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COMPREHENSIVE CONSERVATIVE TREATMENT OF URINARY STRESS INCONTINENCE (usi)
Alongside the growth in the number of ageing women, the problem of USI has become increasingly visible. Although the disease is also diagnosed in young women, while they grow older the number of patients increases proportionally to their age. The condition creates important social problems since it considerably deteriorates the quality of life, women who suffer from it often have to withdraw from professional and social activities, what drastically affects their mental well-being
The factors which contribute to USI are functional disorders of the anatomical structures of the pelvis minor organs resulting from deliveries, physical work associated with an intra-abdominal pressure increase, age-induced involutional and hormonal changes and obesity. Diagnosing and conservative therapy must be based on at least 3 specialities: gynaecology, urology and rehabilitation; often a neurologist or a psychologist have to be consulted as well. Surgery as a sole therapy does not resolve all problems, nor is it accepted by all patients. Thus it seems logical to attempt a causal conservative therapy instead of numerous different surgical approaches, especially when the disease is not clinically advanced.
The Aim of the Study: The large variety of non-invasive methods of USI treatment found in literature has made the authors design a comprehensive, conservative, economical and easy scheme to manage USI out-patients.

Methods: 69 female outpatients (aged 24 - 86) with types 0, I, II USI(acc. to Blaivas and Olsson, 1988, anatomic classification) treated conservatively were included in the study. Urological and gynaecological history of a patient was an important inclusion criterion. The data were classified acc. to Gaudenz and I-QOL questionnaire. The examinations included: physical examination (particularly gynaecological and urological), routine urinalysis, Bonney test, pad test, uroflowmetry, pelvis minor sonography, EMG of pelvic floor

Only USI patients were included in the study (conservative therapy); patients suffering from other forms of incontinence (urge and overflow) were not included.

The therapy was focused on three main issues: * making a patient aware of the role the pelvic floor muscles play - a patient was taught how to exercise particular muscles and persuaded to do exercises routinely at least twice daily. The exercises were based on the muscular synergism confirmed in EMG; * teaching a patient to consciously control the urinary bladder and sphincters by creating an appropriate behavioural discipline; * employing a series of electrostimulations which are to exercise both smooth and striated muscles.

Patients who had hormone deficiency were treated with intravaginal estrogens under gynaecological control.

Intensive kinesitherapy lasted 2 weeks. After the first cycle, a patient was instructed about the exercise and behavioural discipline to be kept at home. After one month, a control test was done and then a decision about further treatment - its termination or continuation - was taken.

When after one month's observation no beneficial results of the therapy were seen in a patient, such patients were not referred to surgery. Instead, they were subjected to further series of electrostimulation accompanied by intensive muscular exercises and then evaluated.

The therapy system described above aimed at higher muscular tone at rest and pelvic floor muscle strength, creating a habit of contracting particular muscles in moments of risk and creating favourable behaviours (hygienic life style, regulation of liquid intake and micturitions). The patients were followed up for 6 months

Results: In the follow-up examination after one month it was found out that: complaints stopped completely in 5 (7%) patients, a considerable improvement was observed in 14 (21%) patients, and no or insufficient improvement was seen in 50 (72%) patients. Out of 64 patients who were treated conservatively according to the same scheme for another 6 months, 52 (75%) were cured or had symptoms acceptable for the patients, and only 12 (17%) patients studied were referred to surgery.

Conclusion: The combination of intensive pelvic floor muscle exercising, electrostimulation and an appropriate life style regime considerably limits or eliminates complaints and clinical manifestations of USI in women and improves the quality of their life.