Pelvic floor disorders: Case study

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Abstract

Interactive case study discussions were an integral part of the program at the 3rd Annual Canadian Urology Forum (2013). The following is a summary of discussions pertaining to a case illustrating the difficulties in the management of pelvic floor disorders.

Case 1

A 49-year-old woman with pelvic organ prolapse, urinary incontinence and fecal incontinence

The patient, MS, is a 49-year-old mother of four. Since her last childbirth, she has experienced both urinary and fecal incontinence. The current presentation is due to significant urge incontinence and frequency (voiding every hour). She also has symptomatic prolapse, with the sensation of incomplete emptying.

The history shows that she did experience a significant (fourth degree) tear during the delivery of one of her children. This required a delayed repair six weeks later. Three years ago, she consulted with a physiotherapist and found that the exercise regimen had a limited effect on her incontinence. She has also consulted with a nurse continence advisor and has already gone through the recommended nonpharmacologic conservative measures. She has tried multiple pessaries, which have helped with her prolapse, but had no effect on incontinence.

She drinks diet cola and coffee, approximately three per day. She has regular menstrual periods.

The physical examination shows that she has a relatively lean body type, with a body mass index of 25 kg/m^2. Her cough-stress test is negative. She has a somewhat bulky uterus, with significant uterine prolapse, 3 cm past the hymenal ring. She has a class 4 cystocele, a rectocele and a weak anal sphincter.

Urodynamics revealed signs of overactive bladder: a gradual rise in detrusor pressure with filling, and she leaked upon standing at a detrusor pressure of 35 cm H_20. She emptied well, with normal detrusor pressure.

Discussion

Based on this case presentation, the participants were asked what they would recommend in terms of management for this patient's prolapse and incontinence. Most participants indicated that they would try a course of pharmacotherapy to try to improve her OAB symptoms. Anorectal imaging and/or referral to a colorectal surgeon were also suggested as a potential means of identifying ways to address her fecal incontinence. Recommending modifications to her diet and lifestyle may also lead to improvements. Eliminating the caffeine from her diet, for example, may help with her urge symptoms. A second round of physiotherapy was also recommended, as it has been quite some time since this intervention was last tried. While surgical repair of her prolapse and renewed use of pessaries were options, the patient in this case indicated she was resistant to these approaches, and that the prolapse does not bother her. Some of the participants argued that she should be counseled about the desirability of intervening with the prolapse now before it worsens and becomes harder to treat.

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