

Urinary Incontinence in Women

What is incontinence?

Urinary incontinence is the involuntary loss of urine.

It is a common problem for women, getting worse with advancing age. 1 in 2 women over the age of 70 has some form of urinary incontinence. Not everyone who has had a baby has incontinence, and women who have not had children may still suffer from incontinence.

Urinary incontinence can be also associated with vaginal prolapse, chronic lower back pain, or bowel issues, including faecal incontinence. Children may also suffer from incontinence but this often has a different cause.

What are the different types of incontinence?

There are two main types of urinary incontinence:

- Stress incontinence
- Urge incontinence

Stress Urinary Incontinence (SUI) is more common, affecting 1 in every 5 women. Women who have not had a baby have a 1 in 10 chance of developing SUI, while for those who have had a baby, the chance rises to approximately 1 in 3.

Urge Urinary Incontinence (UUI) is less common in younger women, affecting approximately 1 in 30 women, but becomes more common with advancing age.

The difference between managing these two types of incontinence are discussed below.

In some instances, both types of incontinence can occur in one person, though the cause for each type is different. This is known as mixed incontinence. Mixed incontinence affects approximately 1 in 10 women.

What is considered normal bladder function?

- Passing urine 4-6 times per day
- Passing urine no more than once per night
- Passing 1-2 cups of urine (250-500mls) each time
- Passing urine in a steady stream until the bladder is empty
- Being able to delay passing urine until convenient, and
- Having no leakage of urine between visits to the toilet

In a woman with normal bladder function, the muscles of the pelvic floor contract when she is doing any physical activities. These activities may include sneezing, coughing, sports or any other physical effort which can cause the pressure in the abdomen to rise.

MAIN POINTS

- **Urinary incontinence is common in women**
- **Women can have stress or urge incontinence or a mixture of both**
- **Learning how to contract pelvic floor muscles correctly can help treat stress incontinence. Some women may need surgery**
- **Bladder training and vaginal oestrogen can assist with urge incontinence**

When the pressure in the abdomen rises, the muscles of the pelvic floor contract, compressing the urethra (the tube which connects the bladder to the outside) and triggering contraction of the sphincter (the muscle that wraps around the urethra to keep it closed). This prevents any leakage of urine.

What causes stress urinary incontinence?

Stress incontinence is the involuntary loss of urine often related to physical exertion. This is caused by either:

- loss of the support of the urethra by the muscles and ligaments of the pelvic floor, or
- loss of the strength of the sphincter

When the pressure in the abdomen rises, insufficient contraction of the pelvic floor means the compression of the urethra will also be insufficient. This in turn leads to insufficient contraction of the sphincter, resulting in the loss of urine and “stress incontinence”.

What causes urge urinary incontinence?

Urge urinary incontinence is the involuntary loss of urine associated with urgency (having to rush to the toilet), or being unable to delay passing urine until a convenient time.

The uncontrollable need to pass urine occurs due to overactivity of the muscle of the bladder wall. It is associated with increased urinary frequency, urgency and needing to wake up multiple times during the night in order to pass urine. Typically, the feeling of urgency can be associated with daily activities, such as when you put the key in the front door, or when water is running. This is also known as overactive bladder syndrome. Some people with overactive bladder syndrome can feel urgency, but not actually leak any urine.

Mixed urinary incontinence is the involuntary loss of urine associated with both urgency and any physical exertion, or when sneezing or coughing.

Management of Stress Incontinence

Strengthening the pelvic floor muscles and learning how to contract them correctly is an important step in managing SUI. About one in two women are unable to contract their pelvic floor correctly. Nurse Continence Advisors or physiotherapists specialised in pelvic floor management can assist you with a personalised training program of pelvic floor muscle contractions. They will also teach you “the knack”. “The knack” is contracting your pelvic floor before coughing, sneezing, or doing anything that raises the pressure in your abdomen. The training can also help you learn how to isolate the muscles of your pelvic floor around the anal area, to help control any anal incontinence and the passage of wind.

If you have any concerns or questions about urinary incontinence, visit your doctor or go to the Find an AMS Doctor service on the AMS website.

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Other approaches to treating stress incontinence

Using stool bulking agents or softeners will help avoid constipation and having to strain when opening your bowels. When emptying the bowels and bladder, it may also help to use a low stool to elevate the knees slightly higher than hips, relaxing the pelvic floor and the abdomen. Additionally, avoiding heavy lifting can help avoid raised intra-abdominal pressure leading to SUI.

Some women may be able to use a continence pessary, which is inserted into the vagina and supports the bladder neck, helping to reduce leakage.

Another non-surgical option is duloxetine, an antidepressant medication known as a serotonin and noradrenaline reuptake inhibitor (SNRI). It may help some women but its use is not approved for this purpose in Australia or New Zealand.

Your doctor may recommend surgery if other treatments have not helped. You may be referred to a specialist urogynaecologist to discuss the benefits and risks of surgery for SUI. The types of surgery available for SUI include urethral bulking agents, midurethral slings, colposuspension, or an autologous fascial sling.

None of the types of surgery currently available have a 100% cure rate, however for 80-90% of women, their surgery will provide significant improvement at 12 months post-surgery.

For incontinence caused by neurological disorders, such as multiple sclerosis or spinal cord injury, management should be tailored to the individual woman's needs.

It's very important to have an accurate diagnosis of SUI before considering surgical treatment because it can make overactive bladder symptoms worse. The diagnosis of SUI can be established with a special test called urodynamic studies. This test is essential before surgery is undertaken.

Management of Urge Incontinence

This usually starts with simple measures, such as using vaginal oestrogen and seeing a physiotherapist to help with pelvic floor rehabilitation. Learning how to retrain your bladder to hold larger amounts of urine can help reduce the urge to pass urine.

Retraining the bladder includes learning how to contract pelvic floor muscles repeatedly and practising how to hold the contraction for a specific period of time. Wiggling your toes can also help reduce urge incontinence as this sends a signal to the bladder to relax.

If you are overweight, even 5% weight loss can improve urinary urgency significantly. Removing bladder irritants can also help reduce the urge symptoms. Common bladder irritants include alcohol, caffeine (especially tea & coffee) and fizzy drinks.

If you are postmenopausal, vaginal oestrogen may be prescribed to use as a vaginal cream or tablet. Oestrogen can plump up the lining of the vagina, which thins out once you go through menopause, and may provide some improvement in incontinence. However, the effect wears off once you stop using the treatment. The amount of oestrogen that gets absorbed into the body is very small and considered safe. Women who have had breast cancer should consult with their doctor to discuss whether or not they can use vaginal oestrogen.

Adding in anticholinergic medications can help in addition to bladder training and weight loss. These medications aim to decrease the contractions of the detrusor (bladder wall muscle). Another available medication is called mirabegron. Some of these medications can be quite expensive as not all of them are available on the Pharmaceutical Benefits Scheme (PBS).

If a trial of two or more medications has not helped, you may need to see a specialist who will talk to you about other treatment options, including injections of Botulinum toxin (Botox) into the bladder wall. Percutaneous tibial nerve stimulation (PTNS), or sacral nerve stimulator implants can also help by interfering the urge signals from the bladder through the process known as neurological modulation.

Where to seek further help/ information:

Your GP can start management, and if necessary, refer you onto a Gynaecology or Urogynaecology clinic.

Helpful online resources include:

- Australian Physiotherapy Association website: <http://physiotherapy.asn.au> then click "Find a Physio" and choose a Women's Health & Continence physio in your area
- www.UGSA.org.au then click "Patient Information"
- www.yourpelvicfloor.org

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