

Treatment options for women with urinary incontinence

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Urinary incontinence (UI) is estimated to affect more than 50% of women older than 65, yet only two thirds seek care for it (1). The main subtypes of UI are: Stress (SUI): urine leak upon increment of the intraabdominal pressure, Urge (UUI): leak by involuntary detrusor muscle contractions, mixed stress and urge (MUI), and overflow incontinence. Many evidence –based studies are available for UI:

1. Stress urinary incontinence

1.1 conservative: weight loss, and in most recent studies evidence was shown that bariatric surgery in obese women confers significant reduction of SUI (and UUI) over a 3 year period (2), Pelvic floor muscle exercises remains the mainstay of conservative treatment.

1.2 Surgery: by midurethral sling, here a study done in 2013 for women with SUI showed that when those were randomized to primary physiotherapy versus midurethral sling surgery, the cure at one year was higher in the sling group (3). Moreover, adding the pelvic floor exercises after the sling surgery would result in even greater improvement (4).

Midurethral synthetic sling (retro pubic or transopturator) remains the gold standard given its relatively short operative time, high efficacy, low complication rate. Third generation slings (named single incision as they require a vaginal incision and are held in place by anchors in the transopturator membrane without additional one in the abdomen or the groin) have recently been demonstrated in studies to offer similar outcomes to the standard full length slings (5).

2. Urge incontinence

2.1 Conservative: anticholinergic drugs have been for long time the first choice, but concerns about adverse effects as brain atrophy and cognitive decline in elderly patients have been raised (6), therefore, B3 adrenergic agonists (Mirabegron) are currently approved for treatment, with high tolerance, but limited use due to its cost. In a recent study, the highest efficacy was reached when a full dose of Mirabegron was combined with anticholinergic compared to monotherapy of either one alone (7).

2.2 Surgery: Intravesical botulinum toxin A, sacral neuromodulation, percutaneous tibial nerve stimulation. Currently offered minimally invasive treatments include fractional CO2 laser, Er. YAG laser therapy, but few data support.

Biography

Mahmood Abdul Kareem Al- Ani has completed his PhD degree in Urology at the age of 35 from the Iraqi board of Medical specializations. He is a lecturer at the Medical College/ Al Iraqia University in Baghdad giving lectures in his field to the undergraduate and postgraduate students. He also runs the urology ward in a leading hospital in Baghdad. He attends his patients at his private clinic and operates on them in a private hospital. He has published many papers in reputed journals and is supervising specialty exams in his field.

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