

GYNAECOLOGY & OBSTETRICS UPDATE



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Urogynaecology Update:

It is known that **50%** of parous women have some degree of genital prolapse and of these 10-20% are symptomatic. Urinary incontinence affects at least **14%** of women over 30 years of age (This indicates that the majority of the patients with incontinence do not seek medical help).

How common is urinary incontinence among women with genital prolapse?

It has been found that almost **60%** of women with genital prolapse and no symptoms of incontinence had underlying urinary incontinence on urodynamic testing. It has also been found that **41%** of patients with prolapse had stress incontinence following reduction of the prolapse with a ring pessary. Stress incontinence may also occur in **19-35%** of continent women following anterior vaginal repair. This can be explained by the fact that with a large prolapse a urethral kinking may occur masking an associated stress incontinence. When the prolapse is replaced with a ring pessary or surgically repaired the urethral kinking may be corrected unmasking the associated stress incontinence. It is estimated that 30% of women with either small or large cystoceles had unstable bladder (detrusor instability) on urodynamic testing.

All patients with prolapse should be thoroughly assessed to identify associated urinary incontinence before deciding on the management of the prolapse

Is genital prolapse the cause of urinary incontinence and other symptoms?

Anterior vaginal prolapse (cystocele) may cause voiding difficulties eg. straining to void or incomplete bladder emptying. It may be also associated with urinary frequency because of a persistent urinary residual or recurrent urinary tract infection. **Prolapse itself is not a cause of incontinence** (40% of cases of prolapse are continent on urodynamic testing). The common association between prolapse and incontinence is due to their common aetiology (eg. childbirth, old age, etc.) that damage the continence mechanism as well as the supportive mechanism of the genital organs.

Surgical repair of the prolapse or its reduction using pessaries do not treat associated urinary incontinence. Furthermore incontinence may appear for the first time or worsen after repair or insertion of a vaginal pessary if the prolapse was masking an existing damage of the continence mechanism.

Should genital prolapse and incontinence be managed separately?

No; except in cases of severe degree of prolapse, as urodynamic testing may be inaccurate in identifying the underlying cause of incontinence. In these cases prolapse should be repaired first.

Both prolapse and incontinence should be managed together. The success of suspension operation for incontinence is markedly reduced if performed after prolapse operation. Repair of prolapse after incontinence operation may cause failure of operation and recurrence of incontinence.

References

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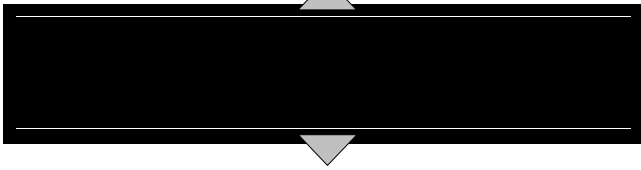
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