

URGE INCONTINENCE SYNDROME IN WOMEN

(A study of 60 cases)

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Urge incontinence is one of the most distressing urologic complication, rather an association, that a gynaecological patient not infrequently suffers from. In this condition, as is well known, the first desire to void urine is sudden, urgent and acute; the patient feels the need for immediate evacuation of bladder, failing which she is incontinent and there is 'leakage'. Sometimes such an urge with urinary incontinence is initiated by sudden straining efforts as in coughing, sneezing, etc., simulating an urinary stress incontinence. Indeed, the common teaching is to differentiate the condition from vesicovaginal fistula and stress incontinence. But their recognition is not always easy, and their differentiation from similar other symptom complex is undoubtedly essential; with this idea in view this work was undertaken.

Material and Methods. Investigation was done mainly in cases of genital descensus, but subsequently nine cases were added, when urge was suspected in them from complaint and clinical examination. Investigation of urinary tract was a part of the routine in addition to the routine general and systemic examination and abdominopelvic examination of the subjects of our study. In all sixty cases were studied in the department of obstetrics and gynaecology of Chittaranjan Sevasadan Hospital.

Cystoscopy was done according to the method described in our previous communication (September 1952). In addition to the routine cystoscopic examination, volumetric study was also done. The bladder was filled with boric acid lotion (4%) by gravity method, in slow drip from a measured reservoir and records were made at first desire to void (FDV); desire to void (DV); urge desire to void (UDV). Before intro-

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ducing the fluid the patient was asked to void urine and then catheter was introduced for the residual urine if there was any.

Observation. The observation can be divided into three parts—clinical observation, routine cystoscopic findings and volumetric cystoscopic findings.

A. *Clinical.* The patients with urge incontinence came in with varying types of complaints as is seen in Table I. Table II shows the nature of gynaecological findings in the subjects of the series. Nine patients suffered from primary urge and fifty-one patients from secondary urge incontinence. Total number of cases of genital descensus studied were one hundred and four; of these, stress incontinence was noticed in 35 or 33.65% cases, urge incontinence in 51 or 49.15%, and combined complaints were found in twenty cases, i.e. 19.23% (Table III).

TABLE I

Complaints	Primary	Secondary
Urge ..	9	51
Stress ..		35
Frequency ..		17
Nocturnal frequency		14
Pain in hypogastrium ..		16
Obstruction ..		11
Dyspareunia ..		9
Hesitency ..		9
Lumbar ache ..		4
Dysuria ..		3

TABLE II

Type of gynaecological patients	Urge incontinence	
	Primary	Secondary
Prolapse uterus ..	6	45
Complete perineal tear ..	1	1
Broad ligament cyst ..		1
T.O. Mass ..		3
Elongation of cervix ..		1
Urinary incontinence ..	2	
	9	51

TABLE III

Total number of genital descensus	Stress incontinence	Urge incontinence	Combined lesion.
104	35	51	20
Percentage	33.65%	49.15%	19.23%

It may be mentioned here that only those complaints have been put in Table I that were thought to be more common in many, or from our observations we had reasons to believe that they might have some relation to pathology as was seen in the urinary bladder. In this group, severity of intensity of urge was obviously less or masked by intensity of primary complaint. Even gentle vaginal examination was found to be tender and painful. More often the tenderness was restricted to the lower region, when massaging of posterior part of urethra and region of the bladder neck elicited pain and tenderness, just a tender

bladder neck on massage. It was also observed that the passing of an ordinary rubber catheter, as for detection of residual urine, or cystoscopic examination for volumetric and cystometric studies, excited severe painful reflexes and the discomfort reached the height when catheter tip passed through the resistance of the internal sphincter and touched the adjoining trigone. This was rather a constant feature and was present even when a marked pelvic descensus was associated. The patient's discomfort at this time simulates her complaint. We record this feature as catheter test + ve.

B. Cystoscopic. Filling of bladder with boric acid lotion for cystoscopic examination was slow and painful and caused much discomfort for the patient. She retained the fluid with much difficulty.

Introduction of cystoscope excited similar painful reflexes as during catheterisation and during its passage the same resistance at the internal sphincter was felt.

The regions of the bladder neck, trigone and paratrigoal areas showed a picture of chronic inflammation, particularly restricted to the area. The area of congestion was found to be triangular in distribution, with its base at the bladder neck and apex directed to Mericer's ridge. Sometimes wide area of trigone was affected, but even then it stopped short of the Torus interuretericus. The rest of the bladder often showed absolutely normal condition. The

affected area showed a variety of pictures closely akin to each other.

(i) There was marked congestion with prominent vessels. They often had radial arrangement and sometimes with prominent vascular knots. Sometimes the vascular distribution had hair-pin like arrangements. In some cases submucous rhexis with extravasation was seen (Fig. A).

(ii) The whole picture in some of the cases, had an uniform congested granular appearance with discrete granules having red tips (Fig. B).

(iii) The affected arc was often found to be oedematous; oedema even went to bullous formation. In not a few the whole picture was replaced by bulliform oedema often becoming confluent (Fig. C).

(iv) The areas of congestion in some cases were associated with nodular elevation close to the region of the bladder neck (Fig. D).

For the sake of convenience, discrete pictures have been depicted here; various combinations of the above pictures were often the rule than exception. But the area affected is constant at the bladder neck with adjoining trigonal and paratrigoal areas.

The Bell's muscle in all these cases could be identified as two prominent ridges terminating at bladder neck; by rotatory movement of the cystoscope, ends of Bell's ridges were seen in some cases as two promi-

nent elevations on either side with intervening floor at the bladder neck forming the "Pseudo-trough". With cystoscope in position, if patient is asked to strain this never sags down—an important point of differentiation from presence of stress incontinence. This has been dealt with in detail in our previous communication (September 1952).

C. *Volumetric study.* This observation is shown in the accompanying chart, in which it is found that First Desire to Void, Desire to Void, Urgent Desire to Void closely approximated each other in case of urge, but this was not the case in normal control and in cases of genital descensus without urge.

Discussion. From the above findings it is evident that urge was a primary complaint only in nine out of sixty cases. The rest were detected only after subsequent investigation and by leading questions. It is also evident that careful history taking thorough vaginal examination and cystoscopic examinations are essential features in diagnosing an urge incontinence in women.

Carefully taken history helps in detection or suspicion of the condition; complaints like stress, frequency, strangury, hesitency, orificial dyspareunia in parous women are suspicious.

A tender bladder neck on massage in the anterior vaginal wall, during vaginal examination, or tenderness elicited by massaging of posterior part of urethra and bladder neck are

helpful. The catheter test is suggestive of the condition.

Cystoscopic pictures, as described above, are diagnostic. They not only help in differentiation from stress incontinence but also in detection of both in a combined pathology. Thus unnecessary surgical intervention can be averted, when stress incontinence is not associated. Volumetric study was found to have an important bearing in the detection or urge and its differentiation from other bladder neck defects, particularly in combined lesions.

Unfortunately the complaint, as is generally elicited from the patients, only on a few occasions becomes so straightforward as one of urge in the desire to void, as to enable one to a ready diagnosis. Even then the complaints can be elicited on subjective questions. The intelligent patients are found to be sometimes perplexed as to the description of the exact nature of it. Moreover, during this work, it was found that complaints were varying, urologic or otherwise, when this symptom was likely to be overlooked. By the way, it may be emphasised that even in obvious cases of urge incontinence mistakes in differentiating stress incontinence do occur and it may be also that both conditions co-exist (19.23% in this series) which needs identification and treatment to ensure a complete relief.

Summary.

1. Urge incontinence was studied in 60 gynaecological cases.

2. 49.15% of cases of genital prolap- nection we take the opportunity to
se had an association of urge. extend our grateful thanks to Dr.
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3. Clinical peculiarity described. ment. Our thanks are also due to
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described. ings.

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References.

Ghose, D.; Roy, D. L.; and Dutta Choudhuri, R.: J. Obst. & Gyn. India; Vol. III, p. 13, 1952.

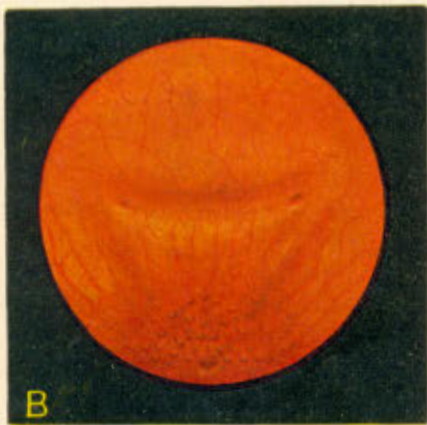
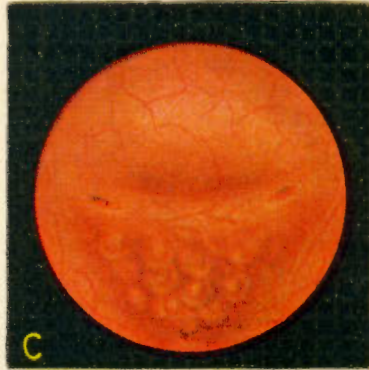
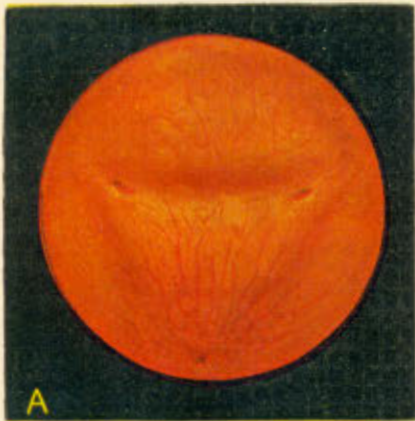


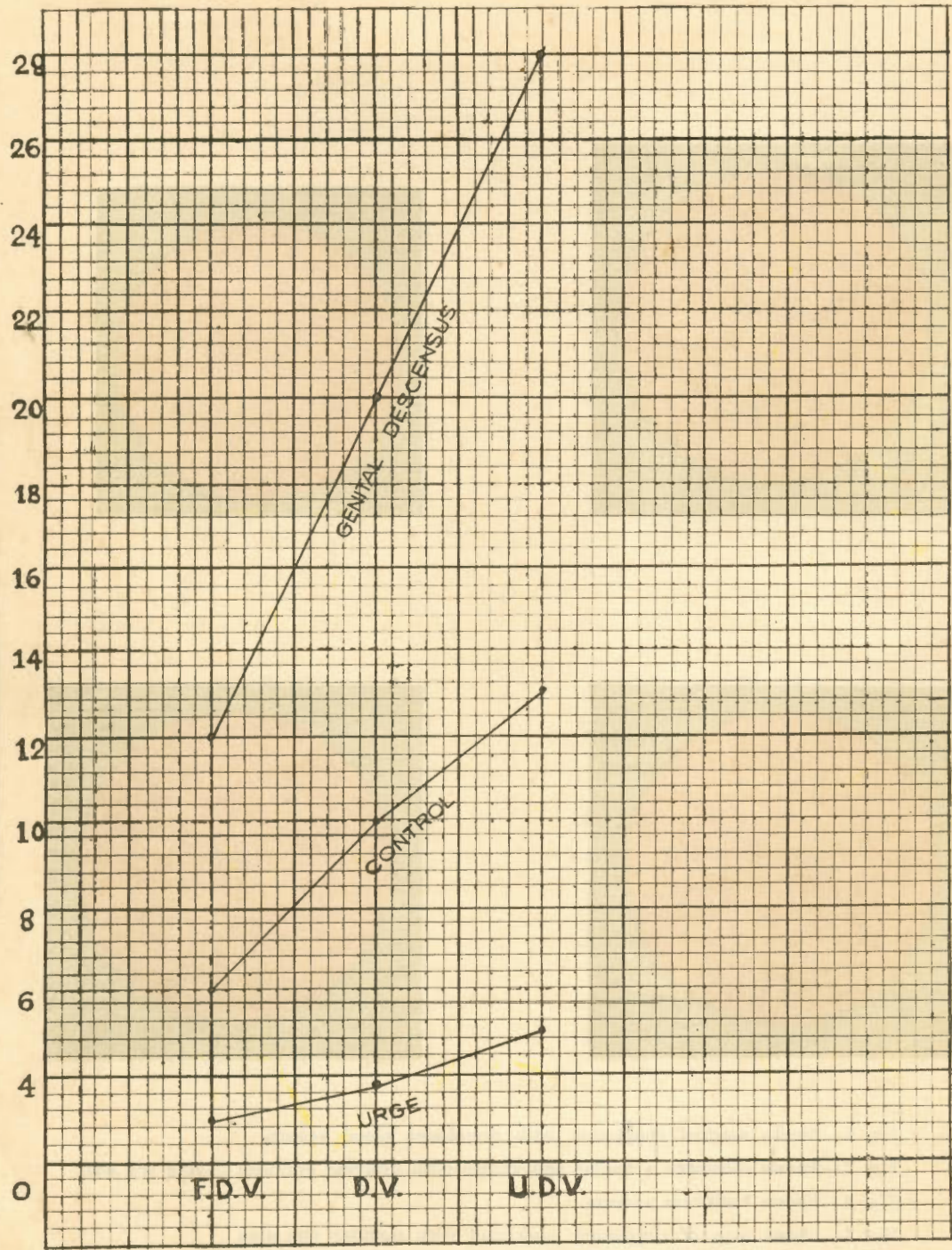
Fig. 1.—Shows marked congestion with prominent blood vessels.

Fig. 2.—Shows congested granular appearance with discrete granules having red tips.

Fig. 3.—Shows bulliform aedema.

Fig. 4.—Shows area of congestion associated with nodular elevation.

BLADDER VOLUME IN OZ.



First desire of voiding, desire of voiding and urgent desire of voiding closely approximated each other in urge cases.