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Urinary incontinence

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PATIENT DETAILS

Patient label

HOME NURSING DETAILS

Last name + first name:

Phone number:

Email address:

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Questions?
Ask your attending doctor or a nurse.

Urinary incontinence is a common problem among women and has a significant impact on daily life. 30% to 50% of women experience urinary incontinence at some point in their lives. This brochure provides information on the most common types of urinary incontinence and their treatment options.

Types of urinary incontinence

Stress incontinence

Stress incontinence or stress-related urine loss is the involuntary leakage of urine during certain activities, such as coughing, sneezing, laughing, lifting or exercising. It happens when there is the urethra is not supported sufficiently, which makes it hypermobile. This problem affects 10% to 20% of all women. Risk factors include:

- pregnancy and (multiple/severe) delivery(s)
- lots of and heavy lifting
- chronic constipation
- chronic cough
- hereditary connective tissue disorders
- menopause
- ageing

Urgency incontinence

Urgency incontinence is involuntary urinary loss accompanied by a sudden strong urge to urinate. Urgency incontinence is often accompanied by frequent urination (frequency) and nocturnal urination (nycturia). The problem occurs in 10% to 30% of women and increases with age. Risk factors include:

- obesity
- menopause
- ageing
- certain medical conditions, such as diabetes, Parkinson's disease and multiple sclerosis

Mixed incontinence

Do you experience both stress and urgency incontinence? This is known as 'mixed' urinary incontinence. In this case, we first treat the type of urinary incontinence that bothers you most or occurs most often.

Examinations

- A **clinical examination** is performed to diagnose stress incontinence. During the examination, we ask you to cough with a full bladder. This allows the doctor to assess your urine loss and the mobility of the urethra. Other conditions, such as vaginal dryness or prolapse, can also be identified during this examination.

- A **pelvic floor ultrasound** may also be performed to assess the mobility of the urethra. Images can be made using an ultrasound probe placed against the labia, the pelvic floor muscles and the sphincter of the anus. During the examination, you will be asked to squeeze and tighten the pelvic floor muscles.

- A **uroflow** is used to analyse your urine flow. In your doctor's office, you urinate on a special toilet with a holder that records your urine flow. We then perform an ultrasound to check whether your bladder is sufficiently empty.

- **A urodynamic examination** maps your bladder function more accurately and may be required for specific urinary complaints. For the examination, thin probes are inserted into the urethra and rectum to measure pressure in the bladder and abdomen. Your bladder is then gradually filled with sterile water. You are asked to indicate when you feel an initial, strong and irresistible urge to urinate. At the same time, the probes record how your bladder reacts to this filling. You will also be asked to cough to discover if urinary incontinence occurs. Afterwards, we will also check how you urinate and whether your bladder is completely empty. This examination is performed in the urology department.

Treatment

Treatment varies depending on the type of urinary incontinence.

Treatment of stress incontinence

Physiotherapy

Pelvic floor physiotherapy helps strengthen the pelvic floor muscles, which help support the urethra. About **75% of patients** with stress incontinence experience a **marked improvement** after this therapy. The effect usually becomes **noticeable after three to six months of** treatment. For lasting results, it is important to regularly do the exercises you learned.

A specialised physiotherapist will teach you how to correctly tighten and relax the pelvic floor muscles. It is best to consult a physiotherapist experienced in pelvic floor therapy. Your doctor can provide a list of specialised physiotherapists in your area.

Vaginal oestrogens

The bladder, urethra, pelvic floor muscles and supporting tissue of the pelvic organs depend on the female hormone **oestrogen**. Oestrogen production decreases sharply after menopause. This makes the urethra drier and weakens the pelvic floor muscles and connective tissue supporting the urethra. This can cause or worsen urinary incontinence.

Vaginal oestrogens can reduce urinary incontinence by locally increasing the amount of oestrogens. These are available in tablet, cream or gel form. After a brief initial treatment (where you take the oestrogens daily for about two weeks), you only have to take the oestrogens **twice a week** before bedtime. Vaginal oestrogens act locally and are absorbed into the bloodstream only to a limited extent, so these **do not significantly increase the risk of breast cancer or thrombosis**. Vaginal oestrogens work locally and are not absorbed into the bloodstream. So, these do not increase the risk of breast cancer or thrombosis.

Urethra pessary

A urethra pessary is a vaginal ring with a knob that is **inserted into the vagina** and **supports the urethra** to prevent stress incontinence.

A vaginal examination determines the correct size of the pessary. A well-fitting pessary does not feel attached, does not interfere with urination or defecation, relieves prolapse symptoms and prevents urinary incontinence. Sometimes it is necessary to try different sizes or types of pessaries to find the right one.

Are you satisfied with the pessary?

You can then use it for a long time (often for years).

No longer satisfied with the pessary?

You can then switch to another treatment at any time.

Handling the pessary yourself

Usually, a six-monthly check-up is sufficient when the pessary is removed, cleaned and reinserted. In between, the pessary can remain in place, even during sexual activity (you or your partner may feel the pessary, but this should not be an impediment).

Depending on the type of pessary and your own preference, you can also remove and reinsert the pessary yourself (so that less frequent follow-up is required):

1. **Removing:** Insert a finger into the vagina and pull the pessary down in a smooth motion.
2. **Cleaning:** It is normal for some vaginal discharge to stick to the pessary. Rinse the pessary with tap water. You may use a mild soap, but then you must thoroughly rinse it.
3. **Reinserting:** Apply lubricant at the level of the entrance to the vagina and possibly on the pessary itself. Preferably use a water-based lubricant, such as K-Y gel (available at pharmacies). Find a comfortable position (e.g. lying down, squatting or with one leg on a chair). Relaxing makes it easier to insert the pessary. Spread the labia with one hand and use your other hand to reinsert the pessary. Make sure the knob of the pessary is pointing downwards when doing this. Push the pessary as deep as possible into the vagina.

Side effects

- A pessary often causes **increased vaginal discharge** that has a typical yellow-green colour. This is normal and harmless.
- Prolonged use of a pessary can lead to granulation tissue, which may sometimes cause **blood loss**. Consult your doctor if you experience abnormal bleeding (e.g. after menopause or between periods).

Medication

Duloxetine is a medicine that strengthens the urethral sphincter muscle, which can reduce urinary incontinence.

In **30% to 40% of patients** with stress incontinence, duloxetine provides a noticeable improvement. Possible side effects include **nausea, headache, dizziness and drowsiness**. Gradually increasing the dose can limit these side effects. Duloxetine may slightly increase blood pressure. Do you have high blood pressure or heart problems? Then have your blood pressure monitored more often.

Sling procedure

Placing a **synthetic sling** (band) that supports the urethra can also remedy stress incontinence.

About **90%** of people with stress incontinence **no longer experience urinary incontinence** after sling placement. The effect is also **maintained**: The sling consists of synthetic material and is therefore stronger than your own tissue.

Sling surgery occurs at a **day hospital**. **Recovery** after sling surgery **usually goes smoothly**. During the first **four to six weeks**, strenuous physical effort is not recommended (heavy lifting, intense sports, etc.). Light activities such as walking, cycling, climbing stairs or light housework are fine. To allow the vaginal wound to heal properly, **swimming, bathing, tampon use and sexual activity** are **not recommended** for six weeks.

Stress incontinence can also be relieved by placing a synthetic sling ('band') under the urethra.

Possible complications include:

- **Groin pain** due to the anchoring of the ligament in the pelvis. This usually disappears within two weeks and can be easily treated with painkillers.
- **Bladder inflammation** occurs in about 5% of patients due to the temporary placement of a catheter during surgery.
- **Difficulty urinating occurs in less than 5% of patients** and is usually a temporary problem due to swelling around the urethra.
- **Exposure of the band** in the vagina sometimes causes pain or blood loss.
- **New or worsened urgency incontinence** occurs in up to 20% of patients, especially those who already had these symptoms before surgery.

Treatment of urgency incontinence

Drinking hygiene

Avoiding caffeine, alcohol and fizzy drinks may improve symptoms.

Vaginal oestrogens

Local oestrogen therapy helps improve bladder function and reduce symptoms of urgency incontinence.

See also under 'Treatment of stress incontinence – vaginal oestrogens'.

Bladder training

Bladder training or bladder drilling helps you improve your bladder control. A specialised physiotherapist will teach you to gradually lengthen the time between successive toilet visits to increase your bladder capacity.

Your physiotherapist will first ask you to keep a 'urine diary' for a few days. You record how often you urinate and the time between visits to the toilet. You are then encouraged to follow a **fixed schedule** for urination (e.g. every two hours). This interval is gradually extended (2.5 hours, 3 hours and so on) until a normal frequency of urination is achieved.

You will also be given practical tips to better manage urges and not immediately give in to the need to urinate. Counselling by a **specialised pelvic floor physiotherapist** is recommended for optimal results. Your doctor can provide you with a list of specialised physiotherapists in your area.

Percutaneous/transcutaneous tibial nerve stimulation

Percutaneous or Transcutaneous Nervous Tibialis Stimulation (PTNS/TENS) is a **non-invasive treatment** that can improve bladder function. A very fine needle (PTNS) or an electrode (TENS) is used to stimulate the tibial nerve, which runs on the inside of the ankle. The nerve then sends signals to the bladder via the spinal cord. This helps the bladder muscle relax so the bladder fills more, which reduces the urge to urinate. **For 70% of patients**, this treatment leads to a noticeable improvement in urgency incontinence.

- For **PTNS treatment**, you visit a **specialised pelvic floor physiotherapist** each **week**. The treatment lasts for three months.
- You can do a **TENS treatment at home** yourself that lasts **three months**. You apply an electrode to the skin on the inside of the ankle **each day for 20 minutes**. Discuss this option with your gynaecologist.

Most patients **experience no side effects**. Sometimes a slight itching or tingling sensation may occur at the electrode site, but this is **temporary** and disappears quickly after treatment.

Medication

There are different types of **medication** that **relax the bladder muscle** and thus reduce the symptoms of urgency incontinence (and also make you urinate less frequently during the day and at night). Like other medications, these products can also have **side effects**. Your doctor will discuss the best option with you. This depends on factors such as your medical history.

Other treatments

If the previously mentioned treatments have insufficient effect on the **urgency incontinence**, **Botox injections into the bladder** or **sacral nerve stimulation** may be considered. These treatments are done at a urologist's office.

- **Botox injections** relax the bladder muscle, which improves the filling of the bladder, which in turn reduces urges to urinate. The injection is usually performed under a brief **general anaesthesia**. The effect is noticeable within **a few days to two weeks** and lasts **six to nine months** on. In some patients, one treatment is sufficient, while others need several infiltrations.
- **Sacral nerve stimulation** is an **invasive form of neuromodulation** that affects the nerves that regulate bladder and bowel function. During a test phase, a temporary neurostimulator is placed under the skin above the buttock. If this trial stimulator produces a marked improvement in symptoms, a **definitive neurostimulator** is implanted.

Additional notes:

Contact details

Doctors

- dr. E. Bauters
- dr. O. Brouckaert
- dr. L. Deblaere
- dr. J. Quintelier
- dr. E. Rossey
- dr. A. Vandenameele
- dr. I. Vanderbeke
- dr. P. Vryens

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Secretariat opening hours
Physical: 8 a.m. – 12:30 p.m. & 1:30 p.m. – 6 p.m.
Phone: 8:30 a.m. – 12:15 p.m. & 1:30 p.m. – 5:30 p.m.

Serious complaints or emergencies?

Please immediately contact

- your attending physician
- the hospital's emergency department
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