

魏添勇

SY33

現職：童綜合醫院婦產部產科主任醫師
台灣婦女泌尿暨骨盆學會副秘書長
經歷：林口長庚醫院婦產部住院醫師
林口長庚醫院婦產部婦女泌尿科研究員
台北長庚醫院產科主治醫師
中國醫藥大學臨床醫學研究所碩士畢
台北醫學大學醫學系畢業

Urinary incontinence in demented women (Dementia). What can we do?

Tien Yung Wei, MD,

Department of OBS&GYN, Tungs' Taichung MetroHarbor Hospital, Taichung, Taiwan

Dementia, is a disease of mental decline, and is a serious loss of cognitive ability to deal with daily life. Previous data indicate more than 35 million people worldwide live with dementia, and the number will be expected to double by 2030. Alzheimer's disease (AD) is the most common cause of dementia with approximately 60% to 70% of all cases of dementia in Taiwan. Urinary incontinence (UI) means any involuntary leakage of urine defined by the International Continence Society, which is also common in the elderly population. UI is more prevalent in the elderly population with dementia than without dementia. The prevalence of urinary incontinence in dementia varies as much as from 11 to 90%. Typically, incontinence occurs in the moderately severe stages of dementia.

Incontinence leads to feelings of embarrassment, low self-esteem, and even depression. It cannot be assumed that those with dementia do not feel these negative emotions associated with incontinence. The causes of UI with dementia may stem from comorbidities, cognitive and functional impairment of neurodegenerative processes, or be medication related. Because treatment of AD with cholinesterase inhibitors by increasing acetylcholine levels in the brain may also increase the incidence of UI. It means the cause of urinary incontinence in dementia patient may not only from stress incontinence, but also urge incontinence, overflow incontinence, or functional incontinence. Much of the incontinence seen in dementia may be functional incontinence where the cognitive impairment interferes with the ability to toilet.

Incontinence in dementia is complex because it is often multifactorial and does not lend itself to easy solutions. A comprehensive assessment is required, including looking at the stage and type of dementia with its resultant effects on the cognitive and functional abilities of the person, exploring their psycho-emotional world and behaviour, scrutinising the environment, and examining for medical factors and pathology in the urinary system. The first-line treatment of UI in dementia is non-pharmacological behavioral therapy. Behavioral therapy programs such as prompted voiding, timed voiding, and habit training can help reduce UI in the elderly with limited physical and cognitive abilities. Pelvic floor muscle exercise, biofeedback and electrical stimulation therapy are recommended for elderly without advanced physical or cognitive dysfunction. If behavioral therapy alone does not work, pharmacological treatment can be considered, but is more effective when the behavioral and pharmacological therapies are combined. Pharmacological treatment involves the use of anticholinergics and beta-3 adrenergic receptor agonist. A careful risk-benefit analysis of medications is essential.

Diagnosis of dementia is usually made by a neurologist, but patients with UI at the urology department may show undiagnosed signs and symptoms of dementia. Therefore, close cooperation between neurologists and urogynecologist is needed to assess and manage UI patients with dementia.

林威霖

SY34

現職：陳澤彥婦產科醫院 主治醫師

經歷：萬芳醫院婦產部 主治醫師

萬芳醫院婦產部 住院醫師

台灣婦女泌尿暨骨盆醫學會 (TUGA) 會員

“Evil twin” : Painful bladder syndrome and endometriosis. Not an unusual combination

Chronic pelvic pain (CPP) is a debilitating condition that profoundly affects women globally, exerting a detrimental impact on their quality of life and daily activities. According to the widely accepted definition, CPP manifests as a syndrome characterized by noncyclic, intermittent, or constant lower abdominal or pelvic pain persisting for a minimum of six months, potentially exacerbated by menstruation or intercourse. Diagnosing CPP presents a clinical challenge due to its vague symptoms, a myriad of possible underlying causes, and the necessity for invasive investigations.

Traditionally, endometriosis has been identified as a prevalent factor associated with CPP, accounting for 71% to 87% of cases and affecting 5-15% of women in their reproductive age. However, emerging evidence has brought interstitial cystitis (IC) to the forefront as another significant contributor to the complexity of CPP. Moreover, various studies have highlighted a high coexistence of these two conditions, further complicating the diagnostic process. The gold standard for diagnosis involves invasive procedures and general anesthesia, contributing to delays in both identifying and initiating treatment.

In 2002, Chung et al. conducted a retrospective review of 60 CPP patients, revealing a strong association between the co-occurrence of endometriosis and IC. Although the term "evil twins" to describe this association has not been standardized, the simultaneous presence of these two conditions has garnered considerable attention. This presentation aims to review the prevalence of endometriosis and IC, underscoring the significance of their co-occurrence in contributing to CPP. As physicians, it is imperative to consider and explore the possibility of both endometriosis and IC coexisting, enabling precision in treatment and ultimately enhancing the quality of life for patients.

王萱

SY35

現職：台北市立仁愛醫院主治醫師
經歷：新竹馬偕紀念醫院婦產部主治醫師
台北馬偕紀念醫院婦女泌尿學科研修醫師

Post-partum pelvic floor dysfunction. We have to face it.

Hsuan Wang, MD

Department of OBS&GYN Jen-Ai Hospital Taipei, Taiwan

For many women, childbirth is a beautiful and transformative experience. However, what follows isn't always talked about openly. Post-partum pelvic floor dysfunction affects a significant number of women, impacting their physical, emotional, and social well-being.

The pelvic floor, a network of muscles, ligaments, and tissues, plays a vital role in supporting our core, controlling bladder and bowel movements, and facilitating sexual function. Yet, the toll that pregnancy and childbirth can take on this area is immense.

From urinary incontinence to pelvic organ prolapse, pain during intercourse to issues with bowel control, these are real challenges faced by women post-partum. And while it's common, it's certainly not normal. No woman should have to silently endure these difficulties, feeling isolated and ashamed.

It's crucial that we break the taboo surrounding this topic. Education, awareness, and open conversations are key. Women need to know that help is available and that seeking support is not a sign of weakness but a step towards regaining control over their bodies and lives.

林益豪

現職：林口長庚醫院婦產部 婦女泌尿科主任
國立清華大學 部定副教授

SY36

Patient selection and share decision making in female IC/BPS patient

間質性膀胱炎/膀胱疼痛症候群病患之病人選擇及醫病分享決策

間質性膀胱炎 (IC)/ 疼痛膀胱症候群 (PBS) · 被認為是一種膀胱或附近器官疼痛 · 常合併頻尿、夜尿、急尿等症狀的慢性膀胱疾病 · IC/PBS 被認為可能與膀胱內上皮細胞的屏障 (GAG layer) 缺損有關 · 以致尿液中物質滲透進入到黏膜下及逼尿肌層 · 使膀胱壁上的神經纖維受到異常的刺激所引起的一系列反應 · 因此引起類似膀胱過動症的症狀 · IC/PBS 最常見於女性 · 約 80~90% 為女性 · 臨床上診斷間質性膀胱炎的方法包括：症狀問卷 · 解尿日誌 · 尿液檢查及理學檢查 (包括陰道內診) · 而膀胱鏡檢查在歐洲及亞洲的學會被認為是評估 IC/PBS 的例行檢查 · 但在美國的學會則被認為是非例行檢查。

到目前為止沒有一種治療方法顯示可以有效的治癒 IC/PBS · 最常用的口服藥物包括 PPS (sodium pentosan polysulfate): Urosan 優而順、抗抑鬱劑、膀胱止痛劑等 · 另外治療也包括膀胱鏡下水擴張治療、膀胱內肝素灌注、膀胱內玻尿酸溶液灌注、膀胱內肉毒桿菌素注射、膀胱內自體血漿濃縮血小板注射等。以上林林總總 ~ 臨床醫師該如何選擇治療方式？過去在 2010 年美國泌尿科學會 (AUA) 曾經提出階梯式的六種療法 · 然而在 2022 年 AUA 最新修正的指引中提出治療的選擇應該在充分的 shared decision-making (SDM) 之後 · 再決定每個病人的治療方式 · 所以了解每種治療方式的優缺點就變得十分重要。

Ref.

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楊采樺 SY37

現職：高雄長庚醫院婦產部 婦科主任主治醫師
高雄長庚醫院婦產科 助理教授
經歷：高雄長庚醫院婦產部 主治醫師
高雄長庚醫院婦產部 研修醫師
高雄長庚醫院婦產部 住院醫師

經閉孔吊帶懸吊術(TOT)及單一切口吊帶手術(SIS)，何者是女性尿失禁的最佳選擇

Tsai Hwa Yang, MD

Department of OBS&GYN, Kaohsiung Chang Gung memorial Hospital, Taiwan

Urinary incontinence has been shown to affect up to 50% of women. Conservative treatment has limited improvement in those with severe SUI. Mid urethral sling is the standard operation treatment in nowadays. There are different approaches in the mid urethral operation. The latest development is the third-generation single-incision slings. In this topic; we will review the short term/ long term outcome and complications of both TOT and SIS.

吳晉睿

SY38

現職：台大醫學院婦產科講師
台大醫院婦產部兼任主治醫師
台大新竹分院婦產部主治醫師
台灣婦女泌尿暨骨盆醫學會專科醫師
台灣福爾摩莎婦女泌尿醫學會專科醫師
經歷：衛生福利部立桃園醫院主治醫師

Management on the patient with lower urinary tract dysfunction for PRS

Chin-Jui Wu, M.D.

Pelvic organ prolapse (POP) surgery represents a common therapeutic approach for women experiencing symptomatic prolapse of pelvic organs. However, the occurrence of lower urinary tract symptoms (LUTS) postoperatively remains a significant concern. The abstract aims to provide the current strategies and emerging approaches for managing LUTS following pelvic organ prolapse surgery.

Surgical techniques play a pivotal role in the occurrence of postoperative LUTS. The choice of procedure, whether native tissue repair or mesh-augmented repair and the inclusion of concomitant anti-incontinence procedures influence the likelihood of postoperative symptoms. Conservative management strategies, such as pelvic floor physical therapy, behavioral interventions, and pharmacotherapy, play a crucial role in alleviating postoperative LUTS. Patient education regarding postoperative expectations and potential LUTS is integral for shared decision-making and postoperative compliance. Pharmacotherapy, including anticholinergic medications and alpha-blockers, may be employed to address specific LUTS, such as urgency and voiding difficulties. Additionally, ongoing research explores the role of novel therapeutic agents and the efficacy of combination therapies tailored to individual patient profiles. In cases where conservative measures and pharmacotherapy are insufficient, revision surgery may be considered. Revision procedures aim to address anatomical and functional issues contributing to LUTS. However, the decision for revision surgery should be based on a careful risk-benefit analysis, considering the potential for further complications.

In conclusion, the management of LUTS following pelvic organ prolapse surgery necessitates a personalized and comprehensive approach. Integrating preoperative risk assessment, employing advanced surgical techniques, and implementing various conservative and pharmacological interventions allow for tailored management strategies. Ongoing research and advancements in surgical and non-surgical approaches are essential to refine management algorithms and optimize outcomes for women undergoing pelvic organ prolapse surgery.