leak.’ There are other medical problems, there are other things going on. Whether the patient has symptoms of stress incontinence and I’m thinking that surgery might be in my decision treatment plan, I then go ahead. Anyone who is going to the operating room I want to make sure I have the right diagnosis before I do the surgery and so I do urodynamics. If someone has urge incontinence or they have detrusor instability, overactive bladder, any one of
those sort of same ideas, the urgency symptom, but I’ve been treating them medically and they’re not getting any better, in those patients I’m going to do urodynamics. If they have had previous surgery, let’s say someone had a procedure done five years ago, six years ago, seven years ago for urinary incontinence, they were dry for a few years and now they’re leaking again, before I go back in to repair it I want to make sure I know why exactly they’re leaking again. So those are the patients you would do it on.”

Roberta Speyer: “A woman that comes in and has this type of a work up is going to be able to then get a much better personalised treatment plan.”

Steve Fleischman, MD: “Right, to be honest, in my practice the thing I find the most beneficial on a day-to-day basis with urodynamics is the ability to objectively show a patient exactly what’s going on. Look, you have the pain when this shows up on the monitor and the urodynamics set up I have in my office uses some fiber optic cables, attaches to a unit which then attaches to a laptop computer so I can have an actual printout of what’s going on physiologically as we’re doing the study, it actually shows itself on the computer screen.”

Roberta Speyer: “If you had to sum it up I think you’re trying to tell them don’t put up with this, this isn’t normal. But let me let you put it into your own words and we’ll finish with that.”

Steve Fleischman, MD: “If I could sum it up I would say the most important thing is, this is not normal. Leaking urine, getting up in the middle of the night several times a night, feeling like you constantly have to go to the bathroom, urgency, frequency, all those things, they are not normal. These are not things that you just say ‘I’m getting older and therefore this is a normal occurrence.’ Urinary incontinence is a quality of life issue. And there is no reason that a young woman in her 40s, 50s and even 60s and 70s should have to leak urine when they don’t want to. There are treatments out there, your doctors will know about it. So if you want to do something about it just ask them and if your physician is not someone who deals with this on a daily basis they can certainly refer you to an individual who will be able to deal with it. There are physicians all around the country who do this on daily basis. Some urologists, what we call urogynecologist, and then a lot of general Ob/Gyns take care of this. So, this is not something you should be living with. It’s something you can have fixed and it’s fixed rather easily these days.”

Mark Perloe, MD: “Thank you very much for this insight for women Dr. Fleischman.”

Steve Fleischman, MD: “Thank you.”

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