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## Incontinencia urinaria pdf 2020

Conservative treatment The first therapeutic step are hygienic-dietary measures, behavior modification techniques and pelvic floor muscle rehabilitation. Pharmacological treatment The medication indicated, above all, in incontinence and emergency stress. Surgical treatment Minimally invasive surgery for patients in whom conservative and pharmacological treatments had no effect. For its efficacy in about 90% of cases, we highlight the procedure for placing the tension-free transvaginal mesh (TOT), which is inserted through a small vaginal incision. It's a tape, usually made of polypropylene. Being porly, it is fixed and integrated into the body. The operation takes about 25 minutes and is usually performed under epidural anesthesia, although it can also be performed under local anesthesia. It is a simple and very invasive intervention, which facilitates the rapid recovery of the patient at home. Incontinence ceases when meshing, although it is recommended to avoid large efforts during the first month after the intervention. Occasionally, there is associated pelvic organ prolapse, with laparoscopic or robotic correction (colposacropexia). This is defined as the involuntary loss of urine that causes discomfort in the patient (International Continence Society (ICS), 2020). The World Health Organization estimates that about 200 million people are impacted by this problem globally. Within the number, the frequency is higher in the elderly and in the female sex (2:1) in relation to the man. In the Peruvian context, 30% of the total population suffers from urinary incontinence, but only 10% of them seek professional help or treatment. The consequences of urinary incontinence become physical and psychological, as urine has negative effects on the skin, infections within the urinary tract and increased falls. These effects psychologically impact the patient because, with the limitation of leaving the house caused by the described effects, feelings of loneliness are generated (1997, as mentioned in Gonzales, 2016). In response, the WHO states that the only disease in elderly people with more care to treat than incontinence is dementia, being one of the most mortality-related problems in Peru (America Television, 2020). There are 5 types of urinary incontinence that are identified as stress, urgency, mixed, overflow and false incontinence. The symptoms of each type will be described below, as care varies between them (Medical Journal of the Mexican Institute of Social Security, 2007). Stress incontinence: Defined as involuntary urine loss sneezing or when the patient makes efforts with his body (Martinez, 2007). This type of incontinence can become chronic (Parodi, 2016) and can originate from two causes: problem within the urinary system (chronic) and, problems outside the urinary tract (temporary character for alternating diseases manifested incontinence)The treatment of stress incontinence includes special exercises called Kegel. These exercises seek to strengthen the muscles that control the bladder. The effects of these exercises are between 3 and 6 months of practice (Benites, 2011). Emergency incontinence: This is the most common urinary incontinence in the elderly. It refers to a dysfunction in emptying associated with involuntary loss of urine and frequent desire to urinate. The bladder becomes unstable at different volumes and contracts. It is emphasized that this type of incontinence can occur after a prostate operation (Parodi, 2016 and Martinez, 2007). In this case, the treatment of incontinence is pharmacological. The Spanish Society of Gynecology and Obstetrics (2015) states that to start treatment an infection must be ruled out (...) If there is infection, it should be treated before continuing the study. In these cases, the same source indicates that physical therapy, d.A. change in diet and medications had positive results in patients with Emergency Urinary Incontinence.Mixed incontinence: Refers to involuntary urine loss associated with urgency and exertion, coughing or sneezing. It is the most common type in women after stress incontinence (Gomez, 2008 and Martinez, 2007). Its etiology is the same described for the two previous types of incontinence. Treatment for mixed incontinence includes therapeutic possibilities such as pharmacotherapy, pelvic floor rehabilitation exercises, palliative (absorbent) treatment, and surgical treatment. Diagnosis should be initiated in a medical entity. Overflow incontinence: In this incontinence the bladder is unable to empty and filling occurs at the limit of stretching. Increases the pressure inside the bladder until the resistance of the urethra is exceeded and there is leakage. It is common in men with benign prostatic hyperplasia obstruction. Symptoms include frequency, urgency, and emergency urinary incontinence. In this case, the suggestions provided by specialists in the area are the practice of uro analysis, the realization of a periodic bladder function and post-urine measurement to do the treatment. This will depend on the severity of incontinence, being the most recommended: bladder training, double urination, time to go to the bathroom and diet measuring fluids (Clinic 2020). False or functional incontinence: Occurs when leaks occur that can be avoided if you reach the bathroom quickly, since in such cases the bladder is pressed to avoid urinating. Similarly, incontinence has the following levels: Mild urinary incontinence: Leakage of a few drops of urine a few days a month. Moderate urinary incontinence: Defined as daily leakage of urine drops. Severe urinary incontinence: Includes the loss of larger amounts of urine at least once a week (Hunskaar, 2003)Acute urinary incontinence: Refers to the sudden onset of urine leakage that can occur during delirium, acute infection, restricted immobility, overflowing urinary retention, fecal impact, and recent onset of drug intake such as diuretics, tricyclics, or psychotropic drugs. ABENA Premium incontinence diapers are made for severe or acute incontinence problems, and for any type of incontinence. These have absorption capacity of up to 4.2 liters, which represent up to 7 hours of tranquility, without leaks or odors. Specialists in the area recommend ABENA, as it allows the saving of bed accessories and the constant change of diapers, uncomfortable for the patient. If you have any symptoms described, go to your doctor. BIBLIOGRAPHIC REFERENCESSABENA (NS) Report: Welcome to ABENA Peru. (See:8 April 2020) Alcazar (1961) Urinary incontinence in women. Retrieved (Consultation:April 7, 2020)Mayo Clinic (2020) Urinary Incontinence. Retrieved: (Consultation:8 April 2020)Elsevier Spain (2015) Treatment of Emergency Incontinence and Overactive Bladder Syndrome – Updated 2015. Retrieved: (Consultation:April 8, 2020)Parodi, José (2016) Dr. José Francisco Parodi – Incontinence in the older adult. Retrieved (Consultation: April 8, 2020)Gomez (2008) Female Urinary Incontinence. Retrieved: (See:8 April 2020)Gonzales (2016) Specialized services for the elderly. Retrieved: . (See: April 7, 2020) Martinez, Nellen – Hummel, Hamul, Hlabe-Cherem (2007) Urinary incontinence in the elderly. Retrieved (Consultation: April 7, 2020)RPP News (2011) Female urinary incontinence and population. Recovered: (See: April 7, 2020) Urinary incontinence is a very prevalent symptom in the adult female population. It generates important psychosocial and economic connotations, affecting the quality of life of the patients who have it. This is a subdiagnosto problem, because patients do not always consult for this reason, so it is important to keep it in mind and do opportunistic screening of primary care. It is difficult to know the health expenditure it generates, to see what is the role of primary care in this disease and when it should be derived to the corresponding level of care. Urinary incontinence is a highly prevalent symptom in the adult female population. It has important psychosocial and economic connotations, and affects the quality of life of these patients. Because it is an underdiagnosed problem due to patients who do not always consult for it, it is very important to keep this in mind and provide an opportunistic screening of Primary Health Care. It is difficult to determine the costs of this, but it is estimated to be 2% of the health budget. For all this, it is very important to know how to make a correct diagnosis of this condition, to determine the different types of incontinence, possible causes and treatments available. The aim of this review is to show the different diagnostic and therapeutic tools available, to show the role of Primary Health Care in this condition and when referring to specialized care. Introduction Urinary incontinence (IU) is a very prevalent symptom among the adult population, affecting 24% of women and increasing by up to 50% in elderly patients1. Even without being a serious condition, it has an important impact on quality of life with remarkable psychosocial and economic connotations, so from primary care, much of this disease should be used to achieve, from the outset, adequate diagnostic guidance and, thus, obtain a better therapeutic response. Referral to a second level of attention will be reserved for cases that give doubt to their affiliation, associated with pain, hematuria, history of recurrent urinary tract infections, pelvic surgery or radiotherapy2, or those patients who do not respond to a first therapeutic approach. IU is a common symptom present in various diseases, affecting all population ranges, age and gender, although it is more common in it has a similar incidence among children, being at maturity more frequent in women. From the age of 65, the prevalence is re-evalued in both sexes. It is defined as any involuntary leakage of urine through the urethra, objectively demonstrative and constituent, for the person suffering from it, an important social and hygienic problem3. In children, the elderly and neurological patients it is not only a medical and social problem, but a significant subjective psychological damage, assuming a severe limitation for their daily activities4. It is a subdiagnosed pathological process, with less than 50% estimated to be consulted for this reason5. Therefore, it is difficult to calculate its socioeconomic impact. In addition to the direct expenses invested in diagnosing and coping with the problem, indirect charges should be added for the incapacity it generates. There is very little data available about the direct cost for UI processing. It is estimated that in developed countries it represents at least 2% of the health budget, and although 90% is due to disposable products (probes, absorbents...), only 2% represent diagnostic and treatment costs2. The most recent and comprehensive study estimated annual direct care spending in 1995 related to urinary incontinence in the U.S. at \$16.3 billion. For example, urinary incontinence can account for between 6.4% and 10% of the budget, or 8.8% of the pharmaceutical expenditure of a geriatric residence. The purpose of this update is to present existing options to diagnose and treat this problem, which creates so much disability in patients in order to optimize resources and try to control spending. Classification The user interface can be classified according to its symptomatology:•UI of stress (IUE) represents 10 to 39% and is defined as involuntary leakage of urine motivated by physical exertion (such as coughing or sneezing), which will cause an increase in abdominal pressure. Its underlying causes are urethral hypermobility or intrinsic asphyxia deficiency. •Emergency IU, which accounts for 1-7%, is defined as involuntary urine leakage accompanied, or immediately preceded, by urgency. The urgent urge to urinate is considered urgent, which is difficult to postpone. It is due to detrusor muscle hyperactivity, neurogenic cause or other mixed IU (IUM), which represents 7-25%, is the involuntary loss of urine associated with urgency and effort. Depending on its duration can be transient, when limited in time, or established if not disappear before 4 weeks of its creation, once acted on its possible causes. As for its intensity it can be mild (loss&lt;600ml/day), moderate (&gt;900ml/day). In the case of women, the most prevalent is THE IUE7. Risk factors A number of UI risk factors have been identified in women: -age. The prevalence of IU increases with age to 50% in women.- Obesity. Epidemiological studies show that obesity and overweight are risk factors for IU. Weight loss, both with diets and surgery, has been demonstrated to improve ui symptoms, so it should be considered as a first-line treatment option in obese women with IU8.-Parity. It's one of the most important factors. The first delivery is associated with an increased UI risk with an odds ratio ratio (OR) of 1.3-1.6; subsequently, there is a linear increase of up to 1.5-2.07. The incidence of IU in women with vaginal deliveries was compared with women with cesarean deliveries at 4 years of age and a higher prevalence of IU was observed in women with vaginal delivery9.- Hormone replacement therapy. As there is a high prevalence of IU in postmenopausal patients, it seems logical to think that decreased estrogen will contribute to the onset of UI symptoms, so the use of hormone replacement therapy has been raised as a treatment in some cases. Other studies, such as HERS10, however, conclude that this may even make the clinic worse. There are no clear data, but it seems that there are irritants such as alcohol, chocolate, etc. that worsen the symptomatology of EUI. Others, such as bread, potatoes and other vegetables seem to decrease the incidence of overactive bladder.-Diabetes. The mechanism is not well known, but may be related to neuropathy and vasculopathy that occurs in this disease.-Others. Gynecological surgery, urinary tract infections, cognitive and functional impairment, menopause, tobacco, neurological diseases, sedentary lifestyle and depression2. DiagnosisFor better diagnosis and therefore better therapeutic guidance, it is advisable to know the possible causes of IU. Opportunistic screening by primary care health professionals at least once throughout life is recommended in asymptomatic women over 40 years of age. In case of risk factors, this screening will be performed annually, from these age groups2. Simply put, this may be due to 2 main causes, either by bladder dysfunction or by sphinterial dysfunction. AnamnesisThe fundamental part of the diagnosis of this disease is a complete anamnesis, where it is essential to document a personal history and pharmacological treatments of the patient. Neurological disorders, obstetric history, pelvic surgery or radiotherapy treatment are of particular importance, such as are the causes or contributors of the user interface. The frequency and severity of symptoms, the onset time, and whether it is associated with any cause recognized by the patient should also be known. It is important to differentiate the predominant type of clinic: whether the stress component or the emergency component or both and what symptoms accompany it (symptoms of emptying or filling, hair or perineal pain, feeling of pressure that makes us think of a prolapse, continuous loss indicating a possible fistula, intestinal habit and whether there is sexual dysfunction). One fact that should be reflected is how the clinic affects the quality of life of patients. To try to collect this information objectively, several validated questionnaires were developed such as ICQ, UAB-q, ISI and ISQ. Its use has a grade B recommendation in the European UI2 guides. Physical examinationThe abdomen and flanks, genital and perineal region should be explored by performing a vaginal touch to assess the existence of pelvic organ prolapse. An exploration of the sacral root area S2-S4 will also be performed, further checking the tone of the anal sphincter. Specific maneuversQ-Tip testConsist to insert a swab through the singe and perform a valsalva maneuver. If the swab is mobilized &gt;30 it is considered urethral hypermobility. Marshall-Marchetti-Krantz Testtt indicates the performance of a Valsalva maneuver checking the loss of urine with it. Subsequently, with the index finger resting on the lower edge of the urethra, the anterior face of the vagina repeats the maneuver to verify the effect that placing a suburethra tape on the anterior loss would have. Both maneuvers are used to evaluate the EUI. Pad testemunhaAlizta the detection and quantification of urine loss. It can be short or long -- it can be short or long-lasting (1 or 24h), the most commonly used currently is the short-lived one. This is considered positive if the absorbent weight increases by 1.3g. In the case of long, the increment should be 8g. Micional JournalRecou the information of all urines and fluids ingested for 3 days, including emergency episodes, leaks, etc. Post-mictictonais residues is considered normal below 50cc. An evacuation or ultrasound probe can be used to measure it. The presence of a high residue may indicate obstruction. Urine testsScurcuroando a systematic and sediment to exclude other processes that may cause the clinic ui. Urodynamic study The alrodynamic study is recommended in all IU patients in whom we consider invasive treatment2. However, some articles conclude that it can be ignored in patients with genuine IUE11, that is, confirmed by anamnesis and physical examination. The study consists of the following elements:-Flujometry. It allows us to know the myonal volume, the maximum flow and the post-cymic residue.-Cystomanometry. Study the filling phase and detrusor behavior by increasing bladder pressure. Identifies detrusor hyperactivity and possible changes in bladder distensibility or accommodation. Under normal conditions, by increasing the volume inside the bladder, the detrusor pressure is poorly modified. Study the emptying phase. It allows to diagnose or rule out obstruction to the flow or insufficiency of the contrusor's constiill capacity, measuring the flow rate during urination and detrusor pressure (table 1). Treatment When selecting a therapy it is important to know aspects of the patient's quality of life, as well as their expectation regarding treatment. Urinary stress incontinence Pelvic floor grafts (ESP) of urinary management. They consist of a series of simple exercises that are performed with pelvic floor musculature,

improving it and thus improving urethral stability. In patients with overactive bladder may inhibit bladder contraction. For postpartum user interface, these exercises must be started before or very early after exercise. There are studies<sup>12</sup> comparing ESP vs. no treatment in women with IU, concluding that they should be recommended as a first-line conservative measure in women with any type of incontinence. However, a Cochrane review<sup>13</sup> concludes that there is no increase in benefit when associating ESP with other treatments. These are in case studies in small groups of patients, so it would take more extensive work to draw conclusions about this. On the other hand, Kafri et al.<sup>14</sup> compared the efficacy of SPEs with bladder training, with medical treatment and combined pelvic floor rehabilitation, demonstrating that they all have long-term benefits, but that the combined use of them brings greater benefit. In any case, we must take into account the low long-term uptake to them, so that approximately 50% will require surgery. Pharmacological treatments SSado to the good results of surgery in this type of IU, and the side effects of these treatments, are hardly used. Duloxetine. It is a serotonin and norepinephrine reuptake inhibitor. Increases muscle tone and promotes urethral closure. Its effectiveness is dubious. It should only be used in cases where surgery is ruled out for reasons of comorbidity or other reasons and there is concomitant depression. Estrogen. They have been used in some cases without showing benefit. Adrenergic  $\alpha$  (pseudoephedrine and mycodrine). They have little efficacy and many side effects. your It's anecdotal. Surgical treatmentTreatment of choice in incontinence that does not respond to other measures and in moderate to severe incontinence. Monofilament or sling meshes and irremovable material, usually polypropylene, are used. There are different types:•Tension-free vaginal tape. It consists of the passage of a mesh through the endopelvic fascia through the transvaginal route. There is an increased risk of bladder injury, so it requires cystoscopy control.2.Tension-free tape transshutter. It is placed through the shutter hole. It's the most used. No control cystoscopy is required. It can be performed under higher outpatient surgery.3.Minicabestrillos. Less invasive. Being something new, there are fewer studies on its effectiveness.•Sling suburetra without adjustable voltage:1.TVA TOA. They can be adjusted after the intervention in case of persistent incontinence, or on the contrary there was an obstruction.2.Other systems: Remeex, Safyre, etc.•Urethral coaption procedures:1.Periurethral injections. It consists of injecting macroparticles to try to approach the urethral edges, reducing urine leakage creating a mechanical obstacle.2.Adjustable periurethral balls. Placing a balloon on both sides of the urethra, which will exert extrinsic compression.3.Artificial urinary sphincter. Prostheses usually 3 components. Emergency urinary incontinence conservative management1. In patients with IU associated with the conditions we should treat them with a degree of recommendation A2. Thus, certain factors must be taken into account; in obese people weight loss should be a frontline measure. Constipation, certain drugs, diapers 2,000 diapers, will be considered. In patients where it is not possible to use other treatments due to age or other comorbidities15.3.Lifestyle changes.•Decreased caffeine intake: improves feeling of urgency and urinary frequency.•Exercise. Improves moderate IU intensity.•Net intake. It is not clear that the ingestion of varied fluids influences the incontinence clinic.4.Emptying requested. Emptying the bladder at a predefined time.5.Bladder training. Regime of urination rules at gradually adjusted intervals. The main objectives are to correct bad urination habits or frequency, increase the period between urinations, increase bladder capacity, decrease emergency episodes by improving your control and, with all this, restore confidence in urine control. Some studies compared bladder training with other treatments or with non-seated patients. It has been seen that it is more effective than not treating and that vaginal repentance, less effective than pelvic floor muscle training. Pharmacological treatmentMedical treatment is mainly used in the USA and IUM. There are several groups of drugs that can be used.1.Anticholinergic. They are the fundamental pillar of drug treatment. They instill the action of acetylcholine, suppressing involuntary bladder contractions and increasing bladder capacity. To evaluate its effectiveness, you should wait 4 to 12 weeks, and you cannot talk about treatment failure if at least 2 different anticholinergics have not been used. All of them have similar effectiveness. The vast majority are oral tablets, but currently there is a new form of administration in patches lasting 72 hours and with few side effects. Most patients leave treatment within the first 3 months because of inefficacy, cost and side effects. European guidelines on urinary incontinence2 recommend that you make a great effort in using conservative measures to try not to use drug treatment in older people. Anticholinergics may worsen cognitive decline in elderly patients who have this problem, or who are at risk of cognitive decline, so their use in this age group should be done with caution.2.Agonists  $\beta$  adrenergics (mirabuto). Produces detrusor relaxation. It is a good alternative if antimuscarinics are not tolerated, or even associated with them if they do not achieve all the desired effect. In patients with uncontrolled HTA requires monitoring of Fc and HTA.3.Tricyclic antidepressants (imipramine and amitriptyline). Anticholinergic/peripheral/ $\alpha$  central adrenergic. Its effect consists of relaxation of the detrusor and the increased tone of the urethral sphincter. These drugs have significant side effects, so they are not used for calcium agonists (verapamil). Less effective than oxybutin, so it is not considered a first choice. The combination of verapamil with oxybutin proved to be more effective than just oxybutin. This should be taken into account in patients taking verapamil for cardiac problems. However, there is insufficient evidence to demonstrate the superiority of drug treatment over conservative treatment. Patients are generally more satisfied with the result of behavioral maneuvers or pelvic floor exercises than with drug treatment. This is reflected in the number of treatment cessations shown in the literature (Table 2). Surgical treatment•Botulinum toxin A (Botox). It is used in the USA by neurogenic or refractory bladder overactive bladder for anticholinergic. Antibiotic prophylaxis should be used 1-3 days before, on the same day and days later. The procedure involves injecting, using an endoscopic procedure, 30 cigars of 1ml each (total volume of 30ml), with a distance of about 1cm (100U) into the detrusor. It is done with the help of a rigid or flexible cystoscope and avoiding the trigon and bladder base. It can be performed under higher outpatient surgery. Clinical improvement usually occurs in 2 weeks. It can be safely repeated16 when the effect decreases, but not before 3 months. The frequency of treatment is usually annual. It is contraindicated in urinary tract infections, neurological diseases and at patients receiving aminoglycosides. Several articles confirm that this treatment offers a clear improvement of all symptoms and urodynamic parameters in patients with overactive bladder and neurogenic bladder17. A study by Rovner et al.<sup>18</sup> shows that patients with UIU due to overactive bladder and neurogenic bladder treated 4 years ago with botulinum toxin A maintain the effect of botulinum toxin, improving the symptomatology and quality of life of these patients.•Neuromodulation. Its indication is UIU in the neurogenic and refractory bladder of the overactive bladder to medical treatment. It consists of stimulation of the sacral center of urination and modulation of the mictionreflex arches. There are different modalities.1.Posterior stimulation of the tibial nerve (SANS, TENS). Weekly sessions 30min 6-12 weeks. It is effective in patients who do not improve with antimuscarinic. Its effect is similar to tolterodol. It should be reported that this is not a curative treatment; with maintenance program is effective up to 3 years. No side effects. A study by Kabay et al.<sup>19</sup> demonstrates the efficacy of this treatment in patients with neurogenic bladder secondary to Parkinson's disease, improving the clinic and urodynamic parameters.2.Sacral neuromodulation interstim®. It improves clinical and urodynamic parameters, but has a high rate of complications that appear in up to 50% of cases: pain, superinfection, displacement of electrodes.3.Stimulation of canndo or genital. Still experimental technique.4.Electrical stimulation. Improves IU compared to placebo and antimuscarinics. Adds benefit to pelvic floor exercises.•Increase enterocystoplasty. As soon as it is used as an overactive bladder treatment, it is most commonly used in microblading caused by tuberculosis or radiotherapy.•Ureteroostomy skin. Very little use, only in extreme cases, because it is a surgery with high comorbidity. The one conclusion, we want to highlight the importance of this clinical problem because of its high incidence and prevalence, the impact it has on patients who suffer from it and the economic impact it generates. That's why he has relevance the correct diagnosis through anamnesis and physical examination, becoming the specialist when necessary and initiating the most appropriate treatment in each case as soon as possible. Through summary, we can say that patients with a moderate to severe intensity IU clinic should be referred to the specialist for initiation surgical treatment, while patients with I.U.I. usually improve with medical treatment, which could be initiated from primary care along with conservative treatment. In case of no improvement, the specialist should be referred to complete the studies and modify the treatment according to the guidelines. Conflict of interest This work has been done without conflict of interest. Copyright © 2017. 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