AKTUELLE THERAPIE DER HARNINKONTINENZ

M. Haydter

Wr. Neustadt

Inkontinenz

- Jeglicher unwillkürlicher/ungewollter Harnverlust
- Einteilung nach Art und Schwergrad
  - Stamey Grad 1-3
  - am besten anhand des Kurzzeitpad oder 24 h Pad- Testes

Inkontinenz - Epidemiologie

Weite Variation je nach Erhebung u. Datenlage –
lt. der Europäischen Urologischen Gesellschaft sind

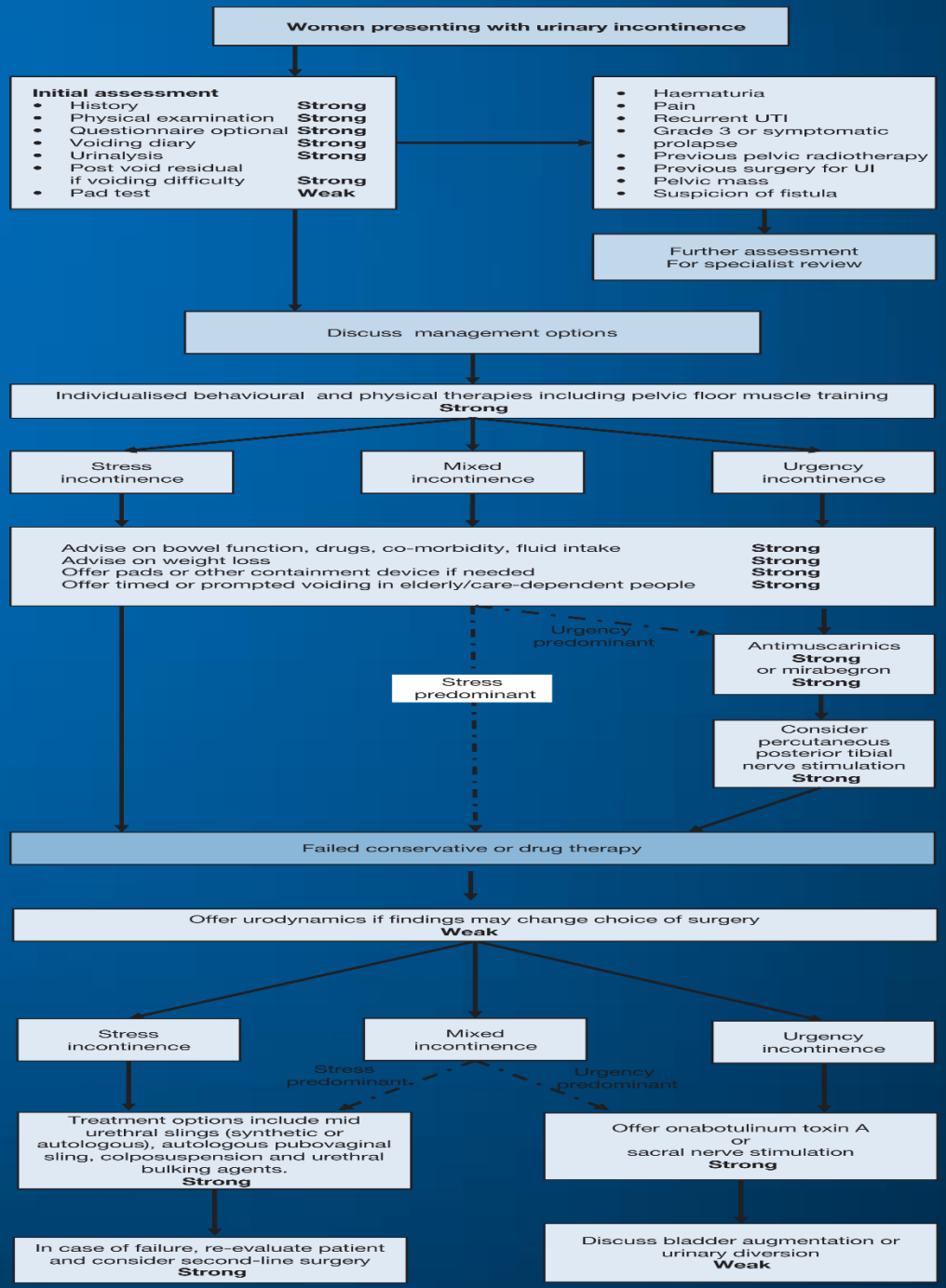
5-69% der Frauen und
1 – 39 % der Männer
betroffen

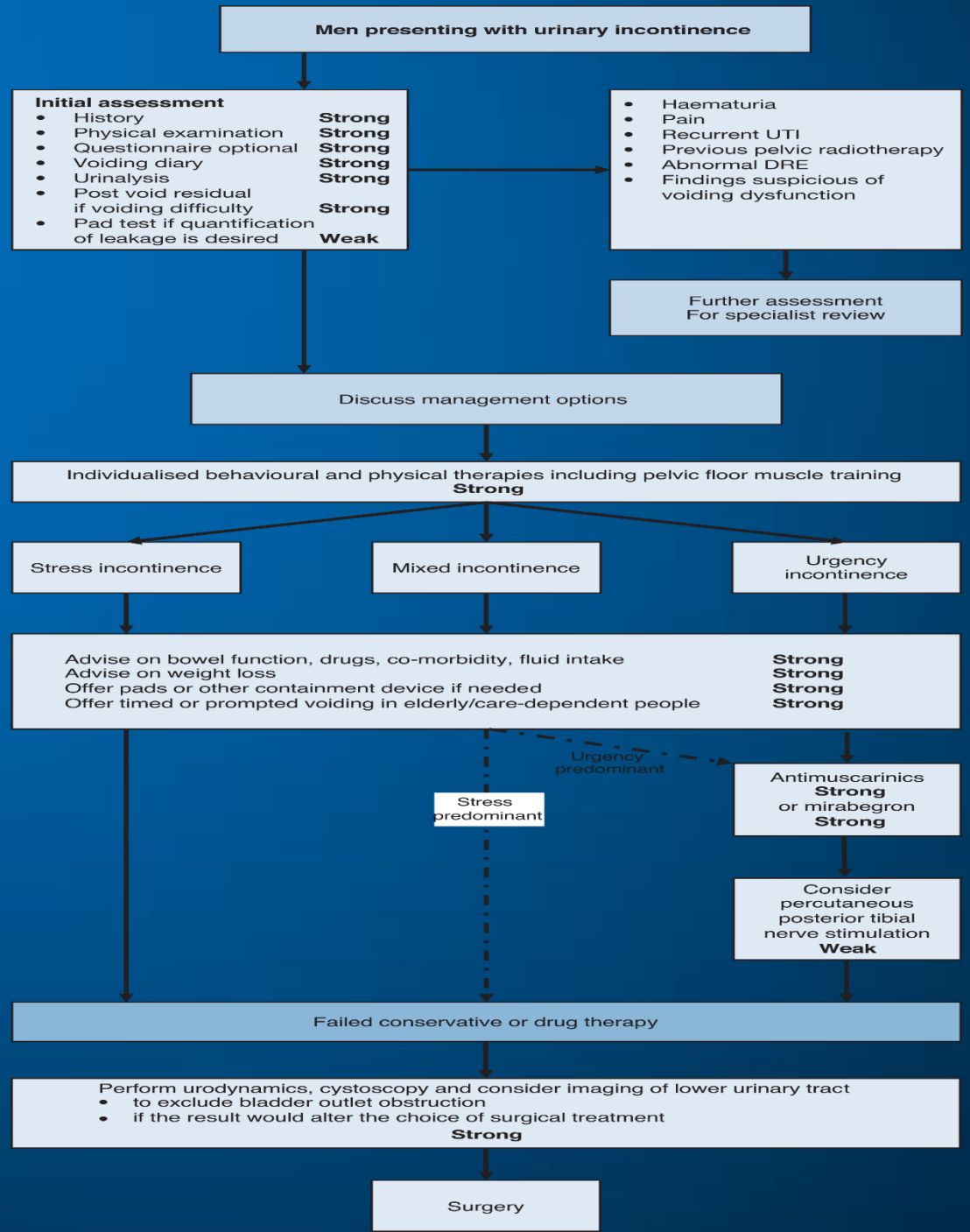
INKONTINENZARTEN

Belastungsharninkontinenz

Mischinkontinenz

Überaktive Blase „nass“ (Dranginkontinenz)


Women presenting with urinary incontinence
Initial assessment
History Strong
Physical examination Strong
Questionnaire optional Strong
Voiding diary Strong
Urinalysis Strong
Post void residual if voiding difficulty Strong
Pad test Weak
Haematuria
Pain
Recurrent UTI
Grade 3 or symptomatic prolapse
Previous pelvic radiotherapy
Previous surgery for UI
Pelvic mass
Suspicion of fistula
Further assessment For specialist review
Discuss management options
Individualised behavioural and physical therapies including pelvic floor muscle training Strong
Stress incontinence
Mixed incontinence
Urgency incontinence
Advise on bowel function, drugs, co-morbidity, fluid intake Strong
Advise on weight loss Strong
Offer pads or other containment device if needed Strong
Offer timed or prompted voiding in elderly/care-dependent people Strong
Urgency predominant
Stress predominant
Antimuscarinics Strong or mirabegron Strong
Consider percutaneous posterior tibial nerve stimulation Strong
Failed conservative or drug therapy
Offer urodynamics if findings may change choice of surgery Weak
Stress incontinence
Mixed incontinence
Urgency incontinence
Stress predominant
Urgency predominant
Treatment options include mid urethral slings (synthetic or autologous), autologous pubovaginal sling, colposuspension and urethral bulking agents. Strong
Offer onabotulinum toxin A or sacral nerve stimulation Strong
In case of failure, re-evaluate patient and consider second-line surgery Strong
Discuss bladder augmentation or urinary diversion Weak


Men presenting with urinary incontinence
Initial assessment
History Strong
Physical examination Strong
Questionnaire optional Strong
Voiding diary Strong
Urinalysis Strong
Post void residual if voiding difficulty Strong
Pad test if quantification of leakage is desired Weak
Haematuria
Pain
Recurrent UTI
Previous pelvic radiotherapy
Abnormal DRE
Findings suspicious of voiding dysfunction
Further assessment For specialist review
Discuss management options
Individualised behavioural and physical therapies including pelvic floor muscle training Strong
Stress incontinence
Mixed incontinence
Urgency incontinence
Advise on bowel function, drugs, co-morbidity, fluid intake Strong
Advise on weight loss Strong
Offer pads or other containment device if needed Strong
Offer timed or prompted voiding in elderly/care-dependent people Strong
Urgency predominant
Stress predominant
Antimuscarinics Strong or mirabegron Strong
Consider percutaneous posterior tibial nerve stimulation Weak
Failed conservative or drug therapy
Perform urodynamics, cystoscopy and consider imaging of lower urinary tract
to exclude bladder outlet obstruction
if the result would alter the choice of surgical treatment
Strong
Surgery

Belastungsharninkontinenz

1st line : Konservative Therapiemassnahmen

Lifestyle Modifikation und physikalische Therapie
(Beckenbodentraining)

Lebensstilmodifikation

Recommendations	**Strength rating**
Encourage overweight and obese adults with UI to lose weight and maintain weight loss.	Strong
Advise adults with UI that reducing caffeine intake may improve symptoms of urgency and frequency but not incontinence.	Strong
Review type and amount of fluid intake in patients with UI.	Weak
Provide smoking cessation strategies to patients with UI who smoke.	Strong

Beckenbodentraining

Summary of evidence	LE
Pelvic floor muscle training (PFMT) for women with UI	
Pelvic floor muscle training is better than no treatment for improving UI and QoL in women with SUI and MUI.	1
Higher-intensity, supervised treatment regimes, and the addition of biofeedback, confer greater benefit in women receiving PFMT.	1
Short-term benefits of intensive PFMT are not maintained at fifteen-year follow-up.	2
Pelvic floor muscle training commencing in the early postpartum period improves UI in women for up to twelve months.	1
Pelvic floor muscle training for post-prostatectomy UI	
Pelvic floor muscle training appears to speed the recovery of continence following radical prostatectomy.	1b
Pelvic floor muscle training does not cure UI in men post radical prostatectomy or transurethral prostatectomy.	1b
There is conflicting evidence on whether the addition of bladder training, ES or biofeedback increases the effectiveness of PFMT alone.	2
Pre-operative PFMT does not confer additional benefit to men undergoing radical prostatectomy.	1b

Verhaltens-/phys. Therapie

Recommendations	Strength rating
Offer prompted voiding for adults with UI who are cognitively impaired.	Strong
Offer bladder training as a first-line therapy to adults with UUI or MUI.	Strong
Offer supervised intensive PFMT, lasting at least 3 months, as a first-line therapy to all women with SUI or MUI (including the elderly and post-natal).	Strong
Offer instruction on PFMT to men undergoing radical prostatectomy to speed recovery from UI.	Strong
Ensure that PFMT programmes are as intensive as possible.	Strong
Do not offer ES with surface electrodes (skin, vaginal, anal) alone for the treatment of stress UI.	Strong
Do not offer magnetic stimulation for the treatment of UI or overactive bladder in adult women.	Strong
Consider PTNS as an option for improvement of UUI in women who have not benefited from antimuscarinic medication.	Strong

Belastungsharninkontinenz - Pharmakotherapie

Recommendations	**Strength rating**
Offer Duloxetine in selected patients with symptoms of SUI when surgery is not indicated.	Strong
Duloxetine should be initiated and withdrawn using dose titration because of high risk of adverse event.	Strong

Duloxetin - Wirkmechanismus

- (SSRI-Hemmer) bei Belastungsharninkontinenz

- wirkt am Seitenhorn der Rückenmarkes (Nucleus ONUF) und erhöht dort durch Stimulation des Sympathikus den Tonus des Beckenbodens

Unkomplizierte Belastungsharninkontinenz – operative Therapie bei Frauen

Recommendations	Strength rating
Offer a MUS, colposuspension or autologous fascial sling to women with uncomplicated SUI	Strong
Inform women of the unique complications associated with each individual procedure.	Strong
Inform women who are being offered a single-incision sling that long-term efficacy remains uncertain.	Strong
Inform women undergoing colposuspension that there is a longer duration of surgery, hospital stay and recovery, as well as a high risk of development of pelvic organ prolapse and voiding dysfunction post-operatively.	Strong
Inform older women with SUI about the increased risks associated with surgery, including the lower probability of success.	Weak
Inform women that any vaginal surgery may have an impact on sexual function, which is generally positive.	Weak
Only offer new devices, for which there is no level 1 evidence base, as part of a structured research programme.	Strong
Only offer adjustable MUS as a primary surgical treatment for SUI as part of a structured research programme.	Strong
Offer bulking agents to women with SUI who request a low-risk procedure with the understanding that repeat injections are likely and long-term durability is not established.	Strong

Belastungsharninkontinenz – operative Therapie bei Frauen

- Künstliche Bänder zur Unterstützung des Beckenbodens (retropubisch oder transvaginal)
- Raffungsverfahren zur Stabilisierung (Kolposuspension nach BURCH)
- Künstlicher Schliessmuskel

Komplizierte Belastungsharninkontinenz – operative Therapie bei Frauen

Recommendations	Strength rating
Management of complicated SUI should only be offered in expert** centres.	Weak
The choice of surgery for recurrent SUI should be based on careful evaluation of the individual patient including multichannel urodynamics and imaging as appropriate.	Weak
Inform women with recurrent SUI that the outcome of a surgical procedure, when used as a second-line treatment, is generally inferior to its use as a first-line treatment, both in terms of reduced efficacy and increased risk of complications.	Weak
Consider secondary synthetic sling, colposuspension or autologous sling as first options for women with complicated SUI.	Weak
Inform women receiving AUS or ACT© that although cure is possible, even in expert centres, there is a high risk of complications, mechanical failure or a need for explantation.	Weak

Pelvic Organ Prolaps und Belastungsinkontinenz

Recommendations for women requiring surgery for bothersome pelvic organ prolapse who have symptomatic or unmasked SUI	Strength rating
Offer simultaneous surgery for pelvic organ prolapse and SUI.	Strong
Inform women of the increased risk of adverse events with combined surgery compared to prolapse surgery alone.	Strong
Recommendations for women requiring surgery for bothersome pelvic organ prolapse who do not have symptomatic or unmasked SUI	
Inform women that there is a risk of developing de novo SUI after prolapse surgery.	Strong
Warn women that the benefit of surgery for SUI may be outweighed by the increased risk of adverse events with combined surgery compared to prolapse surgery alone.	Strong

Belastungsharninkontinenz – operative Therapie bei Männern

Recommendations	Strength rating
Offer duloxetine only to hasten recovery of continence after prostate surgery but inform the patient about the possible adverse events and that its use is off label for this indication in most European countries.	Weak
Only offer bulking agents to men with mild post-prostatectomy incontinence who desire temporary relief of incontinence symptoms.	Weak
Do not offer bulking agents to men with severe post-prostatectomy incontinence.	Weak
Offer fixed slings to men with mild-to-moderate* post-prostatectomy incontinence.	Weak
Warn men that severe incontinence, prior pelvic radiotherapy or urethral stricture surgery, may worsen the outcome of fixed male sling surgery.	Weak
Offer AUS to men with moderate-to-severe post-prostatectomy incontinence.	Weak
Implantation of AUS or ProACT© for men should only be offered in expert centres.	Weak
Warn men receiving AUS or ProACT© that, although cure can be achieved, even in expert centres, there is a high risk of complications, mechanical failure or a need for explantation.	Weak
Do not offer non-circumferential compression device (ProACT©) to men who have had pelvic radiotherapy.	Weak

Überaktive Blase mit Inkontinenz

First line Therapie sind konservative Massnahmen

- Lifestylemodifikation
- Verhaltenstherapie
- Beckenbodentraining

Lebensstilmodifikation

Recommendations	**Strength rating**
Encourage overweight and obese adults with UI to lose weight and maintain weight loss.	Strong
Advise adults with UI that reducing caffeine intake may improve symptoms of urgency and frequency but not incontinence.	Strong
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Provide smoking cessation strategies to patients with UI who smoke.	Strong

Verhaltens-/phys. Therapie

Recommendations	Strength rating
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Offer instruction on PFMT to men undergoing radical prostatectomy to speed recovery from UI.	Strong
Ensure that PFMT programmes are as intensive as possible.	Strong
Do not offer ES with surface electrodes (skin, vaginal, anal) alone for the treatment of stress UI.	Strong
Do not offer magnetic stimulation for the treatment of UI or overactive bladder in adult women.	Strong
Consider PTNS as an option for improvement of UUI in women who have not benefited from antimuscarinic medication.	Strong

Überaktive Blase mit Inkontinenz

Medikamentöse Therapie (2nd line)

- Antimuskarinika
- β3-Agonist
- Topisches Östrogen bei Frauen

Überaktive Blase mit Inkontinenz

Recommendations	Strength Rating
Offer antimuscarinic drugs for adults with UUI who failed conservative treatment.	Strong
Consider extended release formulations of antimuscarinics drugs, whenever possible.	Strong
If an antimuscarinic treatment proves ineffective, consider dose escalation or offering an alternative antimuscarinic formulation, or mirabegron, or a combination.	Strong
Encourage early review (of efficacy and side effects) of patients on antimuscarinic medication for UUI.	Strong

Antimuskarinika

- Wirken über muskarinerge Rezeptoren (v.a. M2 u. M3)
- Typische antimuskarinerge NW (Mundtrockenheit, Obstipation)
- Nur 10 % der Patienten bleiben deshalb langfristig bei der medikamentösen Therapie

Antimuskarinika

- Kein Vorteil bzgl. Wirkung für ein bestimmtes Präparat
- Cave zentrale NW (v.a. bei Demenz!) – hier am ehesten Trospiumchlorid (nicht liquorgängig)
- Vorteil für Solifenacin: M2/M3 selektiv

Mirabegron

- Wirkmechanismus über Aktivierung des Sympathikus über betaadrenerge Rezeptoren am Detrusor
- Bei Versagen der antimuskarinergen Therapie
- Nebenwirkungen sind u.a. Bluthochdruck und Nasopharyngitis
- Keine negativen kognitiven Auswirkungen für ältere Patienten

Östrogen

Recommendations	Strength rating
Offer long-term vaginal oestrogen therapy to post-menopausal women with UI and symptoms of vulvo-vaginal atrophy.	Strong
In women with a history of breast cancer, the treating oncologist should be consulted.	Weak
For women taking oral conjugated equine oestrogen as hormone replacement therapy who develop or experience worsening UI, discuss alternative hormone replacement therapies.	Strong
Advise women who are taking systemic oestradiol who suffer from UI that stopping the oestradiol is unlikely to improve their incontinence.	Strong

Überaktive Blase mit Inkontinenz

Operative Therapie (3rd line)

- Sacrale Neuromodulation
- Intravesicale Botox-Injektion

Überaktive Blase mit Inkontinenz

Recommendations	Strength rating
Offer sacral nerve modulation to patients who have UUI refractory to antimuscarinic therapy.	Strong

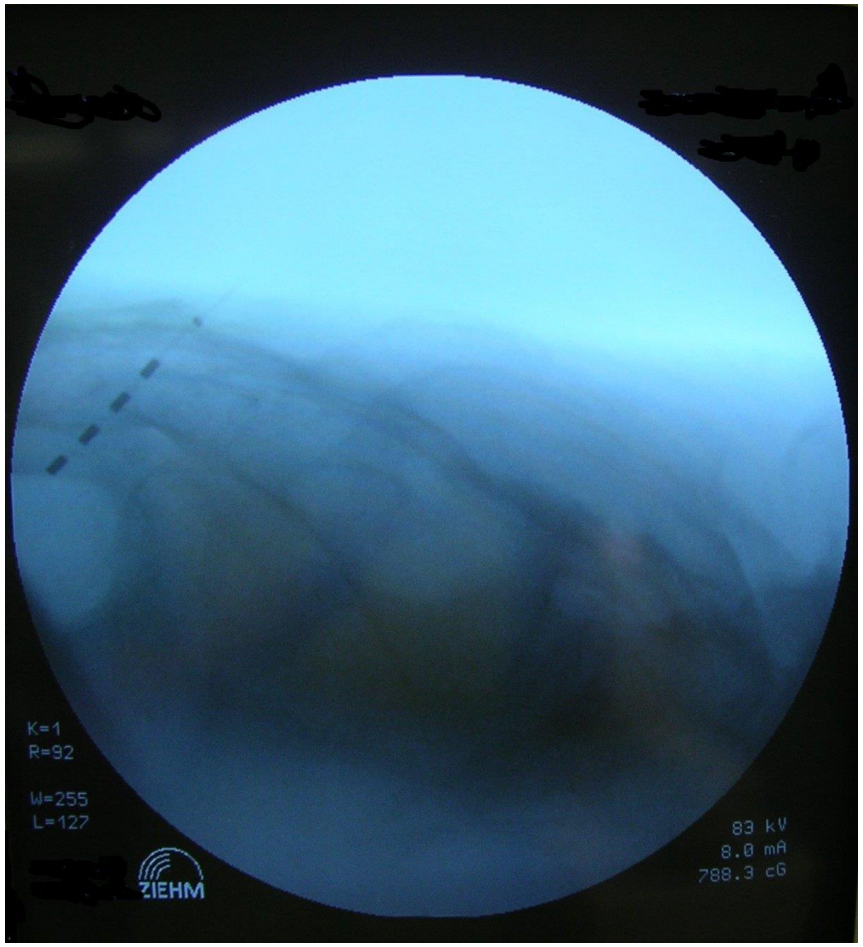
Offer bladder wall injections of onabotulinum toxin A (100 U) to patients with UUI refractory to conservative therapy (such as PFMT and/or drug treatment).	Strong
Warn patients of the limited duration of response, risk of UTI and the possible prolonged need to self-catheterise (ensure that they are willing and able to do so).	Strong

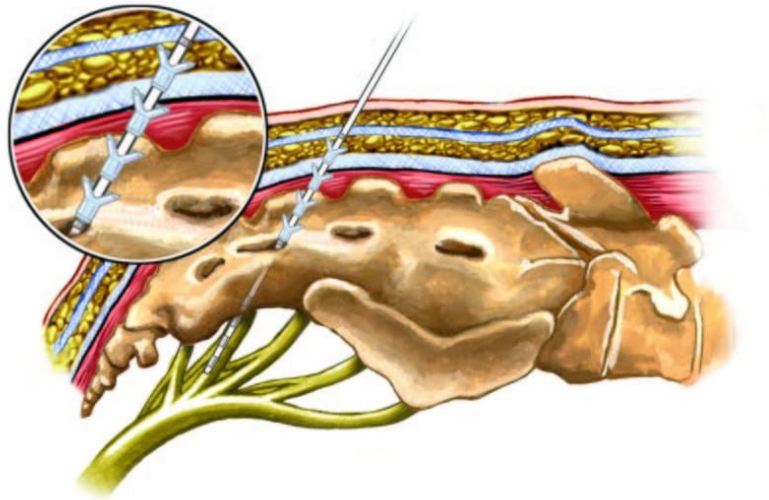
Sacrale Neuromodulation

- Stimulierung der Hinterwurzeln des Sakralmarkes über spezielle Elektroden, die in die Neuroforamina eingebracht werden (meist S3, manchmal S2 oder S4)

- Weltweit > 160 000 behandelte Patienten

Tined Lead Position





active electrode mostly at the ventral edge of the OS Sacrum

Sacrale Neuromodulation

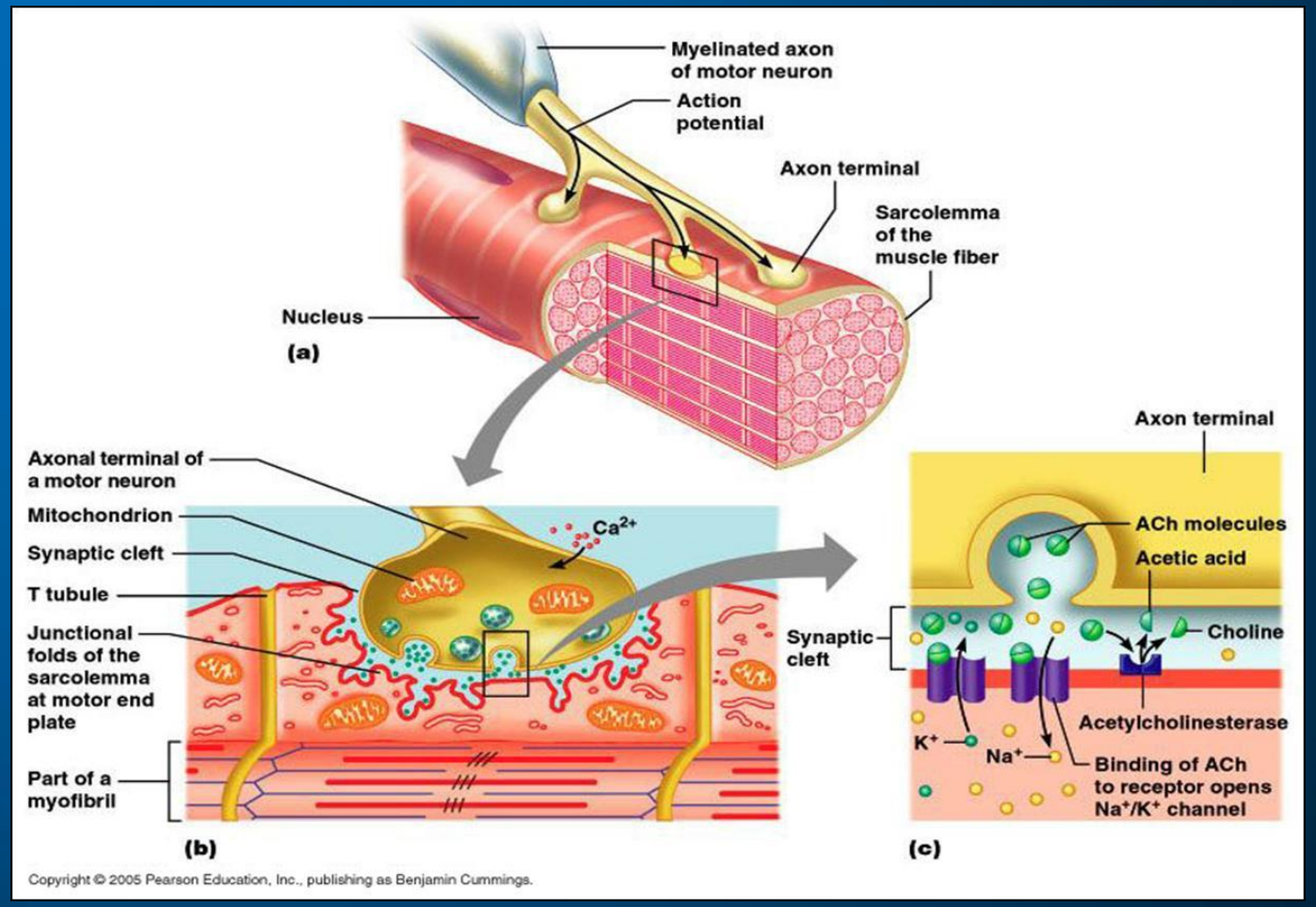
- Elektrische Stimulation von afferenten somatischen Nerven über das sacrale Rückenmark (vorzugweise S3 Hinterwurzel)
- Ziel ist die Modulation unwillkürlicher abnormer Reflexe des unteren Harntraktes und Wiederherstellung der Harnkontrolle

Sacrale Neuromodulation

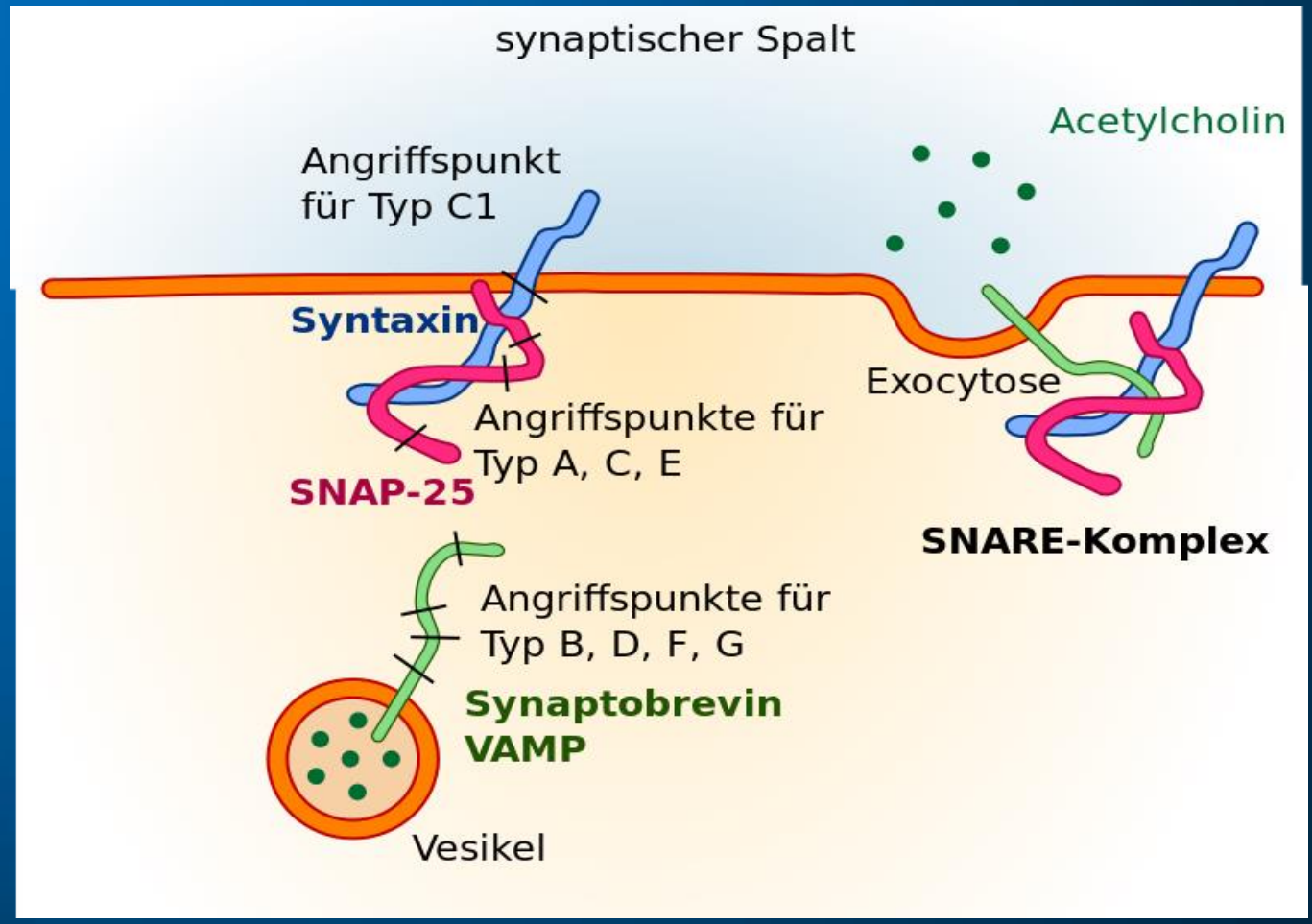
Botulinumtoxin

- Synapsenblockade an d. motorischen Endplatte
- Wirkung auf efferente und afferente Nerven
- Wirkungseintritt nach 1-2 Wochen
- Wirkdauer ca. 9 Monate (glatte Muskulatur)

Botulinumtoxin



Botulinumtoxin



Botulinumtoxin

- Als Nebenwirkung kommt es häufig zur Restharnbildung
- Dieser Effekt ist mit dem Abklingen der Wirkungs des Toxins reversibel
- Patienten sollten vor der Injektion im Umgang mit dem Einmalkatheterismus eingeschult und postoperativ auf etwaige Restharnbildung untersucht werden

Mischinkontinenz

Recommendations	Strength rating
Treat the most bothersome symptom first in patients with MUI.	Weak
Warn women that surgery for MUI is less likely to be successful than surgery for SUI alone.	Strong
Inform women with MUI that one single treatment may not cure UI; it may be necessary to treat other components of the incontinence problem as well as the most bothersome symptom.	Strong

Ultima Ratio

In Einzelfällen bei Versagen aller anderen Therapieformen

- Supravesicale Harnableitung
- Blasenaugmentation

Vielen Dank für die Aufmerksamkeit