Ask the Expert - Answers

Q. I had a hysterectomy four years ago. Since then, I have been experiencing progressively increasing urgency. I drink one XL cup of coffee per day but when I have to go, I have to go and you better get out of my way. I remember speaking with my gynecologist about the possibility of my bladder dropping when she explained the procedure, risks, etc. Is it possible that this is what's happening to me?

A. You're describing urinary urgency and it's a common and frustrating symptom. There are many conditions that cause this symptom with the most common being bladder infections and overactive bladder. There are other much less common causes.

In general, a "dropped bladder" or a cystocele doesn't cause urinary urgency or urge incontinence. Cystoceles are usually associated with stress urinary incontinence (leakage of urine with coughing, laughing, sneezing or physical activity). While surgery can often repair a cystocele and help stress incontinence, repairing a cystocele or dropped bladder doesn't usually cure urinary urgency.

The good news is that urinary urgency can often be greatly improved with simple nonsurgical approaches. We encourage you to see a specialist who should be able to help make this problem much better.

Q. I am 62 years old and have had urine leakage for the past few years. I use to wear a Kotex pad but they would not be able to hold the urine so I switched over to Tena Pads which work well. I need to change the pad two times a day and it is full. At home I do not wear a pad as I am able to go to the bathroom frequently. I do not want to have surgery. Are there other options? I heard of botox but does it last?

A. There are two types of incontinence that women generally describe - urge incontinence and stress incontinence. Stress incontinence is leakage associated with coughing, laughing, sneezing and activity, whereas urge incontinence (aka "gotta go, gotta go leakage") is associated with urgency and trouble reaching the bathroom. These conditions are caused by two very different mechanisms and thus have very different treatments. In general, we treat stress incontinence with pelvic floor strengthening, pessaries or surgery, and urge incontinence with dietary changes, medication and sometimes with advanced treatments such as Botox or neuromodulation.

Without more information, it's hard to tell what type of incontinence that you have. However, whatever the cause, you have some nonsurgical options that can be very effective for some women and we encourage you to see someone with specialized training to get a full range of options.

Botox can be very effective for women with severe urge incontinence due to overactive bladder. It does gradually wear off, requiring additional injections to keep the incontinence under control. However, many women see an effect lasting six to nine months and need less than two injections per year.

Q. Should someone with urinary incontinence issues be seen by a urologist or urogynecologist? What is the latest in surgical procedures, since women are suing over mesh implants?

A. Both urologists and urogynecologists are qualified to care for women with urinary incontinence. We recommend seeing someone who focuses his or her practice on incontinence and who has specialized training, usually a fellowship, in either urogynecology or female urology. We have both at UMass Memorial.

There is a great deal of controversy over the use of mesh and the issue is far too complex to review in detail here. However, it's important to note that the 2011 FDA warning that led to the mesh lawsuits focused on vaginal mesh for prolapse repair rather than the mesh slings used for urinary incontinence. We have more than 20 years experience with midurethral mesh slings in the United States and many patients still decide to undergo mesh slings for their stress incontinence. Those who don't want to undergo any mesh procedure still have other surgical and nonsurgical options including fascia lata slings, Burch urethropexy and pessaries. We recommend you meet with a fellowship trained urologist or urogynecologist for reliable up-to-date information.

Q. I am 62 and had a hysterectomy when I was 23 due to cervical cancer. Now I hate to say I have to wear a pad 24 hours a day because of infrequent incontinence. I never know when it is going to happen except when I cough or sneeze. And then it is a given. I've heard a lot about surgical repair but have had so many other surgeries, I'm not sure I want to go through it again. It just drives me crazy.

A. We are sorry to hear about your needing a hysterectomy so young and now having urinary leakage. It's difficult to know why you're leaking based on the information above. It might be related to the hysterectomy. If you had radiation for your cancer, that could play a role. However, your description of leaking rarely and only with a cough or sneeze leads me to suspect that you have stress incontinence due to a weakened urinary sphincter. If this is true, we may be able to improve the situation with a minor outpatient procedure. Because your history is complex, we recommend an evaluation and urinary testing to learn why you're having a problem and what can be done to improve it.

Q. I had TVT done in 2004. Procedure was successful, but I have breakthrough incontinence now. What do long term studies of TVT reveal? Will I require a redo and, if so, does the tape break down?

A. We generally view a midurethral sling or TVT as permanent but some women will have recurrent incontinence after a TVT. We caution our patients that sometimes the sling will only improve incontinence and not completely cure it. In addition some women develop new incontinence that's unrelated to the sling.

The mesh is considered permanent and while there is some gradual degradation of the sling over time, it doesn't completely breakdown. We've used these slings in the US for about 20 years. So far the long-term data suggests that the sling works well for up to eight years for most women. There's no reason to believe slings stop working after eight years - we just don't have any definitive data telling us how well it works for longer periods. We have many patients who had their sling over 10 years ago and they're still doing well.

It's difficult to explain why you're leaking again based on the information in your question. The sling might have failed or you may have a different type of incontinence. If the problem is bothering you, we recommend you see someone with special training in incontinence to be sure the proper testing and counseling is performed.

Q. I am 48 years old and cannot exercise without having to stop to urinate, and I have to wear a pad always because I continuously leak. What options might I have to help this problem?

A. Without examining you, we can't know for sure what's causing your leakage or incontinence. While there are several causes of urinary incontinence with exercise, we suspect that you have stress urinary incontinence. This is a very common condition, typically first appearing in women in their mid-40s. Stress incontinence is caused by a loss of support to the urethra, which allows a little bit of urine to escape with coughing, sneezing and exercise. This is very different from urge incontinence which is caused by the bladder contracting and causing urge symptoms (some call this the "gotta go" incontinence). This type of leakage is treated very differently from stress incontinence.

You have several options to mange stress incontinence. Pelvic muscle exercises (or Kegel exercises) can strengthen the pelvic floor muscles and help some women reduce their leakage. Unfortunately, some women still leak urine despite effective Kegel contractions and need additional help such as pessaries or surgical repair. A pessary is a molded piece of rubber or silicon that sits in the vagina and supports the urethra. A properly fit pessary is very comfortable and in many women will significantly reduce or completely eliminate stress incontinence. For patients that fail the pessary or decide they don't want to use one, we usually suggest surgery. Many patients undergoing surgery select a midurethral sling, which is a same-day, highly effective long-term treatment for stress incontinence.

We recommend seeing an expert in female urinary incontinence for additional information and guidance so that you can decide the best treatment for you.

Q. Recently my uterus has been prolapsed, mostly toward the end of the day. It goes back up after a full night rest. I am able to hold my urine very well and have no leakage. I am 54 years old with two grown kids. What seems to be the problem?

A. Uterine prolapse is a very common condition and your symptoms are very typical for women who have the condition. When the uterus is prolapsing, it's the result of the normal support structures failing. The uterus is typically held up by the uterosacral ligaments and cardinal ligaments, which can be damaged during a pregnancy and by delivery. Some women don't heal these ligaments as well as others and over time, these supports gradually fail and allow the uterus to drop or prolapse.

Women with this problem typically feel the uterus or vagina drop to the vaginal opening over the course of the day. Sometimes the uterus comes outside of the vagina. Most women describe pressure and discomfort but not usually pain. Most women can push the uterus back up into the pelvis with her finger but if one remains standing and active, the uterus will prolapse again because there is nothing to hold it up. When a woman lies down (such as going to bed at night), the uterus falls back into the pelvis and stays there until she stands up. When she stands up and is active, the uterus will then gradually come down again. Some women may have symptoms such as urine leakage or problems passing their urine or stool.

While uterine prolapse can be uncomfortable, it's not dangerous and only in extreme cases can it be a threat to a woman's health. Some women worry that if untreated, they'll stand up one day and their insides will just fall on the floor. This doesn't happen. Over time prolapse usually worsens but this is gradual and many women never get worse.

Women with this very common condition have many treatment options available. We encourage you to see fellowship-trained providers who will be able to help you identify the best treatment option for you.

Q. I can feel a balloon-like thing protruding from my vagina. What could it be?

A. Without examining you, it's difficult to tell you what is ballooning out of the vagina. There are many possible conditions such as a vaginal cyst, urethral cyst, or prolapsing vagina or uterus. The most likely explanation is that the vagina or uterus is prolapsing.

Some will notice that I did not list the bladder or rectum falling down. In these cases, where there is a vaginal bulge and a woman is told her bladder has dropped, the bulge that the woman sees and touches is the vaginal wall falling out of the vagina. The bladder is likely dropping behind the vaginal skin but what these women see and feel is vaginal skin and not the bladder. This is an important distinction because the problem lies in the vaginal supports failing to hold up the vagina and bladder and not that the bladder is pushing down on the vagina. This is similar to a hernia, which is caused by the abdominal wall failing to hold in the bowel, rather than the bowel pushing through the abdominal wall.

There are surgical and nonsurgical options available and we recommend an evaluation by someone specializing in uterovaginal prolapse so that you can make an informed decision of the best treatment for you.

Q. I am a young 66 years old. I was scheduled for vaginal hysterectomy and bladder repair. I cancelled surgery. I have stage 3 dropped bladder. What are my alternatives? Okay to do nothing? Do I need surgery? If yes, why not just bladder surgery?

A. We emphasize to our patients that a "dropped bladder" is in fact a dropped vagina. The fibrous supports to the vagina fail, allowing the vaginal wall to bulge out and be felt. The bladder sits on top of the vagina and often drops down with the prolapsing vagina. What your fingers are touching is the vaginal skin rather than the bladder itself.

It's important to understand that this is a quality of life condition and any woman with vaginal prolapse should identify how the prolapse limits her life and daily activities. If it doesn't bother her or limit her activity in any way, it's very reasonable to consider doing nothing and avoiding surgery. You should be aware that it's unusual for prolapse to resolve on its own and the natural history of prolapse is for it to gradually progress over months and years. If you don't have surgery now, it's possible you'll develop more prolapse and decide to have surgery later. However, it's also possible that your bulge never progresses any further and you might never need surgery.

If the prolapse is progressing or bothering her, then a woman can consider nonsurgical options such as a pessary, which is a shaped piece of medical grade silicon rubber that is placed in the vagina to support the prolapse. Alternately, there are many surgical options for the repair of prolapse. Without examining a patient, it's difficult to know if a hysterectomy would be indicated. Procedures can be performed to repair prolapse and preserve the uterus, while sometimes it's better to remove the uterus as part of the repair and other times we can leave it.

Whatever you decide, we encourage you to get more information from a provider specifically trained in managing urogynecologic problems such as vaginal prolapse and who clearly explains your condition, clearly explains all of your options to you, and helps you decide what treatment is best for you and your life.

Q. I had surgery because of pudendal neuralgia 14 months ago and I am still, although better, dealing with pain. Do you have a pain clinic to help with this?

Similiar question below...

Q. I have been dealing with pelvic nerve pain that includes the both labia, clitoris, perineum and anus since December 2012. Pain travels to my pubic bone, legs, feet and lower belly. I have seen a neurologist (who was little help) and a urogynecologist WMC. MRIs all normal. I had a laparoscopic

procedure that was negative for endometriosis. I saw a specialist in NH (Dr. Mark Conway), who did an EMG that showed a problem with my pudendal nerves bilaterally. I don't know of anyone more local who is very familiar with treating pudendal nerve entrapment or neuralgia. I am on 2400 mg of gabapentin and 30 mg of amytriptiline daily. Everything I do hurts, but sitting is extremely painful, so travel is very difficult. I am hoping to find someone local to work with Dr. Conway in managing my care. Any recommendations would be appreciated.

A. We are very sorry to hear of your pain. Managing this problem can be very difficult for patients and providers and you have learned there are very few providers who can effectively address this problem. Unfortunately, none of our urogynecology providers have much experience or expertise with this problem. Some patients have seen some success with physical therapy and you may want to consider giving this a trial.

Q.Earlier this year I was diagnosed with VVS. Since then with treatment I have had that diagnosis removed or no longer have it, but in the interim was also diagnosed with BV, with a 5-day cycle of Metro gel and 3m of other precautions. I still have BV, next course of action was a 5-day cycle of Metro gel and 12 weeks of twice a week. I have an appointment in September, but I do not feel any better so I am guessing it is not better. Is there any other treatment available? I am recently married and this has been a big toll on my marriage.

A. We are very sorry to hear about the problems you are having. Bacterial vaginosis (or BV) is caused by an overgrowth of a bacteria called gardnerella vaginalis and can be difficult to manage in some women. The therapies you describe typically clear this infection and it is unusual for BV to persist after these treatments. One possible explanation is that you do not have BV but have a different condition causing your symptoms. Without knowing your symptoms, it is difficult to be sure. This problem is best managed by your general ob/gyn rather than a urogynecologist. If you do not have an ob/gyn, the Medical Center has many on staff who would be happy to help you solve this problem.