

Clinicians' Forum

From time to time, the editors of *Menopause Management* field interesting clinical questions and dilemmas. In this forum, our Editorial Advisory Board members, experts in a range of fields related to midlife women's health, tell readers how they handle these situations.

For this question, we also called upon a guest expert in the field of urogynecology to provide additional perspective.

Participants

Steven R. Goldstein, MD
Professor of Ob/Gyn
New York University School of Medicine
New York, NY

Paul D. Miller, MD
Professor of Psychiatry and Behavioral Sciences
University of Washington School of Medicine
Seattle, WA

James A. Simon, MD
Clinical Professor of Ob/Gyn
George Washington University School
of Medicine
Washington, DC

Laszlo Sogar, MD, PhD
Chief, Division of Gynecology
Acting Director, Department of Obstetrics
& Gynecology
University Hospitals, Cleveland
Cleveland, OH

Question: Stress and urge urinary incontinence are frequent problems at menopause and beyond. How do you differentiate one from the other during a routine office visit, and what is your initial clinical approach to management?

Answers:

My practice is as a generalist in obstetrics and gynecology, although most of the patients I see are peri- and postmenopausal. If one simply waits for patients of this age to volunteer difficul-

ties with urine loss you will have relatively few patients doing so. However, it appears that an overwhelming number of women are not totally continent, and yet believe that this is an inevitable part of the normal aging process, especially those with one or more child. At each visit I ask every woman if she experiences any loss of urine. Sometimes this evokes a surprise on the patient's part and I will rephrase it by asking, "Do you ever wet yourself before you reach the bathroom?" Many patients will complain of urinary frequency and getting up at night several times to urinate. Part of this is a normal consequence of aging, especially if patients are on abundant medications such as diuretics.



Steven R. Goldstein, MD

If patients do report any loss of urine it is important to distinguish whether it occurs with increasing abdominal pressure (coughing, laughing, sneezing, exercise, etc.) or just involuntary leakage without increased intra-abdominal pressure, especially if they feel an urge to go (key in the front door syndrome, hearing water running, etc). The historical symptoms that the patient offers will help to initially distinguish most people with hyper mobile urethra (stress urinary incontinence) versus urge incontinence (any involuntary loss of urine). Furthermore a significant proportion of people may have both processes coexisting. All such patients should have a routine urinalysis, and urine culture and sensitivity to rule out urinary tract infection. I also very quickly ascertain if the degree of urine loss for that particular patient is serious enough for the patient to consider either medication, minimally invasive surgery, or a course of pelvic floor "physical therapy" (biofeedback). If the patient has no interest whatsoever in pursuing therapeutic options, I often

will advise her to let me know if and when it worsens. If the patient seems concerned enough and is interested in therapeutic options, then further testing to distinguish between these two types of urine loss is imperative.

Obviously a good physical examination of the external genitalia, urethra, and signs of any loss of pelvic support is essential. Estrogen status also is important. Most gynecologists are quite familiar with the "Q-tip test." In this test, a sterile cotton-tipped applicator with 2% lidocaine jelly is placed into the urethra and then the patient is asked to strain (Valsalva maneuver). A positive test of urethral hypermobility is usually a deflection greater than 30°. If this is present, and/or if patients are amenable to the possibility of surgery, I will refer them to a urogynecologist at my institution for consultation. If they are not interested in surgery but seem motivated for intensive pelvic floor exercise, I will refer them to our unit that performs such a program with biofeedback. If the history suggests urge incontinence and the Q-tip test does not suggest hypermobile urethra, I often will begin a course of extended-release transdermal oxybutynin. Patients given this therapy should be warned that there may be some initial dry mouth or constipation.

The most important aspect of promoting urinary control and health is allowing the patients to disclose symptoms in a comfortable manner with the reassurance that living with urine loss is not an inevitable part of aging.

— Steven R. Goldstein, MD

When I see a patient complaining of "incontinence" I check for the following:

1. Incomplete bladder evacuation. We do a post-voiding residual, since retained residual urine can lead to infection and/or hydronephrosis
2. Poor renal (water) concentrating ability. This can reduce urine volume

and increase urine osmolality with water restriction. The very first renal tubular function lost in early chronic renal failure is this reduced concentrating ability.

3. Diabetes check to make sure there is no glycosuria.

— *Paul Miller, MD*

While mixed incontinence (a little of both) commonly exists, the patient usually can tell you the diagnosis. It is important to ask if she loses urine during stress (while running, walking, sneezing, coughing, straining, etc) or if she has the irresistible urge to void and loses urine when she has certain “cues.” These can include being unable to find a bathroom, when water is running, when she has the urge to urinate normally but there is a long line at the ladies room, etc. A good history is very revealing. I start there.

— *James A. Simon, MD*



James A. Simon, MD

The International Continence Society has recently reclassified the concept of urge and urge incontinence as “overactive bladder.” It is defined by any of a number of clinical symptoms associated with the lower urinary tract. These would include: urgency with or without urine loss, frequency and nocturia. Thus it becomes rather straightforward to differentiate from pure stress incontinence simply by clinical history and physical exam. Unfortunately, as patients age they develop overactive bladder on top of stress incontinence (mixed incontinence) and the clinical picture may become unclear, in which case appropriate urodynamic testing becomes necessary.

In clinical practice one needs to ask detailed questions in the history. Ques-

tions that should be part of the history would include: How many times a day do you void? How long before the urge becomes unbearable? What happens then? Can you initiate voiding without maneuvers? How many times do you get up during the night? Do you lose urine during the night? Have you stopped certain activities because of your symptoms? The clinician should have a standard questionnaire as part of the medical record when screening indicates lower urinary tract dysfunction. These can be obtained from any textbook of urogynecology.

After taking the history, the next step is to perform a pelvic exam and a urine analysis with culture. If one makes the diagnosis of overactive bladder then behavioral modification may be useful. This can be accomplished initially by the use of voiding diaries. The patient should then be educated regarding the findings in those diaries. If that approach fails, pharmacotherapy would be the next step. Regarding stress incontinence, the history and physical exam with demonstrable leaking with cough or Valsalva maneuver is sufficient to diagnose and initiate therapy. Physical therapy with exercises for the pubococcygeus muscle have been shown to be effective. However, the majority of my patients have poor compliance with the necessary regimens and will choose a surgical procedure instead of the exercises. With the advent of tension-free vaginal tape (TVT) and trans-obturator tape (TOT) the surgery is minimally invasive and highly successful.

Additionally the clinician must be aware of many comorbidities that adversely impact on symptoms of overactive bladder and stress incontinence. The first of these is obesity, which dramatically impacts the prevalence of stress incontinence. Many of these patients have undiagnosed diabetes that then impacts overactive bladder. The second is urogenital atrophy. The role of estrogen therapy in the treatment of

stress incontinence is controversial, but I feel that it can be a significant adjunct to the management of overactive bladder. A third comorbidity is neurologic symptoms, especially loss of central nervous system control of reflexes (ie, early dementias).

— *Laszlo Sogar, MD, PhD*

Do you have a clinical question or situation that you would like to pose to our panel of experts?

All queries should be submitted to the managing editor at lmckeown@menopausegmt.com. To reach the managing editor by phone or fax, please call 732-282-0703 or fax to 509-463-0447. Please include your name, professional title and a phone number or e-mail address.