



Incontinence

Urinary Incontinence

Incontinence is the inability to voluntarily control urination. It may be a result of an inability of the bladder to hold urine or a deficiency in strength of the Distal Urethral Sphincter (DUS) or a combination. There are several types of incontinence which present requiring treatment:

1. Urge incontinence – this occurs when the patient has the urge to go to the toilet and leaks before getting there.
2. Stress incontinence – leakage with a laugh, cough or sneeze, usually only a small amount.
3. Combination – the cough, laugh or sneeze or pressure increase in the abdomen leads to stimulation of a bladder contraction and more than a drop leaks out.
4. Total incontinence where there is continuous leakage. This may be the result of an abnormal opening or “hole” or may be overflow where the bladder fills up and leaks out like a reservoir spillway.

Investigations:

Generally speaking a number of tests are carried out including bloods tests, urine tests and imaging of the urinary tract, which may include:

1. Ultrasound examination with measurements of bladder volumes before and after emptying.
2. X-rays with an injection of “dye” to show up the collecting systems and bladder outline. Sometimes side views of the bladder are taken in the standing position to see if it has “dropped down”.
3. Urodynamics. It may be necessary to carry out a Urodynamics Test (see brochure). That test is designed to indicate whether the bladder is “twitchy” or what is referred to as an unstable bladder having irregular or un co-ordinated contractions.
4. Cystoscopy Sometimes it is necessary to carry out a Cystoscopy, which is an endoscopic examination of the bladder. That procedure is carried out with a General Anaesthetic and it may be possible to increase the holding capacity of the bladder by filling it with water called a “hydrodilation” while the patient is asleep (under the anaesthetic).

Treatment

1. Occasionally significant responses to controlling incontinence can be achieved using exercises such as Kegel or Pelvic Floor routines.
2. Timed toileting may be useful where the patient “goes by the clock” and each day prolongs the time interval.
3. A Time/Volume chart may be useful to see the amount passed and the frequency.
4. Medications

Surgery

Botox Injection

In some cases of bladder instability when other medications and treatments fail a cystoscopic examination of the bladder is carried out with the patient under General Anaesthetic. At that time it is possible to carry out a number of injections of a small amount of Botox which then paralyses the bladder muscle to reduce its irritability. That does not mean that the bladder cannot be felt and cannot work at all. It simply reduces the frequency and urgency of urination.

Peri-urethral bulkamid injection

This is one simple and easy Day Surgery method of reducing the leakage from stress incontinence. While there are a large number of procedures available to achieve this end this is the quickest, easiest and simplest. It involves an injection of a Protein (Collagen) type material around the opening of the bladder, rather like putting a new washer in a tap. It is carried out under a General Anaesthetic and may be suitable for both women and men who have leakage. Before having the injection generally a skin test is carried out to make sure the patient has no sensitivity to the material. That is carried out in the Consulting Rooms with a small amount injected under the skin of the arm where it can easily be observed.

Allergic reactions are very rare

The procedure involves passage of a cystoscope and the substance is injected under the "skin" of the opening of the bladder causing it to narrow. After any procedure to control incontinence it is possible that urine might stop flowing altogether or that the bladder may not empty completely. That is usually temporary.

Bladder emptying is always checked after the operation with an ultrasound examination after the patient empties the bladder. If the amount left behind is unacceptable, then it would be necessary for a patient to carry out Clean Intermittent Self Catheterisation (CISC). That involves passing a small tube through the normal opening into the bladder to drain out the remaining urine. It is a procedure which is easily taught and learned and is usually only for a short period of time (a few days). The need for CISC is always discussed prior to undergoing any incontinence-correction procedure. CISC is no different from going to the toilet as the tube is passed while the person is there. Most patients consider it better to be dry and have to occasionally pass a catheter than have leakage

.Because Contigen is a natural product, over time it will tend to dissolve and symptoms may return requiring the patient to have a "top up". Often that is after 2-3 years.