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Female voiding dysfunction

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Female voiding dysfunction is poorly understood; it lacks standard definitions, and there is no consensus on diagnostic criteria. In the majority of women who are neurologically intact the cause is idiopathic. It affects the sufferers' quality of life, but unfortunately there is a paucity of published literature on its management. This review examines the current knowledge on the management of this common problem. Diagnosis is aimed at identifying the underlying aetiological factors, which are discussed, as well as the importance of a detailed history and focused physical examination. Investigations essential to management are outlined. Developments in the medical treatment of voiding dysfunction have been disappointing. The role of surgery is even more limited except for those with postoperative voiding problems after new-generation sling procedures. Intermittent self-catheterisation, supervised and supported by a dedicated nursing specialist, remains the mainstay of management. A multidisciplinary approach is essential to success. Emerging treatment modalities such as sacral and peripheral neuromodulation and the use of α_1 -blockers are discussed. Botulinum toxin A injections have been useful in some cases. There are relatively few publications on the effectiveness of these interventions in clinical practice. These issues need to be addressed by quality research. Female voiding dysfunction presents a challenge to urogynaecologists and urologists alike.

Key words: voiding dysfunction; female; Fowlers syndrome; sacral neuromodulation.

Female voiding dysfunction is complex in nature, poorly understood, and difficult to treat. Voiding disorders in men are relatively common and are usually due to bladder outlet obstruction secondary to prostatic hyperplasia or hypertrophy; extensive data on the aetiology and management of this condition exist. In women there is a lack of standard definition, and data on the prevalence of voiding dysfunction are conflicting.

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Consensus on the diagnostic criteria for female voiding dysfunction is also poor. The International Continence Society (ICS) states that 'normal voiding is achieved by a voluntarily initiated continuous detrusor contraction that leads to complete bladder emptying within a normal time span, and in the absence of obstruction'.¹ It should follow that female voiding dysfunction falls outside this definition. Stanton et al defined voiding dysfunction in women as 'a condition in which the bladder fails to empty completely and easily after micturition', with uroflow studies showing repeated peak flow rates of < 15 mL/seconds and/or 200 mL or more of residual urine.²

The incidence of female voiding dysfunction varies from 6.8 to 61.7% in selected populations based on symptoms alone, and appears to increase with age.²⁻⁴ Lepor et al studied the prevalence of female voiding dysfunction in the community and showed that 40% of women aged 80 have symptoms of poor stream compared to 10% of 19-29-year-olds. Interestingly, however, other symptoms such as hesitancy, intermittency, incomplete emptying and abdominal straining were commoner in younger age groups.⁵ Asymptomatic patients can have objective urodynamic evidence of suboptimal voiding, while some patients with a clear history may have no measurable explanation of their symptoms. Urodynamic evidence of voiding difficulty was confirmed in only 21.2% of symptomatic patients in a study by Groutz et al in 1999.³ Often there is no correlation between the subjective and objective evidence of voiding difficulty. Dietz et al, in a study of the relationship between symptoms and uroflowmetry, demonstrated that only hesitancy, poor stream and interrupted voiding have a strong association with objective voiding dysfunction.⁶

Voiding disorders in women are common and may go unrecognised until the patient presents with troublesome symptoms such as recurrent urinary tract infections or overflow incontinence. Little is published on the impact of voiding dysfunction on the quality of life of sufferers, but one can assume that voiding dysfunction may have a negative impact on one's normal activities and state of mind. Das et al showed that voiding dysfunction can have a serious impact on the physical, social and psychological aspects of life of the sufferers.⁷ Possible sequelae of abnormal voiding are far-reaching and include pelvic discomfort, urinary retention with or without incontinence, recurrent urinary tract infection and the consequent risk of upper urinary tract damage, altered sexual function, and the potential need for self-catheterisation. This chapter will focus on the diagnosis and the management options for women with voiding dysfunction.

CLASSIFICATION

There is no agreed classification for female voiding dysfunction. Stanton advised that any classification should consider not only the anatomical, functional and neurological aspects of micturition but also relaxation of pelvic floor muscles.² There is no such classification specific to voiding female dysfunction. The ICS¹ has taken a functional approach to describing the abnormalities of voiding, focusing mainly on bladder and urethral activity during micturition. Voiding dysfunction, according to the ICS, can be due to the bladder (detrusor underactivity, acontractile bladder) or can be urethral (bladder outlet obstruction, intermittent involuntary contractions of peri-urethral striated muscle during voiding, detrusor sphincter dyssynergia, non-relaxing urethral sphincter obstruction). Detrusor sphincter dyssynergia and non-relaxing

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