

## Letters to the editor / Lettres à l'éditeur

### Contribution of behavioral and cognitive therapy to managing functional urinary disorders in woman



*Apport de la thérapie comportementale et cognitive dans la prise en charge des troubles fonctionnels urinaires de la femme*

**Keywords:** Urgency-frequency syndrome; Behavioral and cognitive therapy; Woman

**Mots clés :** Urgenturie ; Thérapie cognitive et comportementale ; Femme

#### 1. English version

##### 1.1. Introduction

Some lower urinary tract dysfunctions remain unexplained after urodynamic testing. Functional etiology is then considered. A comprehensive care combining muscular training and behavioral and cognitive therapy (BCT) [1–3] can be proposed before a more invasive investigation.

In our practice, this approach is mainly applied to patients who complain of urgency-reformulation frequency with leakages.

We present our experience in 3 cases of women complaining of that syndrome with variable degrees of severity.

##### 1.2. Patients

###### 1.2.1. Case #1

Woman aged 66, who had daytime and night-time frequency with important leakages occurring at urgency. Urodynamic testing was close to normal except a delayed first desire to void (190 mL).

###### 1.2.2. Case # 2

Woman aged 62, who had daytime and night-time frequency. During cystometry a rapid progression of desire was observed but functional bladder capacity was normal. She did not have much leakages.

###### 1.2.3. Case # 3

Woman aged 43 who had daytime frequency with large leakages. Urodynamic testing was normal.

##### 1.3. Methods

Initially 10 sessions (45 min duration) of treatment were offered to every patient. Sessions took place once a week except the last 2 that were 2 or 3 weeks apart. If necessary, additional booster sessions were also allowed.

The goal of the treatment was to manage urgency. Therefore, an appropriate treatment program including urgency-coping strategies was offered.

General principles were information, highlighting of inappropriate behavior, re-learning (increase of the delay between voiding and of the number of voiding at normal desire), reformulation, activity exposure and problem solving.

Used tools during session were relaxation, muscular training (feeling, steadiness, duration) of perineum, and abdominal breathing.

Learned techniques were simulated at home (training), then applied in urgency condition (activity exposure). Each patient fulfilled daily voiding diary; a planning of drinks was established jointly with the physiotherapist.

Evaluation was performed initially and during the last session using the discomfort visual analog scale (VAS) and the French score measurement of urinary disability (MHU) [4] obtained from questioning (items are urgency, frequency, dysuria, stress incontinence).

All sessions were conducted by the same physiotherapist.

##### 1.4. Results

The number of proposed sessions (10) could be reduced (7: case #3) or greatly increased (20: case #1) depending on the response to treatment (Table 1).

In these 3 cases improvement was observed:

- in urinary functional symptoms: increased daytime voiding interval (case #2: from 0.5 hour to 2.5 hours), decreased daytime leakages (case #3: from 7–8 per week to 3–4 per month) and recurrence of voiding at normal desire (from 30% in case #1 to 50% in case #3) (Table 1);
- in quantization scores: comparing the less improved case (#1) and the more improved (#2) the range of improvement was (25% to 44%) in VAS and (36% to 71%) in MHU

##### 1.5. Discussion

The aim of this paper is to describe a non-usual method of treatment of functional urinary disorders. This diagnosis is

Table 1  
Evaluation of patient complaint at inclusion and at the end of treatment.

	Case #1 (66 years) 20 sessions		Case #2 (62 years) 9 sessions		Case #3 (43 years) 7 sessions	
	Initial	End	Initial	End	Initial	End
Daytime frequency	11	7	10	7	11	7
Night-time frequency	5	3	3	2	1	0
Daytime voiding interval	0.5 h	1 h	0.5 h	2.5 h	0.5 h	2 h
Voiding delay after strong desire	< 1 min	5 min → 15 min	5 min	60 min	5 min → 10 min	15 min → 60 min
Daytime leakages	7–30/weeks	5–10/weeks	1–2/weeks	1/2 weeks	7–8/weeks	3–4/months
	++/+++	+/+++	+/++	+	++/+++	+/++
Night-time leakage	35/w	14/w	0	0	0	0
	++/+++	+/++				
% of voidings at normal desire	0	30	0	33	0	50
VAS/10	6.8	5.1	4.5	2.5	8	5.1
MHU/28	11	7	7	2	7	3

VAS: visual analog scale; MHU: Score Measurement of Urinary Disability.

rarely made in primary care office and in most cases after urological examination and urodynamics.

The first question we can ask ourselves is how many sessions are needed to obtain significant results. If in a first approach 10 sessions are proposed, the number of sessions does not only depend of improvement but also of socio-professional constraints. An alternative is proposed: reproducing the spacing and training sessions at home. The observed high number of sessions required for case #1 results from the severity of incontinence and the low ability of the patient to assimilate instructions.

The usual frequency is chosen to give the woman time to incorporate new habits and verify their sustainable acquisition.

Other parameters essential for significant results are attendance and regularity of training, and acceptance of coping strategies. Therefore, one can reproach this method for being time-consuming.

Recall that educational aspect (habits related to urinary sphere: drinking, feeding, precautionary voiding, removal of avoidance behavior) is used to make the patient more active and self-dependent.

The limitation of this study is the lack of evaluation of the results at middle- and long-term.

## 1.6. Conclusion

Comprehensive care combining muscular training and behavioral and cognitive therapy applied to patients with functional urinary dysfunction leads to significant improvement without invasiveness. Good results are conditioned by targeted medical indication and investment of the patient between sessions. That method appears as a good alternative before considering invasive investigations and/or heavy medical treatment (sacral nerve stimulation, botulinum toxin...).

## 1.7. Consent

Written informed consents were obtained from the patients for publication of this case report.

## Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

## 2. Version française

### 2.1. Introduction

Certains troubles urinaires du bas appareil (TUBA) restent inexplicables après un bilan urodynamique. Ceci amène à la prise en compte d'une étiologie fonctionnelle. Une prise en charge globale associant rééducation périnéale et thérapie cognitive et comportementale (TCC) [1–3] peut alors être proposée avant d'envisager des investigations invasives.

Dans notre pratique, cette approche s'adresse principalement à des patientes se plaignant d'une pollakiurie importante et d'urgenterie associée ou non à des fuites urinaires.

Nous présentons notre expérience concernant trois cas de femmes souffrant de ce syndrome avec différents degrés de sévérité.

### 2.2. Patientes

#### 2.2.1. Cas #1

Femme de 66 ans présentant une pollakiurie diurne et nocturne avec des fuites importantes par urgenterie. Le bilan urodynamique était proche de la normale exception faite d'un retard à l'apparition du premier besoin (190 mL).

#### 2.2.2. Cas # 2

Femme de 62 ans présentant une pollakiurie diurne et nocturne. Pendant la cystomanométrie une progression rapide du besoin a été observée; la capacité vésicale fonctionnelle était normale. La patiente rapportait peu de fuites mictionnelles.

#### 2.2.3. Cas # 3

Femme de 43 ans présentant une pollakiurie diurne et des fuites importantes. Le bilan urodynamique était normal.

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