



Transcript of Video with Dr. Kohli Discussing Stress Urinary Incontinence

Experts in minimally invasive gynecological surgery talk with NWHRC Executive Director Elizabeth Battaglino Cahill, RN at AAGL's recent Global Congress of Minimally Invasive Gynecology. Read the transcripts [here](#).

Dr. Kohli, what is stress urinary incontinence or SUI?

Stress urinary incontinence is a condition where a woman has urinary leakage with generally different types of activities. So typically a woman will come to you and complain of stress incontinence with coughing, sneezing, exercising, laughing, lifting, those types of activities. And it's actually an anatomic condition, which typically results from poor support of the bladder neck. And this is in contrast to urge incontinence or overactive bladder, which is typically a condition where a woman comes in and says I urinate frequently, either day or night and I can't make it to the bathroom in time. So stress incontinence is typically more related to activity as opposed to urge incontinence.

Is there any risk factors for stress urinary incontinence?

That's controversial. One of the things that we've traditionally thought about was childbirth and so as women have children, specifically vaginal deliveries, that there may be some disruption of the supports of the bladder neck resulting in stress incontinence. Some of the recent data is suggesting that in younger women that may be the case but in older women, even if they had Caesarean sections, that is not necessarily the case and so it suggests that certain events associated with time and aging may also contribute. And that may include menopause. It may include just weakening of the tissues as you get older. It may include neurologic conditions, which increase chronic constipation. And then also as a lot of women get older they get a little heavier so weight can actually contribute to this as well.

How common is it?

Very common and in fact more common than most people would think and most patients don't discuss it. But now it's getting to the point where more people are being more vocal because it is such a quality of life issue and people are realizing that their doctors are talking about as well as the fact that there are many treatment options for it. So it may range anywhere from 20 to 50% of women, depending on their age.

Can SUI happen to all women of any age?

Clearly. And in my practice in fact the youngest patient who has opted for a surgical correction was 24 and my oldest was 94. So there's a huge range and I think a lot of young patients feel very embarrassed talking to their physicians because they feel well this is something that only happens to older patients and that's clearly not the case. But every woman is going to have a different risk factor and some women may present with it earlier on.

How can women avoid SUI?

Well I think one of the things they can do is pelvic floor exercises. I think that's very important. And I think a lot of women don't consider pelvic floor exercises until they're symptomatic and at that point it becomes much more difficult to treat with exercises but it can sometimes help the progression. In prevention, I think doing the Kegel exercises is important, for many different reasons, including stress incontinence. Also looking at anything that would cause chronic Valsalva or straining. So chronic constipation, jobs where they are doing a lot of heavy lifting, and those types of things, chronic cough and then weight loss is, again, another thing to help prevent stress incontinence.

If a woman thinks she has SUI should she see a specialist?

I think it really depends on how much it bothers her. I have some women who leak ten times a day and they learn to live with it and they're okay with that. There are others who leak once a month and they think it's the worse thing in the world. At the end of the day I think it depends on how much does it bother you, and how much of it is making an impact on your daily life. The good news at this point is the diagnosis and the treatment for most types of incontinence, especially stress incontinence, is very straightforward and is really trickling down to everybody from the specialist to the general OB/GYN and even to the primary care physician.

How is stress urinary incontinence treated?

Well there's a whole range of treatments and I think the misconception that most women have is that (a) it's normal part of aging, (b) there aren't good treatments and (c) if there are treatments they're fraught with complications. And all of those are untrue. If the incontinence is mild, it really can be treated with pelvic floor exercises and there are even physical therapists who specialize in this condition. And so spending time with a physical therapist can help greatly. In other cases there are options for surgery and the surgery has progressed over the last decade to a simple outpatient procedure which can be performed in 15 or 20 minutes. And that was what I offered my 95 year-old and I would have never offered a patient that old a surgery because of the other complications including anesthesia but the surgeries have really progressed with great success and very good safety.

What are the risks associated with the surgical procedures?

Well I think with any type of surgery there's always the risk of anesthetic risks as well as bleeding and infection. But most of these are minimized because it is such a short procedure. These procedures involve making a small incision in the vagina and then passing a trocar connected to a little piece of mesh that sits underneath the bladder neck and stabilizes the bladder neck. So there are risks including the mesh, which include exposure, infection, pain with intercourse. There are also risks with passing of the trocars, which include injury to the adjacent organs but many of those risks are very, very low, especially in experienced hands.

You just mentioned mesh and we know there's been some debate around the safety of surgical mesh in the body. What should women know about surgical mesh?

Well I think when we talk about mesh it's a very broad category. And clearly the different ways of using mesh are associated with different risks and benefits. The TVT or TOT surgical procedure, which is specifically for incontinence, involves a very small piece of mesh, which is 1 cm wide by about 10 to 12 cm long. And there have been over a million procedures done in a very short time over the last decade worldwide. And the real risk of that mesh placement in

terms of exposure, infection or pelvic pain or pain on intercourse is really less than 1%. So it's a very, very safe use of mesh. That's very different than using the large pieces of mesh for prolapse repairs or other parts of pelvic surgery, which may have a very different risk/benefit ratio.

When a woman decides to have a sling procedure, what questions should she ask her doctor about his or her experiences as well as the procedure itself?

I think that's a difficult question to answer because there are a lot of generalists who are very good surgeons and there may also be specialists who aren't very good surgeons. And I think it's important for a patient to ask their physician do you have any specialized training in this. How many of these do you do on a regular basis? What are your surgical success and complication rates? Too often physicians will quote what the literature or the data is and surgery is very specific in terms of those numbers and it's always better that the doctor knows his or her own rates. I also think you should ask, if we have complications who would you send me to? And when the doctor says I would take care of those complications myself, that further reassures the patient that this is a doctor who is experienced and possibly one of the best people in their area.

According to the National Association for Incontinence women spend more on sanitary products for incontinence than menstruation. Why do you think this is the case and what needs to happen to get more women to seek treatment?

I think we've done a poor job educating patients on what the options are and I don't think they realize how effective and how safe they are. Clearly that's changed over the last decade and I think we're now catching up with the physician education as it comes around but now we have to work on patient education. And a lot of my practice is really built on word of mouth. Patients come in they had a great experience they never thought it could be so easy, and now they feel very liberated and they like to talk about it at parties and shopping trips and with their own family members. And then all of a sudden there's more education. I'm hoping that over the next decade we'll have a more structured education, not only in terms of patients but also in physicians who understand the risks and benefits and can offer these treatments to their patients.

Thank you very much. It was my pleasure, thank you.