
SPECIAL ARTICLE

Role of general Obstetricians-Gynecologists in the treatment of stress urinary incontinence in Thai woman

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Nowadays, female urinary incontinence (FUI) is the common problem in Asia especially in Thailand. The incidence in Asia ranges from 4-17% and the incidence in Thailand is 17%⁽¹⁾. Stress urinary incontinence (SUI) is the most common FUI (41%)⁽²⁾. Report from Khon Kaen University Hospital demonstrated the high incidence of mixed type and stress urinary incontinence (94.38%)⁽³⁾. Woman usually present with urinary leakage when they have any activity that increase the abdominal pressure including coughing, sneezing and exertion. The causes of stress urinary incontinence are due to the relaxation of the urethrovesical angle (Hypermobility) and from the defect in the urethral mucosa or urethral sphincter (Intrinsic sphincter defect). The urethra cannot close properly when having the pressure in bladder causing urine leakage. Before starting the treatment, it is important to differentiate the SUI from other causes of FUI such as overactive bladder (OAB) (causes urge incontinence) and overflow incontinence because the treatment are difference. The SUI is treated by pelvic floor exercise and surgery while the OAB is treated by anticholinergic drug and behavioral techniques. Inappropriate treatments cannot relieve the symptoms, cause complications and lead to legal problems. So, the precise diagnosis is very important.

History taking should include all abnormal urinary symptoms such as urgency, urge incontinence, nocturia,

stress incontinence, voiding difficulty, and poor emptying. Proper physical examination and pelvic examination should be done to identify both medical and gynecological problems. Urinalysis should be performed to rule out kidney-ureter-bladder (KUB) pathology. Indications for urodynamic study (UDM) are voiding difficulty, history of previous surgery for SUI, mixed symptoms of OAB and SUI (mixed type incontinence), spinal cord injury and SUI that required surgery. The UDM is used to confirm the diagnosis and to predict outcome of surgery⁽⁴⁾.

The treatment of SUI can be either nonsurgical (medication and pelvic floor exercise) or surgical. The indications of nonsurgical treatment are severe medical conditions, uncontrolled psychiatric problems, fertility desire. Medical treatment for SUI is not widely used because of their side effects. The alpha-adrenergic drugs are associated with hypertension while serotonin reuptake inhibitors can cause nausea, vomiting and headache. Pelvic floor exercise (PFM) is safe but need to be done regularly. However, it cannot be used in aging women who have poor pelvic floor muscle or severe urinary leakage. There are the number of surgical treatment for SUI such as Kelly plication (which is commonly used with anterior colporrhaphy to treat cystocele, Burch colposuspension, and sling operation. Various clinical practice guidelines (CPG), including the guideline from International Continence Society (ICS)⁽⁵⁾,

do not recommend Kelly plication because of its high failure rate (40-50%)⁽⁶⁾. If the first operation fails, success rate for the second operation will also be reduced. The Burch colposuspension has high success rate and can be done at the same time with other gynecologic surgeries, such as hysterectomy. But this operation is not widely used because of its complications such as bladder injury and post operative voiding difficulty. The tension free vaginal tape operation, a new sling operation, becomes more popular due to its minimal invasive procedure, quick recovery, small incision and can be done as outpatient.

The most common question from general obstetricians and gynecologists (OB-GYN) doctors is the operation of choice for SUI if they can not perform Burch colposuspension or sling plication. Can they still perform the Kelly plication for these women. since the recurrent rate is high and many CPGs do not recommend. In the author's opinion, since there is no CPG for the treatment of SUI in Thailand, we should follow the other standard guidelines. The physicians should provide information on the success rate, cost, and complications provided and discussed with their patients in order to make decision. Kelly plication can be performed if the patients do not want to be transferred and accept its high failure rate. However, the patients should be referred if they want better outcome. Urogynecology clinic is now available in many medical schools such as Chulalongkorn, Ramathibodi, Siriraj, Thammasat, Srinakarind such as and Songklanagarind Hospital.

Data demonstrate that general OB-GYN can be able to treat the uncomplicated urogynecological patients. Most patients may require additional tests such as cough provocative test, pelvic floor muscle test, post - void residual urine measurement and urodynamic test (UDM, in case that requires surgery). All these tests except UDM can be done within the gynecological clinic without any special equipment.

The life expectancy of women is now increase. The incidence of urogynecological problems in Thailand is also rising. General OB-GYN specialists in community hospital, provincial and center hospital have to treat these problems due to shortage of urologists. When women come for general and gynecologic check up,

they usually complaint about the SUI symptoms and ask for treatment. General OB-GYN specialists may not be able to provide proper management due to:

1. Limitation of time. There is not enough time to focus on SUI treatments and to explain to the patients about the choices of treatment due to the doctors' work load in gynecology clinic.
2. Lack of basic knowledge about SUI treatments. There was no urogynecology curriculum in the OB-GYN residency training program in Thailand. Most training focused on maternal and child health, family planning, gynecologic oncology which were the important problems. However, the clinicians can attend the meeting or workshop that provided by the Royal Thai College of Obstetricians and Gynaecologists or Thai Urogynecologist Society (TUGS) or taking a training or short visiting in urogynecology clinic in medical schools that have urogynecological clinic.
3. Can not perform special surgical techniques such as sling operation or Burch Colposuspension. The surgical skill requires training and experiences. The patients should be referred if the number of cases is low.
4. Lack of equipment including UDM in the hospital. UDM is a minimum requirement for the urogynecological clinic. However, it can be shared with urologist in the same hospital and some SUI patients may not need the UDM. General OB-GYN can select the cases that needs to be referred for UDM investigation.

In the author's opinion, if there are problems 1-4 and can't be solved. It is better to refer the SUI patients to the experienced doctors.

In conclusion, the role of general OB-GYN in SUI treatment should be one of the following way:

1. Screen, identify and refer the SUI patients.
2. Screen, identify and treat only with nonsurgical treatments: estrogen cream application in woman with atrophic vagina, pelvic floor

exercise, getting rid of risk factors (weight reduction, quit smoking).

3. Screen, identify and treat both surgical and nonsurgical choices. The gynecologists should know SUI treatments, their complications and prevention.

In the near future (around year 2012), RTCOG will begin the urogynecology subspecialty training in Thailand (like in USA, Europe and some countries in Asia). The TUGS in co-operation with RTCOG are now setting up the curriculum for sub-specialty training that will help in setting up the urogynecology clinic in the center hospital and improving the urogynecologic care for Thai woman in the future.

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