Urinary incontinence in women
A surgeon's point of view

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I am a urogynecologist or a pelvic floor surgeon, and I operate on women with urinary incontinence and prolapse. Operations for stress incontinence and prolapse are not life-, limb-, or organ-sparing. Stress incontinence and prolapse surgery is elective surgery to help minimize symptoms and improve patients' quality of life. In my clinical experience, I have been privileged to witness a transformation when symptoms are relieved for women who have had severe prolapse or urinary leakage for most of their lives.

The two standard operations for urinary stress incontinence are the retropubic (or Burch[1]) colposuspension and suburethral sling. Surgeons consider various factors before choosing a procedure. Within the first year after a Burch colposuspension, approximately 85% to 90% of patients regain continence.[2] After 5 years, approximately 70% of patients are still dry.[2] Less information is available about the suburethral sling; however, approximate success rates in the short term are 84% to 90%.[3-5]

In keeping with the trend to perform minimally invasive surgery, it is possible to do the Burch colposuspension laparoscopically. A minimally invasive modification of the suburethral sling called the Tension Free Vaginal Tape is also available. The laparoscopic Burch colposuspension usually results in a shorter hospital stay and quicker return to normal activities. The Tension Free Vaginal Tape can be inserted under local anesthetic and intravenous sedation; it is usually an outpatient procedure.

These newer minimally invasive procedures cost less and seem to have success rates similar to conventional procedures in the short term; however, because they have not been around as long, not much is known about their long-term durability or success rates. There are no standard operations for urinary urgency incontinence or overactive bladder. In this issue of *Canadian Family Physician*, the articles by O'Neil and Gilmour (page 611) and Moore et al (page 602) offer suggestions for overactive bladder, including lifestyle measures, bladder retraining, and anticholinergics.

The last resort

Although I frequently perform surgery for stress incontinence, I am aware of the inherent anesthetic and surgical risks involved, such as bleeding, infection, thromboembolism, and injury to adjacent organs, namely the lower urinary tract. These risks can be minimized by careful patient selection, perioperative planning, intraoperative technique, and administering antibiotics and thromboembolism prophylaxis. Postoperative risks include failed surgery, overactive bladder, and difficulty voiding. These postoperative problems can usually be minimized with various maneuvers and strategies.

Many women tell me they "prefer to avoid surgery if at all possible" or they "wish to reserve surgery as a last resort." Although conservative treatment for urinary incontinence takes time and effort on the patient's part (and success rates are definitely lower than with surgical treatment), almost no risks are involved, and some patients experience complete relief of their symptoms. Surgery for stress incontinence is a very good option; however, I believe *all* women should try conservative therapy before choosing surgical treatment.

How can family physicians help?

Both O'Neil and Gilmour and Moore et al confirm how common urinary incontinence is and emphasize how family physicians are in an excellent position to screen, investigate, manage, and evaluate women with urinary incontinence. O'Neil and Gilmour provide a clear, concise, no-nonsense approach to the basic history, physical examination, investigations, and conservative therapy. Moore et al provide more detail on the specific conservative measures for urinary incontinence.

Unless there are other more pressing lifestyle and health concerns, as suggested by O'Neil and Gilmour, family physicians could inquire about urinary incontinence during annual well-woman examinations. Similarly, the basic physical examination and

teaching of pelvic floor exercises could be incorporated into this visit.

Although urinary incontinence is common in women, it ranges along a spectrum with regard to its frequency, severity, and effect on quality of life. Its place along this spectrum will influence the degree to which family physicians counsel and encourage women to undertake conservative measures or refer them to other health care professionals, such as continence counselors, continence nurses, physiotherapists, and specialist physicians (urogynecologists or urologists with a special interest in urinary incontinence).

O'Neil and Gilmour recommend referring patients to specialist physicians if there has been no response or partial response to conservative measures, previous prolapse or incontinence surgery, severe coincident prolapse, or voiding dysfunction. As various curriculums become more established in training programs, general gynecologists and general urologists will also become better equipped to provide basic surgical care in straightforward cases.

They deserve the best

Most patients know that urinary incontinence is not a sinister or life-threatening condition. Many women accept urinary leakage as a consequence of childbirth and aging. However, urinary leakage can severely affect almost every domain of a woman's life, from leisure and sport activities to social events, work, and even intimacy. Preoccupation about hygiene, odour, others noticing leakage, having to wear protection, or carrying a change of clothes in case of leakage negatively affects their quality of life. Even self-image, self-esteem, and self-worth can be adversely affected by urinary incontinence.

Women are productive, vital members of society who make valuable contributions to their work and home life. They deserve the best from all of us in terms of our empathy and understanding, opportunities for them to approach knowledgeable health care professionals, and our being informed about the available treatment options.

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