**Maggie McKay (Host):** When you need gynecology or urological care, where do you get the answers and treatment? Dr. Kathleen Bertuna will tell us what we need to know about female urinary issues from a gynecologist's perspective.

**Host:** Welcome to Memorial Health Radio with Memorial Health System Ohio. I'm your host, Maggie McKay. Welcome, Dr. Bertuna. So good to have you here.

**Kathleen Bertuna:** It's great to be here. Thanks for having me.

**Host:** Absolutely. So to start off, it seems like there are so many urinary issues for women that we may not even know about until we're having a problem. So from your perspective, let's break it down. Tell us about the problem of urinary frequency for starters.

**Kathleen Bertuna:** Sure. So, urinary frequency is a common complaint in women, especially as women age. I actually see it in all age groups and it can have a lot of different causes and underlying problems. The most common tends to be with our American diet and the ingestion of all of our sugary, caffeinated drinks. And so, that's kind of an easy one to identify. One that's harder can be a condition where the bladder lining thins and the nerves get activated. And a lot of times patient will think they have an early urinary tract infection when in actuality they don't have an overgrowth of bacteria, but they have a condition called interstitial cystitis, and that is basically where the nerves are inflamed because the lining has thinned and it's making it feel like you have to go to the bathroom with very small amounts of urine in the bladder.

**Host:** So, is it more about how often you're going or that you just feel the urge that you need to go?

**Kathleen Bertuna:** It can be both. So, the interstitial cystitis symptoms can range from urinary frequency, feeling like you have to go to the bathroom every 15 to 20 minutes, to also having some pain when your bladder's full or after you empty, or feeling like you truly have a UTI with burning when you pee.

**Host:** And what about urge incontinence?

**Kathleen Bertuna:** So with urge incontinence, that's typically that overactive bladder that gotta go. The triggers can be when you stand up to go to the restroom or when you hear running water or that turning the key in the door, not that anyone has keys anymore. Everything is electronic. But just any of the triggers of where you might be getting to your house and feeling that need and desire to go to the bathroom, but then you can't "hold the pee" and so, that you either leak a small amount and, in some cases, you can leak a large amount.

**Host:** Is that myth true about when you get closer to like your destination where there's a bathroom, the more you have to go, the urge is stronger?

**Kathleen Bertuna:** Yeah, the urge can be stronger. That trigger there, it's very interesting how the bladder is connected to the brain and that the nerves go through the sacrum and then they interact with the nerves going up the spine. And so, that pathway can get accentuated with any emotions that you may have or patterns of behavior, as well as any medical problems that you may have with arthritis or back pain as well as chronic medical conditions like diabetes, those sorts of things.

**Host:** Boy, it all is connected. What about stress incontinence?

**Kathleen Bertuna:** So stress incontinence, you can think of that as the leaking when you laugh, cough or sneeze. And it's usually a weakness in the vaginal floor that supports the urethra. And so, those are patients that risk factors for that can be genetics, so having stretchier tissue; kind of life experiences, whether you had vaginal deliveries, how big those babies were; and then also, kind of what your day-to-day activity is. Are you lugging around, you know, five-gallon buckets all day? Lifting heavy things throughout your life can put a lot of pressure on the pelvic floor and stretch out the tissues.

**Host:** And what about recurrent UTIs?

**Kathleen Bertuna:** Oh, my goodness. This is a huge issue in some of my patients. And it's usually a combination of the bladder symptoms, so feeling the pain when they have a UTI, and then you check a urine culture and they do indeed have the bacteria in the urine. And if you have more than three UTIs per year, that's considered chronic UTIs, and that's a condition that you definitely want to get looked at and treated because of the risk for the bacteria to get into the bloodstream and make you very, very sick.

**Host:** Dr. Bertuna, what is female genital prolapse?

**Kathleen Bertuna:** So, female genital prolapse is when, again, that pelvic floor relaxes and you can have multiple compartments in the vagina stretch. And so, you can think of the vagina kind of as a box, and the top of the box is where the bladder sits. And so, that can get weakened and the bladder can come into the vagina and actually push out. The top of the box would be where the cervix and the uterus are supported. That can weaken and you can actually have that prolapse through the vagina come down through the vagina, through the opening. And then, the back of the box would be where the rectum sits underneath and that tissue can also become weakened and the rectum pushed through that tissue into the vagina and out of the body. Or it can all happen at the same time. So, the box can just be weak in every compartment.

**Host:** It's so complicated. There's so many things that can go wrong, right? What are the symptoms and the non-medical treatments or medication or surgical options for all these things?

**Kathleen Bertuna:** Each of them kind of have a different pathway. When you look at urinary frequency, if it's determined that it's not just due to too much caffeine per se, but that there's no urinary tract infection, there's no bladder stone or kidney stone causing this urinary frequency, then we look at interstitial cystitis more closely.

The first thing we recommend is dietary changes, so things that will irritate the nerves of the bladder, especially with interstitial cystitis are going to be caffeinated beverages, carbonated beverages, any acidic foods, so your citrus fruits and vegetables, especially tomatoes and tomato sauce, spicy foods and alcohol. So, we start with dietary changes first. If those work well, that's kind of where we end treatment. If you're still having the symptoms of the urinary frequency, especially if it's with bladder pain, then a lot of times we like to look in the bladder with a cystoscopy and make sure we don't see anything inside the bladder that could be causing it. And if we see that the lining is really thin, we can stretch the bladder, which will help kind of reset the nerves and stimulate the bladder lining.

After the procedure, it takes about three months for a bladder lining to heal. And during that time, things that will make it heal faster are medicines, and those can be oral medications such as Elmiron, which is taken three times a day, half hour before you eat. Ellavil is a really good medication to help with the kind of frequency and pain from IC. And then, there's also medicine that can be put directly into your bladder once a week with a bladder instillation, and that's a combination of heparin, lidocaine and sodium bicarbonate. And sometimes we add even a little steroid called Kenalog to that mixture. And that tends to really take effect after the second or third installation. And usually by the sixth installation, the bladder feels great and patients are on their way.

**Host:** That all sounds pretty doable and relatively quick, three months. What about other things like urge incontinence and stress incontinence? How do you treat those?

**Kathleen Bertuna:** Sure. So down the urge incontinence pathway, if those are the majority of the symptoms and the leaking is not modified with dietary changes as far as caffeine, the next kind of step is pelvic floor physical therapy, and that's also a similar step for the stress incontinence. And so, you work with a physical therapist that has specialized training in pelvic floor rehab. And it's a phenomenal way to access the muscles and the nerves in that area to increase the capacity of the bladder and to help with the incontinence, not only with urge incontinence, but stress incontinence.

If pelvic floor physical therapy is not available in your area or the outcomes aren't as great as a patient wants, then we can move to medications. Medications for urge incontinence can be lumped into two categories. The first one is going to be antimuscarinics, which tend to be things you've heard about. Probably seen commercials for Vesicare, Sanctura, Detrol, Ditropan. They tend to have side effects such as dry eyes, dry mouth and constipation. They usually have one or two doses associated with them, and they're usually taken one to two times per day. The other class of medications are the beta-sympathomimetics and a medicine in that category is Myrbetriq. They don't have the anticholinergic side effects, but they can slightly raise your blood pressure, so it's something you have to keep an eye on. And you should start to see an effect of those medications as early as two weeks. And usually, we try them for six to eight weeks to see if they're fully effective.

For stress incontinence, medications don't work great. You want to try to tone the bladder neck. So if physical therapy has not improved the leaking to the level that the patient wants, usually the medications are tough because they have a lot of side effects. The medications that tend to work the best are going to be the SSRIs, the selective serotonin reuptake inhibitors, things like Prozac. Also, the combination serotonin and norepinephrine reuptake inhibitors such as the Effexor. But again, those are also used to treat depression and anxiety. But they can have an extra benefit of reducing stress incontinence by toning the neck of the bladder.

**Host:** And when it comes to recurrent UTIs, you always hear cranberry juice. Is that for real?

**Kathleen Bertuna:** So, there is some bacteriostatic capacity or properties of cranberry juice to acidify the urine. However, it's not as quite as effective as some other treatments out there. You want to make sure that the bladder's emptying all the way. So if a patient has a bladder prolapse or cystocele, is the patient retaining a small amount of urine that acts as a reservoir for the bacteria? So, you want to treat that. If the patient's in menopause and they have vaginal atrophy, a thinning of the mucosa in the vagina, you want to treat that usually with estrogen cream to thicken that tissue to make it harder for the bacteria to work its way up the urethra. If a patient is constipated, you want to make sure that you address their bowel function to make sure that there's not an increased load of bacteria sitting in the rectum. All of those things can just increase the chance for UTIs. Once that's addressed, one of the treatments that's worked really well for my patients is adding a medicine called methenamine. And when it's metabolized in the kidney, it really acidifies the urine and makes it difficult for bacteria to grow. So, that's another avenue for patients to help reduce the chance for the UTIs, recurrent UTIs.

**Host:** So, it sounds like all these issues are curable or are they just treatable?

**Kathleen Bertuna:** A lot of them are treatable and curable. It really depends on what the patient is coming in with and how long it's been present. In a patient that has interstitial cystitis, it's very treatable, but sometimes things can trigger it to recur; a stressful event, a trauma, a surgery. So knowing that you have had it, those patients if they get a trigger or they have a flare, if we jump on it immediately, it resolves so much faster.

In patients with chronic UTIs, if we address those underlying issues, a lot of times we can get rid of the recurrent UTIs. With the urge incontinence and stress incontinence, as far as the pelvic floor physical therapy, if that works, then, you know, being reminded to stay up with those exercises continues to help that. We talked about the medications. And then, there's also some surgeries that can be done.

For urge incontinence, the next step would be Botox therapy. Botox is all the rage now, but you can actually make your bladder younger by getting Botox injections in the muscle of your bladder, and that's an outpatient surgical procedure. Some insurances will cover it in the office, but most require you to have outpatient surgery. And that's done about every four to six months to keep your bladder fresh and looking young, and that really helps with the urge incontinence. And then, there's a further procedure that can be done that's called an InterStim therapy that's a pacemaker for the bladder. It's a transsacral nerve stimulator, and that really improves symptoms in 50-80% of women, especially the women that have a lot of back surgeries or comorbidities where there's a lot of nerve damage going to the bladder and away from the bladder. So, it really helps pace the bladder.

With stress incontinence, kind of the gold standard for treatment now is midurethral slings, and those are outpatient surgeries. It is a mesh sling, and I always talk to patients about the risks of mesh, what are the good things about meshes, what are the not so good things about meshes? But usually, you know, the 10-year data on midurethral slings show that they are still 80-90% effective at 10 years. So, that can be a really long-term solution for stress incontinence.

**Host:** Dr. Bertuna, you always see in the middle of the night, those commercials about the mesh and if you've been a victim of mesh surgery. I think that's why people are leery of it. Do you know what I'm talking about?

**Kathleen Bertuna:** Yeah, absolutely. Absolutely. And I try to say, you know, meshes have a place. We use them in a lot of different areas, and I think when they tried to expand meshes to treat more areas in the vagina, that didn't work so well. And not every patient is a candidate for mesh, but most are. So, you really have to look at your overall wellbeing and if you're a candidate for that.

**Host:** Right. And did we cover how to treat female genital prolapse?

**Kathleen Bertuna:** No. So, let's talk about prolapse. It's another one of my favorite areas of medicine. For the prolapse, again, you can start with pelvic floor physical therapy. Then what I tell patients if your prolapse doesn't bother you, it doesn't really bother me. In the sense that if it's not causing you harm, if it's not causing recurrent urinary tract infections, pressure, pain, difficulty doing the things that you want to do, we just keep an eye on it and we monitor it year to year. I always teach some form of pelvic floor exercises during those appointments just to reemphasize if you don't use your muscles, you will lose them. So, continue to have a healthy pelvic floor.

And then moving on from that, there's a non-surgical treatment called a pessary. A pessary is a donut-shaped device that sits in the vagina. And I always tell patients it's like your anti-gravity device. It shouldn't be uncomfortable. You shouldn't know it's there, and it's something that you can usually manage on your own. Some of my patients that have advanced arthritis or difficulty reaching into the vagina and grabbing the pessary, they can be managed by coming into the office and having that removed, cleaned and reinserted.

The pessaries come in different shapes depending on the type of prolapse you have. But essentially, they should be very, very comfortable when they're placed and when they're inside. And you can actually use some of the pessaries for stress incontinence as well. So, I've used that in some patients. And then if the conservative managements aren't working, then you can move up into surgical management and depending on the prolapse, will depend on the surgery. Sometimes it's as simple as putting a new shelf in there with your own tissue. Sometimes it requires more advanced surgery, where again, we start to get into the, "Do you need mesh placed in certain places to keep the prolapse from coming through the vagina?" But those are depending on the degree and which side of the box has a weakness.

**Host:** And what about, I know people pronounce it two different ways, KAY-gels or KEY-gels? I've heard through the years, they say they are effective, then they're not so effective, they are. What's the latest on those?

**Kathleen Bertuna:** I think if you're doing a proper Kegel exercise, you are going to get a benefit. Then frequency of them, I mean, you're talking about doing up to 50 to 100 contractions a day, which it's really hard for people to get in. If they don't know how to do a proper Kegel, which it's not only contracting the muscles, but also kind of pulling them up. Think about when you zip your pants, so it's that squeezing your pelvic floor, but also lifting it as if you're zipping your zipper and doing that upwards of 50 times a day. So usually, I counsel patients to do them, do 10 reps, three to five times per day. A lot of my patients will do that before they get outta bed in the morning. And when they lay back down, because they can remember to do that. You certainly can do it anytime during the day.

Another place to check to see if you're doing a very good Kegel is when you're urinating, can you stop the stream of urine? Now, you don't want to practice it during that time. But if you're like, "Hey, am I doing a good Kegel?" See if you can do that. If you can't, that's where a pelvic floor physical therapist can really help you learn to use those other muscles and which muscles to engage.

**Host:** And so, how do you make your patients feel comfortable? Because I'm sure a lot of people aren't at ease talking about these issues.

**Kathleen Bertuna:** I mean, I think you have to ask, right? And so, it starts at my staff, making them feel comfortable when they call in on the phone that no female urologic or gynecologic complaint is silly or to be dismissed. And then when they come in, asking those questions of, "Do you have any issues with your bladder? Are you having any pelvic pressure or symptoms? Is there anything bothering you with intercourse? Are you sexually active? Do you want to be sexually active?"

If you don't ask the questions, I think women are so stoic and they will just be like, "I'm fine. I'm fine." You know, we're the ones having the babies, right? So, we're very stoic and I love taking care of women, especially my 50 to 90-year-olds, they're an incredible, incredible people to serve from a medical standpoint. But yes, if you don't ask the questions, they're going to be fine. So, you just ask the questions and no answer is silly and no complaint is silly, and to just explore those concerns.

**Host:** Dr. Bertuna, in closing, is there anything else you'd like to add or you'd like women to know when it comes to getting urological care?

**Kathleen Bertuna:** I think women stay very silent about these issues. And going to your yearly visit with your gynecologist is a great time to say, "Hey, this has been bothering me," and they can direct you down the right path to get you relief or help or to talk to you about those issues and, you know, when to become concerned.

**Host:** Thank you so much for your time. It's been a pleasure and very educational.

**Kathleen Bertuna:** Thank you so much for having me. Go women.

**Host:** Again, that's Dr. Kathleen Bertuna. And that wraps up this episode of Memorial Health Radio with Memorial Health System. Head on over to our website at mhsystem.org for more information and to get connected with one of our providers. Please remember to subscribe, rate and review this podcast and all the other Memorial Health System podcasts. Thank you for listening.