78 - Incontinence Part 2
BioBalance Podcast — Dr. Kathy Maupin and Brett Newcomb
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Kathy Maupin: Welcome to the Biobalance health cast. I'm Dr. Kathy Maupin.

Brett Newcomb: And I'm Brett Newcomb. And today we are continuing our conversation about incontinence in women post menopausaly who have had vaginal deliveries of children. In the previous podcast we discussed that and we kind of got deep in the weeds in that discussion and ran out of time. So we'd like to continue that discussion today we'd like to start with revisiting the concern about irritable bladder as opposed to stress induced incontinence. Which is for those women when they cough or laugh or lift a heavy weight. That's a stress event that causes leakage.

KM: It's a gravity event. Rarely do they lose urine when they're lying down. They could, but rarely. But there are two kinds of incontinence that bother women of this age. Stress incontinence is one that has to do with babies, that has to do with heavy lifting throughout their life and other things that put pressure on the pelvis. But the other type is called irritable bladder. Irritable bladder is different. You don't lose urine when you're lifting something. But you may be just standing there talking to somebody at a cocktail party and your bladder spasms and you've wet your clothes. So it is related to nothing it's just irritable. Some women get this once in awhile. It's still embarrassing.

BN: Is that a nerve problem?

KM: It can be. In fact they've gone though all of the different research that causes this and in general it can be a nerve problem. People who have M.S., people who have neurologic abnormalities in the peripheral nerve, meaning nerves not in your brain but outside is a peripheral nerve or outside around your pelvis. So that can cause this. The neurologic problems can cause retention of urine which is even a more difficult problem because you can't empty your bladder. So that is a separate issue so I'm going o table that because that's extensive that it can be an entirely different conversation. This is about women without other medical or neurologic diseases that just all of sudden; their bladders are spasming all the time. They can't get on a plane, they can't travel , they can't get in a car and go on a car trip, they have to stay home and it's really horrible because there's not lead up they're so signal. There's just spasming and you feel it right at the time it comes out. Now I've talked to women about this my whole career of being in gynecology and I talk to them about it now with hormones because hormones do help this condition. Now the way I tell the difference without doing a test between stress incontinence and irritable bladder, is I ask them when it happens, when they notice? I say "what are you doing?" And if they say nothing, I'm not doing anything." And it can happen when you're sitting down, it can happen when you're lying down, it doesn't require gravity to cause it. So I then divide

these two things up and generally a doctor can do surgery on stress incontinence but a urologist shouldn't be doing surgery on irritably bladder because it doesn't help.

BN: The surgery for the stress incontinence has to do with the urethra? Or supporting?

KM: Yea lifting the bladder up. Everything has fallen down and so they're lifting the bladder up. Sometimes gynecologists have to take the uterus out for stress incontinence because the uterus is dragging the bladder down. So that's a surgical thing and by history you can usually tell which is which. We also have at our disposal a sistosicopy which you can look inside the bladder to see if the urethra's straight and if the bladder is swollen and see if the lining is irritated. And with irritable bladder, the linings irritated, it looks kind of reddened and swollen. It is an issue of not neurologic issue in general it is an issue of the urine is now irritating the lining of the bladder so that's hormones.

BN: That's the ph factor in the urines because you're to able to void the bladder.

KM: The acid in the urine is irritating the tissue. Well you're able to void the bladder all the time. You're losing urine all the time. But the reason you're losing it is because the lining of the bladder is contracting in response to irritation. So that is something I get to treat and that I treat very well because testosterone and estrogen both thicken the lining of the uterus and make it normal again just like when you were younger. So that lining thickens up and has a covering that makes it protective. So what happens is you get that back within a month of getting pellets or starting therapy.

BN: So it's like an electric wire that has the rubber coating on it and a current can run through that wire and you don't feel it. But if there's a breakdown in that coating you would get shocked so you get shocked when the urine is forced out because those nerves are sending current in response to the acid in your urine.

KM: Yea they're very superficial then I instead of being behind a thickened covering. If there are any doctors out there yes this is very simplistic of how I'm describing this.

BN: She's explaining it to me, I grew up in Arkansas.

KM: But it is a way of explaining why hormones work. Now again, I didn't really think about that when I started doing hormone pellets, testosnterone and estrogen. I knew estrogen worked, because my whole career, if somebody had an irritable bladder we gave them estrogen cream like Cremrin cream or esterase, and we had them put it right on the urethra, because the bladder and the vagina are responsive to estrogen. So we used local therapy by putting estrogen cream right on the opening to the bladder and it actually helps thicken the urethra so that it was resistant to bacteria. Because another thing people get with this irritable bladder are infections all the time. They don't have a covering. Now I'll describe it as your wearing your rain coat with your hood and they don't have their raincoat on they're just wearing their cotton shirt out in

the rain. So anything is going to irritate this. Bacteria goes right up into the bladder and causes infection all the time.

BN: So bacteria goes up into the bladder?

KM: In general it doesn't.

BN: When women intend to urinate, or do urinate and they clean themselves there actually is a recommended way that mothers are supposed to teach their daughters this is the way that you clean yourselves.

KM: Yea and you're supposed to wipe front to back.

BN: Because if you don't you're dragging bacteria directly to the urethra.

KM: From the rectum to the urethra. And you should always wipe front to back that's one thing that I've found doesn't always get taught anymore. When you're wiping a baby who's a female baby and you've only had male babies and you don't know that you're supposed to wipe front to back, and if you do it the wrong way you're baby always gets infections all the time. And babies don't have a lot of estrogen. But of course I think if you did that to anybody you might get infections over and over again, because that's not how it should be done. But you're putting yourself more at risk. The idea is always wipe front to back. Always wash and urinate before and after sex, because sex also can push bacteria back into the bladder. Now this is anybody.

BN: Not just women over 40 who have had vaginal deliveries.

KM: Right this is everybody. And intercourse does increase the risk of bladder infections so a lot of times when my patients get their libido back and say "oh I'm getting bladder infections" and I'm like "oh well it's working."

BN: So then you have to have conversation with them about sanitary practices.

KM: Right, wiping, and urinating before and after intercourse and if that doesn't work then often times I give them a very mild antibiotic to take every time they have intercourse just to clean out the bladder each time because it's not good for you bladder to get infected all the time. So that's even with hormones at any age.

BN: It's hard to be a woman. You have so much more you have to worry about.

KM: It is very hard to be a woman. Yea, you're just now figuring this out now?

BN: Well, yea you know. I didn't have daughters. And I don't know that I would have discussed with my wife, do you always go urinate before and after sex.

KM: You would notice though.

BN: Maybe, if I hadn't fallen asleep.

KM: Ok well alright.

BN: I'm pretty focused when that happened and it's a very limited focus. So I don't know.

KM: Well now that the women and men listening can at least recommend that it saves you money on antibiotics, it saves you going to the doctor, it saves you all kinds of things.

BN: It saves you a lifetime resistant exposure to antibiotics issue.

KM: Right. I know and we don't want you to be resistant to antibiotic so it's much better to prevent infections. Back to what happens when you don't have any hormones. When you don't have any hormones on your bottom you get old lady bottom. Women do, not you. Women get old lady bottom meaning their vagina gests very narrow and not stretchy. You can't bring it back to life by stretching it because the tissue is very fragile. If they have intercourse it tears. It's like tissue paper. So instead of having nice thick skin that can withstand intercourse and sitting on it all day and urinating it is effected by everything. So women who don't have estrogen have a lot of bladder infections and yeast infectsions and it is itchy.

BN: So if a woman comes in and she complains of frequent yeast infections is one of the first assumptions you make is that she doesn't have enough estrogen?

KM: Yea you have to kind of look at that. You have to look at the bottom and if you've seen an old lady bottom you know what it looks like.

BN: I actually have not.

KM: Ok well, that's probably a good thing since you're not a gynecologist. But gynecologists know what this looks like and the same thing happens inside your bladder.

BN: And that's a technical term? Old Lady Bottom?

KM: No, it's my term. So we look inside the vagina if we can sometimes we have to use these teeny tiny speculums on people who have this, it hurts to much to even do a pap smear. But the bladder is doing the same thing. The urethra gets very ale it's not pink anymore. It gets almost white and scarred. And the lining of the bladder looks the same, it's very pale. No blood flow. Blood flow comes from estrogen and testosterone bringing blood flow there. So everything on the business end of things looks very dried up and people come in and say that that this is awful I burn when I urinate and all these infection. So my answer to that even before I started doing pellets, estrogen creams, estrogen patches. And I didn't have testosterone to help me however.

BN: Ok so maybe this is an off the wall association but I'm real curious and want to ask it. If women dry up and become brittle because there's a loss of blood flow then

estrogen works in women the way Viagra works in men. It increases the level of blood flow to that area and makes it more functional and malleable. Am I understanding that correctly or am I misunderstanding?

KM: Yes, in some ways it does. But that's not the only thing estrogen does.

BN: No I understand that but I'm trying to make connections that make it easier for me to understand.

KM: Estrogen for the vagina and bladder is like an anabolic steroid. It thickens things and makes the look young again and makes them functionally young again. So the irritable bladder that' always doing t his is irritated for a good reason. It's really thin and it's being attacked by urine and bacteria and it ends up just spasming we talked about a systegram is a test that really looks bizarre. You sit on a chair and they put a sensor into your vagina and they put fluid into your bladder and watch it expand and if it does this it shows up on a graph and we know you have an irritable bladder. If it doesn't this and this and also just floods out because spasming bladder a little bit comes out a time it's not just a full emptying. If we see it just flood out then you may have a combination. God forbid you could have a combination of these things. Where you can have a bladder that's falling down and you can have a bladder that is irritated as well. My answer to this is to treat with estrogen and testosterone and I choose pellets because they work more like to bring you back to a normal level like before you were 35. Make sure your doctor gives you normal doses of estrogen if that's the only thing he has at hand or she has at hand. Because if he gives you the lowest dose possible it's not going to work because it's still going to be a thin bladder. Not a good test you have to have decent amounts of estrogen and testosterone to bring yourself back to health.

BN: So you would say the point of giving a woman estrogen is to restore that 60-150 range.

KM: Yes if you have a blood level of 60-150.

BN: And if it's less than that it's not really an effective dose.

KM: Yea it's not going to work for this. It may stop hot flashes but it's not going to work for your bladder and all the other tissues in your body including your skin. It's not going to thicken your skin look young again. But for this once you've figured out which it is or if it's both, the hormones are going to fix a lot of it like giving you back the hormones you need and then you can see if you still need surgery or not.

BN: So do the hormones first and that may take care of it, because all surgeries are dangerous.

KM: Right, you're never as good as how God made you in the beginning. When you get a bladder sling they save you from stress incontinence and they're wonderful.

BN: A bladder sling?

KM: A bladder sling is where they put what looks like a shoe string through tiny incisions in your lower abdomen and then they pull your bladder out and tie them and then close it up.

BN: And then they leave it in there?

KM: Yea, we leave a lot of stuff in there.   We do graphs o the hearts and on the aorta. They should be made of something that does to react with the human body. In general that's what we use. I don't do that procedure, that's a urology procedure.

BN: So the body won't attack it.

KM: But it scars in. And it brings the neck of your bladder up so you can be continent. But it's never perfect. What we had before we had children what we have after. It's never going to be exactly like what we had before we had children.

BN: It's not going to improve on the way God made you.

KM: It's kind of like your breasts are never going to look the like they did before you had children, even if you get implants. It's not going to be the same. I'm not saying not to have children. I mean I have a child.

BN: Or breast implants.

KM: Right I'm just trying to get across those are things we do as women. And that's our sacrifice for having children. So we should be appreciated for that.

BN: And I think you're also getting across that the improvement needs to be more than cosmetic. The improvement needs to be systemic. And that comes with replacing the hormones instead of making some surface level cosmetic intervention.

KM: That's true. It's anatomy and physiology. For this problem in general you have to provide both. Anatomy is how we're made, how we're put together and we're trying to restore the original anatomy and physiology is the chemicals and hormones and the things that circulate.

BN: Let's remind the women who are watching who it is that we are talking about. We are talking about primarily a population of women that are over 40 or postmenopausal who have had vaginal deliveries and those women invariably are going to develop incontinence problems of one kind or another. Other women may get incontinence problems. They may get them because they have the irritable bladder they may get them because they may get them because there is a stress problem or due to other medical issues.

KM: Even if they're very obese and have never had a child they can still have bladder incontinence because the pressure pushes them. I didn't even address that yet, or I didn't address that at all.

BN: Yes, so it's more broadcast then we're talking about. And there are other causes of the same issue but it is particularly focused on this singular population of women who have had multiple vaginal deliveries or a single one especially if the baby was large and who is post menopausal and over 40 they will start to have these problems. And when they have them we want them to know what is going on that it is normal, it doesn't mean they have cancer or they are dying. It is normal, is to be expected and it is treatable. And it is treatable in a hierarchy of interventions, the least invasive; the least expensive one is hormone replacement. So you try with hormone replacement, if that satisfies the problem, then end of the game. If it doesn't satisfy the problem, then you move to a surgical consideration, then you move to.

KM: And to a urologist in general. There are a few gynecologists that are urologically trained but most of the time you're going to go to a urologist.

BN: To a specialist. So if we have not covered all of your information needs you can contact us and let us know that and we'll come back and revisit this topic or any of the topics that we've presented in our various podcasts. You can always reach us with that query at.

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