Hamdan Medical Journal 2013; 6:1–8 (http://dx.doi.org/10.7707/hmj.v6i3.291)

STATE-OF-THE-ART REVIEW

Incontinence – the urological approach: review and own experiences

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Abstract

Urinary incontinence often impairs quality of life more significantly than other chronic diseases such as hypertension, diabetes or depression. Despite identical symptoms, there are various types of urinary incontinence that have different causes and, therefore, require different therapeutic approaches. Although several effective treatment options are available, many patients are not given such treatments and some suffer from serious consequences of incontinence surgery. An exact urological diagnosis is based upon complete understanding of the different pathogenetic mechanisms and the knowledge of modern treatment options, which is necessary to detect the optimal therapy for each patient.

Introduction

Urinary incontinence often impairs quality of life significantly more than other chronic diseases such as hypertension, diabetes mellitus or depression.[1–4] Despite identical symptoms, there are various types of urinary incontinence that have different causes and, therefore, require different therapeutic approaches. Based on case histories alone, the correct diagnosis is given in only 30% of cases, showing that exact urological diagnostics are necessary so that the correct therapy can be instituted.

Urinary incontinence can be classified by:

- stress urinary incontinence in women
- stress urinary incontinence in men
- overactive bladder and urge urinary incontinence
- overflow incontinence
- urinary incontinence in children
- neurogenic urinary incontinence.

Stress urinary incontinence in women

In women with stress urinary incontinence, the urethral closure mechanism becomes ineffective and is unable to withstand increased intra-abdominal pressure. This means that events such as coughing, sneezing, laughing and physical activity cause loss of urine. It is an isolated problem of the pelvic floor; bladder function is completely unaffected.
A distinction is drawn between genuine diagnoses and non-genuine diagnoses, associated with concomitant pathologies. Genuine stress incontinence is characterized by intact anatomy of the pelvis and a regular preserved angle between bladder neck and urethra. However, the non-genuine type also exists, for example a prolapse of the anterior vaginal wall in association with a rotatory descent of the bladder.

Possible causes of deficiency of the urethral sphincter include:

- long-term intense use of the pelvic floor muscles during pregnancy
- overstretching and injury to the pelvic floor during childbirth
- changes in the anatomy of the pelvis that result in the bladder and urethra having a more caudal position, thus making appropriate sphincter function impossible (such as may

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