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# Surgical treatment of urinary incontinence

The purpose of this information sheet is to provide patients with information about the nature and types of urinary incontinence as well as options for treatment.

Around 10% of women suffer from urinary incontinence, almost 20% of whom are women over 65 years of age.

The following factors contribute to urinary incontinence:

- previous pregnancy and delivery (damage to the birth canal)
- congenital weakness of the connective tissue
- menopause or climax (with oestrogen deficiency)
- heavy physical activity
- age-related changes (decrease in the volume and elasticity of the urinary bladder)
- neurological disorders
- damage to the brain and spinal cord

There are several types of urinary incontinence, the most common being stress incontinence (or effort incontinence) and urgency incontinence (or impulsive incontinence).

Stress incontinence or effort incontinence occurs in 20-40% of cases as an involuntary leakage of urine during physical effort (jumping, running, coughing). It is caused by weakness of the connective tissue and muscles of the pelvis and low intraurethral pressure. For mild stress incontinence, regular and proper training of the pelvic diaphragm muscles are useful.

With urgency incontinence (occurs in 45-60% of cases), bladder filling control is affected. The irritability of the bladder increases and control of the urination reflex decreases. Such urinary incontinence can be alleviated with medications and urinary bladder training.

Both types of urinary incontinence can also occur simultaneously (mixed urinary incontinence). To clarify the diagnosis and plan treatment, the doctor prescribes tests and additional examinations, if necessary.

Surgical treatment is indicated for stress and mixed urinary incontinence.

## **Description of surgery**

The purpose of the surgery is to strengthen the junction of the urethra and urinary bladder to prevent stress opening of the urethra. For strengthening, a special prosthesis loop is used, which is applied under the urethra during surgery. Small incisions are made in the vaginal and groin area. The sutures are resorbed on their own and do not need to be removed.

For the surgery, you need to come to the hospital in the morning. **To prevent anaesthesia-related complications, you should not eat for at least six hours or drink for at least two hours before surgery. You should also stop smoking and chewing gum for six hours before surgery.**

### **Post-surgery period**

As a rule, the patient is discharged home the same day. To achieve a good and long lasting result, you should avoid physical exercise, lifting weights over 5 kg, sports, sexual activity, bathing, swimming and using tampons for one month after the surgery.

You should return to the hospital if you have severe abdominal pain, vaginal bleeding, difficulty urinating or a fever above 38 °C after surgery.

### **Possible complications after surgery**

No surgical intervention is without risk, and this surgery can also be associated with complications. The risk of injury to the urinary bladder during surgery is 1-4%.

After the surgery, the following can be seen:

- abnormal urination in 4%
- bleeding in 0.5%
- haemorrhages in 1.5%
- deep vein thrombosis in 0.7%
- surgical wound inflammation in 0.1% of patients

If complications occur, hospitalisation is usually necessary.

The effectiveness of the surgical method is high; complaints of urinary incontinence disappear in 90-95% of patients.

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