Diagnosis and Surgical Treatment of Stress Urinary Incontinence

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Question 1:

Given the fact that urinary incontinence is so prevalent, when planning a hysterectomy in patients for reasons such as abnormal uterine bleeding or leiomyomas, how should we be screening for urinary incontinence to determine if additional procedures should be considered? Are there recommendations regarding surgical technique to reduce an asymptomatic patient’s risk of subsequently developing urinary incontinence?

Response from Dr. Garely and Dr. Noor:

The best method of screening for urinary incontinence in patients who need a hysterectomy not for a pelvic floor disorder is by questioning. If the patient has no complaint of losing urine with stress events (cough, laugh, or sneeze), it is unlikely that a hysterectomy will contribute to the future development of incontinence.

The current recommendation for patients who have no underlying pelvic floor prolapse and who have no history of stress incontinence is to add no additional procedures at the time of hysterectomy.

Question 2:

How do you recommend we counsel patients with urinary incontinence about timing of surgery? Are there better outcomes if patients are treated when symptoms are relatively minor, or should patients consider waiting as long as possible to decrease their risk of reoperation secondary to advancing age and failure of the original surgery?

Response from Dr. Garely and Dr. Noor:

Urinary incontinence is a quality of life issue. Doing nothing is acceptable if the patient is not bothered enough to seek treatment. Once the patient has made a decision for treatment, timing is based on the
Question 3:

Is there a role for generalist obstetrician–gynecologists in the diagnosis and treatment of incontinence, or should all evaluation and treatment be done by female pelvic medicine and reconstructive surgeons?

Response from Dr. Garely and Dr. Noor:

All general obstetrician–gynecologists should be skilled in the evaluation and diagnosis of urinary incontinence. Many patients will have overactive bladder and urge incontinence, which are treated with pelvic floor exercises and medications. Depending on the training of the individual physician, treatment strategies requiring surgical intervention should be done by a skilled surgeon. Referral to a specialist should be based on what has been accepted as the standard in your community.

Question 4:

After seeing television advertisements describing mesh complications, many women have concerns about the use of mesh or other synthetic materials in their surgical treatment plans. How do you counsel those patients about the use of mesh in the treatment of stress urinary incontinence?

Response from Dr. Garely and Dr. Noor:

Mesh is used in the vagina for two reasons: the treatment of vaginal prolapse and the treatment of stress incontinence. Any mesh placed through the vagina is called a “transvaginal mesh.” The U.S. Food and Drug Administration has looked extensively at complications that can develop from the use of mesh in both applications. Slings to treat incontinence have been determined to be safe. While it is possible to get urinary tract injuries and vaginal erosions, these complications are rare and usually easy to treat.

The advertisements looking for patients harmed by mesh are mostly focused on injuries from mesh used to treat prolapse. Currently, the tension free vaginal sling is still considered to best treatment option available for stress incontinence.

Question 5:

Are there any special considerations for management of significant stress urinary incontinence in a patient who plans future childbearing?

Response from Dr. Garely and Dr. Noor:

There is no general consensus on how to manage stress incontinence in patients who desire future childbearing. The first option is to complete childbearing and then undergo treatment. The second option is to treat the incontinence (usually with a sling) and then make a plan for the mode of delivery should pregnancy occur. Most specialists would recommend a cesarean delivery after the sling to mitigate trauma to the operative site. There are limited studies looking at the failure rates of slings following a vaginal delivery.
Question 6:

How do you counsel a woman who desires elective cesarean delivery to decrease her risk of subsequent urinary or fecal incontinence and pelvic floor dysfunction?

Response from Dr. Garely and Dr. Noor:

There are medical and social issues regarding elective cesarean deliveries. A recent American College of Obstetricians and Gynecologists’ Committee Opinion, No. 559 (see Obstet Gynecol 2013;121:904–7), recommended planning for vaginal delivery when there are no maternal or fetal indications for cesarean delivery. This conclusion was reached focusing on nonpelvic floor issues and despite findings from multiple studies which demonstrated that pelvic floor injury occurred less frequently in patients who underwent elective cesarean delivery. From the perspective of autonomy, I believe that my patients have the right to mitigate the risks of injury from vaginal delivery by choosing an elective cesarean delivery. With that said, any patient who desires three or more pregnancies needs to understand that after the second cesarean delivery there is an increased risk of morbidity related to the cesarean delivery itself. I don’t advocate elective cesarean deliveries in patients who want more than two pregnancies.

Question 7:

When counseling a patient, how do you address the issue of obesity and its effect on both stress urinary incontinence and subsequent surgical outcome? Are there evidence-based guidelines helpful for establishing goals for weight loss to improve outcomes?

Response from Dr. Garely and Dr. Noor:

The association between obesity and incontinence has been well established. Patients whose body mass index (BMI) exceeds 30 are at the highest risk. With increased weight there is direct pressure placed on the bladder. Combining this with a cough, laugh, or sneeze, it becomes increasingly difficult for the urethra to maintain continence. Weight reduction strategies (diet or surgery) should be recommended to patients with high BMIs prior to considering anti-incontinence surgery. Surgical success will be lower in patients with higher BMIs because it is harder to make the sling “just right.” Under- or over-tensioning is possible and the patient needs to have reasonable expectations regarding surgical outcome.

There are currently no evidence-based guidelines for weight loss goals, but lower BMIs are better.