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Los Angeles Times

That sinking feeling

Incontinence and other pelvic floor disorders are surprisingly common -- but treatable.

August 25, 2008 | Devon Schuyler, Special to The Times

Maria Stubbs, a 44-year-old mother from Carson, wasn't surprised when she leaked a little urine after the birth of her third daughter 10 years ago; she had experienced a bit of leakage during and immediately after all three of her pregnancies. But when a full year had passed and she was still crossing her legs to stave off leakage every time she coughed, she knew she had a problem.

Her low point occurred when she was washing dishes and suddenly urinated on the kitchen floor. "After I cried, I told my husband I had to do something," she said.

Stubbs' experience is surprisingly common, but researchers are only now beginning to realize just how widespread it is. Problems such as incontinence and dropped pelvic organs -- together called pelvic floor disorders -- affect 1 in 3 women, according to a 4,000-person Kaiser Permanente study funded by the National Institutes of Health (NIH). Other research shows that at least 11% of women end up having surgery for a pelvic floor disorder.

The pelvic floor is a group of muscles, ligaments and nerves that form a sling across the opening of a women's pelvis. A strong pelvic floor holds the bladder, uterus, bowel and rectum in place and allows them to function properly.

Muscles in the pelvic floor tend to weaken as women grow older, with pregnancy and obesity adding extra pressure. Childbirth may also stretch or damage the muscles, especially if forceps are used or severe tearing occurs. The result can be incontinence, which refers to leakage of urine or stool, or pelvic organ prolapse, in which pelvic organs sag into the vagina. In severe cases, the uterus may even herniate between the legs.

Many women avoid seeking treatment because they're embarrassed to talk about their condition or don't think anything can be done. Fortunately, a variety of therapies are available -- many of them introduced just a few years ago.

"Things have improved a lot in the past 10 years," said Dr. Mary McLennan, director of urogynecology at St. Louis University in Missouri.

Open procedures are being replaced by minimally invasive ones, new medications are now available, and researchers are gaining a better understanding of what causes pelvic floor problems -- and how to treat them.

Urinary incontinence

The mainstays of treatment for urinary incontinence are pelvic floor exercises and bladder training. "Surgery should be at the very end of the list," said Dr. Jeanette Brown, a uro- gynecologist who directs the Women's Continence Center at UC San Francisco.

Pelvic floor exercises are especially helpful for stress incontinence, in which urine leaks from the strain of laughing, coughing, sneezing or lifting. Bladder training is used for urge incontinence, in which involuntary bladder-muscle contractions cause a sudden urge to urinate. In bladder training, women learn to go to the bathroom on a specific schedule, gradually increasing the amount of time between visits

If incontinence persists, one option is medication. None have been approved to treat stress incontinence, but women with urge incontinence can choose from a

variety of medications to reduce nerve impulses that trigger bladder emptying: Ditropan, Detrol, Enablex, Sanctura and Vesicare. A common side effect with these is dry mouth.

Surgery for stress incontinence used to require opening up the abdomen, but the current procedure of choice -- in which a surgeon places a long piece of mesh under the urethra to support it -- is performed through tiny incisions.

"If they have [the surgery] on a Friday, most people can be back to work the next week as long as they're not doing heavy lifting," said Dr. Karl Luber, a urogynecologist who directs the female continence program for Kaiser Permanente in San Diego. He said that the success rate two years after the procedure is about 85%. Possible side effects include bleeding and infection.

Surgery for urge incontinence is riskier and less effective. One technique involves implanting a device called InterStim that stimulates the sacral nerve in the lower back. Although experts don't fully understand how the device works, the sacral nerve plays a role in bladder function. Possible side effects include pain and infection at the implant site.

Additional treatments for stress incontinence include attempts to strengthen the pelvic floor muscles with magnetic or electrical stimulation, and bulking up the tissues around the urethra with collagen injections. Although these treatments may help some women, studies have been mixed on whether they work. Some doctors are injecting Botox into overactive bladder muscles as a treatment for severe urge incontinence, although it hasn't been approved by the Food and Drug Administration for this use.

Pelvic organ prolapse

Some women with urinary incontinence also have pelvic organ prolapse, although having one condition doesn't mean that one will develop the other.

People with pelvic organ prolapse have fewer treatment options than those with

urinary incontinence and are more likely to have surgery. "It's harder for me to help prolapse than stress incontinence," said Dr. John DeLancey, a professor of obstetrics and gynecology and director of pelvic floor research at the University of Michigan in Ann Arbor. Treatment options for pelvic organ prolapse are limited to using a pessary or having surgery. A pessary is a diaphragm-like device that's used to support internal organs. Although pessaries have come a long way since 400 BC, when Hippocrates described inserting half a pomegranate into the vagina to correct prolapse, they don't fit everyone well.

If a pessary doesn't work, surgery becomes an option. In it, sutures or mesh are used to support the vagina and restore the prolapsed organs to their proper positions. Although nearly a third of all prolapse operations are repeats, this doesn't necessarily mean the operation was a failure. "That person may have had 15 years of good relief," DeLancey said.

Fecal incontinence

Fecal incontinence is the least understood and most difficult to treat of the pelvic floor disorders. "We've just started to study this in the last 10 years, so we don't always know what works," said Donna Bliss, a professor of nursing at the University of Minnesota.

The first therapies used are nonsurgical measures, such as pelvic floor exercises that target the anal sphincter. Another treatment is bowel habit retraining, which involves getting to a toilet at regular intervals. Some people may benefit from dietary changes or antidiarrheal drugs to bulk up the stool and make it easier to control.

Although several surgical procedures are available, "we don't have an ideal surgery therapy for fecal incontinence yet," said Dr. Howard S. Kaufman, chief of colorectal and pelvic floor surgery at USC in Los Angeles. A procedure to tighten the anal sphincter has high failure rates, and implanting an artificial bowel sphincter can cause infections and other complications.

Some doctors are attempting to correct fecal incontinence by injecting bulking agents into the anal muscle. Another experimental treatment is sacral nerve stimulation, which is already approved for use in urinary incontinence.

A dramatic difference

DeLancey pointed out that women have plenty of time to weigh their options when it comes to treating pelvic floor disorders. "They're not dangerous; they're not going to harm your health," he said. But he emphasized that treatment can make a dramatic difference in people's lives.

Maria Stubbs, who recently had a piece of mesh implanted to stop her leakage after an earlier surgery failed six years out, advised women with symptoms like hers to talk to their doctor. "Get help, because it's out there," she said.