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Geriatric Gynecology: Considerations from a Urogynecologist's Perspective

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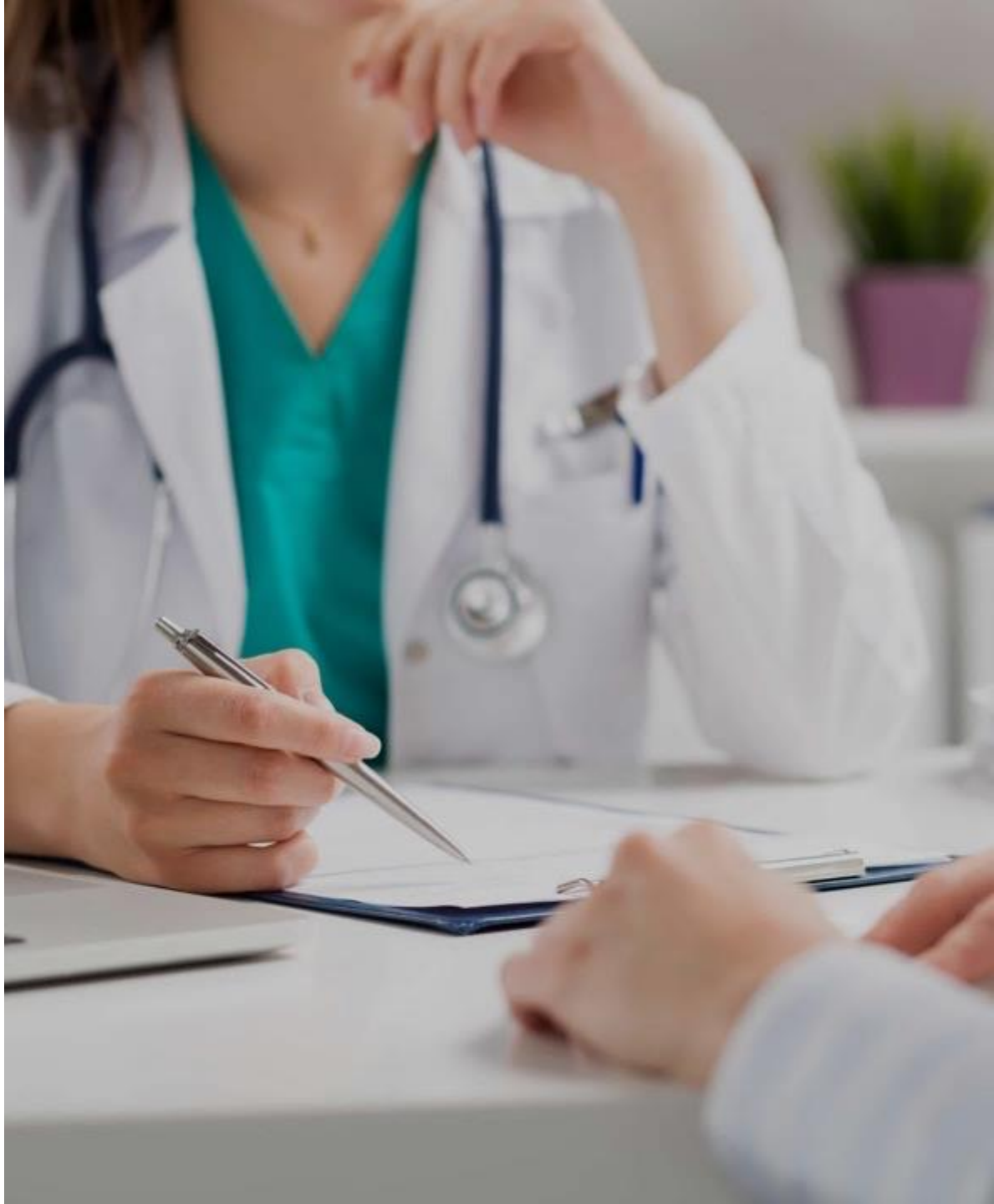
I have nothing to disclose

LEARNING OBJECTIVES

Objective #1 Review medical conditions commonly seen in the geriatric population in the Urogynecologist's office

Objective #2 Discuss potential barriers to care in the Geriatric population, specifically regarding urogynecologic diagnoses

Objective #3 Review specific treatment options for the above medical conditions



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UROGYNECOLOGIC CONDITIONS COMMONLY SEEN IN THE GERIATRIC POPULATION

- Pelvic Organ Prolapse (POP)
- Urinary Incontinence (UI)
- Fecal Incontinence (FI)
- Constipation
- Recurrent UTIs
- Sexual dysfunction

UNIQUE CHALLENGES IN THE GERIATRIC POPULATION

- Medical Comorbidities
- Polypharmacy
- Mobility/Falls
- Cognition/Memory
- Transportation
- Perioperative management

PATIENT #1

- 84 year old P4 with Parkinson's Disease, HTN, Hyperlipidemia, A fib, s/p TAH/BSO in the 1990s who presents with pelvic organ prolapse, mixed incontinence, and rare fecal incontinence
- She is most bothered by her urinary incontinence as she wakes up multiple times at night
- Her mobility is worsening, she is experiencing cognitive decline
- She is on multiple medications
- She is accompanied by her daughter who works full time
- She lives alone and does not drive

ON EXAM…

- PVR 250 cc
- Urinalysis positive for leukocytes and nitrites
- Positive Cough Stress Test
- Stage 3 POP (anterior wall, posterior wall and vaginal vault), multiple vaginal erosions
- Large stool burden

DIAGNOSES

- Urinary retention
- Acute cystitis
- Mixed incontinence
- Stage 3 POP
- Constipation
- Fecal incontinence

PELVIC ORGAN PROLAPSE (POP)

Lifetime risk of POP: 30-50%

Lifetime risk of undergoing surgery for pelvic organ prolapse by age 80: 11-19%

RISK FACTORS FOR POP

- **Advancing Age**
- Menopause
- Parity
- Obesity
- Hysterectomy
- Connective Tissue Disorders
- Chronic Constipation

ADVANCING AGE

Epidemiologic studies consistently report an increased risk of POP with advancing age

In one study, over 1000 women reporting for routine gynecologic evaluation reported a progressive increase in the rate of prolapse with increasing age – every additional 10 years conferred an increase risk of prolapse of 40%

The WHI showed a statistically significant progressive increase in the prevalence of rectocele with age (50 to 59 compared to 60 to 69 and 70 to 79)

In another small study, the number of women seeking care for symptomatic pelvic disorders increased with **age**, the largest number of consults in women in their 70s

MENOPAUSE

There is a direct and independent correlation between menopause and an increased risk for POP

Estrogen receptors are found in the uterosacral-cardinal ligament complex and levator ani muscles

One study showed that postmenopausal women had lower concentrations of serum estrogen and estrogen receptors in the pelvic floor ligaments

TREATMENT OF POP

- Expectant management
- Pelvic floor physical therapy
- Estrogen cream
- Pessaries
- Surgery

BACK TO OUR PATIENT…

- First step would be to fit her for a pessary to help her better empty her bladder – recheck PVR in 1-2 weeks
- Treat UTI based on culture results
- Re-evaluate urinary symptoms after UTI is treated
- Prescribe vaginal estrogen cream
- Bowel regimen

POTENTIAL BARRIERS TO CARE

1. **Risk of falls in the middle of the night** – essential to treat nocturia to prevent patient from trying to get out of bed on her own in the middle of the night
2. **Medical Comorbidities** – likely contributing to her urinary symptoms
3. **Polypharmacy** – need to carefully decide antibiotics for this patient, and consider non-medication options for OAB
4. **Transportation** - pessary fitting requires 1-2 week follow up and then q2-3 month follow ups
5. **Ability to self apply vaginal estrogen cream?**
6. **Cognition** – will she remember to take her medications? Will she remember she has a pessary?

URINARY INCONTINENCE

Prevalence in 20 years and older: 10-60%

Prevalence in 60 and older: **50-70%**

Overactive bladder (OAB) is more prevalent in the geriatric population

RISK FACTORS FOR UI

- **Age**
- Obesity
- Parity
- Medical comorbidities and medications

AGE

In large surveys of nonpregnant women, urinary incontinence was reported to affect 3% of adult women over age 35, rose to 7% for ages 22-64, and rose to **38-70%** for women over age 60

In nursing homes, reported rates of urinary incontinence range from **43-77%**

MEDICAL COMORBIDITIES AND MEDICATIONS

Diabetes, stroke, depression, fecal incontinence, genitourinary syndrome of menopause, HRT, pelvic radiation all increase risk of UI

Prevalence of UI among dementia/women with cognitive impairment – 10-38%

One study reported that both women and men with urgency urinary incontinence were more likely to avoid diuretics as the drugs were associated with worsening symptoms

TREATMENT OF UI, SPECIFICALLY OAB

- Behavioral modifications – timed voiding, fluid management, treatment of constipation
- Estrogen cream
- Pelvic floor physical therapy
- Medications
- Neuromodulation
- Bladder botox

FECAL INCONTINENCE

Prevalence is approximately 7.7%

Prevalence increases with advancing age

RISK FACTORS FOR FI

- **Age**
- Diarrhea
- Fecal Urgency
- Specific medical conditions including IBD, neurologic conditions, Diabetes

INITIAL TREATMENT OF FI

- Supportive care – avoiding foods that worsen symptoms and improving perianal skin hygiene
- Medical therapy
- Pelvic floor physical therapy

CONSTIPATION

Prevalence is 12-19% in the general population

In women 65 and older, **34%** have symptoms of constipation

Symptoms based disorder without specific diagnostic criteria

Symptoms may include hard stools, infrequent defecation (less than 3 stools/week), excessive straining, splinting or manual disimpaction

TREATMENT OF CONSTIPATION

First rule out alarming symptoms -hematochezia, iron deficiency anemia, family history of colon cancer or IBD, unexplained weight loss, obstructive symptoms

If no alarming symptoms, normal colonoscopy and normal lab results, **reasonable to trial lifestyle modifications and laxatives**

FIBER AND MEDICATIONS

- Adults require 25-35 grams of fiber daily, most do not meet this requirement
- First step is increase fiber in diet, or supplement
- Increase daily water
- Increase physical activity
- Laxatives (miralax, magnesium)

PATIENT #2

- 77 year old P2 with dementia who lives in a nursing home who presents with OAB and fecal incontinence
- Main concern is urinary incontinence
- Two E Coli UTIs in the past 6 months without dysuria, fever or flank pain, which were treated with antibiotics
- Daily fecal incontinence

ON EXAM…

- PVR 25
- Urinalysis positive for leukocytes and nitrites
- No POP on exam
- Rectal exam with poor squeeze tone

DIAGNOSES

Asymptomatic bacteriuria

Overactive Bladder

Fecal incontinence

RECURRENT UTIS

UTI is the most common infectious illness in adults 65 and older

Definition: Two UTIs in 6 months or three UTIs in 1 year

Often difficult to diagnose in this population because of chronic urinary symptoms and cognitive impairment

Asymptomatic bacteruria is prevalent in this population (15-20%), and UTI is therefore often overdiagnosed

ASYMPTOMATIC BACTERURIA

Isolation of >100,000 CFU of bacteria in a clean catch specimen without symptoms of a UTI

Important to specifically isolate UTI symptoms (dysuria, urinary urgency and frequency, fever with cystitis symptoms, CVA tenderness) so as not to overtreat with antibiotics, or miss the underlying infection

Minimum criteria for the initiation of antibiotics for urinary tract infection in long-term care residents

With indwelling catheter
At least one of the following:
Fever (>37.9°C [100°F] or 1.5°C [2.4°F] above baseline)
New CVA tenderness
Rigors
New onset delirium
Without indwelling catheter:
Acute dysuria **OR**
Fever (>37.9°C [100°F] or 1.5°C [2.4°F] above baseline) **AND**
At least one of the following:
New or worsening urgency
Frequency
Suprapubic pain
Gross hematuria
CVA tenderness
Urinary incontinence

TREATMENT APPROACHES TO RECURRENT UTIS

Treat UTI based on culture result

Preventive strategies include vaginal estrogen cream, methenamine hippurate, daily prophylactic antibiotics

BACK TO OUR PATIENT…

- Urinalysis and urine culture only if patient is symptomatic
- Prescribe vaginal estrogen cream
- Treat Overactive Bladder
- Bowel regimen, Pelvic floor physical therapy

POTENTIAL BARRIERS TO CARE

- **Medical comorbidities** – likely contributing to her pelvic floor disorders
- **Cognition** – dementia will likely make it difficult to differentiate recurrent UTI and asymptomatic bacteriuria
- **Polypharmacy** – important to keep in mind if decision is made to prescribe antibiotics
- **Falls/mobility** – nocturia increases risks of falls in the middle of the night
- **Transportation** – patient lives in a nursing home and may be difficult for her to come to appointments

SEXUAL DYSFUNCTION

Prevalent in the older population, difficult to give exact number

Causes are typically multifactorial – medical illness, medications, comorbid psychiatric illnesses, psychosocial stressors

TREATMENT OF SEXUAL DYSFUNCITON

- Multimodal approach
- Counseling
- Address medical concerns
- Address partner issues

PATIENT #3

- 80 year old P1 with A fib and HTN who presents with POP, urgency incontinence, and constipation
- Patient desires surgical management of her POP

ON EXAM…

- PVR 50 cc
- Negative Cough Stress Test
- Stage 3 POP – anterior, posterior and uterine prolapse
- Stool burden

DIAGNOSES

Stage 3 POP

Urgency incontinence

Constipation

BACK TO OUR PATIENT..

- Discuss treatment options for POP including pessary vs. surgery
- Is surgery safe in an 80 year patient?

COMMON PERIOPERATIVE COMPLICATONS IN THE ELDERLY

- Electrolyte imbalances
- Delirium
- Falls
- Deconditioning
- Functional loss
- Discharge to rehabilitation facilities

TAKEWAY POINTS

Common urogynecologic conditions in the geriatric population include:

POP	UI	FI	Constipation	Recurrent UTIs	Sexual Dysfunction

Understanding and addressing age specific challenges that impact treatment plan is of utmost important

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