



Urinary incontinence is the accidental or involuntary leakage of urine. Incontinence can develop in adults of any age but is more likely to occur in women. This is due to the structure of the female urinary tract, the demands of pregnancy and childbirth, and the hormonal changes of menopause.

Incontinence is not a disease or a natural consequence of ageing but is a symptom of various conditions and disorders.

As shown in the illustration, the urinary tract consists of the two kidneys, two ureters, bladder and urethra. The urinary sphincter and pelvic floor muscles contribute to bladder control.

The main types of incontinence are stress incontinence, urge incontinence, mixed incontinence, overflow incontinence and complete incontinence.

Stress incontinence

Weakness of the pelvic floor muscles allows movement of the bladder neck or bladder base. The altered position of the bladder prevents the urinary sphincter from fully closing the urethra. Urine leaks out when the bladder is put under pressure, for example, while exercising, coughing, sneezing or laughing. Pregnancy, vaginal childbirth, and hysterectomy are common causes of a weak pelvic floor in women.

Postmenopausal women are prone to stress incontinence because the reduced level of the hormone oestrogen stops the bladder neck and urethra from closing properly. In men, surgical removal of the prostate gland to treat cancer is a common cause of stress incontinence.

IMPORTANT: FILL IN ALL DETAILS ON THE STICKER

DEAR SURGEON: When you discuss this pamphlet with your patient, remove this sticker and put it on the patient's medical history or card. This will remind you and your patient that this pamphlet has been provided. Some surgeons ask their patients to sign the sticker to confirm receipt of the pamphlet.

Urge incontinence

This is caused by uncontrollable bladder spasms. Symptoms and signs include an urgency to urinate followed by involuntary leakage of urine before reaching the toilet. Any condition that damages the nerve pathways to the bladder can cause urge incontinence, such as diabetes, Parkinson's disease, multiple sclerosis, spinal cord injury, stroke and complications of pelvic surgery, among others. In many cases, a cause cannot be found.

Mixed incontinence

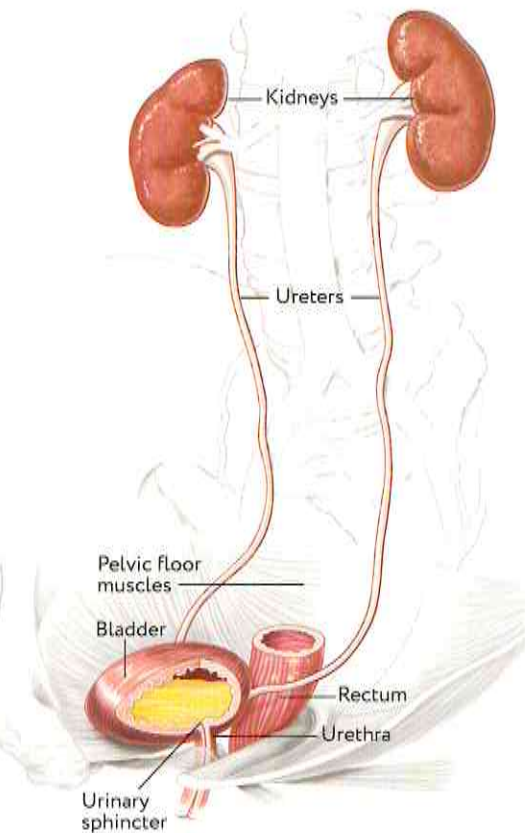
The symptoms of two or more types of incontinence are present at the same time, usually stress incontinence and urge incontinence.

Overflow incontinence

Overflow incontinence results from urinary retention, which is the bladder's inability to empty itself. Urine dribbles out because the bladder is full beyond its capacity. This can be caused by a failure of the bladder to work or by something blocking or restricting the flow of urine. For example, prostate enlargement (benign prostatic hyperplasia or BPH) is a common cause in older men. See the Society's patient education pamphlet on "Surgical treatment of an enlarged prostate – a guide for men", available from your urologist.

Complete incontinence

A person with complete incontinence has no control over the bladder. Causes can include fistula.



Talk to your Doctor

The aim of this pamphlet is to provide general information. It is not a substitute for advice from your doctor and does not contain all the known facts about incontinence treatments. This pamphlet should only be used in consultation with your doctor. If you are not sure about the risks, benefits and limitations of treatment, ask your doctor. Seek the opinion of another doctor if you are uncertain about the advice you are given.

CONSENT FORM: If you need surgical treatment, your surgeon will ask you to sign a consent form. Read it carefully. If you have any questions about the consent form, surgery, risks or anything else, ask your surgeon.

YOUR UROLOGIST

NON-SURGICAL TREATMENTS

Fluid intake

Fluid intake can be adjusted to help ease symptoms. For example, your doctor may advise you to drink six to eight glasses of water per day, and cut back on bladder irritants such as coffee, tea, alcohol, acidic fruit juices and soft drinks. Not everyone's bladder is sensitive to these drinks, but you may find that reducing or eliminating your intake improves incontinence symptoms. If you wake in the night to urinate, it may help to drink less in the evening. Make up for this by drinking more fluids during the day.

Pelvic floor exercises

Pelvic floor exercises strengthen pelvic floor muscles and may reduce the symptoms of stress and urge incontinence.

Also known as Kegel exercises, they can be performed anywhere at any time. The details are contained in separate patient education materials available from

your doctor or other sources.

Bladder training

Bladder training teaches the bladder to hold larger amounts of urine and can reduce the symptoms of urge incontinence. Keep a bladder diary for a few days. Record details such as your fluid intake, how often you urinate, and any accidental urine leaks. Your doctor will determine the program in discussion with you.

Continence Aids

Pads and other aids can assist patients in the management of their incontinence. Some people may qualify for financial assistance with this, for example, CAPS.

Medications

Urge incontinence

- Antispasmodic drugs that relax the bladder muscles can sometimes be used to treat this condition.
- In rare cases, tricyclic antidepressant medications may be used in low doses

for their effect on the bladder muscle.

- Oestrogen pills, creams or skin patches may ease symptoms in postmenopausal women with mild stress incontinence.
- Finasteride or dutasteride may be useful for men whose urinary incontinence is caused by prostate enlargement. These drugs are not commonly prescribed in Australia and New Zealand.
- Certain drugs such as diuretics or some high blood pressure medications can worsen incontinence symptoms. Your doctor may prescribe other medicines to replace those you currently take.

Stress incontinence

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MINIMALLY INVASIVE TREATMENTS

Pessary

A pessary is a small ring worn high inside the vagina. The ring exerts pressure on the front wall of the vagina, which helps to correct the position of the urethra. A pessary can ease the symptoms of stress incontinence in some women.

Urinary catheter

A urinary catheter is a thin tube inserted up the urethra to drain urine from the bladder. Catheterisation may be suitable for some people with overflow incontinence or for those who cannot empty their bladder because of nerve damage or spinal injury. Clean intermittent catheterisation involves inserting the catheter at set times or when the person feels the need to urinate. Urine drains down the catheter into the toilet. Alternatively, an indwelling (long-term) catheter is kept in place and attached to a bag that collects the urine for later disposal. Some men can opt for the condom catheter, which is worn on the penis and does not require a catheter in the urethra. The use of any type of urinary catheter requires strict hygiene to reduce the risk of infection.

Urethral injection

Urethral injections help to keep the bladder neck closed and add

bulk to the sphincter region. This is used for stress incontinence. The surgeon injects 'a bulking' agent into the urethral wall.

Botox injections (Botulinum toxin)

Botox (Botulinum toxin) injections weaken bladder muscles and reduce the uncontrollable spasms associated with urge incontinence. The dose and number of injections in the bladder wall depend on the severity of incontinence symptoms.

ANAESTHESIA DURING SURGERY

Depending on the surgical procedure, you will be given local, spinal, epidural or general anaesthesia. Modern anaesthetic drugs and procedures are safe with few risks. However, a few people may have a serious reaction to them. Issues to discuss with your anaesthetist include:

- if you have ever had a reaction to an anaesthetic drug
- if you are allergic to antibiotics or other medicines
- all medicines you are currently taking or have recently taken, including prescription drugs, over-the-counter medicines and herbal remedies. It may be helpful to write a list.

Your anaesthetist can explain more about the type of anaesthesia that is best for you and the associated benefits and risks.

Interpreter Service If you have trouble reading English, telephone the translating and interpreting service. **Australia:** Translating and Interpreting Service (T.I.S.) 13 14 50 (national number). **New Zealand:** Interpreting and Translation Services 09 276 0014 (Auckland).

ITALIAN Se avete difficoltà nel leggere in inglese, telefonate al servizio interpreti e traduttori. Australia: 13 14 50 Nuova Zelanda: 09 276 0014

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MAORI Mehe raruraru ana koe ki te riiti i nga korero-pukapuka i roto i te reo Paakeha, me waea atu koe ki te tari kai whakamaori i nga kupu korero pukapuka me te reo. Te naama hei waea - tangaatu mou i Ahitereiria (Australia) ko: 13 14 50. Te naama waea i Aotearoa (New Zealand) ko: 09 276 0014.

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ARABIC إذا وجدتم صعوبة في قراءة الإنجليزية اتصلوا بخدمة الترجمة الخطية والشفوية على الرقم 13 14 50 في استراليا و 09 276 0014 في نيوزيلندا

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SURGICAL TREATMENTS FOR INCONTINENCE

Surgery may be recommended in cases of severe incontinence or when other treatments have failed. Many different surgical procedures are available.

The best procedure for you depends on

a range of factors including:

- the type of incontinence
- the severity of symptoms
- whether the urinary tract has a structural abnormality

- whether surgery is needed to treat other conditions, such as prolapse of the uterus
- your surgeon's recommendations and experience with specific procedures.

SURGICAL PROCEDURES FOR WOMEN

The success of the urethral sling and Burch colposuspension is excellent for 90 out of 100 women. The "TVT" procedure is more recent but has similar results.

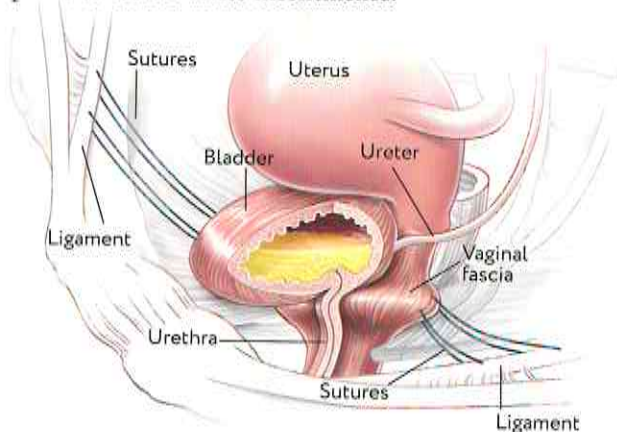
Fascial sling

The objective is to support and compress the damaged sphincter by putting a sling around the urethra at the bladder neck.

An incision in the front vaginal wall exposes the bladder neck. The sling is passed behind the pubic bone on each side of the bladder neck.

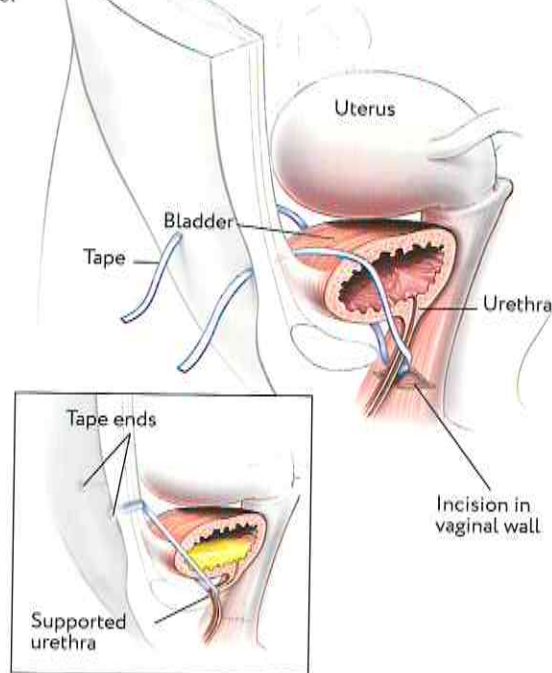
Burch colposuspension

As shown below, sutures are placed through the vaginal fascia (on either side of the bladder neck) and sutured to ligaments in the pelvis to correct stress incontinence.



Mid-urethra sling procedure

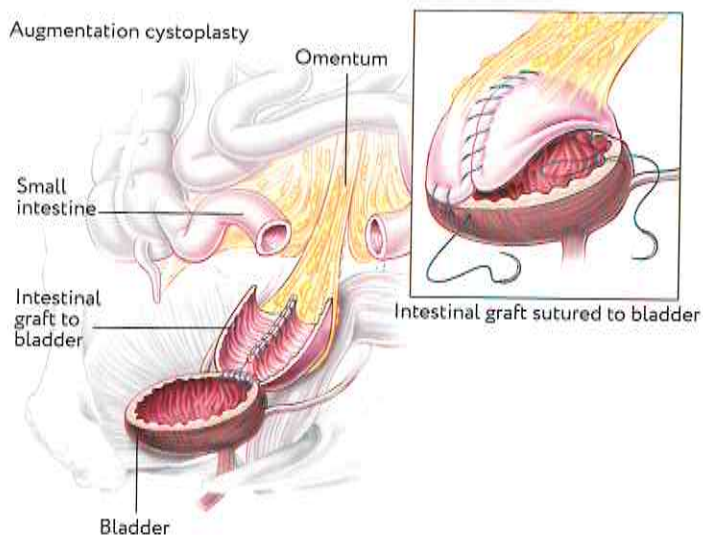
Two small incisions are made just above the pubic area, and a small vertical incision is made in the front vaginal wall. The mesh tape or sling is positioned around the urethra and brought through the incisions. The ends of the mesh tape or sling are cut off and not stitched to the tissues. The incisions are closed. The mesh tape or sling supports the urethra and prevents the escape of urine.



SURGICAL PROCEDURES FOR WOMEN AND MEN

Augmentation cystoplasty

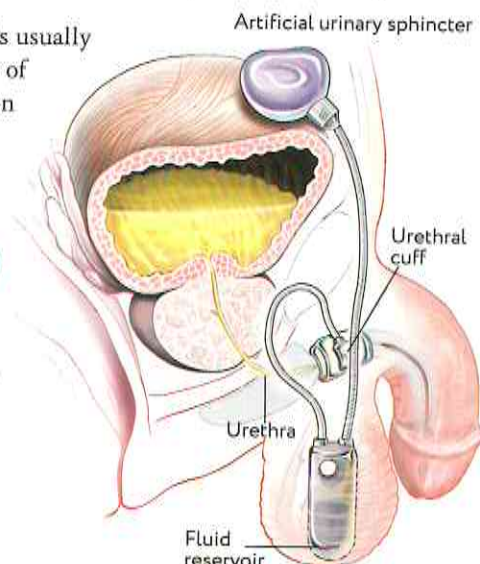
Augmentation cystoplasty enlarges the bladder with a small piece of intestine. This operation is used to treat difficult cases of urge incontinence.



Artificial urinary sphincter

The artificial sphincter is a urethral cuff controlled by a pump implanted under the skin. The cuff is inflated with fluid so that it squeezes the urethra closed. Pressing the pump drains the fluid from the cuff into a small reservoir. The deflated cuff allows the passage of urine. The cuff automatically fills with fluid again after a few minutes.

This technique is usually used for severe cases of stress incontinence in men and women.



Sacral nerve neuromodulation

A pulse generator is implanted usually in the buttock. This sends electrical impulses via a lead to the nerves in the sacrum to regulate bladder activity.

RECOVERY AFTER SURGERY

Depending on the procedure, you can usually expect a hospital stay of one to three days. Most patients need to wear a urinary catheter, which can vary from one day for a sling procedure to 10 days for more complex surgery. Medical or nursing staff will show you how to care for your catheter and reduce the risk of infection.

Get plenty of rest over the next few weeks. Avoid heavy lifting and strenuous exercise for up to six weeks.

Avoid constipation. The build-up of

hard stools in the rectum can press against the urethra and interfere with urination, while straining on the toilet puts pressure on the bladder. Eat high fibre foods such as fruits, vegetables and whole grain cereals. Drink six to eight glasses of water every day. Avoid bladder irritants such as coffee, tea, soft drinks, and acidic fruit juices. Monitor your fluid intake and perform pelvic floor exercises daily for the best postoperative results.

Obesity puts pressure on the bladder and pelvic floor, so it is important to

maintain a healthy weight.

Stop smoking. Smoking irritates the bladder, impairs healing and is a risk factor in the development of bladder cancer.

See your doctor if you have unusual symptoms such as high fever, severe pain or urination problems.

Conditions such as urinary tract infections, vaginal infections and constipation can cause temporary or intermittent incontinence. Symptoms resolve once the underlying condition resolves. See your doctor for prompt diagnosis and treatment.

POSSIBLE COMPLICATIONS OF INCONTINENCE SURGERY

All surgery carries some degree of risk despite the highest standards of practice. It is not usual for the surgeon to outline every possible side effect or complication of a surgical procedure. However, it is important that you have enough information about side effects and complications to fully weigh up the risks, benefits and limitations of surgery.

If you have particular concerns about possible complications, discuss them with your surgeon. You may find it helpful to prepare a written list of issues and questions before meeting with your surgeon. These possible complications are listed to inform you, not to alarm you. There may be others that are not listed.

General risks of surgery

The risks of any surgical procedure include:

- allergic reaction to anaesthetic
- nausea following anaesthesia can be severe but usually resolves quickly
- excessive bleeding from the operated site that may require a blood transfusion (about one patient in 100)
- infection of the wound that may require antibiotics
- the risk of chest infection, blood clots, and lung and cardiovascular complications are increased in smokers and obese people.

Specific risks of surgery

Specific risks of incontinence surgery include:

- damage to the bladder, urethra or other structures
- nerve damage
- slow healing of the wound
- structural abnormalities, such as vaginal prolapse

- urination problems caused by surgical overcorrection, for example, a sling procedure may cause urinary obstruction if the sling presses too tightly against the urethra
- further surgery to treat complications or worsened symptoms
- a mechanical device, such as the artificial sphincter, may stop working or need further procedures to keep it in good condition
- about three of every 10 patients who undergo augmentation cystoplasty lose the ability to urinate at will and must self-catheterise
- the procedure may not help to relieve symptoms, and other procedures or options may have to be considered
- inflammation of the pubic bone (osteitis pubis) may occur in some patients.

Risks of minimally invasive treatments

- Vaginal pessaries increase the risk of vaginal infections and urinary tract infections.
- Urinary catheters increase the risk of urinary tract infections. Bacteria can be transferred from the equipment.
- Urinary injections can cause infection and temporary urinary retention (inability to pass urine).
- Urethral injections have a modest success rate. About three to five of every 10 patients can expect good results.
- Urinary injections may need to be repeated because the body gradually absorbs the bulking agents.
- Botox injections give temporary relief of symptoms. Treatment must be repeated every six to 10 months to maintain good results.

REPORT TO YOUR UROLOGIST

Notify your urologist at once if you notice any of the following:

- nausea or vomiting that is worsening
- persisting or increasing pain, and pain not reduced by painkillers
- persistent bleeding from the vagina that is smelly or becomes heavier than a normal period and is bright red
- persistent redness, pain, pus or swelling around an incision, or fever more than 38°C or chills, which may indicate infection
- pain or burning on passing urine or the need to pass it frequently
- abnormal or persistent leakage of urine
- any concern you may have about your surgery.

If you cannot contact your urologist, go to your family doctor or Accident and Emergency at your nearest hospital.

COSTS OF TREATMENT

Your doctor can advise you about coverage by public health insurance, private health insurance and out-of-pocket costs. You may want to ask for an estimate that lists the likely costs. This includes medical and hospital fees, and other items. Ask which costs can be claimed on public or private health insurance. As the actual treatment may differ from the proposed treatment, the final account may vary from the estimate. It is better to discuss costs with your doctor before treatment rather than afterwards.