A WOMAN'S UROLOGIST
RESTORING CONFIDENCE

Stress Urinary Incontinence

What is it?

Stress urinary incontinence (SUI), more simply called stress incontinence is nothing to do with stress as we generally know it. It is a type of urinary leakage that occurs when we exert ourselves. "Stress" is referring to abdominal "stress" or movement – anything that causes us to use our lower abdominal muscles – cough, sneeze, jumping, hurrying or running may be accompanied by a urinary leak. When SUI is severe, leakage may occur just on becoming upright or with minor activity such as blowing your nose or tripping over something.

When leakage occurs accompanied by urgency, the compelling need to hurry to the loo, we call it urgency and if we don't make it we call it urge incontinence. The tendency to leak with urgency is often accompanied by a tendency to urinate more often day and night. The grouping of urgency, urge incontinence, urinating frequently day or night is referred to by the term: Overactive bladder (OAB). See other section on the Overactive Bladder.

Both stress urinary incontinence (SUI) and OAB are common conditions. Both can occur at the same time and this is called mixed urinary incontinence. Often, both components have to be treated independently to achieve complete continence.

What are the causes?

Childbirth is the most common cause of mild SUI. Forceps delivery, prolapse surgery, hysterectomy, spina bifida and previous failed SUI surgery are some of the causes of more severe SUI called intrinsic sphincter deficiency.

What tests do I need?

As the problem increases in severity the benefit of an accurate diagnosis, (i.e. doing tests to work out exactly what structures are malfunctioning) increases. We gauge whether the problem is severe by how much of a departure from normal is present. Examples of a severe problem would include the requirement to wear several heavy pads per day, not being able to do exercise, even simple walking, and finding that you are limiting what outings you participate in because of a fear of leakage. These latter problems are more often features of bad intrinsic sphincter deficiency or severe OAB.

If you have a severe problem, there is a very real prospect that treatment may help provided you have the right treatment. To work that out, we need to determine how much of the problem is due to faulty bladder function as opposed to a urethra that is fixed in an open position (rather than being closed at rest).

We carefully fill the bladder measuring the pressures required to cause leakage – this is called 'Urodynamic' testing. Testing can unravel any complex problem related to previous failed treatment or complications related to treatment. For example, if a previous operation has caused obstruction to flow, recurrent urinary infection and overactive bladder or urge incontinence, we can see the cause of the obstruction during an Xray during which we measure the pressure during urination. This type of test is called fluoroscopic (or video) urodynamics.

How is SUI managed?

Happily, both SUI +/- OAB may improve significantly with pelvic floor muscle exercises. Generally speaking, a conservative approach to both problems is taken for at least 6 months. Over this time in addition to becoming good at the exercises, it is an opportunity to optimise urinating function, fluid intake and treat other reversible problems such as urinary infection.

There is evidence that when educated by an expert physiotherapist or continence advisor, pelvic muscle exercises are more likely to be effective.

When the urethra is quite well supported and the stress incontinence is mild, an injection into the urethra (often 2 are required) may suffice. This helps to 'bulk' up the urethra to create more apposition and less leakage.

Sling procedures (mesh and non-mesh) are used to treat moderate to severe stress incontinence. Members of the Woman's Urologist Group are trained to offer fascial (non-mesh) slings to women with SUI in addition to synthetic or mesh slings.

The mesh or synthetic sling offers excellent results with a quick recovery from surgery. The risk of mesh related problems is considered very low. This involves a small vaginal incision and two small lower abdominal stab incisions.

The fascial sling is slightly bigger operation that involves an additional small lower abdominal incision from which a strip of your own tissue (fascia) is harvested from the fascial layer that lies on top of your abdominal muscles. This strip of tissue is then used as a sling and placed via the vaginal incision. It is an appropriate option as a first procedure and is also offered when other procedures have failed. It also offers excellent long-term results.

This procedure does not run the risk of causing rejection of the tissue in the way that synthetic or mesh slings do, as the sling is made of your own body tissue.

Very rarely, for recalcitrant stress incontinence that has failed all slings, an artificial urinary sphincter can also be placed by a Woman's Urologist.
The Australian Commission for Safety and Quality in Health Care (ACSQHC) recently published its recommendations regarding SUI and pelvic organ prolapse.
https://www.safetyandquality.gov.au/our-work/transvaginal-mesh/resources/
Regarding the options provided with in the ACSQHC, your Woman's Urologist member is well trained to advise regarding the suitability of each option for you.