



Information for Women

About Incontinence and Vaginal Prolapse

ACKNOWLEDGEMENTS

This booklet was edited and compiled by the multidisciplinary Pelvic Floor Pathway Working Group of the Saskatchewan Ministry of Health, with significant input from and oversight by gynecologists, urologists, family physicians, women's health nurse practitioners and pelvic floor physical therapists from the Saskatchewan Health Authority.

The contributions of everyone involved, especially patients who reviewed the contents in draft form, helped ensure this resource will serve the needs of patients. The illustrations were created by the Saskatchewan Health Authority's Medical Media Services and are used with permission. Some photos used with permission from Dreamstime and iStockphoto.

See more information:

www.sasksurgery.ca/patient/pelvicfloor.html

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■ Introduction



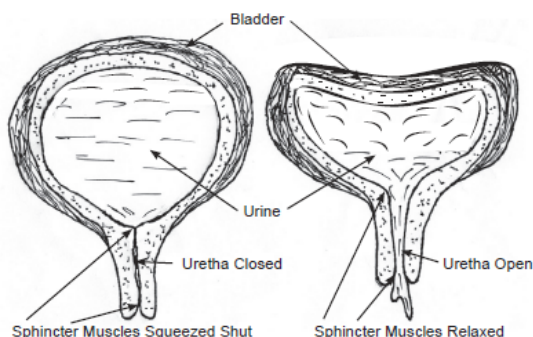
Urinary incontinence (leaking urine) is a common condition that affects about 30% of adult women. Sometimes women also have other problems like a bulge or pressure in the vagina (prolapse). This booklet explains what these things are, what causes them, and what can be done to help.

If you have any of these problems, this booklet is a good way to start learning more about them. Speak to a doctor or member of the Pelvic Floor Pathway Team to get a personal diagnosis or treatment.

Part 1 - Understanding the Problem

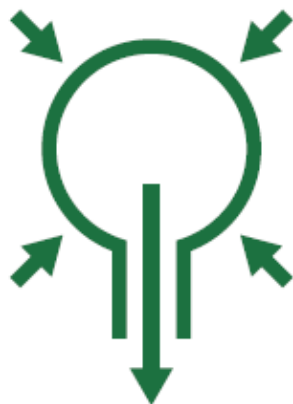
HOW THE BLADDER WORKS

In your body, urine is stored in an organ called the bladder. Your bladder is relaxed most of the time. When you want to urinate, your brain tells your bladder to contract, sending the urine out.



WHAT IS INCONTINENCE?

Urinary incontinence means that you leak urine when you don't want to. About one third of women sometimes leak urine. Some women leak only a little, and some may leak a lot. Not all women feel that leaking is a serious problem for them.



There are two main reasons why women leak urine: **stress incontinence** and **urge incontinence**.

If pressure from outside squeezes the urine out of the bladder, that is stress incontinence

Stress incontinence means you leak urine when you cough, sneeze, exercise, bend over or lift heavy objects. This leakage happens because these events cause an increase of physical pressure on your bladder.



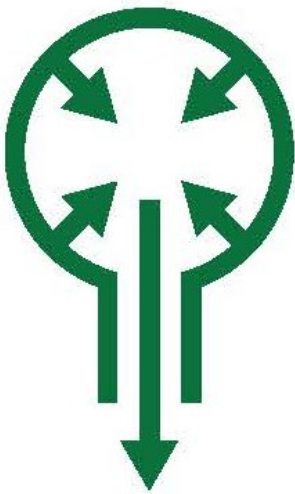
Coughing or sneezing increases the physical pressure on your bladder.

With stress incontinence, the problem is that the muscles and tissues in your pelvic floor are not strong enough to resist external pressure. When extra pressure is placed on the abdomen from activities like coughing, laughing, jumping or lifting, urine is forced past the muscles that keep the urethra closed. This can happen when the muscles in your pelvic area are weakened by having babies, by chronic constipation requiring straining, by obesity, or simply by getting older.

PART I: UNDERSTANDING THE PROBLEM

Urge incontinence is when you feel an urgent need to pass urine and you are unable to make it to the toilet in time. Your bladder is contracting when you don't want it to! You may have little or no warning that this is going to happen, or you may have a sudden strong need to urinate. There may be triggers that cause this urgency, such as hearing running water, feeling chilled, arriving at your house door, or standing up from a chair or bed. People with urge incontinence may also need to urinate often and get up several times in the night. With urge incontinence, the problem is an overactive bladder muscle.

Many women have a combination of stress and urge incontinence called ***mixed incontinence***. It is good to know what kind of incontinence you have because the causes and treatments are different.



If your bladder suddenly contracts on its own, that is urgency; if urine leaks out, that is urge incontinence

WHAT IS NORMAL?

An average woman urinates up to 7 times during the day (about every 2-3 hours). It is normal to get up once in the night to urinate, and twice as you get older.

Normal bladder capacity is 300 –600 ml (250ml = 1cup)

Normal fluid intake is about 6-8 cups of water or other drinks per day. Drinking more or less than this amount can make leaking worse. Drinks that have caffeine, like tea, coffee and colas, can also make leaking worse because they irritate the bladder.

Fecal incontinence means an unwanted leakage of bowel contents – gas, liquid or solid stool. Some women have problems with both fecal and urinary incontinence. This can be because of pelvic floor muscle weakness.

PART I: UNDERSTANDING THE PROBLEM

WHAT IS VAGINAL PROLAPSE?

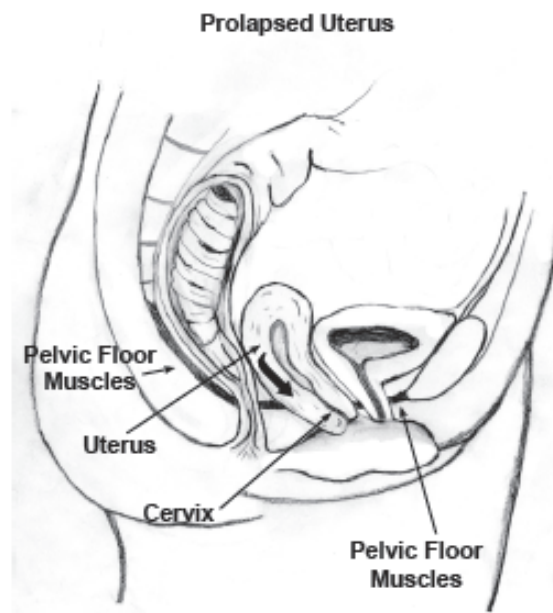
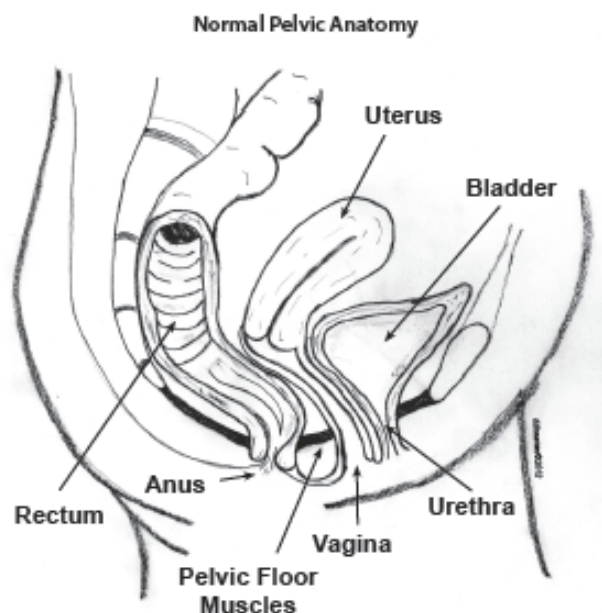
A **vaginal prolapse** can happen when the tissue and muscles inside the pelvis become weak. This weakness allows the vagina, uterus, bowel or bladder to come down. Imagine a sock turning itself inside out.

The main symptom of vaginal prolapse is a bulge between the legs that you can see or feel. It may go in and out of the vagina depending on whether you are standing, sitting or lying down. It feels bigger with activities that put pressure on the area such as lifting, coughing, straining with bowel movements, and in the evening after being upright all day. Prolapse may stay the same size for long periods

or it may get bigger over time. For a few, the bulge becomes smaller and less noticeable.

Prolapse happens because of weakness, damage or stretching of the support structures at the bottom of the pelvis that hold your organs in. These muscles are called the “pelvic floor.” Although it can occur in any woman, prolapse is often caused by having babies, increasing age and obesity. Other factors that may stretch or weaken pelvic tissues include constipation, chronic cough or long-term heavy lifting.

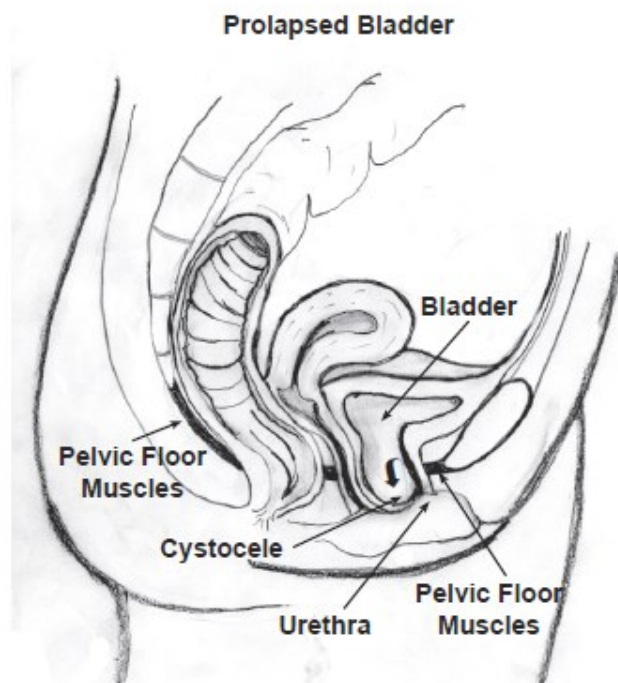
Prolapse does not usually cause pain or constipation, but it can be uncomfortable and may affect the bladder, bowel and sexual function.



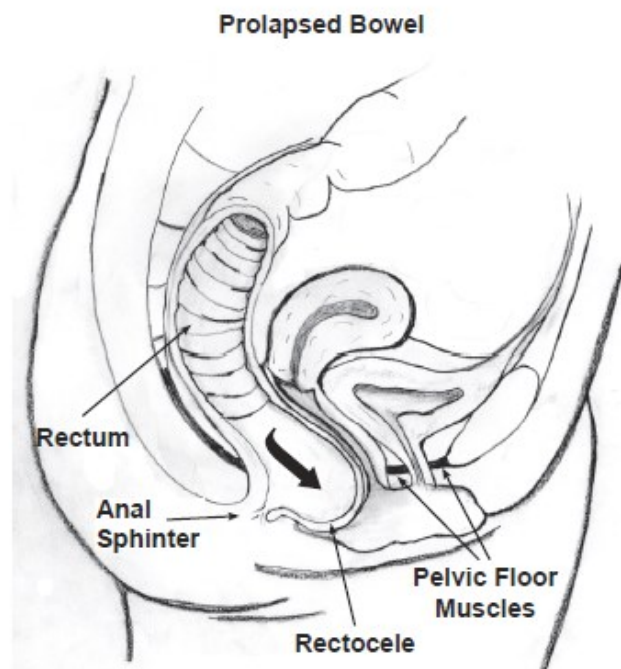
Illustrations courtesy Medical/Media Services, Saskatchewan Health Authority.

PART I: UNDERSTANDING THE PROBLEM

Prolapsed bladder (cystocele): When the bladder collapses into the vagina, it can make it harder to empty the bladder completely when you urinate. Incomplete bladder emptying can cause bladder infections. Some women with bladder prolapse also have urinary incontinence.



Prolapsed bowel (rectocele): When the bowel collapses into the vagina from behind, stool can go in the wrong direction with straining. This can cause incomplete emptying of the bowel. Some women may need to push on the prolapse with their fingers in the vagina to help empty the bowel. Changing the stool consistency, aiming for soft, formed stool and avoiding constipation, plus learning correct evacuation postures and techniques can help relieve some of these symptoms.



Sexual function: When prolapse is present, it is the walls of the vagina that collapse inward and create a bulge between the legs. Some women find that the prolapse gets in the way of sexual intercourse. The woman or her partner may worry about hurting the woman or making the prolapse worse, but this is not

the case. Intercourse is safe, even when prolapse is present. If intercourse is painful, it may be related to other factors, such as vaginal dryness related to menopause.

Part 2 - Treatment Options

SELF MANAGEMENT

A. LIFESTYLE CHANGES

With **urge incontinence**, the problem is an overactive bladder muscle. Urge incontinence can be improved by reducing things that irritate the bladder. This may involve lifestyle changes such as avoiding caffeine (e.g. coffee, tea and colas) and other irritants such as alcohol, cigarettes, artificial sweeteners, spicy foods and citrus. Regular toileting every two-to-three hours may also help some women with urge incontinence to prevent episodes of leaking.



Caffeine content of some common foods and drinks

Product	Serving Size (unless otherwise stated)		Milligrams of Caffeine (approximate values)
	oz	ml	
Coffee, filter drip	8	237	179
Coffee, decaffeinated	8	237	3
Tea (leaf or bag)	8	237	50
Green tea	8	237	30
Decaffeinated tea	8	237	0
Cola beverage, regular	12	355 (1 can)	36 - 46
Cola beverage, diet	12	355	39 - 50
Chocolate milk	8	237	8
Candy bar, milk chocolate	1	28g	7
Baking chocolate, unsweetened	1	28g	25 - 58
Chocolate cake	2.8	80g	36
Chocolate pudding	5.1	145g	9

Source: Health Canada (www.hc-sc.gc.ca)

Stress and urge incontinence, and fecal incontinence, can be improved by changes like:








- Achieving a healthy weight by eating a nutritious diet and getting regular exercise,
- Drinking six-to-eight cups of fluid per day, two-thirds of which should be water.
- Avoiding constipation.

PART II: TREATMENT OPTIONS

Fecal incontinence (leaking stool) can improve with:

- Dietary changes to improve stool consistency
- Pelvic floor muscle strengthening
- Correct toileting techniques

The Bristol Stool Form Scale (shown here) describes the different types of stool form or consistency. Types 1 and 2 are hard, constipated stool which can be difficult to pass. Types 3 and 4 are soft, formed, normal stool which are easy to pass. Types 5, 6 and 7 are loose and very difficult to control especially if there is weakness in the pelvic floor and anal sphincter muscles. The desired stool form is Type 3 or 4.

BRISTOL STOOL FORM SCALE		
Type 1		Separate hard lumps like nuts (difficult to pass)
Type 2		Sausage shaped but lumpy
Type 3		Like a sausage but with cracks on surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces (entirely liquid)

PART II: TREATMENT OPTIONS

B. BLADDER RETRAINING

If you have *urgency/urge incontinence* there are some things that you can do for yourself to control the leaking. For example, you can change what you eat and drink to help reduce irritation of the bladder, as explained in the previous section. You can also learn to control the bladder muscle better. This is called “bladder retraining.”

Urge suppression and bladder retraining

When your bladder muscle contracts, the urge to urinate is strong and uncomfortable. The common reaction is to rush to the bathroom as soon as possible. But you can retrain your bladder to wait, if you consciously try to suppress the urge. The feeling of urgency comes in waves. It starts, grows, peaks and fades away. This can take a few minutes. When you feel the urge to urinate:

1. Stop what you are doing and **be still**.
2. Sit down and **squeeze** your pelvic floor muscles. This technique is referred to as “freeze and squeeze.”

3. Take a few deep breaths and **relax** your body and mind.
4. **Distract** your mind by counting backwards, saying the alphabet, reciting nursery rhymes etc.
5. When the urge subsides, calmly **walk to the toilet**.

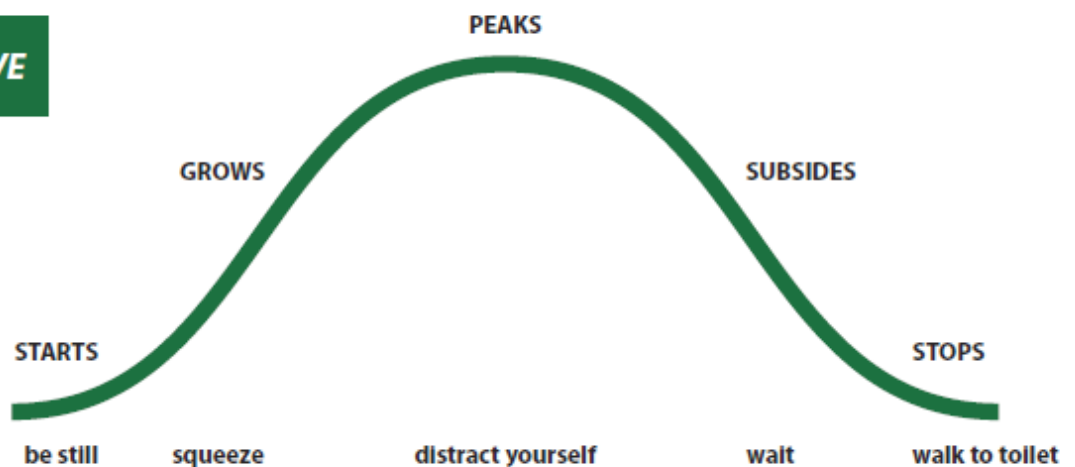
If you have common triggers for urge incontinence (e.g. hearing running water or putting your key in the door), you can use this technique to manage the urge and break the habit. Practice squeezing the muscles at the same time you are confronted with the trigger. With practice, urge suppression becomes easier and more successful.

Self care may stop you from leaking as often, but it probably will not stop the leaking completely. You may still wear pads, just in case.

USING INCONTINENCE PADS

If you wear pads all the time or most of the time, you should use a barrier cream to prevent irritation.

THE URGE CURVE



PART II: TREATMENT OPTIONS

C. PELVIC FLOOR MUSCLE EXERCISES

Strong pelvic floor muscles give us control over our bladder and bowel, and support our organs in the pelvis. Strengthening the pelvic floor muscles can improve stress and urge incontinence and pelvic organ prolapse.

What is the pelvic floor?

The pelvic floor muscles stretch like a trampoline from the tailbone (coccyx) to the pubic bone (back to front) and from one sitting bone to the other (side to side). These muscles are normally firm and thick.

The bladder, uterus and bowel lie on top of the pelvic floor muscle layer. There are three openings in the pelvic floor layer for the urethra (the tube from the bladder), the vagina, and the anus (opening from the bowel) to pass through. The pelvic floor muscles normally wrap firmly around these openings to keep them closed. There is also an extra circular muscle around the anus (anal sphincter) and the urethra (urethral sphincter) to help with the closure.

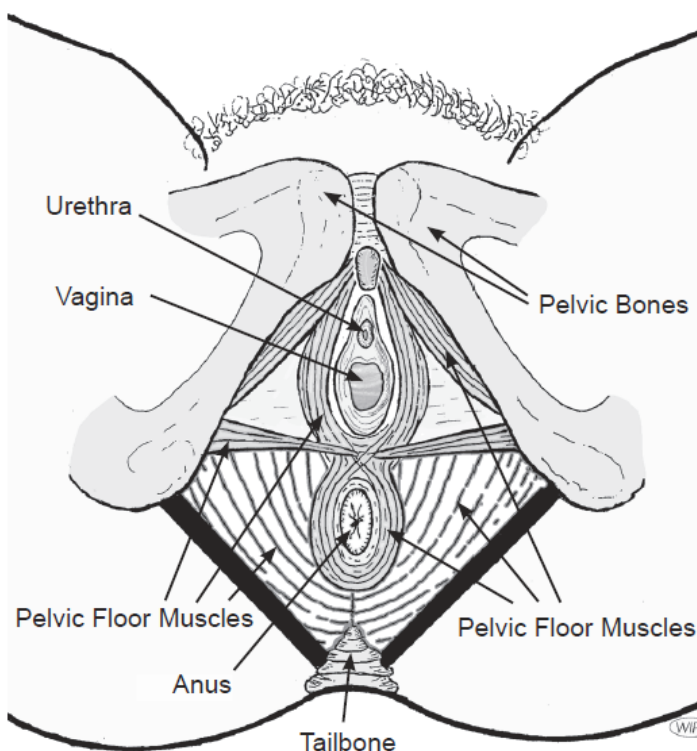
When the pelvic floor muscles are contracted, the pelvic organs are lifted and the sphincters tighten, closing the openings of the vagina, anus and urethra.

Pelvic floor exercises

Special exercises, sometimes called **Kegel exercises**, help to strengthen the muscles of the pelvic floor. You can do these exercises at home by yourself. Many women find that coaching from a specially trained physiotherapist helps them to learn the exercises properly and get them off to a good start.

Finding the right muscles:

Imagine that you are trying to stop your urine flow or are trying to hold back gas. You should feel your vagina and your anus tighten. Lie down and insert a clean, moist finger into the vagina. Tighten the pelvic floor muscles. You should feel a squeeze around your finger.



PART II: TREATMENT OPTIONS

Doing the exercises:

1. Start by doing the exercises lying down with your knees bent.
2. Squeeze your pelvic floor muscles. Hold for five to 10 seconds. Relax for 10 seconds. Work your way up to repeating this exercise 5 to 10 times.
3. You may only be able to hold for a few seconds to start. That's okay. Start there and work your way up.
4. Repeat these exercises two or three times a day.
5. Challenge yourself! Do these exercises in sitting or standing positions, while you walk, sidestep or jump. Increase the repetitions and decrease the rest time.

If you are doing exercises yourself at home, here are some tips:

- Make sure that you are using the pelvic floor muscles only, not the legs or buttocks.
- Avoid holding your breath when doing these exercises.

Get the knack

Use the pelvic floor when you need it most. Squeeze before you cough, sneeze, laugh or lift something heavy. This is called “the knack.”

Tips for remembering to sneak in a squeeze:

- Try to link your pelvic floor exercises with certain activities: morning and bedtime, watching television, waiting at red lights.
- Red dots: put stickers in places to remind you to do your exercises. For example, put one on the bathroom mirror, rearview mirror, bedside table or t.v.

Keep it up

Do the exercises regularly and don't give up! It may take three to six months to see full results. You may test your pelvic floor strength once a month by trying to stop your flow of urine, but **do not** do your exercises while you empty the bladder. That might confuse the bladder.



PART II: TREATMENT OPTIONS

PELVIC FLOOR PHYSICAL THERAPY

If you are having difficulty with the exercises or you are not getting the results you had hoped for, you may be doing the exercises incorrectly. Research shows that 50 per cent of women cannot learn pelvic floor muscle exercises from hearing or reading instructions. For those who need individual coaching and support, there are **specially trained physical therapists** who can help.

The therapist will perform a physical evaluation, including a vaginal examination, to assess your pelvic floor function and tailor an exercise program



to meet your specific needs. In addition to teaching you how to isolate and correctly perform your pelvic floor muscle exercises in one-on-one sessions, the physical therapist will give you a comprehensive home program of exercises for:

- Pelvic floor muscle strengthening
- Abdominal (core) muscle strengthening
- Posture correction.

The physical therapist will also teach you:

- strategies and techniques to prevent urine leaks due to coughing, laughing, sneezing, bending, lifting and more vigorous activities
- strategies and techniques to help you control/ defer bladder urgency
- toileting techniques to help you completely empty your bladder if you are having difficulty doing so and to have bowel movements without straining

And will

- Provide you with information and support for lifestyle changes that will help you to reduce incontinence and symptoms of prolapse.

Sixty to 75 per cent of women who participate in pelvic floor physical therapy programs are satisfied with the results.

There are no side effects but you must continue with the exercises or lifestyle changes or symptoms will return.

PART II: TREATMENT OPTIONS

MEDICATIONS FOR URGE INCONTINENCE

Medications used to treat urgency and urge incontinence work to relax the overactive bladder and reduce the unwanted bladder contractions. Medications are NOT available for stress incontinence or prolapse. Medications may decrease episodes of urge incontinence by 50-60 per cent. If it is successful, medication is a long term treatment. You will only see improvement as long as you are taking the medication.

There are several different medications that can be used for urge incontinence. You may see improvement within a few days. Your condition may keep improving for up to a month after starting the medication.

The number of medications for urge incontinence has increased over the last 10 years, and more options will become available with time. If initial medical treatment is not satisfactory, discuss other options with your care provider.

Types of medication

Oxybutinin is a common medication for incontinence. Your doctor will probably recommend it first. If you respond to oxybutinin, your doctor can adjust the dose to your symptoms. It might take some time and patience to find the right dose.

<i>Drug</i>	<i>Trade name</i>
oxybutinin	Ditropan, Ditropan XL, Uromax, Oxytrol Gelnique
tolterodine	Detrol LA
fesoterodine	Toviaz
darafenacin	Enablex
solifenacin	Vesicare
tropium	Trosec
mirabegron	Mirbetriq

Oxybutinin is fast acting and lasts about 8 hours, so it is sometimes used on an as needed basis (such as when you are going out, going to work or traveling). If symptoms are only bothersome at night, you may use it before going to bed. If symptoms are only bothersome in the day, you may use it in the morning or twice per day.

Your doctor will ask you if you have any side effects from the oxybutinin. If there are side effects, or if the medication is not helping, there are other medications you can try. Don't hesitate to tell your doctor if you have any concerns.

Managing medications:

If your medication is doing a good job of controlling your incontinence, you may choose to live with some of the side effects. Most side effects are not serious, and will go away when the medication is stopped.

The most common side effect of this type of medication is dry mouth. Some people notice dry eyes or nasal passages. Dry mouth may be reduced by lowering the dose or trying things that improve the flow of saliva (sugarless gum or candy and over the counter saliva substitute sprays or gels). Constipation, stomach upset and drowsiness can also occur.

Your doctor will not prescribe this type of medication for you if you have certain underlying medical conditions. These include gastroparesis (a problem emptying the stomach), some types of glaucoma, rhythm problems of the heart, or dementia. If these problems start when you are using the medication, stop taking it and see your doctor.

PART II: TREATMENT OPTIONS

PESSARY

A pessary is a silicone disc or ring that is specially fit for you by a doctor or nurse. The pessary is inserted into the vagina (like a tampon) where it helps to support the pelvic organs and stop them from coming down (*vaginal prolapse*).

A pessary can also be used to treat **stress Incontinence**, because it puts gentle pressure on the urethra (tube that drains the bladder) to help it stay closed. About two-thirds of women find that a pessary helps.

Some women try a pessary while they wait for stress incontinence or prolapse surgery, and others use a pessary to avoid surgery.

Most women can wear a pessary safely for several days at a time. Pessaries can be left in for most activities of daily life, but should be removed for sexual activity.

Using a pessary

You will be fitted with a pessary that is the right size and shape. It might take a few tries to find a pessary that will provide support without causing discomfort or slipping out. You will be taught to insert and remove the pessary on your own. A string can be attached to the pessary to assist with removal.

Your doctor might prescribe low dose estrogen cream to use for keeping your vaginal tissue healthy.

You will be instructed to remove your pessary once or twice weekly. For example, remove it overnight on Monday and Thursday every week. If you are menopausal and do not use estrogen, removal of your pessary is recommended every night.

On the evenings when the pessary is removed, you may use your estrogen and prepare the pessary for insertion the following morning.

Pessary care

The pessary is washed with mild soap (avoiding perfumes) and rinsed well. After drying, a new string may be attached, so the pessary is ready to be reinserted the following morning. Boiling or sterilizing the pessary is not necessary.

Over time, pessaries may become discoloured. They only require replacement if cracks develop on the surface.

You will be asked to return for a follow up check after using a pessary for two to four weeks.



It might take a few tries to find a pessary that provides supports without causing discomfort. (Photo courtesy Superior Medical Limited.)

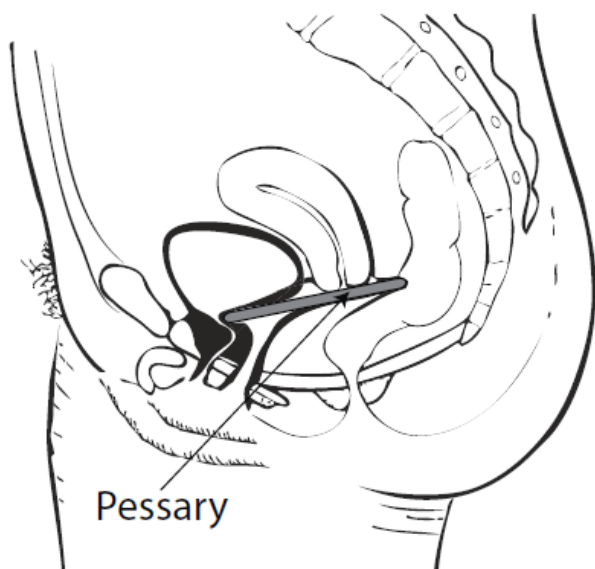
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PART II: TREATMENT OPTIONS

Is there a risk to using a pessary?

A pessary is very safe when users follow the instructions for care and management. The main risk of using a pessary is the development of an infection or erosion (ulcer) in the vagina which can result in bleeding or a foul smelling discharge. You should see your doctor if you develop these symptoms. A rest from using the pessary may be necessary.

Because emergencies may occur where a woman is not able to speak for herself, she should let someone close to her know about her pessary use so it can be removed.



PART II: TREATMENT OPTIONS

SURGERY FOR STRESS INCONTINENCE

Surgery will cure or reduce stress incontinence in at least eight out of 10 women. However, many women have both stress and urge incontinence. Even if stress incontinence goes away, they may continue leaking because of urge incontinence. This is not a failure of the surgery.

Medical technology is always changing, and new operations are frequently introduced. Right now the most common form of stress incontinence operation is a *vaginal tape* (mesh tape placed under the urethra to help keep it closed). When done alone, this procedure is usually day surgery (come to hospital and go home the same day).

If you are interested in surgery, you will meet with a surgeon to discuss your condition. The surgeon will describe the surgical options available, and the type of operation he/she thinks is best for you.

About surgery

Surgery can be done under local, spinal, or general anesthetic. With local or spinal anesthetic only the nerves of your pelvic area are frozen. With general anesthetic you are given medication to relax your whole body and put you to sleep during surgery. Your questions about anesthetic can be answered at your pre-admission clinic visit or by your surgeon.

Risks of surgery

Risks of any surgery include infection at the surgical site, bleeding, damage to surrounding structures and anesthetic-related risks.

Surgery for stress incontinence may cause the stream of urine to slow down. This is not considered a significant problem. However, there is a small risk that the surgery will actually make it difficult for a woman to urinate. This problem is usually temporary, and requires the women to urinate by inserting a catheter (tube) into her bladder. If the problem doesn't go away soon, a second surgery might be required, but this is rare.

In rare cases, surgery for stress incontinence can cause urge incontinence to get worse.

Operations that use mesh or other artificial material may have problems such as exposure of the mesh, pain, or infection. In very rare cases, this may require removal of part or all of the material.

Pre-admission clinic visit

This visit, if required, takes place prior to your surgery date. Nurses review your history, answer questions, and perform necessary tests. You may be taught how to put a catheter (tube) inside your bladder. You may also see an anesthetist or other medical specialist.

PART II: TREATMENT OPTIONS

If you are using medication for urge incontinence you may be asked to stop the medication a day or two before your surgery. Be sure to ask your surgeon about use of bladder medications around the time of your surgery.

Postoperative care

- You may have pain in your incisions anywhere from a few days to a few weeks.
- Do not have vaginal intercourse for one month.

- Do not lift more than 10 lbs or perform heavy work for one month. Time off work depends on your type of work and the type of surgery performed.
- You cannot drive until you can safely give all your attention to the road without pain or sedation from medications. You will need a ride home from the hospital.

Your questions can be answered at your pre-admission clinic visit or by your surgeon.



Your questions can be answered at your pre-admission clinic or by your surgeon.

PART II: TREATMENT OPTIONS

SURGERY FOR VAGINAL PROLAPSE

Surgery will cure prolapse in about seven out of 10 women who choose this treatment. On average, three out of 10 women who have surgery will have a second surgery for prolapse at some point in the future.

The type of surgery you need depends on the organs that need to be repaired. In addition to lifting prolapsed organs such as the bladder or bowel, your surgeon might recommend removing the uterus (hysterectomy) or lifting the top of the vagina (vault suspension). Surgery for prolapse can also be combined with surgery for stress incontinence.

If you are interested in surgery, you will meet with a surgeon to discuss your condition. The surgeon will talk to you about your condition and the type of operation he/she thinks is best for you.

About the surgery

Prolapse surgery usually is done through the vagina but depending on the anatomy of the patient and the training of the surgeon, it may be done through the abdomen. After prolapse surgery, patients are typically in hospital for one to three days. Depending on the operation planned, a patient may occasionally be scheduled as day surgery.

Risks of surgery

Risks of any surgery include infection at the surgical site, bleeding and damage to surrounding structures (bladder and bowel). There is also small risk of nerve

injury related to your position during surgery, blood clot in the legs/lung, medical complications (such as pneumonia and cardiac problems), and anesthetic related risks.

There is a small risk that prolapse surgery will make it difficult for a woman to urinate. This problem is usually temporary, and requires the women to urinate by inserting a catheter (tube) into her bladder. In rare cases, surgery for prolapse can cause onset of urinary incontinence. Another risk of prolapse surgery is short or long term pain with intercourse.

Pre-admission clinic visit

This visit, if required, takes place prior to your surgery date. Nurses review your history, answer questions, and perform tests. You may be taught how to put a catheter (tube) inside your bladder. You may also be seen by an anesthetist or other medical specialists.

Postoperative care

- If you have a catheter, it may be removed in hospital, or you may come back to have your catheter removed following your discharge.
- Vaginal discharge and irregular small amount of bleeding are common during your recovery.
- Pain typically lasts for a few weeks, but depends on the surgery performed and the patient.
- Do not have vaginal intercourse until examined by your surgeon at your postoperative visit.
- Do not lift more than 10 pounds or perform heavy work for six weeks. Time off work depends on your type of work and the type of surgery performed.

- You cannot drive until you can safely give all your attention to the road without pain or sedation from medications. You will need a ride home from the hospital.

■ Part 3 - Do I Want to Seek Treatment?

THE FIRST DECISION: TREATMENT OR NOT?

Treatments are available for incontinence and prolapse, but it is up to you to decide whether you want to seek treatment or not. Incontinence and prolapse are not life-threatening conditions. Your symptoms may or may not get worse as you get older. The decision depends on how bothersome your symptoms are.

Use this worksheet to help you work through the decision.

Decision: Do I want to seek treatment or not?

1. What is your reason for making this decision _____

2. When do you need to make a choice? _____

3. How far along are you with making a choice?

- ☐ I have not yet thought about the options ☐ I thinking about the options
☐ I am close to making a choice ☐ I have already made a choice

4. How much do the symptoms of incontinence or prolapse affect your...

(Circle best answer to each question.)

<i>Ability to perform tasks in your workplace or household?</i>	Not at All	Slightly	Moderately	Greatly
<i>Ability to take part in physical recreation or exercise?</i>	Not at All	Slightly	Moderately	Greatly
<i>Entertainment or participation in social activities?</i>	Not at All	Slightly	Moderately	Greatly
<i>Ability to travel more than 30 minutes from home?</i>	Not at All	Slightly	Moderately	Greatly
<i>Sex life?</i>	Not at All	Slightly	Moderately	Greatly
<i>Emotional health (nervousness, depression, etc.)?</i>	Not at All	Slightly	Moderately	Greatly
<i>Other _____</i>	Not at All	Slightly	Moderately	Greatly

* adapted from IIQ-7

5. Overall, how much do your symptoms affect your quality of life?

Not at All Slightly Moderately Greatly

6. What is your preferred option?

- ☐ Seek treatment: get a referral to the pathway clinic
☐ No treatment at this time: you may want to revisit the decision in six months to one year
☐ Not sure: discuss with your primary care provider and call the clinic within one month

■ Part 4 - Assessment & Diagnosis

THE NEXT STEP

If you decide to seek treatment for your condition, the next step is assessment by your doctor or gynecologist, or referral to a Pelvic Floor Pathway Clinic.

You will be asked to bring some information to your first appointment. You may receive a package of forms, including:

- ☐ a medical history form
- ☐ a three-day bladder diary (asking you to record the type and amount of fluid you drink, the time and amount of urine voided, and amount and number of times you experience urine leakage over a three-day period)
- ☐ questionnaires about your symptoms and how they affect your quality of life

Your full cooperation is required in completing these forms and bringing them to your assessment appointment.

At your assessment the health care provider will:

- ☐ Go over your forms and history
- ☐ Discuss your problem with you
- ☐ Perform a targeted physical exam **including a pelvic examination** to assess for prolapse and pelvic floor muscle strength

The health care provider will help you compare treatment options open to you and choose from:

- ☐ Pelvic floor physical therapy
- ☐ Medication
- ☐ Pessary
- ☐ Surgery

Any treatment will involve further appointments, and some will require more detailed tests and pelvic examinations. For some programs, wait times may apply.



■ Part 5 - Selecting a Treatment

SELECTING A TREATMENT

Once you have a complete assessment and a detailed diagnosis, you will be ready to make a treatment choice. Whether you are affected by urge incontinence, stress incontinence, vaginal prolapse, or a combination of all three, you will find that there are several treatment options available. Your health care provider will help to explain about your condition and the treatment options, but the decision about treatment is made by you.

It can be hard to make a choice when there are several good options available. It is a good idea to make a list of all the treatment options for your condition, and gather information about the positives and negatives of each option. On the following pages, you will find charts that summarize the pros and cons of each treatment discussed in this booklet. You may want to get information from other trusted sources, too. Make a list of any questions you want to ask when you meet your health care provider.

Once you have reviewed all the information about treatment options, you might be able to eliminate some options. On the charts provided, you can check the “pros” that are very important to you, or the “cons” that are not acceptable. Then you can make a tentative decision about which treatment you want to try.





A health care provider will also help you through the steps of this decision-making process and let you know if your options are limited by your physical condition and/or your medical history. Explain to your health care provider which treatment you tentatively selected, and why. Your health care provider wants you to make an informed choice that is right for you.



Once you have selected a treatment, please do your best to follow instructions and put effort into improving your condition. But if the treatment you select doesn't seem to be helping, you can begin the decision making process again.

PART V: SELECTING A TREATMENT

Comparing Treatment Options for Stress Incontinence

Self-Care 	Pros <ul style="list-style-type: none"> <input type="checkbox"/> Improves leaking in about 50% of women <input type="checkbox"/> Learning "the knack" of contracting muscles before a cough or sneeze may show improvement quickly <input type="checkbox"/> Changes to exercise and diet have other health benefits <input type="checkbox"/> No cost involved <input type="checkbox"/> No risk involved 	Cons <ul style="list-style-type: none"> <input type="checkbox"/> Does not improve leaking in about 50% of women <input type="checkbox"/> Involves changes in lifestyle and behavior which can be difficult for some people <input type="checkbox"/> Changes must be maintained or improvements will be lost <input type="checkbox"/> Requires motivation to get the best effect
Pelvic Floor Physical Therapy 	Pros <ul style="list-style-type: none"> <input type="checkbox"/> 60 -70% of clients are satisfied with results <input type="checkbox"/> May show improvement quickly, when used with behavior management. <input type="checkbox"/> Possible improvement in sexual sensation <input type="checkbox"/> No risk involved <input type="checkbox"/> Public programs are offered at no cost in Pelvic Floor Pathway clinics and in some other communities. 	Cons <ul style="list-style-type: none"> <input type="checkbox"/> 30-40% of clients are not satisfied with results <input type="checkbox"/> Takes 3-6 months to see the full effect <input type="checkbox"/> Requires commitment to attending sessions and doing daily exercises <input type="checkbox"/> Exercises must be continued or improvements will be lost <input type="checkbox"/> Wait times may apply for public programs <input type="checkbox"/> Cost of private physiotherapy services is paid by the patient, unless covered by private insurer
Pessary 	Pros <ul style="list-style-type: none"> <input type="checkbox"/> Effective for stress incontinence in 66% of women <input type="checkbox"/> Immediately effective <input type="checkbox"/> Minimal risk if used correctly <input type="checkbox"/> May be used in pregnancy and childbearing years. <input type="checkbox"/> Insert and remove by yourself <input type="checkbox"/> May be used "as needed" (e.g. for sports, travel or special events) 	Cons <ul style="list-style-type: none"> <input type="checkbox"/> Not effective for stress incontinence in 34% of women <input type="checkbox"/> Not all women can be successfully fitted with a pessary <input type="checkbox"/> Wait time may apply for pessary fitting and follow up visit. <input type="checkbox"/> May require extra visits to answer questions and check fit <input type="checkbox"/> May need to switch size to obtain best effect <input type="checkbox"/> Leaving the pessary in longer than suggested may lead to vaginal ulcers, bleeding and discharge <input type="checkbox"/> Must be removed twice a week and for intercourse <input type="checkbox"/> Cost of pessary, topical estrogen is paid by the patient, unless covered by private insurance
Surgery 	Pros <ul style="list-style-type: none"> <input type="checkbox"/> 80-90% symptoms of stress incontinence cured (slightly lower in those who have had previous surgery) <input type="checkbox"/> Immediately effective <input type="checkbox"/> Results are permanent in most cases <input type="checkbox"/> May be combined with prolapse surgery <input type="checkbox"/> Cost of surgery covered by public health plan 	Cons <ul style="list-style-type: none"> <input type="checkbox"/> 10-20% of women not cured (slightly higher in those who have had previous surgery) <input type="checkbox"/> Small risk (<5%) of long-term difficulty emptying bladder <input type="checkbox"/> Small risk of pain with intercourse requiring removal of mesh <input type="checkbox"/> Small surgical risk related to anesthetic, infection, other damage <input type="checkbox"/> Not recommended to have children following surgery <input type="checkbox"/> Wait times may apply <input type="checkbox"/> Possible hospital stay <input type="checkbox"/> Postoperative pain (a few days to a few weeks) <input type="checkbox"/> No lifting or intercourse for 30 days <input type="checkbox"/> May need to be off work for a time

PART V: SELECTING A TREATMENT

Comparing Treatment Options for Urge Incontinence

Self-Care 	Pros <ul style="list-style-type: none"> <input type="checkbox"/> Improves leaking in about 50% of women <input type="checkbox"/> Eliminating caffeine shows effects after 1-2 weeks <input type="checkbox"/> Fluid management and toileting management may have immediate effect <input type="checkbox"/> No cost involved <input type="checkbox"/> No risk involved 	Cons <ul style="list-style-type: none"> <input type="checkbox"/> Does not improve leaking in about 50% of women <input type="checkbox"/> Involves changes in lifestyle and behavior, which can be difficult for some people
Pelvic Floor Physical Therapy 	Pros <ul style="list-style-type: none"> <input type="checkbox"/> 60-70% of clients are satisfied with results <input type="checkbox"/> May show improvement quickly when used with freeze and squeeze <input type="checkbox"/> May be able to discontinue urge incontinence medication <input type="checkbox"/> Possible improvement in sexual sensation <input type="checkbox"/> No risk involved <input type="checkbox"/> Public programs are offered at no cost in Pelvic Floor Pathway clinics and in some other communities. 	Cons <ul style="list-style-type: none"> <input type="checkbox"/> 30-40% of clients are not satisfied with results <input type="checkbox"/> Takes 3-6 months to see the full effect <input type="checkbox"/> Requires commitment to attending sessions and doing daily exercises <input type="checkbox"/> Exercises must be maintained or improvements will be lost <input type="checkbox"/> Wait times may apply for public programs <input type="checkbox"/> Cost of private physiotherapy services is paid by the patient, unless covered by private insurer
Medications 	Pros <ul style="list-style-type: none"> <input type="checkbox"/> Improves leaking in 50-60% of women <input type="checkbox"/> Oxybutinin takes 1-2 weeks to see full effect <input type="checkbox"/> Other medications take about 1 month <input type="checkbox"/> Oxybutinin is fast acting and can be used on an occasional basis <input type="checkbox"/> Side effects go away when medication is stopped 	Cons <ul style="list-style-type: none"> <input type="checkbox"/> Does not improve leaking in 40-50% of women <input type="checkbox"/> Side effects include dry mouth, dry eyes, stomach upset, constipation and blurred vision <input type="checkbox"/> Not recommended if pregnant or trying to conceive <input type="checkbox"/> Hassle of remembering to take the medication regularly <input type="checkbox"/> Need to talk to doctor or nurse practitioner frequently until the best medication and dose is determined <input type="checkbox"/> Symptoms return if you stop taking the medication <input type="checkbox"/> Cost of medications is paid by the patient, unless covered by private insurer

PART V: SELECTING A TREATMENT

Comparing Treatment Options for Vaginal Prolapse

Pelvic Floor Physical Therapy 	Pros <ul style="list-style-type: none"> <input type="checkbox"/> Some improvement when mild prolapse is present <input type="checkbox"/> Improvement in bladder and bowel emptying with toileting techniques <input type="checkbox"/> Possible improvement in sexual sensation <input type="checkbox"/> No risk involved <input type="checkbox"/> Public programs are offered at no cost in Pelvic Floor Pathway clinics and in some other communities. 	Cons <ul style="list-style-type: none"> <input type="checkbox"/> Significant improvement of prolapse symptoms is not expected <input type="checkbox"/> Takes 3-6 months to see the full effect <input type="checkbox"/> Requires commitment to attending sessions and doing daily exercises <input type="checkbox"/> Exercises must be continuous or improvements may be lost <input type="checkbox"/> Wait times may apply for public programs <input type="checkbox"/> Cost of private physiotherapy services is paid by the patient, unless covered by private insurer
Pessary 	Pros <ul style="list-style-type: none"> <input type="checkbox"/> Immediate, comfortable relief of vaginal pressure for most women <input type="checkbox"/> Minimal risk if used correctly <input type="checkbox"/> May be used in pregnancy and childbearing years <input type="checkbox"/> Insert and remove by yourself <input type="checkbox"/> May be used "as needed" (e.g. sports, travel, special events) 	Cons <ul style="list-style-type: none"> <input type="checkbox"/> Not all women can be successfully fitted with a pessary <input type="checkbox"/> Wait time may apply for pessary fitting and follow up visit. <input type="checkbox"/> May require 1 or 2 extra visits to answer questions and check fit <input type="checkbox"/> May need to switch size to obtain best effect. <input type="checkbox"/> Leaving the pessary in longer than suggested may lead to vaginal ulcers, bleeding and discharge <input type="checkbox"/> Must be removed twice a week and for intercourse <input type="checkbox"/> Cost of pessary, topical estrogen is paid by the patient, unless covered by private insurer
Surgery 	Pros <ul style="list-style-type: none"> <input type="checkbox"/> 70-75% chance of long term improvement <input type="checkbox"/> Immediately effective <input type="checkbox"/> May be combined with stress incontinence surgery <input type="checkbox"/> Cost of surgery covered by public health plan 	Cons <ul style="list-style-type: none"> <input type="checkbox"/> 25-30% chance of not having long term success <input type="checkbox"/> Small risk (less than 5%) related to anesthetic and surgery <input type="checkbox"/> Small risk of pain with intercourse from narrowing of vagina or tenderness in incisions <input type="checkbox"/> Not recommended to have children following surgery <input type="checkbox"/> Wait times may apply <input type="checkbox"/> 1-3 day hospital stay <input type="checkbox"/> May go home with a catheter <input type="checkbox"/> No lifting allowed for 6 weeks <input type="checkbox"/> No intercourse allowed for 6 weeks <input type="checkbox"/> Need to be off work for 6 weeks



Healthy People, Healthy Saskatchewan

The Saskatchewan Health Authority works in the spirit of truth and reconciliation, acknowledging Saskatchewan as the traditional territory of First Nations and Métis People.

PIER—Patient Information and Education Resource

May 2022