INVOLUNTARY URINATION (URINARY INCONTINENCE)

WHAT IS INVOLUNTARY URINATION?

Involuntary urination is also known under its medical term: urinary incontinence. Incontinence is a common term for involuntary urination or feces. Incontinence is not a disease in itself, but a symptom with several possible causes. It should therefor be examined and not just put up with. It is vital to get all symptoms diagnosed and investigated by a doctor or through a clinic specialised in incontinence (Inkontinensclinic).

Involuntary urination affects 3-400,000 women of all age groups, and many do not consult their doctor about it. Frequency increases with age. The most common cause is a weak pelvic floor - often related to childbirth but can also be a side effect of obesity, chronic cough, lack of oestrogen, or lower abdominal surgeries.

There are mainly two types of incontinence: urge incontinence and stress incontinence, but it can also be a mix of the two.

URGE INCONTINENCE

Urge incontinence is characterised by frequent urine leaks, an intense need to pee and very short signalling. For example, you might barely have time to open up the front door when you suddenly feel the need but cannot get to the loo in time. It could also be a completely uncontrollable full bladder void.

STRESS INCONTINENCE

Stress incontinence is caused by pressure on the bladder, notably during physical effort such as sneezing, coughing, lifting, and sport. They tend to be small drops but can accumulate to a larger amount of urine f. ex. throughout a whole run or other prolonged physical activity.

DIAGNOSIS AND INSPECTION

Firstly, the lower abdomen must be examined both gynecologically and with an ultrasound. At home, make a bladder diary journaling the incontinence for at least 3 days, taking note of your liquid intake and excretion. Only thereafter can the doctor make the correct diagnosis. You will also have to get checked for bladder infection.

During the gynaecological examination, the doctor will often be able to see a prolapse (sinking) of the vaginal wall. Prolapse implies that the organs which usually sit above the pelvic floor have sunk because of its fragility. The latter can cause a prolapse of the urethra (urethrocele), the bladder (cystocele), the uterus (descensus), the vagina (vaginal prolapse), the small intestine (enterocele), or the rectum (rectocele).

TREATMENTS

A lot of the time, the problem can be solved with pelvic floor or bladder training. We can refer you to a specialised physiotherapist who can help you learn the exercises. Women at menopause are generally offered a local vaginal oestrogen treatment. In certain cases it can be necessary to undergo further medical treatments and/or surgery.

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Urge incontinence can be treated with bladder-relaxing medicine, such as Vesicare, Toviaz, etc. The medication must be tested for a month to assess efficiency and side effects. For the cases where medication isn't effective, it is also possible to get Botox injections in the bladder muscles.

Stress incontinence can be treated with urethral inserts, such as Efima, Contam which can be bought in pharmacies, Matas, and on the web (eg **probs and pearls**). The small, tampon-like insert supports the bladder neck and thereby acts as a plug preventing leaks during physical activity. Sometimes it is possible to get surgery for stress incontinence using TVT, short for Tensionfree Vaginal Tape. The latter is a sort of band made of mesh which is placed as a sling under the urethra to support it. That way, when making a physical effort such as a jump, sneeze, cough, run, etc, the urethra will be clammed shut without being tightened. The TVT supports the urethra, thereby hindering or at least reducing the gap. When placed on the right patients, the result is very efficient: over 90% of patients are satisfied with the operation, and over 70% do not experience anymore leaks. It is possible to inject some filling around the urethra for elderly patients in order to fill the gap further.

WHAT CAN YOU DO?

Pelvic floor training

Pelvic floor training can be done regardless of age and gender, and 60-70% find it effective. The most common exercise is to do a lying down bridge until you reach a pinching/tightness sensation in the rectum. The bridge should be hold for 8-10 seconds and repeated 30 times. Do it 3 times a day, every day, for at least 3 months in order to obtain results.

Bladder training

To train your bladder, start by trying to hold the urine in for 5 minutes every time you need to pee. Hereafter try increase the amount until you only feel the need to pee every 3-4 hours. You have to practise controlling your incontinence, by f. ex. going to the loo at specific times until you find a peeing schedule that works for you. Remember that bladder training takes a long time, at least 3-4 months, so don't lose hope!

Residual urine & Double/Triple Voiding

If you feel the need to void only a short time after you last did so, it might be because you haven't fully emptied your bladder. Double or triple voiding is a technique where you void in 2-3 times. Sit comfortably and give yourself time to void. The bladder is a muscle, which means it must retract itself without you pushing your abdominal muscles. Try instead to stand up and walk around for ½-2 minute(s) and void again once or twice. This way you can allow your bladder to gradually pull itself back and thereby fully empty itself.

PELVIC PHYSIOTHERAPY

You would benefit from contacting a pelvic physiotherapist / uro-gyn physiotherapist, as they can provide very good help for targeted training of the pelvic floor. it costs approx. DKK 600 for the first, and DKK 400 for the second visit, but it is, in our opinion, totally worth it.

See the list below:

Dorthe Svarre http://urogyn-fysio.dk
Bækken fysioterapeuter: https://www.klinik-fordeltemavemuskler.dk
Kontinentsforeningen: https://kontinens.org
BirtheBondeklinikken
https://www.birthebonde.dk/

WHO CAN I CALL WITH QUESTIONS?

You are welcome to call Kvindeklinikken during telephone hours on 36 46 71 40.

Revised September 2022. To be revised on an ongoing basis and certainly no later than September 2025, before in case of any significant changes.