Welcome to Project ECHO Population Health Network: Reproductive Health Series

Series 2: Session 2

"Women's health in the midlife: Incontinence and prolapse"

Supporting general practice, commissioning health services into gaps and driving service integration.

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Acknowledgement of Countries

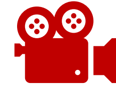
I'd like to begin by acknowledging the Traditional Owners and custodians of the unceded lands and waterways

- the Wadda Wurrung, Gulidjan, Gadubanud, Keeray Wurrung, Peek Wurrung, Gunditjmara, Djab Wurrung, Wotjobaluk, Dja Dja Wurrung, Jadawadjarli, Wergaia, Jupagalk and Jaadwa peoples.

We recognise their diversity, resilience, and the ongoing place that First Peoples hold in our communities. We pay our respects to the Elders, both past and present and commit to working together in the spirit of mutual understanding, respect and reconciliation. We support self determination for First Nations Peoples and organisations.

Ask the question. Do you identify as Aboriginal or Torres Strait Islander?

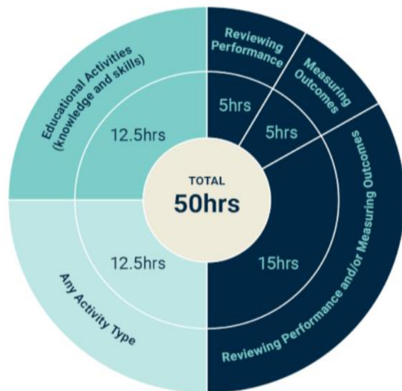
Etiquette/Zoom use



- Clearly name yourself with first name and surname.
- Introduce yourself / Role / Region / Organisation in "chat"
- Use chat to ask questions
- Please remain on 'mute' except when speaking
- Please turn video on
- In-session Evaluation at the end

- These sessions will be recorded for ongoing training and quality improvement purposes.
- The didactic presentations ONLY will be disseminated on our learning channel.
- Discussions will be de-identified where used for QI or research purposes.
- Please let us know if you would not like your comments recorded.

Minimum requirements



WVPHN Your CPD Centre

ECHO is a Peer Group Learning Activity
EA- Passive activity
RP- Interactive activity
MO- QI activity supported by ECHO

Agenda– Reproductive Health Series 2: Session 2
“Women’s health in the midlife: Incontinence and prolapse”

Facilitator: Dr Bianca Forrester, Clinical Lead of Innovation and Learning, Western Victoria Primary Health Network

Presenter: Dr Chin Yong, Urogynaecologist and Female Pelvic Floor Reconstruction Surgeon,

- Incontinence and prolapse

Panel for discussion:

Celia Bolton, Director and Physiotherapist, Inner Strength Healthcare

Dr Kate Graham, Clinical Editor HealthPathways and COVID Clinical Advisor, Western Victoria Primary Health Network

Network Co-ordinator: Jemma Missbach, Project ECHO Coordinator, Western Victoria Primary Health Network

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Women's health in midlife: Incontinence and vaginal prolapse

Dr Chin Yong

Urogynaecologist & Female Pelvic Floor Reconstruction Surgeon

Learning outcomes

1. Identify and offer opportunistic pelvic floor screening to patients with risk factors

2. Summarise the treatment pathways for pelvic organ prolapse and urinary incontinence (UNDERSTAND)

3. Outline the role of conservative management in primary care setting.

Pelvic Floor Disorders - Why is it important to know?

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Pelvic organ prolapse (POP) occurs in up to 50% of women after childbirth

- 40% will be symptomatic
- 10-20% lifetime risk of undergoing surgical correction of POP

Urinary incontinence affects 37% of Australian women (Australian Institute of Welfare Report 2006)

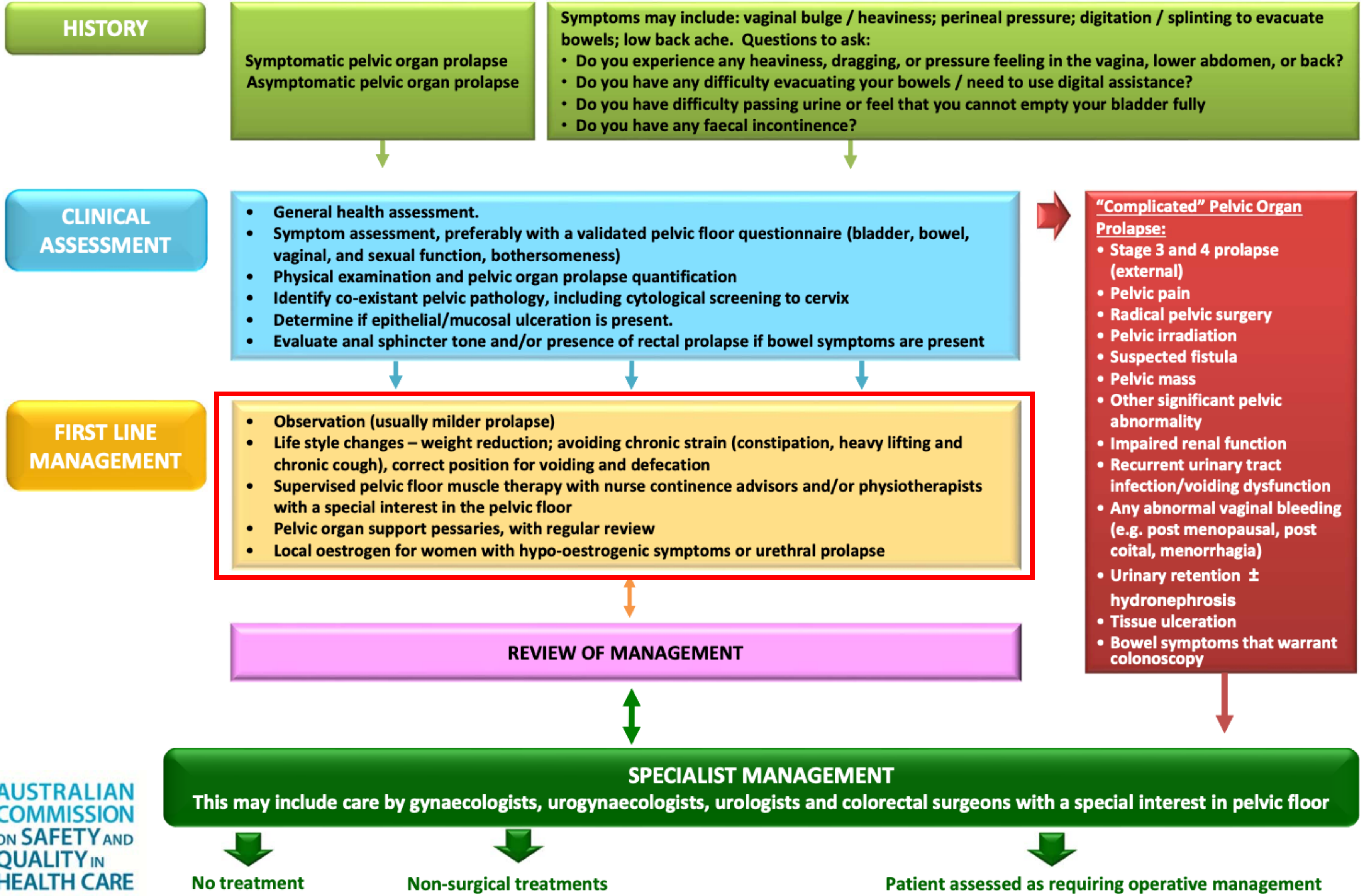
- 65% have some type of UI but only 31% seek help from professional

Faecal incontinence affects up to 13% of Australian Women → one of the 3 major cause of admission to aged-care facility

Most women believe that it is “normal” to have PFD after childbirth & also part of ageing process

Most women do not usually disclose the problem unless get asked/screened

Care Pathway for the Management and Referral of Pelvic Organ Prolapse (POP)



MULTIDISCIPLINARY APPROACH

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Care Pathway for the Management and Referral of Urinary Incontinence in Women

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HISTORY

How bothersome is the incontinence?
How frequent is the incontinence?
For how long has it been occurring?
What is the quantity of the leakage?

When does the patient leak urine?
- When performing some activity, such as coughing, lifting or exercise
- When they had the urge or feeling they needed to empty their bladder but could not get to the toilet fast enough
- Without activity or a sense of urgency
- With both activity and a sense of urgency

CLINICAL ASSESSMENT

- General health assessment
- Assess whether the patient has completed her family
- Assess quality of life and desire for treatment
- Urinary symptom assessment (including bladder diary and questionnaire)
- Physical examination: abdominal, pelvic and perineal
- Cough test to demonstrate if stress incontinence present
- Urinalysis ± urine culture -> if infected, treat and reassess if appropriate
- Assess oestrogen status and treat as appropriate
- Assess pelvic floor muscle function
- Assess post-void residual urine

"Complicated" Incontinence:
- Recurrent incontinence
- Debilitating severe incontinence
- Incontinence associated with:
  - Pain
  - Haematuria
  - Recurrent infection
  - Patients with neurological conditions
  - Patients using medications that cause an atonic bladder
  - Voiding dysfunction
  - Pelvic irradiation
  - Radical pelvic surgery
  - Suspected fistula
- Incontinence with
  - Significant post void residual OR
  - Significant pelvic organ prolapse OR
  - Pelvic mass
- Primary nocturnal incontinence
- Nocturnal enuresis
- Continuous incontinence

PROVISIONAL DIAGNOSIS

STRESS URINARY INCONTINENCE (SUI) (incontinence when performing activity)

MIXED URINARY INCONTINENCE (MUI) (both incontinence types present - treat most bothersome symptom first)

URGE INCONTINENCE / OVERACTIVE BLADDER (OAB) (need to empty bladder but could not get to the toilet fast enough)

FIRST LINE MANAGEMENT

- Consider continence products for temporary support during treatment
- Lifestyle interventions include weight loss and avoiding chronic straining (lifting, coughing or constipation) for all patients
- Supervised pelvic floor muscle therapy with nurse continence advisors and/or physiotherapists with a special interest in the pelvic floor
- Vaginal devices such as cones, weights, urethral support devices
- Bladder irritants such as caffeine and alcohol should be minimised for urge incontinence / OAB
- Bladder retraining for urge incontinence / OAB
- Pharmacological treatments such as anticholinergics or beta-adrenergic agonists for urge incontinence / OAB

REVIEW OF MANAGEMENT

SPECIALIST MANAGEMENT
This may include care by gynaecologists, urogynaecologists, urologists with a special interest in pelvic floor and geriatricians

No treatment

Non-surgical treatments

Patient assessed as requiring operative management

MULTIDISCIPLINARY APPROACH

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Patient education

Improve patient understanding of the underlying condition

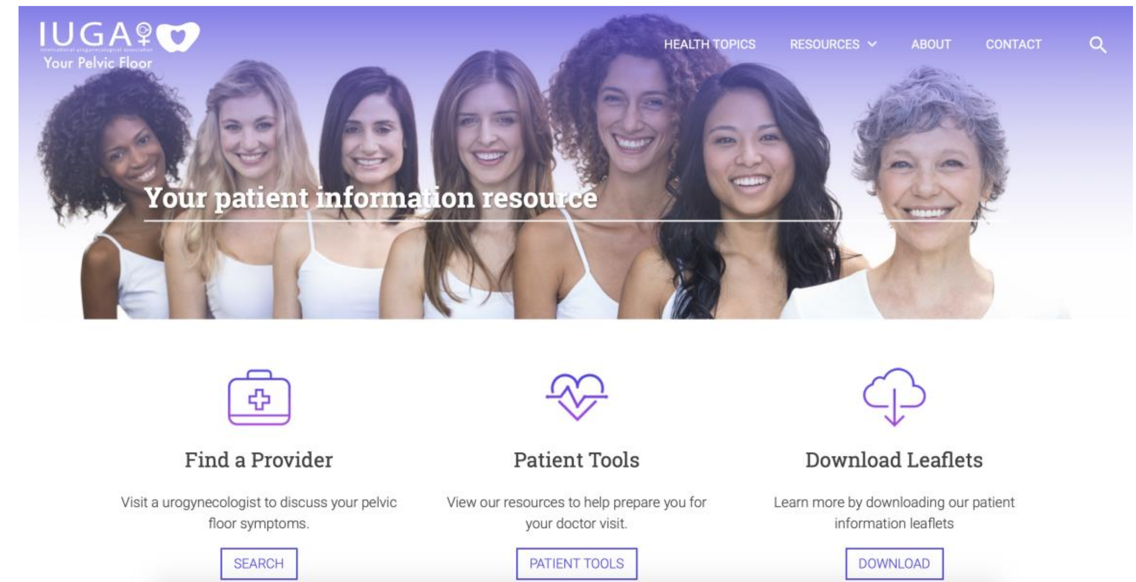
More likely to improve compliance to recommended treatment

Where to find information for patients?

> https://www.yourpelvicfloor.org/

> https://www.ugsa.com.au/patient-resources/

> https://www.drchinyong.com.au



Conservative management in pelvic organ prolapse

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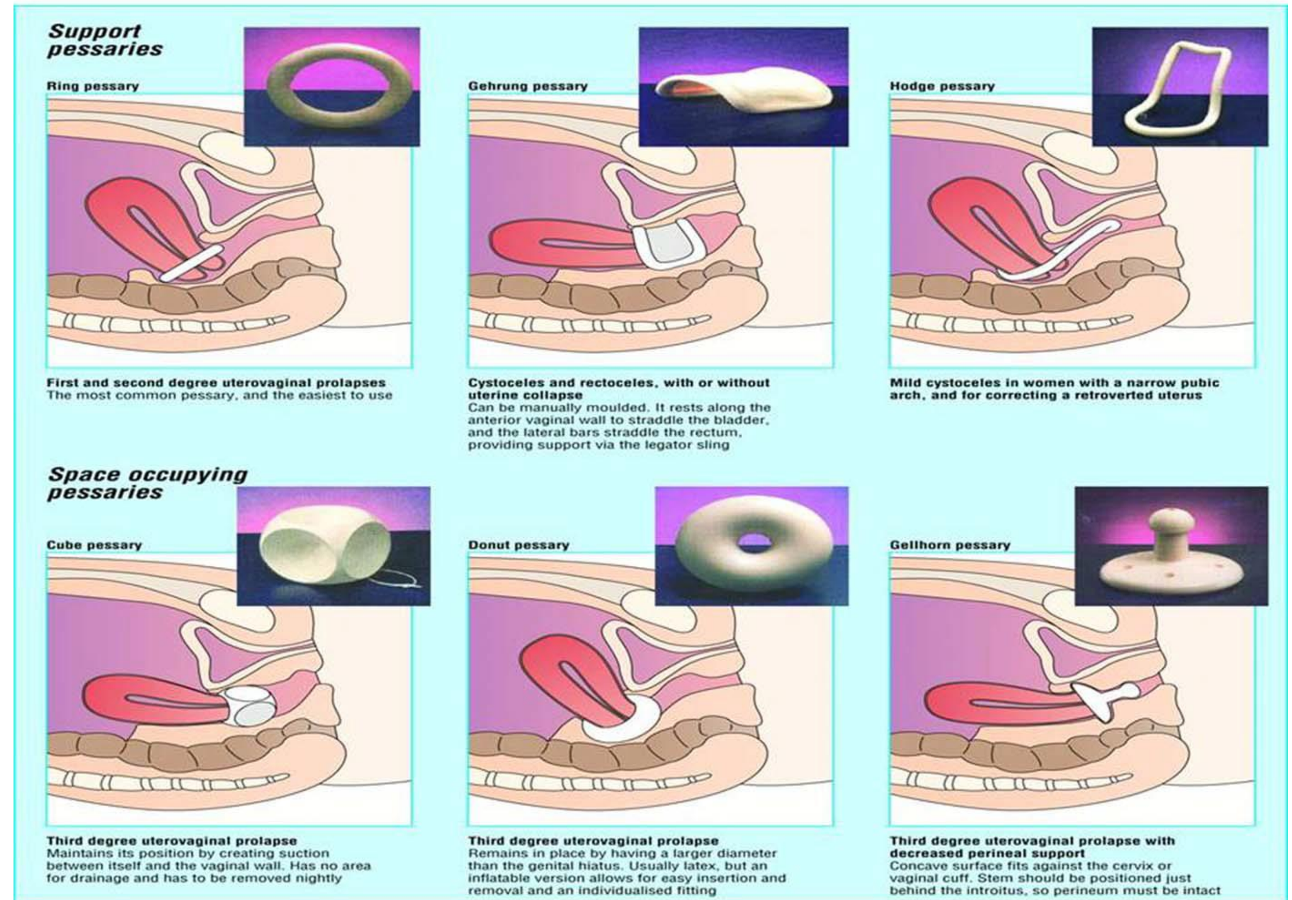
Vaginal pessaries

Can be used on its own or combined with PMFT

Various options available:

- Support pessaries - Ring ± support, Hodge, Gehrung, C-POP
- Space occupying pessaries – Gelhorn, Donut, Cube



When to consider surgery?

Failed conservative management

Patient declined non-surgical management

Pelvic floor mesh update

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All TVM mesh for POP treatment were withdrawn from Australian market since Jan 2018

Abdominal mesh use for POP treatment (Off-label use)

Synthetic midurethral sling for treatment of stress urinary incontinence remain available

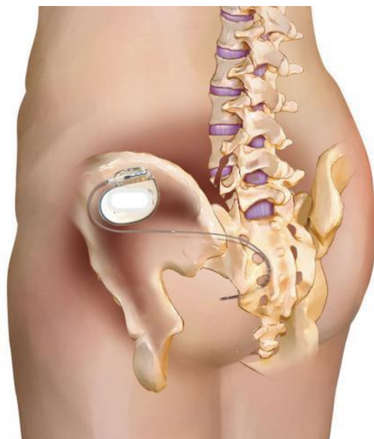
Increasing interest in mesh-free, native tissue pelvic floor reconstruction using autologous fascia lata due to mesh controversies

Advanced therapies for urge urinary incontinence (UUI)

1. Intravesical botox injections – average effect between 6-9 months

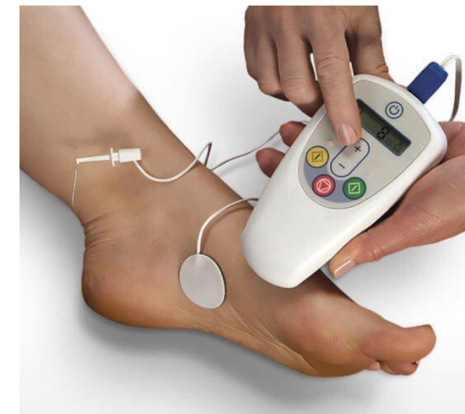
- 20% complete resolution of UUI, at least 75% reduction in UUI in 46% of pts

2. Sacroneuromodulation – two staged procedure (85% success at 12m, effect sustained at 5 yrs)



3. Percutaneous tibial nerve stimulation

- Retrograde stimulation of sacral nerve plexus through posterior tibial nerve
- 77% patients maintained moderate to marked improvement in OAB at 3yr
- Intensive treatment regime (30 mins, 12 weekly treatment)



Take home message

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- Opportunistic screening for pelvic floor disorder
- Uncomplicated pelvic organ prolapse can be managed in community
- Conservative therapy should be the first line management
- Know your local pelvic floor physiotherapist
- Not all prolapse require surgery
- Specialist input if patient presented with multiple pelvic floor symptoms, pelvic mesh complications or failed conservative management

60 yo woman with bothersome vaginal bulge & mixed urinary incontinence

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Using 2-3 pads daily for past few years

Obstructive voiding symptom – slow urine flow, straining to void, incomplete emptying.

Nocturia 2-3x/night, recurrent UTI 3-4x/year

No bowel issues, not sexually active

Obs hx: 1 x forceps, 3 vaginal births

Menopause at age 52

Med hx: HTN, cardiac arrhythmias, type 2 DM, anxiety disorders

Meds: Candesartan, frusemide, metoprolol, Eliquis, metformin, fluoxetine

Surgical hx: Hysterectomy for menorrhagia and fibroid in 40's

Non-smoker, independent of ADLs

Examination:

Abdomen – previous hysterectomy scar, no mass

Atrophic vulva and vagina, erythema from long-term pads use

Mild bladder leakage with valsava

Visible vaginal bulge beyond vaginal opening

Management Approach:

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1. Identify presenting problems and other health conditions that can potentially have an impact long-term management plan

a. Vaginal prolapse with obstructive voiding

b. Mixed urinary incontinence

c. Multiple comorbidities

d. Polypharmacy

2. Assessment/investigations:

a. MSU to rule out active UTI

b. Pelvic USS – rule out pelvic mass/pressure effect from pelvis

c. Renal tract USS – exclude urinary tract abnormalities contributing to recurrent UTI

d. Baseline FBC, biochemistry, renal function test, HbA1c

Management Approach:

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3. Implement conservative mx

a. Optimizing general health and review current medications that could exacerbate urinary incontinence

b. Bladder diary – assess fluid intake/output, frequency/type of UI

c. Fluid intake/caffeine intake modification based on bladder diary findings

d. Containment method – incontinence pads & vulva hygiene

e. Scheduled voiding

f. Vaginal estrogen and barrier cream on vulva

g. Caution with anticholinergics use to treat overactive bladder – presence of obstructive voiding symptom, drug interactions with fluoxetine

h. Pelvic floor physio – bladder retraining, PFM rehab

i. Vaginal pessary to reduce prolapse

Totally made up case, because we didn't get one!

Sally – 54 , Presents with a UTI – 3rd time this year.

PHx	Meds:	Family History:	Screening:
• 2x Caesarian sections • Hypertension • GDM in pregnancy • DVT following an ankle fracture	• Perindopril 2mg	• Sister – breast cancer age 42 • Mother – breast cancer age 56	• UTD with cervical screening – last done last year (GP collected) • Mammogram done earlier this year • Lipids / sugars normal

- Some stress incontinence at times – mainly with cough / sneeze, worse with UTIs
  - Has to get up at night to urinate
  - Had some issues with incontinence before menopause but felt worse since, not sure if this was because the menstrual cups she used to help
  - No dragging / pelvic pain or bulging at introitus
  - Last period age 51, vaginal dryness, some mood changes, occasional flushes
  - Reluctant to consider HRT due to family history
  - C/S delivery due to failed ventouse, large babies
- Last CST – in notes: cervix difficult to visualize due to anterior wall prolapse.

Questions of the group

- *Sally is unaware of her prolapse – is it worth worrying about?*
- *How much risk is vaginal oestrogen for people with only a family history of Ca*
- *Should she have bladder function tests / u/s before pelvic floor physio?*

HealthPathways
PROJECT ECHO Women's Health

HealthPathways
Western Victoria

WHAT IS HEALTHPATHWAYS?

A web-based information portal providing locally agreed, evidence-based clinical guidelines and referral pathways designed to support primary health care providers, in particular General Practitioners, in the assessment, management and referral of patients.

Provides information on:

- How to assess and manage a range of conditions
- How to refer patients to local specialists and services in the timeliest manner
- Reference materials
- Educational resources
- Patient resources

A dynamic website with new pathways constantly under development and existing pathways regularly reviewed by local GPs and specialists to ensure they remain aligned with best practice, relevant to the local context.

CLINICAL

Menopause

Urinary Incontinence in Women

Pelvic Organ Prolapse

Persistent Pelvic Pain

Referral

Continence Specialist Services

Non-acute Gynaecology Assessment (> 24 hours)

Acute Gynaecology Assessment (Same day)

CONTACT

•New to HealthPathways?
Visit https://westvic.communityhealthpathways.org/ and select 'register now'

•Use the "send feedback" button on the website or email: healthpathways@westvicphn.com.au

•The HealthPathways team can arrange for passwords to be bypassed if you provide your practice IP address.

WHO CAN USE HEALTHPATHWAYS?

•GPs and Health Professionals within the Western Victoria region can access HealthPathways. The portal is not designed to be used by the general public and can only be accessed by using a secure login and password. There is no cost to access.

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Western Victoria PHN – Needs Assessment

We are listening!

- Western Victoria PHN want to understand the needs of the communities that we serve. The 2024 Needs Assessment consultation process is underway.
- Please follow the link and tell us what health issues are most important to you and your community.
- **https://www.meetingplacewestvicphn.au/needs-assessment**

Celebrate the end of the year with Western Victorian Primary Health Network

Western Victoria Primary Health Network invites primary care professionals in our region to attend a professional networking social evening.

Please join us for a relaxed night of socialising, networking and connecting with colleagues in your region to celebrate 2023. Bring your whole team and make the most of this opportunity to mix with your fellow GPs, primary care professionals, and health service representatives.

Finger food supplied, drinks at bar prices.

Ballarat Goldfields

Ballarat – Tuesday, 14th November
6pm to 8pm

Oscar's Hotel, 18 Doveton Street South, Ballarat

Wimmera Grampians

Horsham – Wednesday, 15th November
6pm to 8pm

Horsham Golf Club, 304 Golf Course Road, Haven

Geelong Otway

Geelong – Wednesday, 29th November
6pm to 8pm

The Myers Bar at Centra, 131 Yarra Street, Geelong

Great South Coast

Portland – Tuesday, 21st November
6pm to 8pm

Portland Golf Club, 755 Madeira Packet Road, Portland

Warrnambool – Wednesday, 22nd November
6pm to 8pm

Lady Bay Resort, 2 Pertobe Road, Warrnambool

Hamilton – Tuesday, 28th November
6pm to 8pm

Hamilton Golf Club, 170 Rippon Road, Hamilton

Lake Imaging (https://lakeimaging.com.au) is the co-sponsor of the Geelong, Warrnambool and Ballarat events.

Scan QR code to register now

For Ballarat and Horsham events please RSVP by **31 October 2023**.
For Portland, Warrnambool, Hamilton and Geelong events please RSVP by **6 November 2023**.

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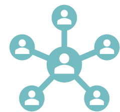
- Please join us for a relaxed night of socialising, networking and connecting with colleagues in your region.
- Bring your whole team and make the most of this opportunity to mix with your fellow GPs, primary care professionals, and health services representatives.
- Six locations across the region – Register now.

Session Evaluation

- Please take the time to evaluate this **session**
- Link pasted into the chat



Upcoming Sessions

- Weekly from **2 November** until **30 November**

If you have a case, you would like to discuss with the group:

- **Case template** here
- Email projectechocovid19@westvicphn.com.au
- Use the comment box in the evaluation form

Would your general practice like the support of a paediatrician?

Strengthening Care for Rural Children trial (SC4RC) Commencing 2024

- Fortnightly access to a paediatrician via video telehealth for 11 months
- Phone and email support
- Specialised Project ECHO

Register your interest today!

$3000 QI grant per practice

Up to 54 hours of RACGP and ACRRM CPD hours accredited

Funded by Grampians Health Ballarat and Barwon Health