Chirurgie – Gynäkologie Beckenboden-Kontinenz

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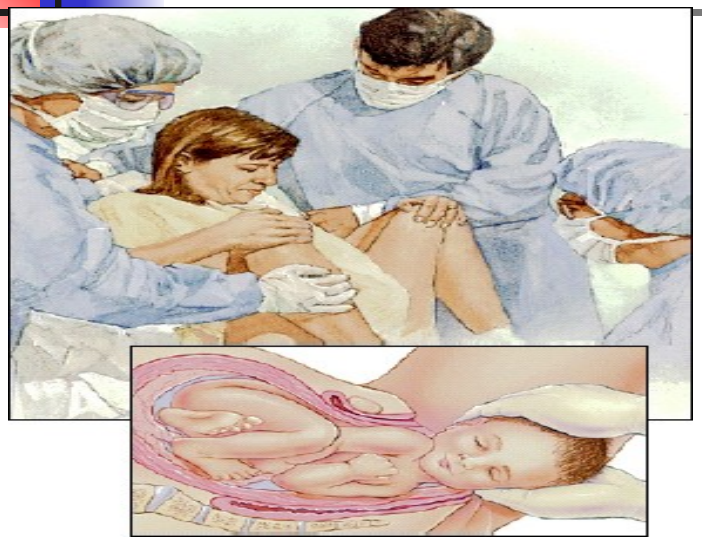
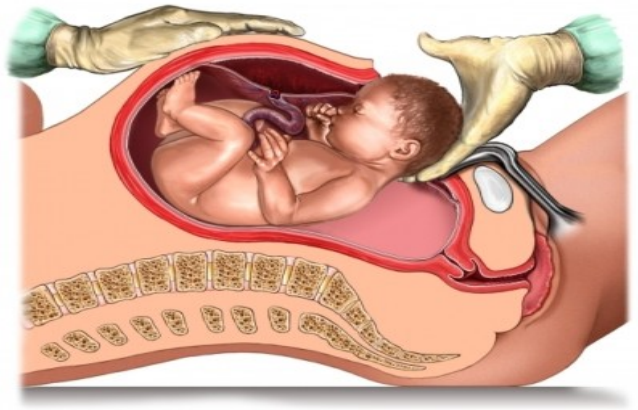
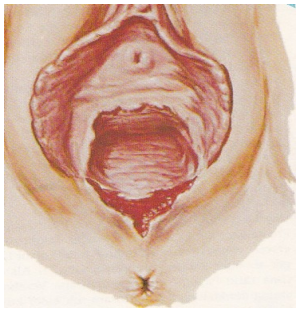
Medizinische Kontinenzgesellschaft Österreich
www.kontinenzgesellschaft.at

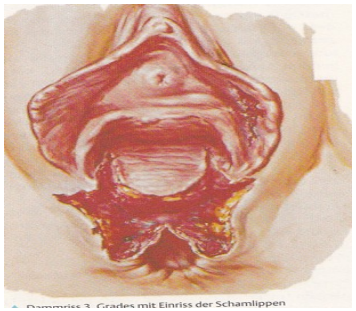
Geburtshilfe Einfluss Kontinenz?

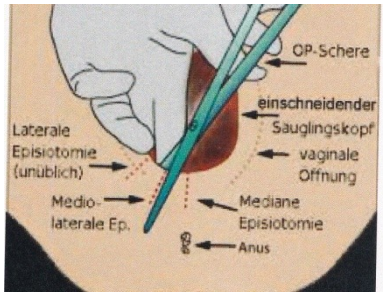
Schwangerschaft -Vaginalgeburt –Epi- Vakuum - Zange – protrahierte Austreibung-Sectio

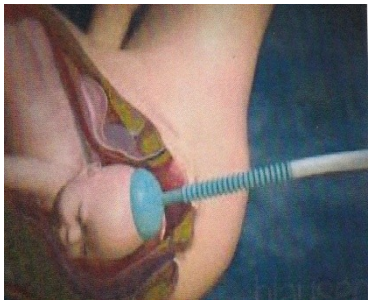


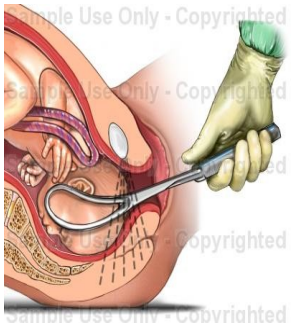












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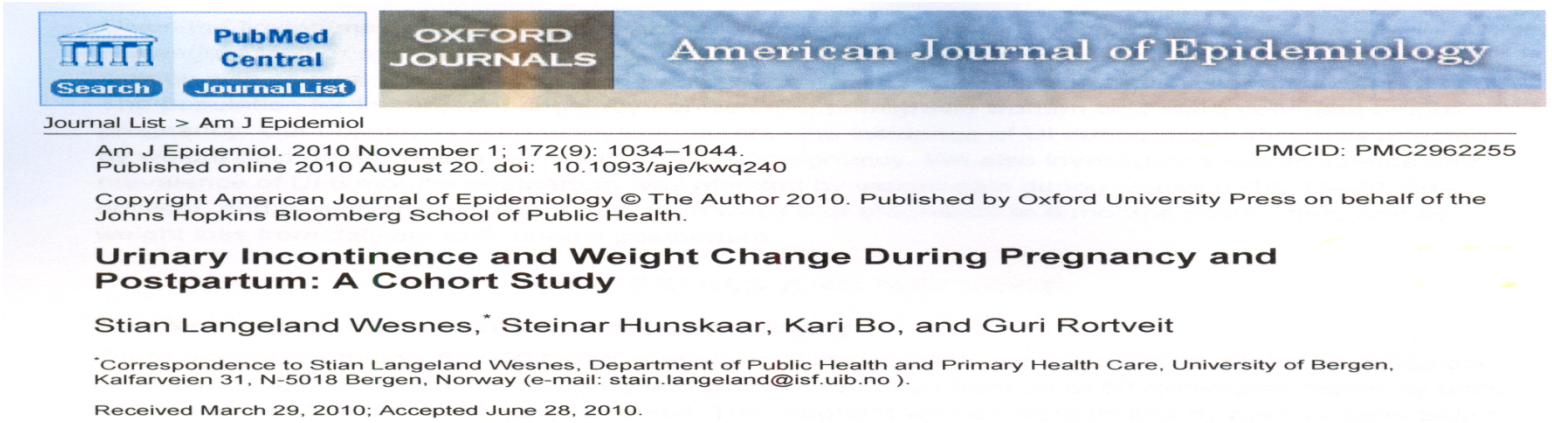
Harninkontinenz Schwangerschaft und post partum?

Wesnes et al. Am J. Epidemiol. 2010



PubMed Central Search Journal List

OXFORD JOURNALS American Journal of Epidemiology

Journal List > Am J Epidemiol

Am J Epidemiol. 2010 November 1; 172(9): 1034–1044.
Published online 2010 August 20. doi: 10.1093/aje/kwq240
PMCID: PMC2962255

Urinary Incontinence and Weight Change During Pregnancy and Postpartum: A Cohort Study

Stian Langeland Wesnes,* Steinar Hunskaar, Kari Bo, and Guri Rortveit

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Received March 29, 2010; Accepted June 28, 2010.

- 12679 primär kontinente schwangere Frauen
- Harninkontinenz in 30.SSW+6 Mo. p.p.?
- Fragebogen-Analyse

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Harninkontinenz in der 30.SSW + p.p.

Wesnes et al. Am J. Epidemiol. 2010

Table 1.

Baseline Pregnancy-related Data on 12,679 Participants From the Norwegian Mother and Child Cohort Study, 1999–2006

	All Women			BMI Group[a]								
				Underweight			Normal Weight			Overweight		
	No.	%	Mean (SD)	No.	%	Mean (SD)	No.	%	Mean (SD)	No.	%	Mean (SD)
Total no. and % of women	12,679	100		427	3		8,342	66		3,463	27	
Incident UI at week 30	5,102	40		162	38		3,225	39		1,522	44	
Incident UI 6 months	1,562	21		50	19		1,007	20		451	23	

- 39% Harninkontinenz in der 30.SSW
- 20% Harninkontinenz 6 Mo post partum

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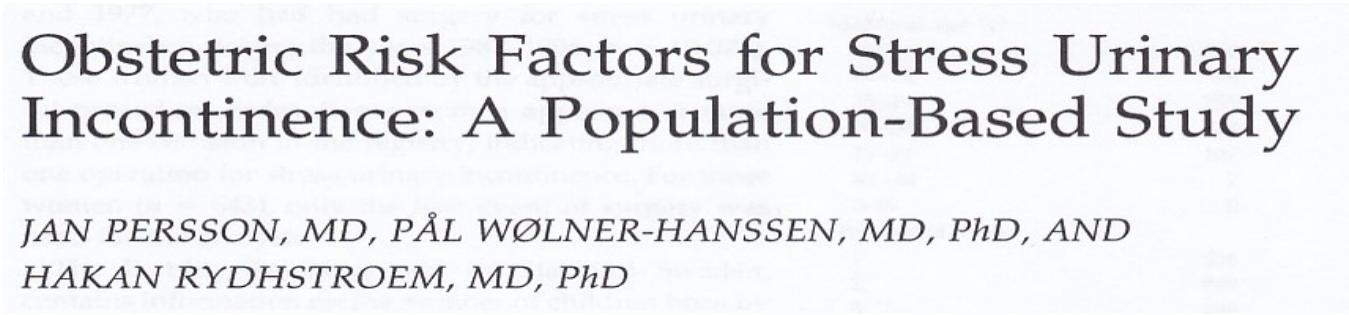
Geburtshilfliche Risikofaktoren für Harninkontinenz

Obstet. Gynecol. 2000; 96:440-445



Obstetric Risk Factors for Stress Urinary Incontinence: A Population-Based Study

JAN PERSSON, MD, PÅL WØLNER-HANSSEN, MD, PhD, AND HAKAN RYDHSTROEM, MD, PhD

- 1942 Patientinnen - Schwedisches Geburtenregister
- **Operative Therapie** der Stressinkontinenz

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Harninkontinenz

Anzahl der Geburten –

Persson et al Obstet Gynecol 2000

Table 2. Odds Ratios for Later Incontinence Surgery According to Parity

No. of children	OR	95% CI
0	1.0	—
1	3.57	3.13, 4.00
2	5.26	4.76, 5.88
3	6.67	5.88, 7.14
≥4	7.14	6.67, 8.33
All parous women	5.56	5.00, 6.25

OR = odds ratio; CI = confidence interval.
Stratification for women's year of birth. Nulliparous women are used as reference. Calculations irrespective of mode of delivery.

- Zunahme HIK
  mit Zahl der Geburten

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Harninkontinenz
Geburtsgewicht
Persson et al. Obstet. Gynecol. 2000

Table 3. Effect of Birth Weight of Largest Vaginally Delivered Infant on Odds Ratios for Later Incontinence Surgery

	Instrumental delivery included		Instrumental delivery excluded	
Birth weight (g)	OR	95% CI	OR	95% CI
< 3000	0.76	0.61, 0.99	0.74	0.58, 0.95
3000–3999	0.84	0.76, 0.93	0.83	0.74, 0.92
4000–4999	1.30	1.17, 1.45	1.30	1.17, 1.46
5000+	1.48	0.90, 2.44	1.77	1.08, 2.91

Abbreviations as in Table 2.
Each subgroup was compared with all other subgroups. Stratification was made for year of birth, maternal age at first delivery, parity at last delivery, and episiotomy. Women with diabetes mellitus were excluded.

- Zunahme HIK mit Geburtsgewicht

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Harninkontinenz
Alter bei erster Geburt
Persson J et al. Obstet. Gynecol. 2000

Age (y)	OR	95% CI
≤ 19	0.60	0.51, 0.72
20–24	0.61	0.55, 0.73
25–29	1.26	1.15, 1.38
30–34	1.80	1.59, 2.03
35–39	2.61	2.14, 3.19

- Zunahme HIK
  bei höherem Alter

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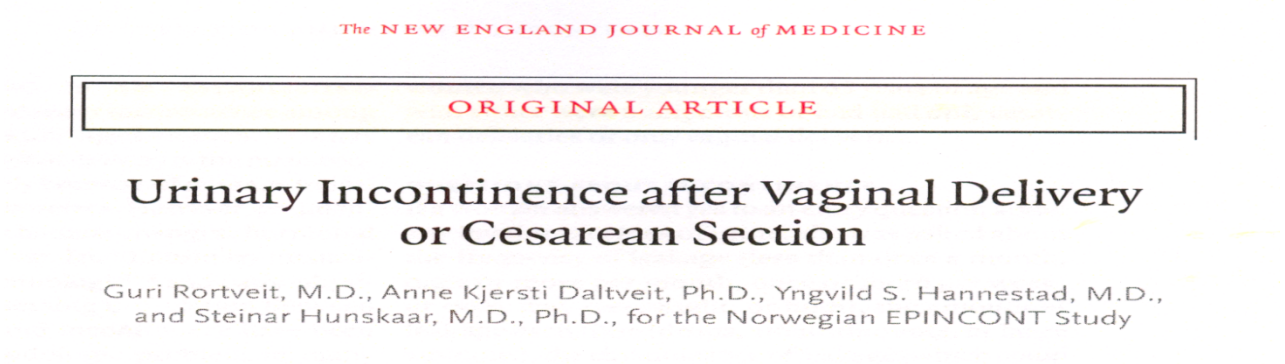
Harninkontinenz
Vaginalgeburt oder Sectio
EPINCONT Studie 2003



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Urinary Incontinence after Vaginal Delivery or Cesarean Section

Guri Rortveit, M.D., Anne Kjersti Daltveit, Ph.D., Yngvild S. Hannestad, M.D., and Steinar Hunskaar, M.D., Ph.D., for the Norwegian EPINCONT Study

- 15307 Frauen (Fragebogen mit Geburtsregister verlinkt)
- 20-65 Jahre (Nullipara/nur Sectio/nur Vaginal)
- Variable: Sectio/Vaginalgeburt/Alter/BMI/Parität/ Jahre n.Geburt/Geburtsgewicht

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Harninkontinenz - später

Nullipara /Sectio/Vaginalgeburt
Rortveit et al. N Engl J Med 2003

Table 3. Observed Prevalence and Age-Standardized Prevalence of Urinary Incontinence, According to Mode of Delivery.*

Variable	All Women	Any Incontinence	Moderate or Severe Incontinence	Stress Incontinence	Urge Incontinence	Mixed-Type Incontinence
			number of women (percent)			
Any age						
No deliveries	3,339 (21.8)	338 (10.1)	125 (3.7)	158 (4.7)	52 (1.6)	104 (3.1)
Cesarean sections	669 (4.4)	106 (15.8)	37 (5.5)	47 (7.0)	15 (2.2)	37 (5.5)
Age-standardized		(15.9)	(6.2)	(6.9)	(2.2)	(5.3)
Vaginal deliveries	11,299 (73.8)	2732 (24.2)	1173 (10.4)	1664 (14.7)	203 (1.8)	768 (6.8)
Age-standardized		(21.0)	(8.7)	(12.2)	(1.8)	(6.1)
50–64 Yr						
No deliveries	394 (21.2)	60 (15.2)	21 (5.3)	38 (9.6)	8 (2.0)	12 (3.0)
Cesarean sections	49 (2.6)	14 (28.6)	7 (14.3)	6 (12.2)	4 (8.2)	4 (8.2)
Vaginal deliveries	1,417 (76.2)	425 (30.0)	201 (14.2)	235 (16.6)	34 (2.4)	144 (10.2)

- Nullipara/Sectio höher/Vaginalgeburt höchsten
- Zunahme mit dem Lebensalter der Patientin

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Harninkontinenz

Verlängerte Austreibungsperiode?

Brown et al. BJOG 2011

Effects of prolonged second stage, method of birth, timing of caesarean section and other obstetric risk factors on postnatal urinary incontinence: an Australian nulliparous cohort study

SJ Brown,[a] D Gartland,[a] S Donath,[b] C MacArthur[c]

[a] Healthy Mothers Healthy Families Research Group and [b] Clinical Epidemiology and Biostatistics Unit, Murdoch Children's Research Institute, Melbourne, Australia [c] School of Health and Population Sciences, University of Birmingham, UK
Correspondence: A/Prof. S Brown, Healthy Mothers Healthy Families Research Group, Murdoch Children's Research Group, Level 1, 369 Royal Parade, Parkville, Victoria 3052, Australia. Email stephanie.brown@mcri.edu.au

Accepted 17 January 2011. Published Online 13 April 2011.

- 1507 Geburten
- Kontinente Primipara
- Definition verlängert: > 2 Std; > 3 Std epidural
- Harn-IK 3 Monate post partum? Fragebogen
  (Harnabgang 1x pro Monat, unabhängig Menge und Beeinträchtigung)

Lothar.Fuith@bbeisen.at

Harninkontinenz – Verlängerte Austreibungsperiode?

Brown et a. BJOG 2011

- Verlängerte Austreibung - mehr Harn-IK nach 3 Monaten
- Vaginaloperative Entbindung – kein Einfluss
- Sectio vor Wehen/oder Eröffnungsperiode weniger Harn-IK

Table 3. Relationship between method of birth with and without prolonged second stage labour and postpartum urinary incontinence (*n* = 1051)*

	Adjusted odds ratio	95% CI
Method of birth		
Caesarean No labour	0.2**	0.1–0.5
Caesarean before second-stage	0.2**	0.1–0.4
Caesarean during second-stage	0.5	0.3–1.1
Spontaneous vaginal birth—second-stage not prolonged	1.0 (ref)	
Spontaneous vaginal birth—second-stage prolonged	2.2*	1.1–3.4
Operative vaginal birth—second-stage not prolonged	1.2	0.7–1.6
Operative vaginal birth—second-stage prolonged	1.9*	1.0–2.8

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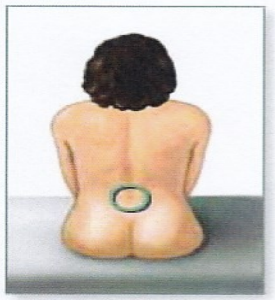
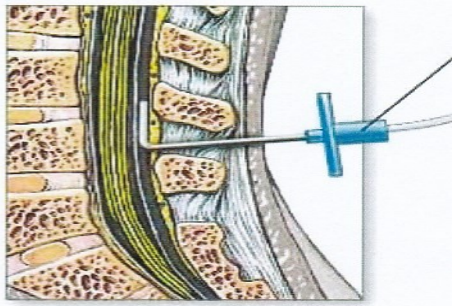
Harninkontinenz

Risiko durch Epidurale?

Persson et al Obstet Gynecol 2000 / Ewing et al J Obstet Gynaecol 2005





Obstetric Risk Factors for Stress Urinary Incontinence: A Population-Based Study

JAN PERSSON, MD, PÅL WØLNER-HANSSEN, MD, PhD, AND HAKAN RYDHSTROEM, MD, PhD

Epiduralanästhesie
(ausgeschlossen Diabetes+intrumentelle Entbindung)
stratifiziert nach Geburtgewicht und Episiotomie

	OR	95% CI
Multipara	1.41	1.22, 1.64
Primipara	1.27	0.88, 1.85

Journal of Obstetrics and Gynaecology, August 2005; 25(6): 558–564

Taylor & Francis
Taylor & Francis Group

Obstetric risk factors for urinary incontinence and preventative pelvic floor exercises: Cohort study and nested randomized controlled trial

P. EWINGS, S. SPENCER, H. MARSH, & M. O'SULLIVAN

Taunton and Somerset NHS Trust, Taunton, Somerset, UK

Table III. Results of multivariate logistic regression: final model

Factor	Odds Ratio (95% confidence interval)	p-value
Previous/existing incontinence	4.49 (3.09 to 6.53)	<0.0001
Chronic constipation	1.86 (1.03 to 3.34)	0.04
At least one episiotomy	1.96 (1.25 to 3.07)	0.004
Recent epidural/spinal	0.62 (0.42 to 0.92)	0.02

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Harninkontinenz und Episiotomie?

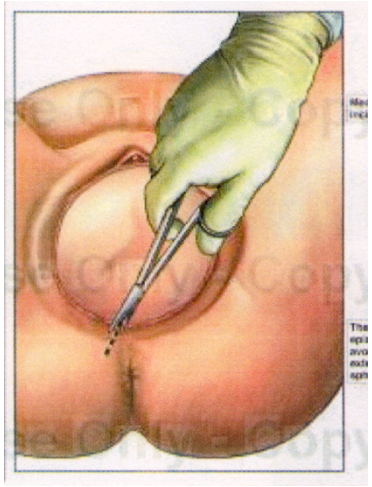
Cochrane Database Syst Rev. 2009 Jan 21;(1):CD000081.

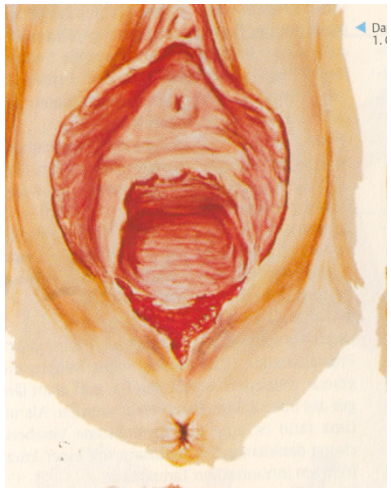
Episiotomy for vaginal birth.

Carroli G, Mignini L.

Centro Rosarino de Estudios Perinatales, Pueyrredon 985, Rosario, Santa Fe, Argentina, 2000. gcarroli@crep.com.ar

Update of:





- Routine vs restriktive Episiotomie kein Unterschied bei Harn-IK (RR 0.98; 95% CI 0.79-1.20)

Stuhl-Inkontinenz nach Geburt

MacArthur BJOG 2011

Exclusive caesarean section delivery and subsequent urinary and faecal incontinence: a 12-year longitudinal study

C MacArthur,[a] C Glazener,[b] R Lancashire,[a] P Herbison,[c] D Wilson[d] on behalf of the ProLong study group

[a] Public Health, Epidemiology and Biostatistics, School of Health and Population Sciences, University of Birmingham, Birmingham, UK [b] Health Services Research Unit, University of Aberdeen, Aberdeen, UK [c] Department of Preventive and Social Medicine and [d] Department of Women's and Children's Health, Dunedin School of Medicine, University of Otago, Dunedin, New Zealand

Correspondence: Prof C MacArthur, Public Health, Epidemiology and Biostatistics, School of Health and Population Sciences, University of Birmingham, Birmingham B15 2TT, UK. Email c.macarthur@bham.ac.uk

Accepted 23 February 2011. Published Online 8 April 2011.

- 7879 Geburten (nur Sectio/nur Vag./oder beides)
- 12 Jahre Beobachtung
- Fragebogen: Stuhl-IK ja/nein; gelegentlich; häufiger

Geburt / Stuhl-Inkontinenz?

MacArthur et al BJOG 2011

- Kein Unterschied Sectio/Vaginalgeburt
- Mehr Stuhl-IK >35Lj
- Mehr Stuhl-IK >Multipara
- Mehr Stuhl-IK >BMI>30)

Table 5. Logistic regression of faecal incontinence at 12 years and delivery mode history

Variable	Total	Symptoms *n* (%)	Odds ratio (95% CI)	*P* value
Delivery mode history				
Only SVD	1852	213 (11.5)	Reference	
Only CS	403	47 (11.7)	0.94 (0.66–1.33)	0.716
SVD + CS	293	39 (13.3)	1.06 (0.73–1.54)	0.758
Any forceps	956	160 (16.7)	1.48 (1.18–1.85)	0.001
Any vacuum, no forceps	248	27 (10.9)	0.91 (0.59–1.40)	0.667
Age at first birth (years)				
<25	1273	175 (13.7)	Reference	
25–29	1492	160 (10.7)	0.83 (0.65–1.05)	0.121
30–34	788	118 (15.0)	1.35 (1.03–1.77)	0.033
≥35	199	33 (16.6)	1.62 (1.05–2.50)	0.029
Number of births				
One	410	43 (10.5)	Reference	
Two	1834	228 (12.4)	1.35 (0.95–1.93)	0.095
Three	1014	130 (12.8)	1.47 (1.00–2.15)	0.051
Four or more	494	85 (17.2)	2.04 (1.33–3.13)	0.001
Body mass index				
<18.5	61	9 (14.8)	1.49 (0.72–3.09)	0.284
18.5–24.9	1785	194 (10.9)	Reference	
25–29.9	1020	131 (12.8)	1.21 (0.96–1.54)	0.114
≥30	642	119 (18.5)	1.90 (1.47–2.44)	<0.001
Not known	244	33 (13.5)	1.29 (0.87–1.93)	0.210

CS, caesarean section; SVD, spontaneous vaginal delivery.
Based on 3752 women: 11 with delivery mode history missing.

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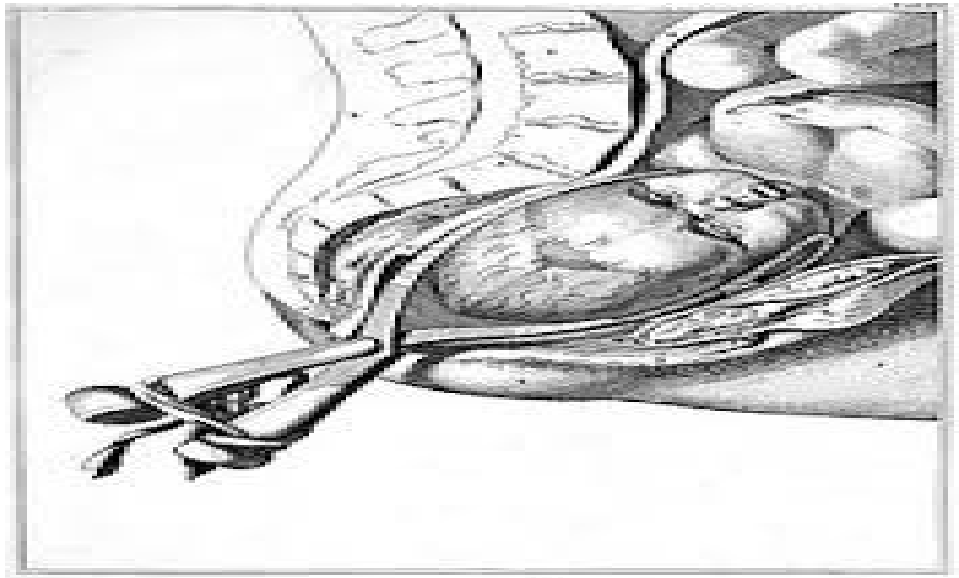
Geburt - Stuhl-Inkontinenz

Zange

MacArthur et al BJOG 2011



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Grosser Effekt der Zangengeburt auf spätere Stuhl-Inkontinenz

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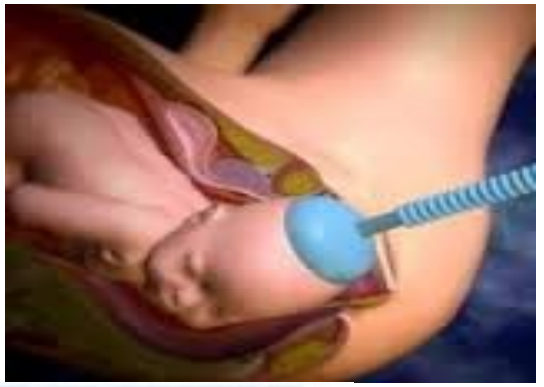
Geburt – Stuhl-Inkontinenz

Vakuum

MacArthur et al BJOG 2011

- Kein Einfluss der Vakuumextraktion auf Stuhlinkontinenz



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Vermeidungsstrategien?

Harn/Stuhl Inkontinenz

- Kein Einfluss: Geburtenzahl, Geburtsgewicht, Alter bei Geburt
- Geburtsverlauf (Austreibungsperiode)
- Beckenbodentraining
- Wunschsectio für alle?

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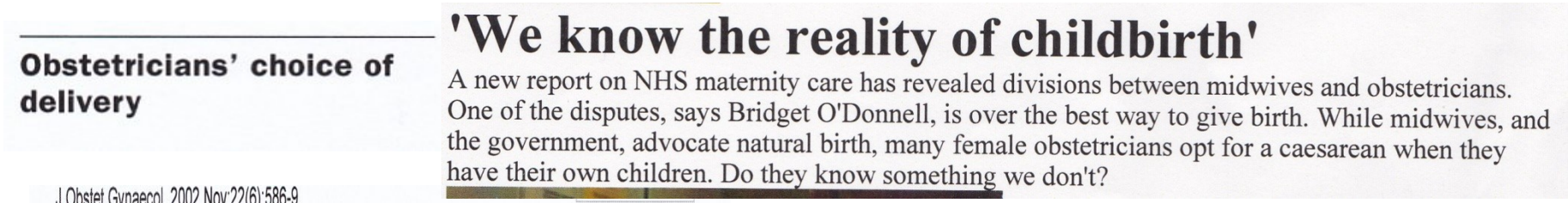
Wunsch: 2-3% der Sectiones Gründe?

- Angst
- Schmerzen
- Z. nach Geburtstrauma
- Sicherheit
- Beckenboden

Wunschsectio - **Gynäkologinnen**

Inkontinenzprophylaxe? Sicherheit?

Gabbe et al 2001 Lancet / MacDonald et al J Obstet Gynaecol 2002/Guardian 2008



Obstetricians' choice of delivery

'We know the reality of childbirth'

A new report on NHS maternity care has revealed divisions between midwives and obstetricians. One of the disputes, says Bridget O'Donnell, is over the best way to give birth. While midwives, and the government, advocate natural birth, many female obstetricians opt for a caesarean when they have their own children. Do they know something we don't?

J Obstet Gynaecol. 2002 Nov;22(6):586-9.

Scottish female obstetricians' views on elective caesarean section and personal choice for delivery.

MacDonald C[1], Pinion SB, MacLeod UM.

- Gynäkologinnen > Wunschsectio
  21-31% (GB) 46% (USA)
- 15.5% (Schottland)

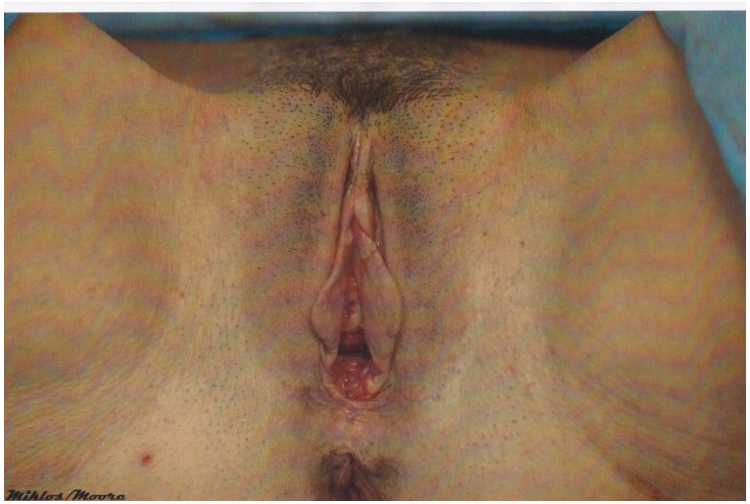
Lothar.Fuith@bbeisen.at

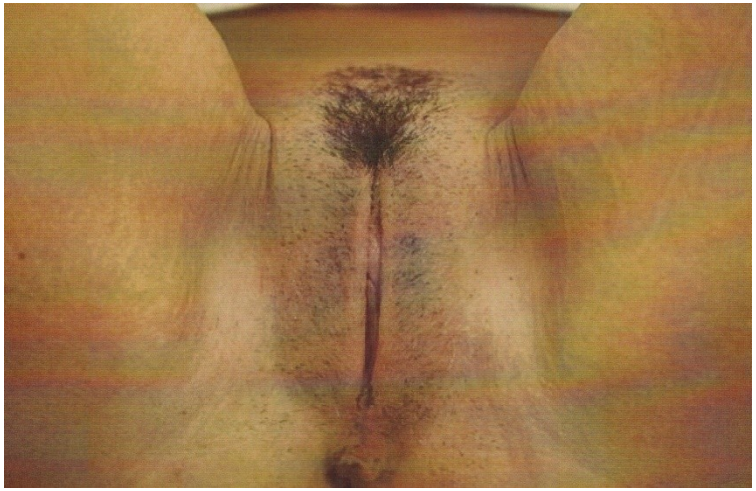
Wunschsectio – **Patientinnen**

Neu: „vaginal laxity“ Folgen der Vaginalgeburt

Vaginal Rejuvenation and Cosmetic Vaginal Surgery

Robert D. Moore, DO, FACOG, FPMRS, FACS
Director Advanced Pelvic Surgery, International Urogynecology Associates of Atlanta and Beverly Hills, Vaginal Rejuvenation Center of Atlanta, Atlanta Medical Research, Inc, GA, USA; Adjunct Professor Obstetrics and Gynecology, Emory University, Atlanta, GA, USA





Lothar.Fuith@bbeisen.at

Hormone – Menopause
Kontinenz

- Einfluss auf Harninkontinenz?

- Einfluss auf Stuhlinkontinenz?

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Hormontherapie Jahr bis 2000 Mammakarzinom

- Bei Hitzewallungen
- Prophylaxe der Osteoporose
- Prophylaxe von Herzinfarkt
- Für die Schönheit
- Bei Inkontinenz

Neues Präparat gegen Beschwerden im Klimakterium

3. April 2001, 13:15

poster

Wiener Forschungsteam entwickelte Therapie mit Rotklee

Wien - Die natürlichen Wirkstoffe des Rotklees - so genannte Isoflavone - hat ein Wiener Forschungsteam unter der Leitung Univ. Prof. DDr. Johannes Huber von der Universitäts-Frauenklinik für die medizinische Betreuung von Frauen in den Wechseljahren nutzbar gemacht. Das Nahrungsergänzungsmittel Menoflavon ist ab sofort in den Apotheken erhältlich, eine Monatspackung kostet 349 Schilling. Pro Tag sollte eine Kapsel, die etwa 40 Milligramm Isoflavon enthält, eingenommen werden.
"Die Isoflavone sind Östrogene aus der Pflanzenwelt und mit denen des Menschen fast ident", sagte Huber am Dienstag, bei

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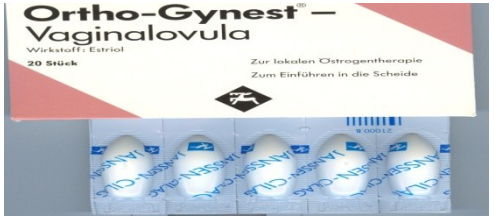
Unterschied
systemische – lokale Hormontherapie



- Tabletten/Pflaster: Ö messbar im Blutspiegel
- Zäpfchen/Salben: Ö nicht-messbar erhöht

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Hormone und Harninkontinenz

Hormonwirkung an Rezeptoren

- Östrogen-Rezeptoren Urogenitaltrakt
- Bessere Durchblutung lokal
- Östrogen> (Kollagen – Produktion)

Maturitas. 2008 Nov 20;61(3):243-7. Epub 2008 Oct 9.

Estrogen therapy influence on periurethral vessels in postmenopausal incontinent women using Dopplervelocimetry analysis.

Kobata SA, Girão MJ, Baracat EC, Kajikawa M, Di Bella V Jr, Sartori MG, Jármy-Di Bella ZI.

UNIFESP - são paulo federal university, São Paulo, Brazil.

BJOG. 2002 Mar;109(3):339-44.

The effect of oestradiol on vaginal collagen metabolism in postmenopausal women with genuine stress incontinence.

Jackson S, James M, Abrams P.

Department of Gynaecology, John Radcliffe Hospital, Oxford, UK.

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Heart **E**strogen/progestin **R**eplacement **S**tudy **HERS**

Obstet Gynecol. 2005 Nov;106(5 Pt 1):940-5.

Postmenopausal hormone therapy: does it cause incontinence?

Steinauer JE, Waetjen LE, Vittinghoff E, Subak LL, Hulley SB, Grady D, Lin F, Brown JS.

Department of Obstetrics, Gynecology and Reproductive Sciences, University of California-San Francisco, 1001 Potrero Avenue, San Francisco, CA 94110, USA.
steinauerrj@obgyn.ucsf.edu

Obstet Gynecol. 2001 Jan;97(1):116-20.

Postmenopausal hormones and incontinence: the Heart and Estrogen/Progestin Replacement Study.

Grady D, Brown JS, Vittinghoff E, Applegate W, Varner E, Snyder T; HERS Research Group.

University of California, San Francisco, San Francisco, California 94105, USA.
dgrady@itsa.ucsf.edu

- Östrogen+Gestagen Kombination
- 1208 Frauen **ohne** Inkontinenz (?: stress/urge IK)
- 4 Jahre Beobachtung
- Doppelblind Hormon vs Placebo

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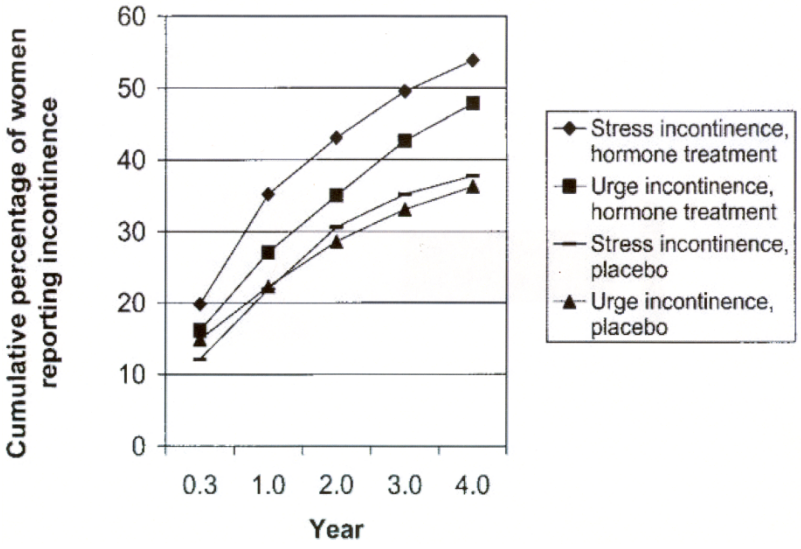
Ergebnisse HERS

Heart/progestin replacement study

- Stress-IK
  54% HRT - 38% Placebo
- Urge-IK
  48% HRT - 36% Placebo
- >4 Monaten diff.



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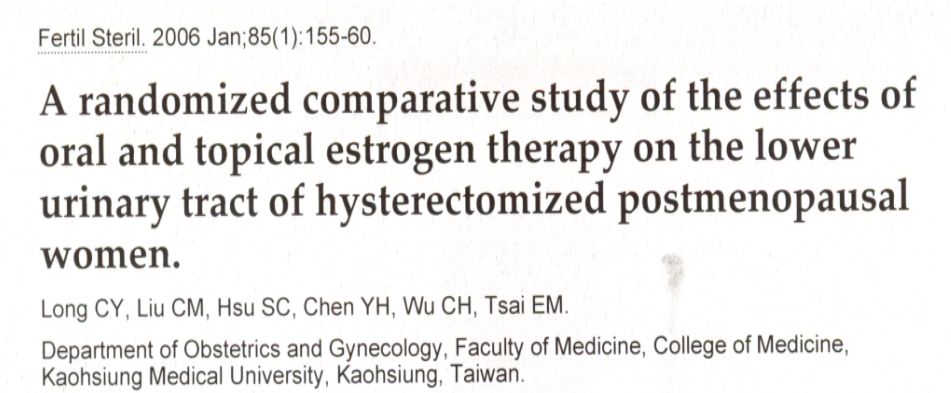
HRT immer negative Effekte für Kontinenz?

- Lokaltherapie positive Effekte
- Überaktive Blase besser

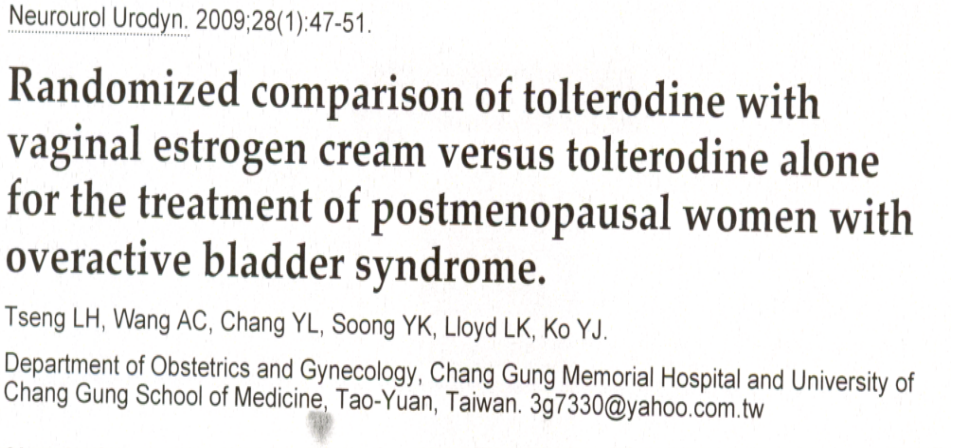


Fertil Steril. 2006 Jan;85(1):155-60.

A randomized comparative study of the effects of oral and topical estrogen therapy on the lower urinary tract of hysterectomized postmenopausal women.

Long CY, Liu CM, Hsu SC, Chen YH, Wu CH, Tsai EM.

Department of Obstetrics and Gynecology, Faculty of Medicine, College of Medicine, Kaohsiung Medical University, Kaohsiung, Taiwan.



Neurourol Urodyn. 2009;28(1):47-51.

Randomized comparison of tolterodine with vaginal estrogen cream versus tolterodine alone for the treatment of postmenopausal women with overactive bladder syndrome.

Tseng LH, Wang AC, Chang YL, Soong YK, Lloyd LK, Ko YJ.

Department of Obstetrics and Gynecology, Chang Gung Memorial Hospital and University of Chang Gung School of Medicine, Tao-Yuan, Taiwan. 3g7330@yahoo.com.tw

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Hormone zur Therapie HIK

Irrweg der Medizin bis 2009 ?

Cochrane data base / AWMF

Cochrane Database Syst Rev. 2009 Oct 7;(4):CD001405.

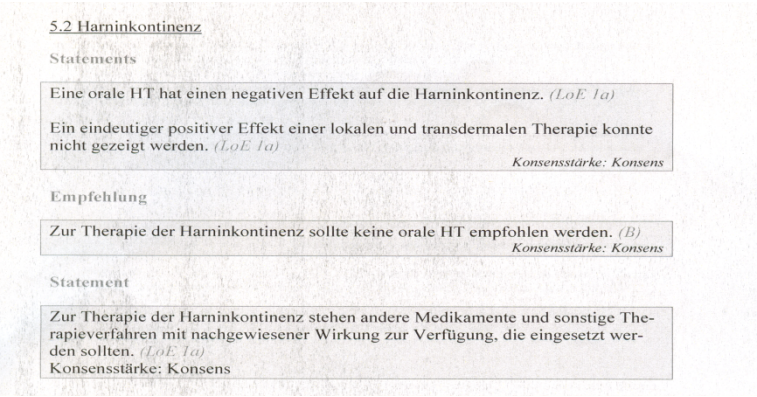
Oestrogen therapy for urinary incontinence in post-menopausal women.

Cody JD, Richardson K, Moehrer B, Hextall A, Glazener CM.

Cochrane Incontinence Review Group, University of Aberdeen, 1st Floor, Health Sciences Building, Foresterhill, Aberdeen, UK, AB25 2ZD.

Update of:

Cochrane Database Syst Rev. 2003;(2):CD001405.



5.2 Harninkontinenz

Statements

Eine orale HT hat einen negativen Effekt auf die Harninkontinenz. *(LoE 1a)*

Ein eindeutiger positiver Effekt einer lokalen und transdermalen Therapie konnte nicht gezeigt werden. *(LoE 1a)*

Konsensstärke: Konsens

Empfehlung

Zur Therapie der Harninkontinenz sollte keine orale HT empfohlen werden. *(B)*

Konsensstärke: Konsens

Statement

Zur Therapie der Harninkontinenz stehen andere Medikamente und sonstige Therapieverfahren mit nachgewiesener Wirkung zur Verfügung, die eingesetzt werden sollten. *(LoE 1a)*

Konsensstärke: Konsens

- **Cochrane 2003**: Östrogen kann HIK verbessern.
  Hinweis auf HERS – Daten 2003 zu früh
- **Cochrane 2009**: Lokaltherapie positiv- Systemische Therapie verschlechtert HIK!
- **AWMF 2009**: keine system. Therapie bei Inkontinenz

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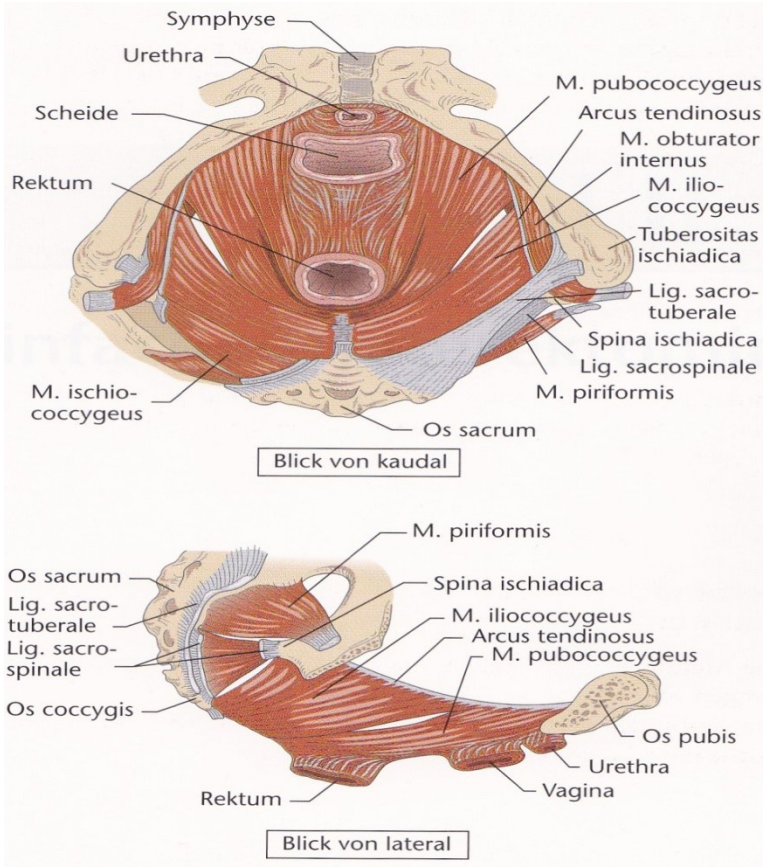
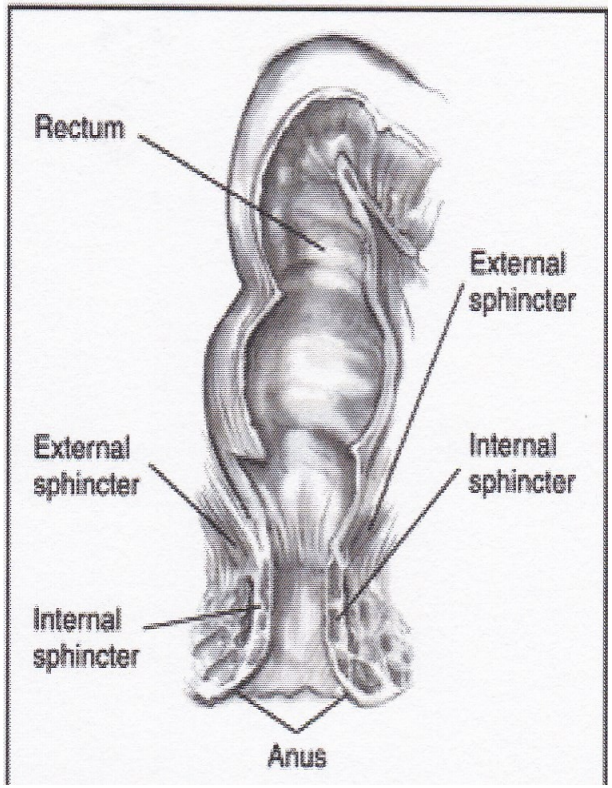
Hormone und Stuhlinkontinenz Östrogenrezeptoren?





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Östrogenrezeptoren Anus/Rectum

Am J Obstet Gynecol. 1991 Feb;164(2):609-10.

Estrogen receptors in the external anal sphincter.

Haadem K[1], Ling L, Fernö M, Graffner H.

Dis Colon Rectum. 2010 Dec;53(12):1687-91. doi: 10.1007/DCR.0b013e3181f05422.

Wolters Kluwer

Expression of estrogen and progesterone receptors in the anal canal of women according to age and menopause.

Parés D[1], Iglesias M, Pera M, Pascual M, Torner A, Baró T, Alonso S, Grande L.

Author information

Int Urogynecol J (1998) 9:136–139

International Urogynecology Journal

Original Article

Non-Evidence of Estrogen Receptors in the Rectal Mucosa

D. E. E. Rizk[1], T. E. L. Helal[2], N. Mason[1] and B. Berg[1]
[1]Faculty of Medicine and Health Sciences, United Arab Emirates University; [2]Al-Ain Hospital, Al-Ain, United Arab Emirates

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Effekte der Hormontherapie auf Stuhlinkontinenz

Br J Obstet Gynaecol. 1997 Mar;104(3):311-5.

The influence of oestrogen replacement on faecal incontinence in postmenopausal women.

Donnelly V, O'Connell PR, O'Herlihy C.

Department of Obstetrics and Gynaecology, University College Dublin, National Maternity Hospital, Ireland.

- 20 Pt. Postmenopausal, HRT systemisch
- 5/20 asymptomatisch; 13/20 gebessert
- Grössere Studie geplant

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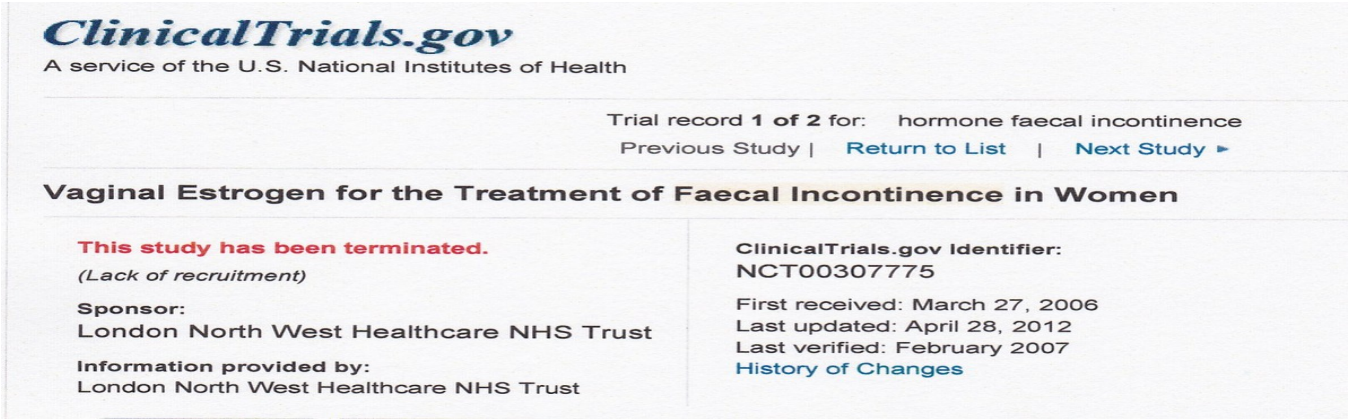
Hormone Stuhlinkontinenz –Studien?



ClinicalTrials.gov
A service of the U.S. National Institutes of Health

Trial record **1 of 2** for: hormone faecal incontinence
Previous Study | Return to List | Next Study ►

Vaginal Estrogen for the Treatment of Faecal Incontinence in Women

This study has been terminated.
(Lack of recruitment)

Sponsor:
London North West Healthcare NHS Trust

Information provided by:
London North West Healthcare NHS Trust

ClinicalTrials.gov Identifier:
NCT00307775

First received: March 27, 2006
Last updated: April 28, 2012
Last verified: February 2007
History of Changes

- Unklar
- Lokale Effekte?

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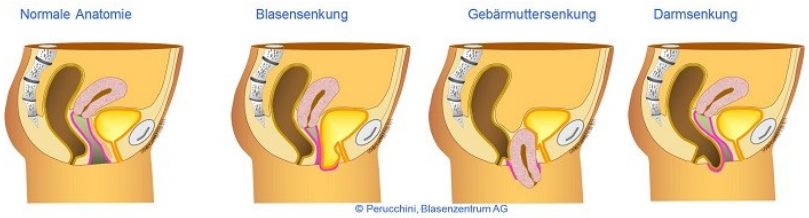
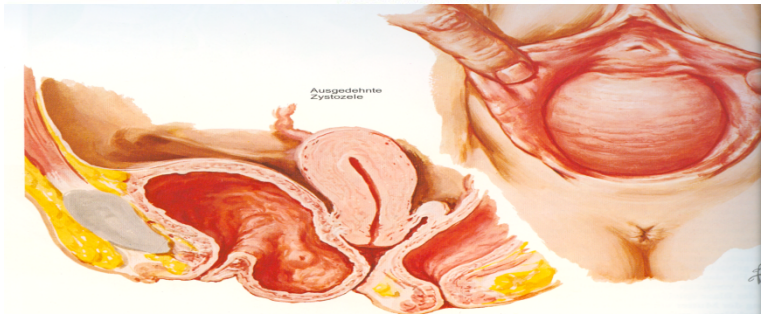
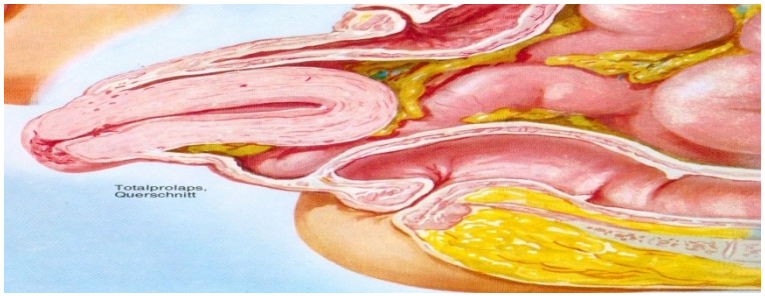
Gebärmutter – Scheidensenkung

Gibt es neue Korrekturoperationen?

- **Cystocele**
- **Descensus uteri**
- **Rectocele**







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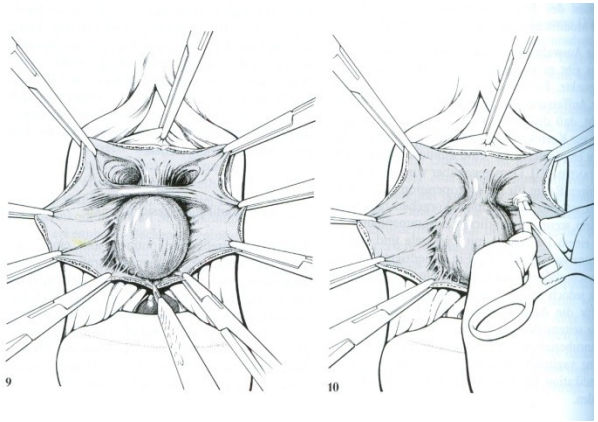
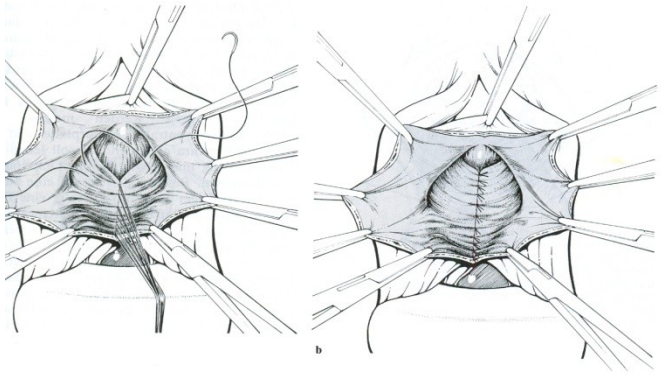
Cystocele
Kolporrhaphia anterior





- Vordere Kolpotomie
- Keine Inkontinenz-operation
- Durchaus gute Effekte
- Cave: Quetschhahn-HIK

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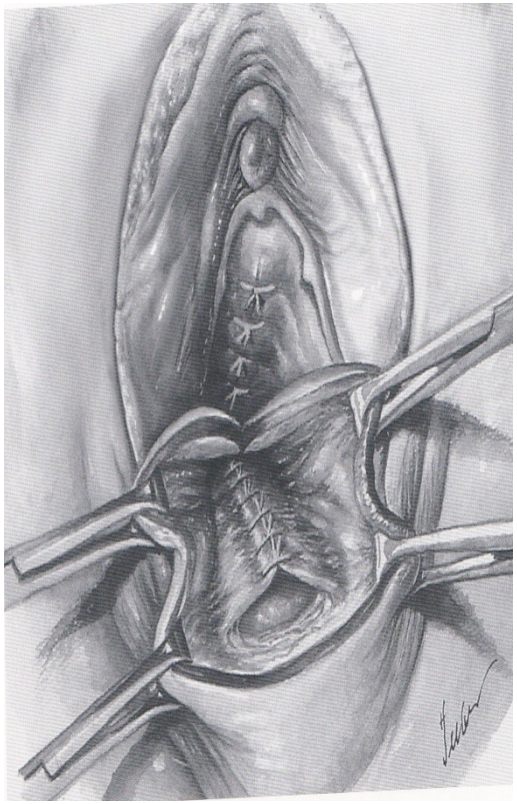
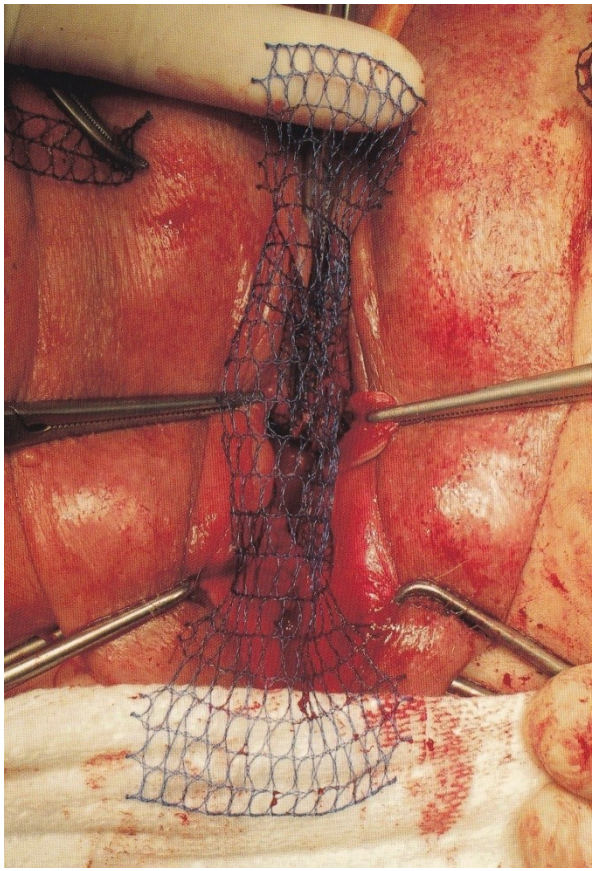
Rektocele

Kolporrhaphia posterior – Netz?

Raffung der Rektovaginalfaszie





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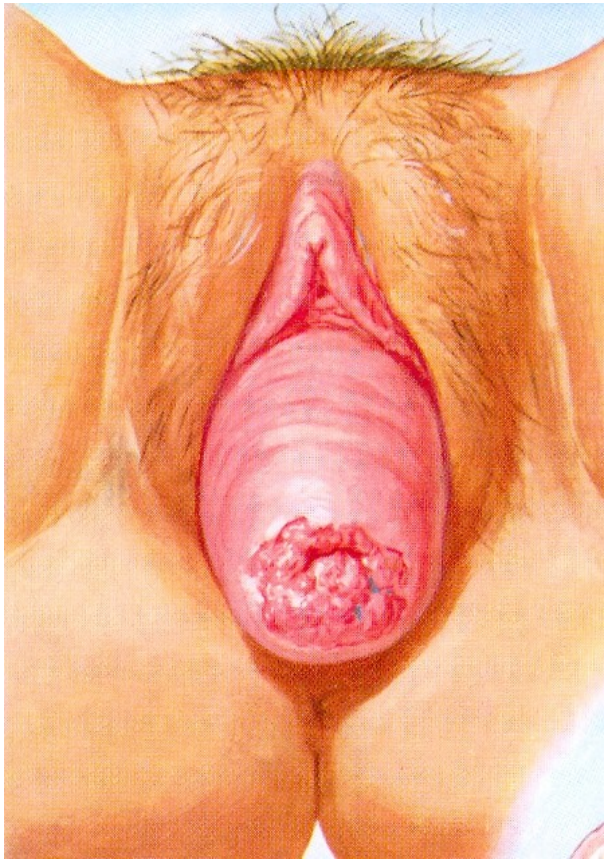
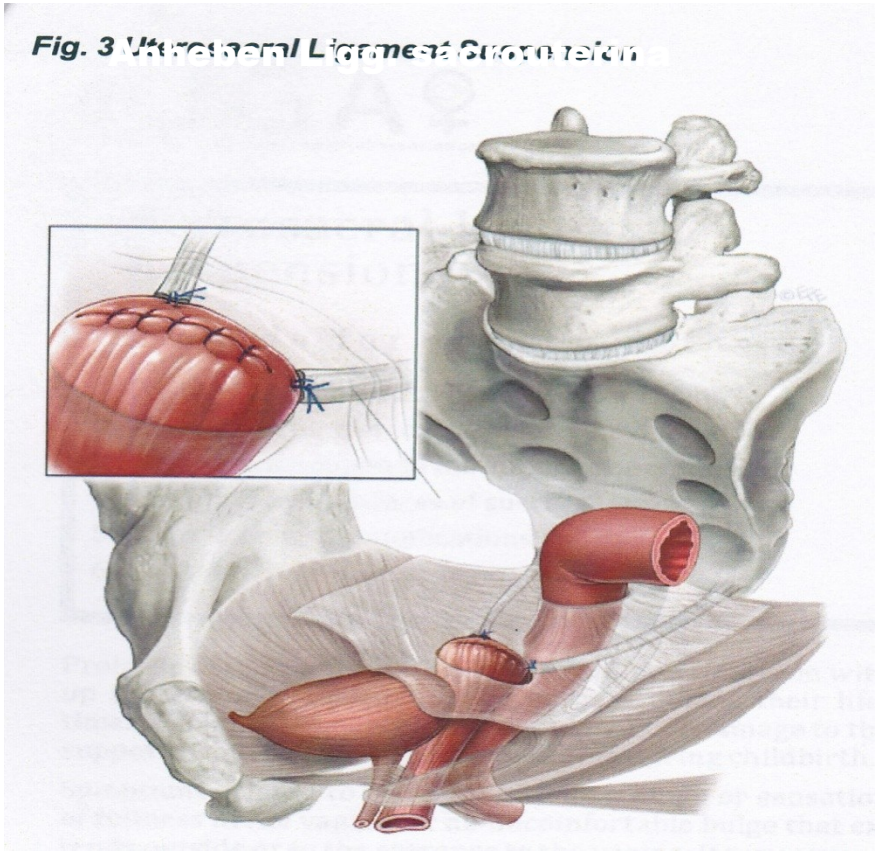
Descensus uteri - Uterusprolaps

Uterusexstirpation: Anheben der Ligg. Sacrouterina an vagina





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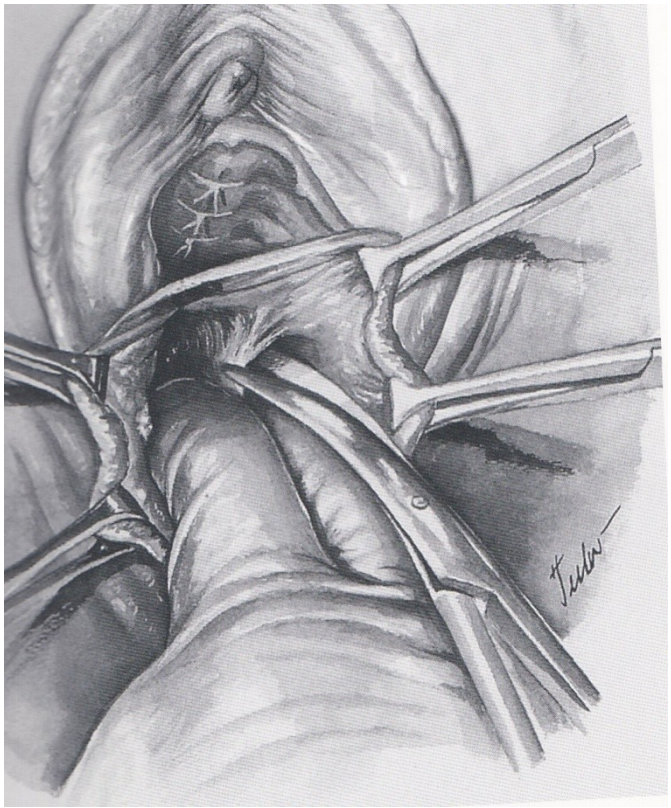
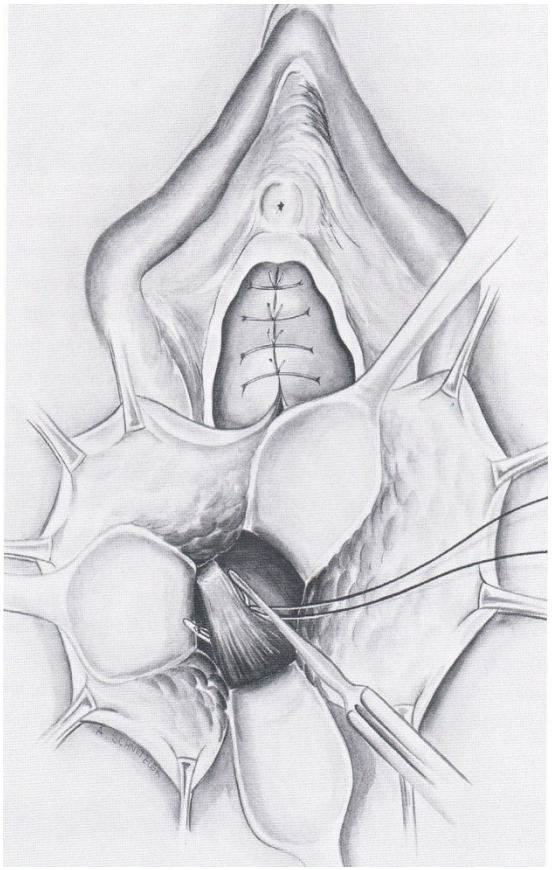
Uterusprolaps

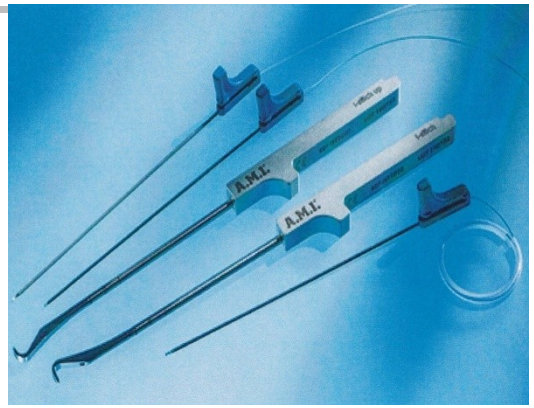
Uteruserhalt: Detollenaere et al. BMJ

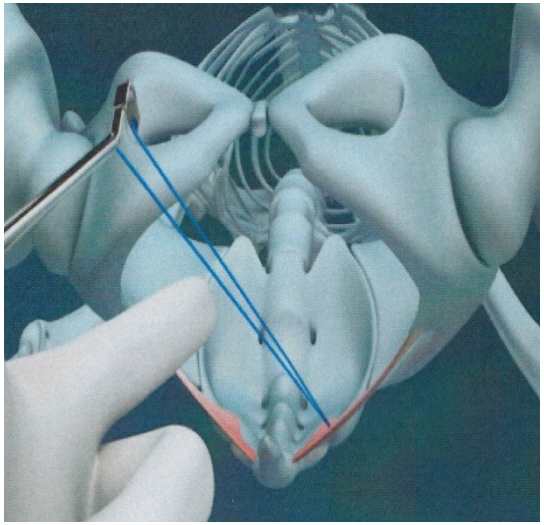
2015+ Neue Leitlinie AWMF 2015

Vaginale sacrospinale Hysteropexie: 2 cm med. spina ischiadica; nicht-resorb.poylpropylen 0; re+-li









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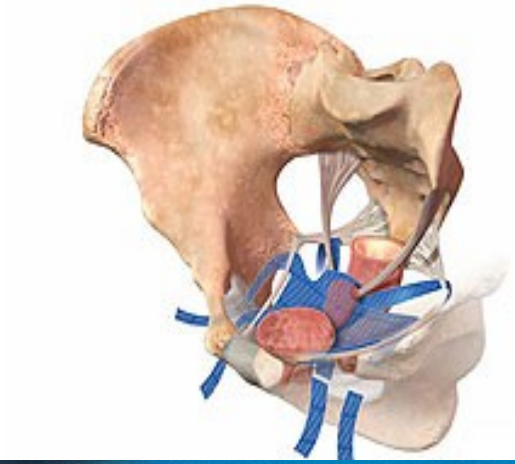
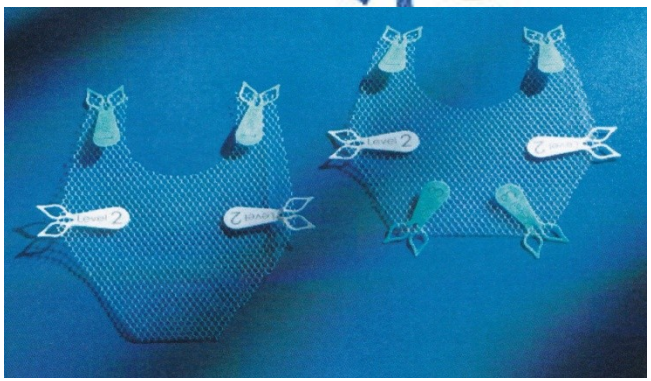
ab 2005 auf Markt –2012 vom Markt genommen

Prolift (Johnson&Johnson)

- + Uteruserhalt
- + „Schönes“ anatomisches Resultat
- - Bandarrosionen (26%)
- - Dyspareunie (63%)





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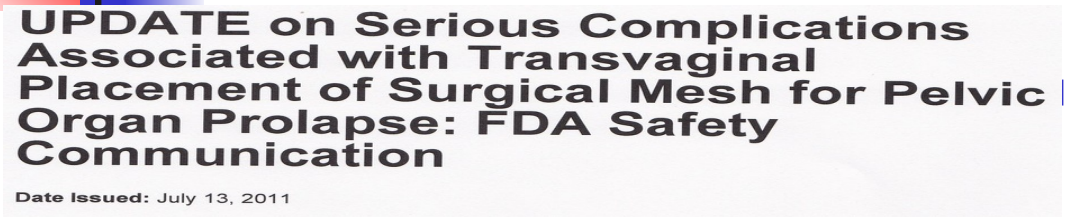
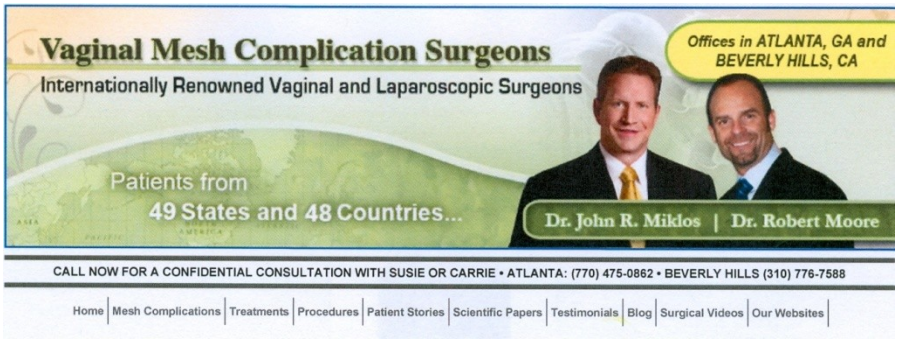
FDA warning 2008
Johnson&Johnson Rückzug vom Markt


UPDATE on Serious Complications Associated with Transvaginal Placement of Surgical Mesh for Pelvic Organ Prolapse: FDA Safety Communication

Date Issued: July 13, 2011

Nur noch wenige Netze verfügbar



- Tausende Klagen wegen Prolift in USA


Jury Awards Woman $11.1 Million in Ethicon Vaginal Mesh Case Against Johnson & Johnson

In February 2013, Johnson & Johnson and Ethicon lost the first of some 4,000 Gynecare Prolift cases to go to trial. The jury awarded the plaintiff a total of $11.1 million; $3.35 million in compensation for her injuries, and $7.76 million in punitive damages against J&J.

- Ursachen? TVT keine Probleme

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Zusammenfassung

- Geburtsverlauf – Einfluss Harn+Stuhl IK
- Harninkontinenz:
  Syst. Hormontherapie – negativ
  Lokale Hormontherapie – positiv
- Stuhlinkontinenz – Hormone?
- Uteruserhalt bei Prolaps möglich
- Cave Netze in Gynäkologie

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Medizinische Kontinenzgesellschaft Österreich

(MKÖ) Jahrestagung

Linz 20.-21. Oktober 2016

Medizinische Kontinenzgesellschaft Österreich

www.kontinenzgesellschaft.at

Vielen Dank!

Lothar.Fuith@bbeisen.at