Patient-Centered Care of Women with Stress Urinary Incontinence

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Disclosures

- Primary Investigator, Patient-Centered Outcomes Research Institute
- National PI, Medtronic TITAN2 clinical study
- Site Investigator, Cook Myosite Cellebrate Clinical Trial
- Consultant, Medtronic
- Consultant, Axonics
- Consultant, Laborie

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Learning Objectives

Provide clinicians with an overview of stress urinary incontinence from a patient-centered approach

Review the literature on what matters to patients and how we can better meet their needs when counseling patients

Discuss an update on complications of mid-urethral mesh sling surgery

Raise awareness of trauma-informed care

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Urinary incontinence:

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Patient-centered care starts with… *acknowledging the problem*

- Pelvic floor problems are embarrassing, and nobody talks about it
- Providers and patients think that it's a normal part of aging
- There is a delay in seeking care

- Highly prevalent
  - up to 50% of women report urinary incontinence
- Negatively impacts daily life and quality of life
- Direct health care costs of urinary incontinence are $15-20 billion US dollars a year

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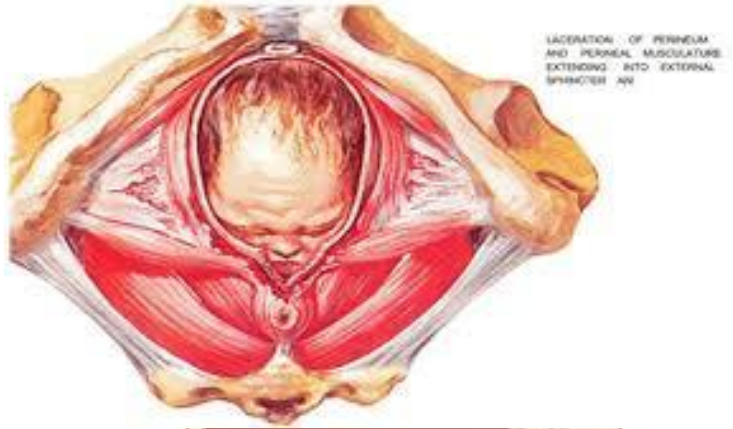
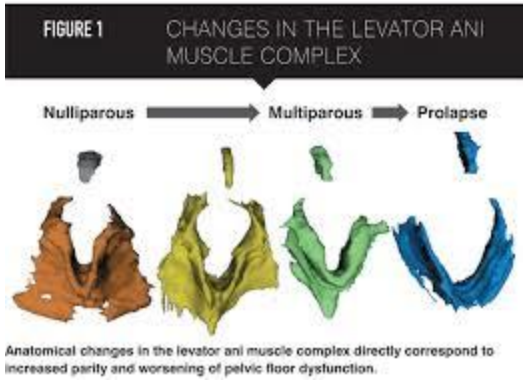
Wu J et al, 2013, Wu J et al, 2014, Wu J et al, 2014
Chong et al, 2011, Olsen et al, 1997, Hawkins et al, 2011, Milsom I et al. *2001*

Common contributing etiologies

- Female stress urinary incontinence, pelvic floor prolapse, and bowel leakage have multifactorial etiologies
- Childbirth injury is the common risk factor
- Additionally
  - Denervation of the pelvic floor
  - Aging/hormonal changes
  - Conditions with increased intraabdominal pressures (obesity, COPD/asthma)
  - Connective tissue disorders





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Urinary incontinence - 2 main types

- Stress urinary incontinence (leakage with physical activity)

- Urgency incontinence (leakage with urgency to void)

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Stress urinary incontinence

- SUI
  - Most common type of bladder leakage
  - Can occur across the lifespan
- Decreased urethral resistance –
  - multifactorial
- Severity –
  - mild, moderate, severe
- Bother –
  - impact on activities
- Patient interviews –
  - What matters is quality of life

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Evaluation of a patient with SUI

- History of Present Illness
  - SUI vs Mixed UI vs Urgency incontinence by clinical history and symptoms
  - Risk factors
  - Severity of symptoms
  - Level of bother
- Exam
  - Cough stress test - positive
- Diagnostic Data
  - UA – r/o infection if symptomatic, versus Asymptomatic Bacteriuria
  - Post void residual by bladder scan
  - Optional/if indicated – Urodynamics, Cystoscopy

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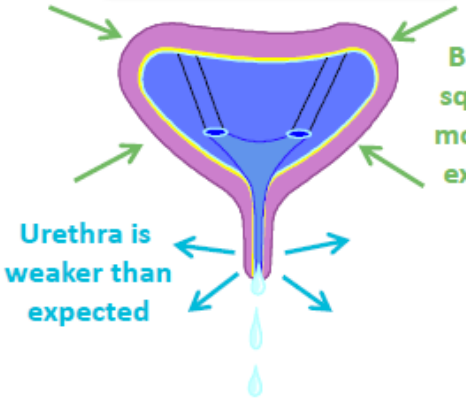
Treatment Options for Urinary Incontinence

Stress Incontinence
Leakage with laughing, coughing, physical activity

Mixed Incontinence

Overactive Bladder
Urinary frequency, urgency, and/or incontinence associated with urgency



Non-Surgical

- Pelvic floor muscle training
- Pelvic floor physical therapy
- Incontinence pessary
- Urethral inserts

Surgical

- Urethral bulking
- Sling
  - Autologous fascia (your own tissue)
  - Mesh (retropubic or transobturator approach)
- Retropubic suspension (Burch)

Clinical Trials

Reduce Risk Factors

- Patient education
- Weight loss
- Stopping smoking

1st line: Behavioral Therapy

- Bladder control strategies & bladder training
- Fluid management & avoidance of bladder irritants
- Pelvic floor physical therapy

2nd line: Non-Surgical

- Overactive bladder medications
- Vaginal estrogen

3rd line: Minor Procedure or Surgical

- Botox® injections into the bladder
- Peripheral tibial nerve stimulation
- Sacral neuromodulation (Interstim®)

Clinical Trials

Virginia Mason

904012 (10/14)

*If you are not improving and still experiencing bothersome symptoms, please call your physician and schedule a follow up appointment

Stress Urinary Incontinence: Treatment Options

- ***Women want to know all their options and the pros and cons of each***

  - Fluid and behavioral management
  - Incontinence pessary
  - Pelvic Floor Physical Therapy
  - Urethral bulking
  - Sling surgery (with mesh or autologous tissue)
  - Clinical trials

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Int Urogynecol J. 2020 Feb;31(2):243-248. doi: 10.1007/s00192-019-04165-8. Epub 2019 Dec 12.

I leaked, then I Reddit: experiences and insight shared on urinary incontinence by Reddit users

Chris Du [1], Wai Lee [2], Dena Moskowitz [3], Alvaro Lucioni [2], Kathleen C Kobashi [2], Una J Lee [4]

- Users with UI were initially self-aware of their incontinence. They were interested in optimal product use. Users struggled with major life adjustments and relating to others. Nonetheless, they learned gradually to cope with their symptoms. Last, postpartum women specifically wanted additional immediate help for managing UI, often in the form of pelvic physiotherapy.
- **Three emergent concepts were formed: the sense of isolation, acceptance over time, and self-drive to manage their UI.**

Conservative management

- Pad use
- Limiting fluids
- Preventative voiding
- Avoidance of high impact activities

Tobacco cessation

- Coughing raises intraabdominal pressure
- Treating chronic cough

Obesity/Weight loss

- Epidemiological studies: Obesity =strong risk factor for UI
  - Stronger assoc for SUI-predominant MUI than Urge UI
  - dose-response effect of weight on UI, with each 5 unit increase

  in BMI assoc with 20-70% increase in risk of UI
- Surgical Weight Loss/ Behavioral Weight Loss
  - Weight loss studies indicate that both surgical and nonsurgical weight loss leads to significant improvements in prevalence, frequency, and/or symptoms of urinary incontinence.

Whitcomb, 2011

Published in final edited form as:
Obstet Gynecol. 2010 August ; 116(2 Pt 1): 284–292. doi:10.1097/AOG.0b013e3181e8fb60.

Improving Urinary Incontinence in Overweight and Obese Women Through Modest Weight Loss

Rena R. Wing, PhD, Jennifer M. Creasman, MSPH, Delia Smith West, PhD, Holly E. Richter, PhD, MD, Deborah Myers, MD, Kathryn L. Burgio, PhD, Frank Franklin, MD, PhD, Amy A. Gorin, PhD, Eric Vittinghoff, PhD, Judith Macer, John W. Kusek, PhD, Leslee L. Subak, MD, and **The Program to Reduce Incontinence by Diet and Exercise (PRIDE)**

- PRIDE STUDY: Overweight and obese women (N=338) with 10+ urinary incontinence episodes/week were assigned randomly to an intensive 6-month behavioral weight loss program followed by a 12-month weight maintenance program (intervention; n=226) or to a structured education program (control; n=112).
- **Weight losses between 5% and 10% of body weight were sufficient for significant urinary incontinence benefits**

Pelvic Floor Physical Therapy

- **PFMT remains the first-line treatment for female SUI with high levels of evidence and grades of recommendation**
- Low risk
- Requires motivated patient
- Cochrane Review 2014
  - Women with SUI who were in the PFMT groups were 8 times more likely than the controls to report that they were cured and 17 times more likely to report cure or improvement

Stupp, 2011, Braekken, 2010; Hagan, 2011; Hagan, 2013, Dumoulin, 2014

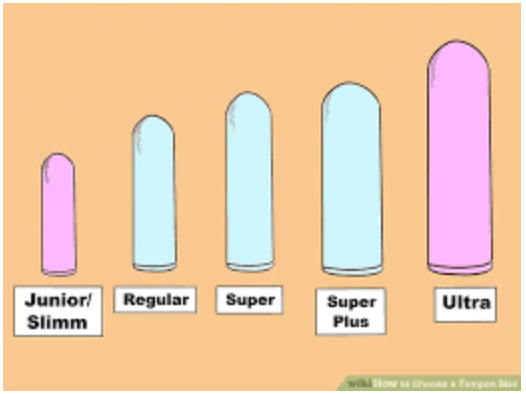
Pessary- usually used to reduce prolapse, but can also be fit to support suburethral area

- Patient selection
  - Symptomatic patient with desire to avoid surgical intervention
  - Vaginal pessary not tolerated due to pain/poor tissue quality/poor vaginal compliance
  - Not done with childbearing
- Outcomes: Short, medium, long term studies
  - High satisfaction
  - Low complication rate (pain, bleeding, constipation)

Clemons et al, 2012

Incontinence pessary

- Support of the urethra
  - Ring, ring with support, incontinence ring
- Alternatives- vaginal inserts
  - Poise bladder support
  - Super size tampon



Medications

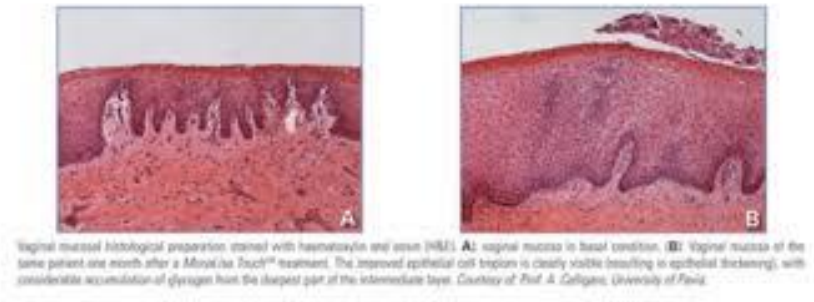
- Duloxetine (Cymbalta)
  - noradrenaline and serotonin reuptake inhibitor
  - Indicated for SUI in Europe; not approved in US (increased risk of suicide)
- Vaginal estrogen
  - 2012 Cochrane review: may improve UI; most data in OAB/urgency incontinence pts
  - Some/limited observational evidence for improvement in SUI in post menopausal women
  - Topical vaginal (thicken urethral mucosa, enhance vascularization of the peri-urethral tissues) vs systemic estrogen (decrease in collagen cross linking, increase in turnover)
- Imipramine
  - tricyclic antidepressant
  - bladder relaxation, increased outlet resistance
  - Off label use for MUI
- Alpha agonist

Table 3. Drugs used in the treatment of stress incontinence. Assessments according to the Oxford system (modified

Drug	Level of evidence	Grade of recommendation
Duloxetine	1	A
Imipramine	3	D
Clenbuterol		
Methoxamine	2	D
Midodrine	2	C
Ephedrine	3	D
Norephedrine (phenylpropanolamine)	3	D
Estrogen	2	D

KE Andersson et al, ICS, 2008

CO^2 vaginal laser



- The use of fractional CO2 MonaLisa Touch® (DEKA, Florence, Italy) or Er:YAG lasers SMOOTH® (Fotona, Slovenia) for vulvovaginal atrophy and urinary incontinence has increased in popularity
- **The most common use of vaginal lasers is for the treatment of genitourinary syndrome of menopause (GSM)**
- Mode of action: Pulsed laser photothermal energy targets collagen structure, capillaries, and epithelial layer
- Not covered by insurance; Out of pocket costs >$2-3K
- FDA warning July 2018

FDA Warns Against Use of Energy-Based Devices to Perform Vaginal 'Rejuvenation' or Vaginal Cosmetic Procedures: FDA Safety Communication

FDA U.S. FOOD & DRUG ADMINISTRATION

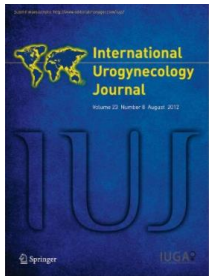
Polyacrylamide hydrogel (PAHG, Bulkamid®) urethral bulking

- Treatment of Stress Urinary incontinence/Mixed urinary incontinence/intrinsic urethral sphincter deficiency
- Non-particulate homogenous gel
- FDA approved in the US in 2020
- 10 years of use in Europe with 3-7 year durability
- 70-90% success using patient-reported outcome measures
- Low risk
- Performed in the office with local, or under anesthesia in outpatient surgery center

Int Urogynecol J. 2016 Mar;27(3):367-75. doi: 10.1007/s00192-015-2781-y. Epub 2015 Jul 26.

Polyacrylamide hydrogel (Bulkamid®) for stress urinary incontinence in women: a systematic review of the literature

Kasi AD[1], Pergialiotis V[2], Perrea DN[3], Khunda A[4], Doumouchtsis SK[5,6].



2016

- Review identified 8 studies involving 767 patients treated with Bulkamid®
- Used in a highly varied patient population
- A high proportion had had previous incontinence treatment
- In this mixed population, efficacy varies
  - **Objective success rates at 3-12 months: up to 80%**
  - **Subjective success rate at 3-12 months: up to 90%**
- Safety profile good, most common AEs are transient and uncomplicated:
  - UTI 3-7%
  - Pain at injection site, haematuria, voiding difficulties
  - No extrusions, migrations or immune reactions

Neurourology Urodynamics ICS SUFU WILEY

Joint position statement on midurethral slings for stress urinary incontinence

[1]Society of Urodynamics, Female Pelvic Medicine and Urogenital Reconstruction, Two Woodfield Lake, 1100 E. Woodfield Rd., Suite 350, Schaumburg, IL, 60173. Email: info@sufuorg.com

[2]American Urogynecologic Society, 1100 Wayne Avenue, Suite 825, Silver Spring, MD, 20910. Email: info@augs.org

The purpose of this Position Statement by the American Urogynecologic Society (AUGS) and the Society of Urodynamics, Female Pelvic Medicine and Urogenital Reconstruction (SUFU) is to support the use of the midurethral sling (MUS) for the surgical management of stress urinary incontinence (SUI).

Developed in the 1990s, MUS treats SUI in a minimally invasive, outpatient procedure. This technique uses a small mesh strip composed of monofilament polypropylene placed through the vagina under the midurethra and exiting from 2 small sites in either the suprapubic or groin area.[1] They are often referred to as full-length slings to differentiate them from smaller single-incision slings or mini slings. This document refers to full-length MUS.

SUI, defined as the involuntary urine leakage associated with coughing, sneezing, or other types of exertion, is prevalent, with 13.6% of women in the United States having had at least 1 surgery for SUI in their lifetime, resulting in 260,000 continence surgeries annually.[2] Between 2008 and 2010, the FDA received reports of complications associated with transvaginal mesh used to treat pelvic organ prolapse and MUS used to treat SUI. This may have led to a negative perception of the MUS. In 2019, the FDA reaffirmed the findings of its safety panel and literature review stating that the safety and effectiveness of the full-length MUS is well established.[5] The FDA has not recalled or published warnings against the full-length MUS. Most experts who deal with female SUI are supportive of the use of the MUS and the majority of women who have had one placed are satisfied.[6]

JUSTIFICATION FOR THE POSITION STATEMENT

1. *Polypropylene material is safe and effective as a surgical implant*. Polypropylene material has been used in most surgical specialties (including general surgery, cardiovascular surgery, transplant surgery, ophthalmology, otolaryngology, gynecology, and urology) for over five decades.[7] As an isolated thread, poly-

LONG-TERM DURABILITY OF MIDURETHRAL SLINGS: A TIME TO EVENT ANALYSIS IN A TERTIARY REFERRAL SETTING

Kevin Gioia, Erika Wolff, Dena Moskowitz, Alvaro Lucioni, Kathleen Kobashi, Una Lee

UT Table | **Sling outcomes at 1, 5, and 9 years**

	Virginia Mason success rate*	Completely dry rate
1 year	97%	47%
5 years	81%	29%
9 years	70%	31%

*Patient perception of being at least 70% improved or having no more than 1 incontinent episode/week

Source: Kevin Gioia, MD

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Autologous Fascial Sling Outcomes

- A.k.a. Pubovaginal sling
- Can be rectus fascia or fascia lata
- Patient selection: intrinsic sphincter deficiency, fixed urethra, h/o mesh complication, vs primary SUI
- **Good long term durability (85-92%)**
- Complications: Retention (transient vs long term), wound infection, de novo urge/urgency incontinence, voiding dysfunction

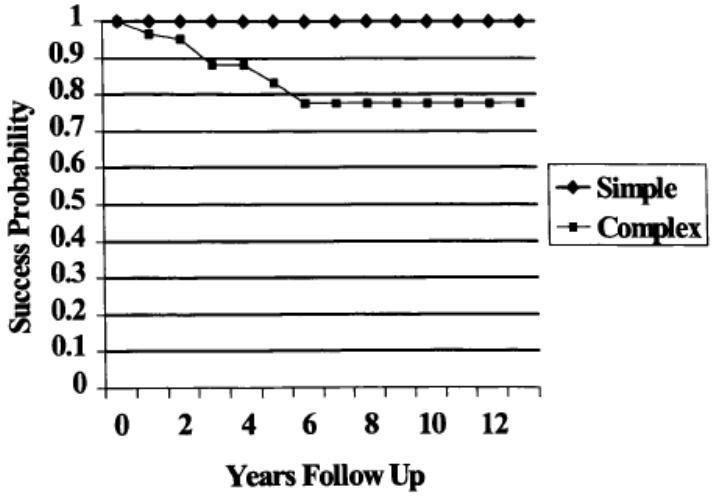
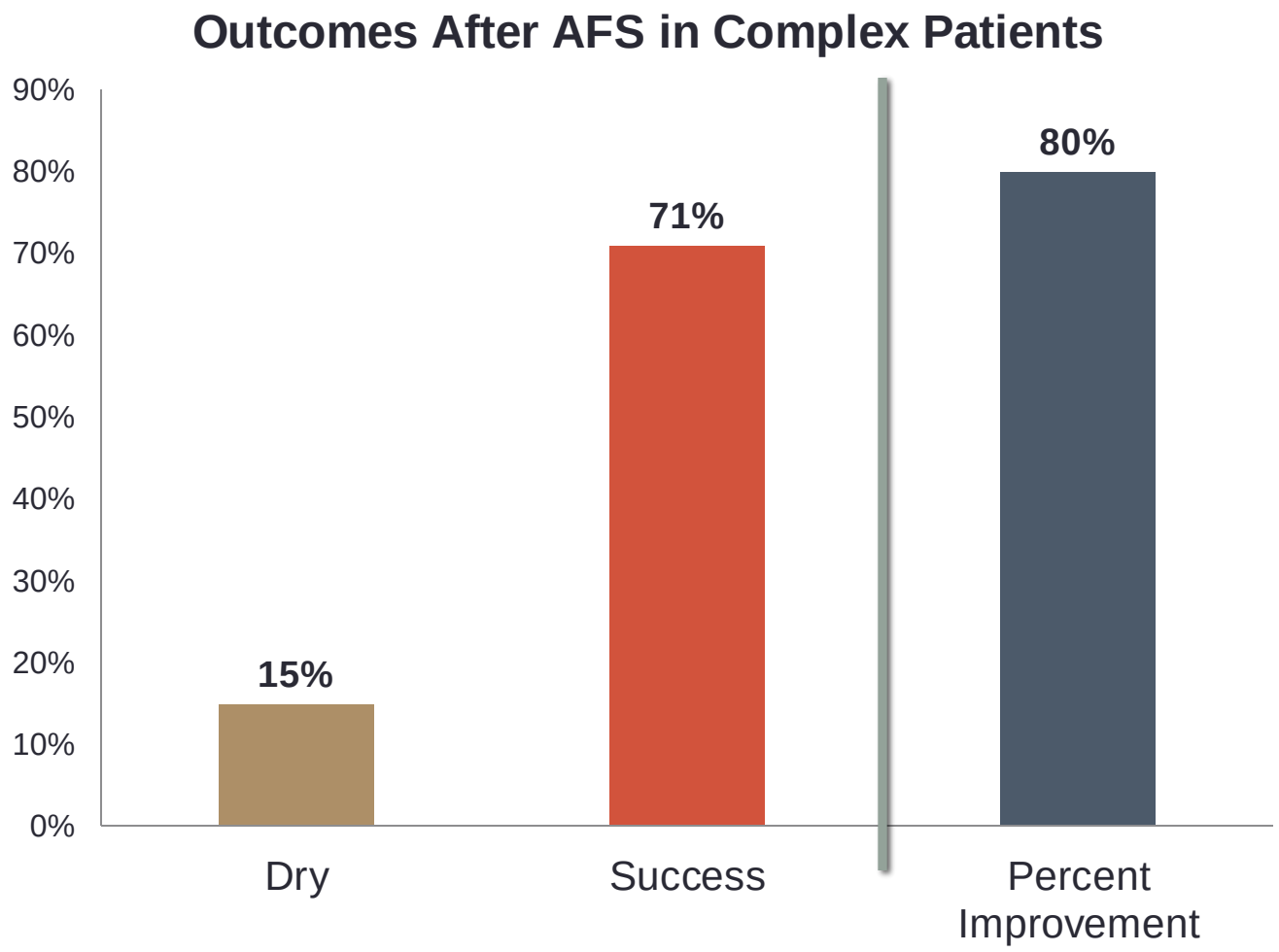


FIG. 5. Kaplan-Meier curve for success rate for stress incontinence following pubovaginal sling (simple versus complex cases)

Chaikin, Blaivas 1998, *Athanasopoulos K, McGuire*, 2011

Virginia Mason data: Autologous Fascial slings (n=77, mean f/u 6 yrs)



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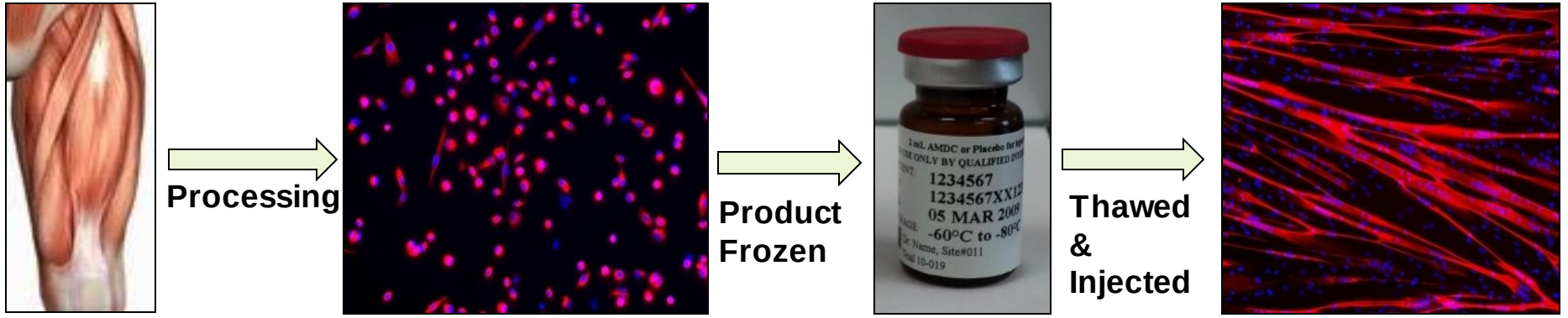
Cook Myosite Clinical Trial - Cellebrate

Women with Stress urinary incontinence



- Phase 3 multicenter placebo controlled clinical trial of cell based therapy for female stress urinary incontinence
- Office based procedures
- Goal is to regenerate female continence structures around urethra

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Mesh:
What do providers need to know?

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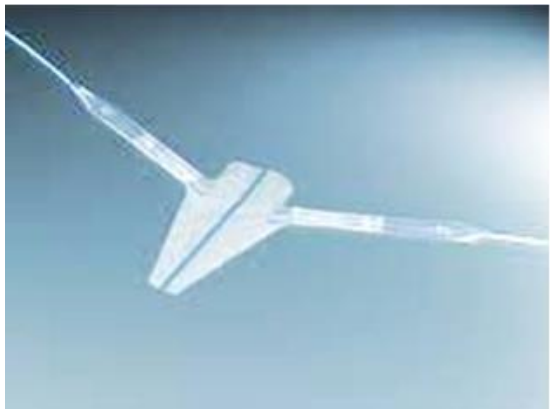
3 categories of polypropylene mesh use

1. Mid-urethral sling mesh for SUI – thin strip of mesh under the urethra, placed vaginally
2. ~~Transvaginal mesh for POP – off the market due to high rate of complications~~
3. Intra-abdominal mesh for POP (sacrocolopopexy) – lightweight mesh designed for vagina prolapse



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Urology. 2022 Mar:161:36-41. doi: 10.1016/j.urology.2021.12.006. Epub 2021 Dec 17.

Listening to Learn: A Qualitative Analysis of Women's Experiences with Mesh Mid-urethral Sling Surgery

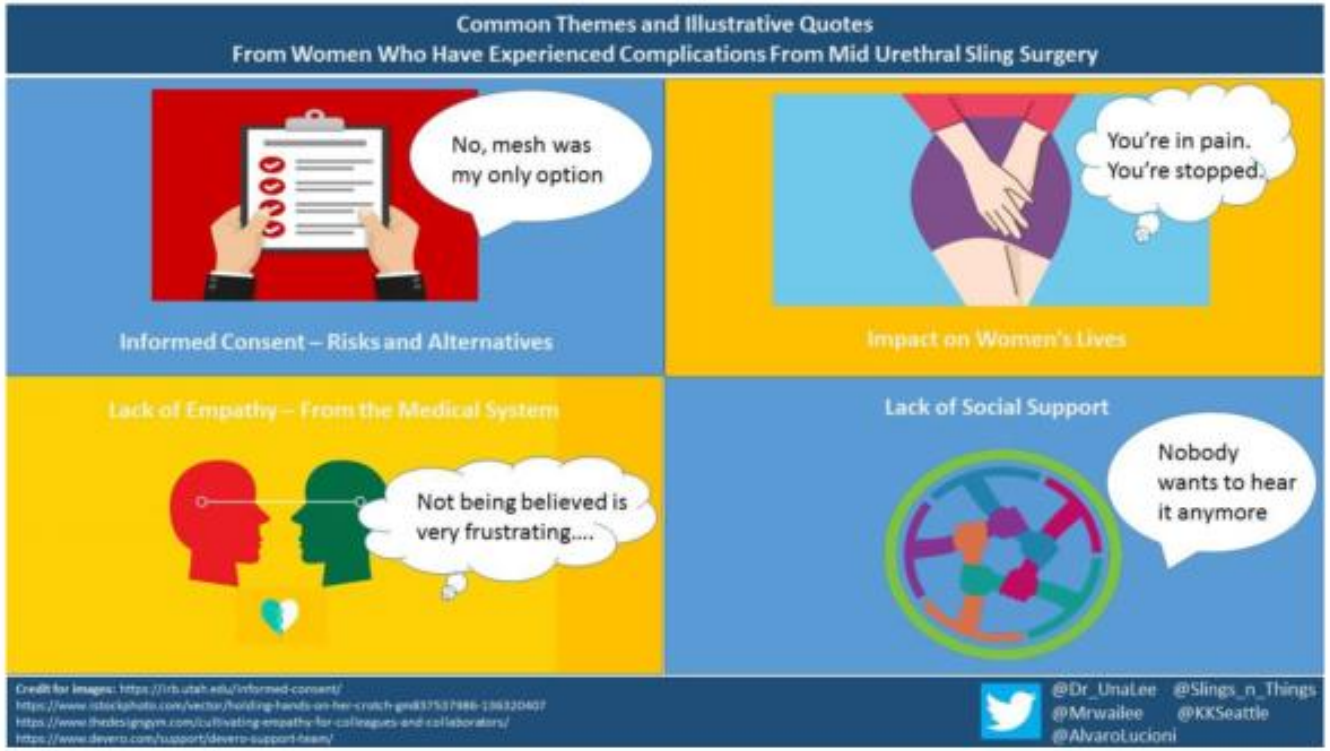
Pansy Uberoi [1], Wai Lee [1], Alvaro Lucioni [1], Kathleen C Kobashi [1], Donna L Berry [2], Una J Lee [3]

- Most sought SUI care after becoming frustrated with their symptoms. However, some participants experienced barriers to care or dismissal of their symptoms by their physicians.
- While participants expected improvements in SUI symptoms after MUS surgery, some expected improvement or resolution of other pelvic floor-related issues such as bowel symptoms. Despite having improved SUI symptoms, participants described non-SUI symptoms as negative outcomes from their MUS surgery.
- Overall, participants wished SUI-associated embarrassment could be lessened and suggested public service announcements to help normalize discussion of SUI symptoms.

Listening to Women: A Qualitative Analysis of Experiences after Complications from Mesh Mid-urethral Sling Surgery

Pansy Uberoi, Wai Lee, Alvaro Lucioni, Kathleen C. Kobashi, Donna L. Berry, and Una J. Lee

OBJECTIVE To gain a detailed understanding of women's experiences after undergoing revision surgery for mesh mid-urethral sling (MUS) complications, qualitatively organize those experiences, and present insights as potential springboards for future research.



Themes	Illustrative Quotes
Informed consent	
Understanding risks	• "With what I know now...I would tell him, 'You misinformed me'." • "That was never discussed. Easy in and out." • "I mean, there's always risks with surgery, but nothing specific to the implant itself."
Understanding alternatives	• "They didn't really tell...at least my gynecologist and urologist didn't tell me there is a natural way." • "Please tell your patients there is an option. It does not have to be mesh. It can be their own tissue." • "Give the choice...Don't just say 'We're going to do this. Here's the mesh and this is what I'm going to do.' But tell them 'or'. There's an or." • "I didn't know there was a thing called a pessary and I didn't find out until I happened to talk to a lady at work." • "None. No. Mesh was my only option." • "So, they used a piece of your own fascia? (pause) God, I wish I'd known that."
Impact on women's lives	
Physical activity/ Lifestyle	• "It stops your life. You're in pain, you're stopped." • "You become more sedentary. I used to do body building shows." • "I don't get to swim anymore. Swimming was like my release."
Productivity/Work/ Family life	• "I was out of work....six months I put up with that." • "I spent two and a half years crawling around my house, not being able to use the bathroom or take care of my family."
Pain	• "It hurts to sit here." • "I still have residual pain."
Sexual	• "Sex, once I could have it, was like...I was like wait a minute, this is not the same." • "The mesh would actually scrape my husband, so it was awful. It was just awful." • "My husband and I have sex maybe once a month because it is so excruciatingly painful." • "I feel like that was robbed from me because I had a great sex life."
Lack of empathy	
From surgeons and providers	• "He said 'Well, it takes at least a year for your body to heal'...'Here's some hormone cream, use this'." • "[Providers] wouldn't listen." • "They [surgeon] wouldn't see me back...What do you do?" • "According to them, I was just crazy." • "I just think it's important that not only Urologists, but like ER doctors and other surgeons and other general practitioners know the risks of what we've been through because I don't think there is an understanding in the field." • "Be honest and upfront with what the reality of the situation is, because I don't feel like that was conveyed very well." [postoperatively] • "The whole mindset of not being believed is very frustrating."
Support	
Social support	• "Nobody wants to hear it anymore." • "Who do you talk to?" • "[Friends] they get tired of listening." • "You lose people when you get sick...They can't handle it."
Coping	• "I take care of my uncle who has dementia and I can really really vent to him because he doesn't remember anything 15 minutes later...It works really well." • "I'm a bottler, so I just hold it all in." • "Facebook had a mesh support group." • "I believe I medicated myself very well." • "Wine helped a lot." • "Getting some THC candy."

Table 1. Themes and illustrative quotes derived from qualitative analysis of women's experiences after mesh sling complications

J Urol. 2022 Feb;207(2):407-416. doi: 10.1097/JU.0000000000002203. Epub 2021 Sep 21.

The Evolving Story of Mesh Mid Urethral Slings: The Surgeon's Perspective

Wai Lee [1], Pansy Uberoi [1], Alvaro Lucioni [1], Kathleen C Kobashi [1], Donna L Berry [2], Una J Lee [1]

- **Results:** Twenty-four interviews of surgeons from diverse geographic locations and practice types were performed.
- Many surgeons described MUS surgery as rewarding and favorably impactful for women with SUI, while others grappled with the serious risks associated with MUS surgery. Those who had treated women with life-altering pain after MUS recounted impactful patient stories.
- Many stated that recognition, acknowledgement, and appropriate referral of complications were fundamental to responsible and ethical care. Some surgeons expressed frustration and concern about the raised level of controversy and anxiety regarding the MUS landscape. All participants expressed that there was substantial room for improvement in multiple domains. Participants also shared their optimal strategies relevant to MUS surgery.
- **Conclusions:** Despite diverse views regarding the role of the MUS, there was **agreement among surgeons that the surgeon-patient relationship, thorough informed consent and patient counseling, and accountability are essential when implanting MUSs.**

Female Urinary Incontinence: Know the Non-Mesh Alternatives

February 7, 2019 by Virginia Mason Team Member 1 Comment

By Una Lee, MD

It is important for all women to be educated on how their urinary tract works and options that exist when problems occur. A mid-urethral mesh sling is a common surgery that treats stress urinary incontinence. It has been one of the standard surgical treatments for stress incontinence since 1997. The synthetic mesh sling works by acting as a "hammock" under the urethra, helping to keep it closed with activities like coughing or sneezing. However, women should be aware that there is an infrequent but known risk of minor, moderate or serious complications associated with mesh sling surgery. Many women ask if there are alternatives to mesh slings. Absolutely!

First, a quick review of incontinence basics. Urinary incontinence is the leakage of urine that can occur in women of all ages, and commonly occurs or worsens after childbirth. There are difference types of urinary incontinence, including:

- Stress incontinence – leakage with physical activity, like laughing or coughing
- Urgency incontinence – leakage that occurs when you have a strong urge to urinate and are rushing to the bathroom
- Mixed urinary incontinence – a common condition of having both stress and urgency incontinence
- Post-void dribbling – leakage after you urinate
- Incontinence without sensation – leakage that occurs with no awareness

Weight loss is another non-surgical opportunity. Studies have shown that modest amounts of weight loss (5 percent of total body weight) can significantly decrease urinary incontinence. For many women this is motivating and encouraging, while promoting their overall health.

Stopping smoking is another effective step. Smoking and the chronic cough associated with tobacco use can make urinary leakage worse. Abdominal pressure from frequent coughing will in turn increase pressure on the pelvic floor and urethra, causing leakage.

Pelvic floor physical therapy with a qualified physica incontinence is a totally natural option. You learn how muscles correctly and how to use this skill to prevent and is a skill you can use for life.

Incontinence pessaries are medical grade discs that urethra. The size and shape is custom fitted to you, a good non-surgical option to try.

Urethral bulking is an injection into the inner lining o abilities of the inner part of the urethra. While not ge for the right patient.

The **Burch procedure** preceded sling surgery as a sta of creating a hammock supporting the urethra, suture not as effective as the sling procedure, the Burch proc

A variation on the sling procedure known as the **autol** years and has stood the test of time. A strip of fascia, thigh or lower abdomen, then placed to support the u and safe, the downside is that it's more invasive and r

Enrolling in a **clinical trial** may be an option for some are fully informed of the study's process and potentia to talk to their health care provider before participati investigating using muscle-derived, regenerative cells information on participating in clinical trials, click her

Vaginal laser treatments, using a carbon monoxide (dryness and atrophy. Currently, there is not enough evidence to support the claims that they treat stress urinary incontinence. Additionally, laser treatments are costly and typically not covered by insurance.

Medications for urinary incontinence generally help with urgency incontinence and overactive bladder symptoms, but not stress urinary incontinence. So they can help with that "gotta go" feeling and resulting leakage, but not with leakage that happens during Zumba class. These medications are designed to help with bladder control. Most are prescription, so ask your doctor if bladder medications are appropriate for you. One treatment, the oxybutynin transdermal patch, is

Treatment with **vaginal estrogen** helps treat thinning tissues in the vaginal area. By improving the quality of the tissues, symptoms of urinary urgency can improve. Some women report their incontinence improves as well.

Botox injections in the bladder can dramatically help women who have leakage of urine that is associated with urgency, but are not effective for stress urinary incontinence.

Bladder pacemakers, also known as InterStim therapy, regulate bladder signals by stimulating the sacral nerves located near the tailbone. This electrical stimulation helps the brain and bladder communicate for better urinary control. The implants help reduce urinary urgency and resulting leakage, urinary frequency and urinary retention (the inability to empty the bladder).

Urinary incontinence is a common, costly and important quality of life issue for women. Gaining a thorough understanding of the condition is the first step. Given the sensitive nature of these bodily systems and their impact on women's lives, knowing the range of treatment options is key to making the right choice for you.

Una Lee, MD is a urogynecologist/urologist dedicated to women's health. Dr. Lee and her partners in the Urology Department at Virginia Mason offer all FDA-approved treatments for urinary incontinence, with the knowledge and experience to support the best outcomes.

Engaging and Amplifying Women's Voices in Stress Urinary Incontinence Research Prioritization

- 2 year collaborative national project
- Engaging women on what matters to them
- Patients become partners in the process
- What comparative effective information would help women make better informed decisions on urinary incontinence surgery?

This patient engagement project is funded through a Patient-Centered Outcomes Research Institute (PCORI) Eugene Washington PCORI Engagement Award (21347-BRIVM)

What we have learned about patient-led engagement

- Patient and stakeholder engagement is vital to conduct research that addresses what information patients need and want to make informed healthcare decisions.
- Intentional outreach is necessary to represent diverse perspectives, especially those of underrepresented minorities.
- Virtual engagement can effectively solicit perspectives from patients and stakeholders.

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Initial findings: Important research topics in SUI surgical treatment, ***from the patient perspective***

- Risks of treatment
- Is the treatment of safe?
- How likely are post-op complications other than pain?
- How likely are problems urinating after surgery?
- Risks of mesh use for incontinence surgery
- How likely are UTIs after surgery?
- Surgeon knowledge of all treatment options available
- How much will the treatment help with leakage?
- How are post-op complications treated?
- How likely is post-op pain?

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Patient centered care

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Sensitivity to Emotional-Social-Psychological Needs

- Delay in seeking care
- Embarrassment
- Misinformation
- Fear of getting worse
- Sexual concerns
- Affects ability to be physically active
- Patients want to feel better and have their symptoms treated

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Trauma-informed care

- Sensitivity and awareness of a complete picture of a patient's life situation — past and present — in order to provide effective health care services with a healing orientation.
- Adopting trauma-informed practices can improve patient engagement, treatment adherence, and health outcomes, as well as support wellness

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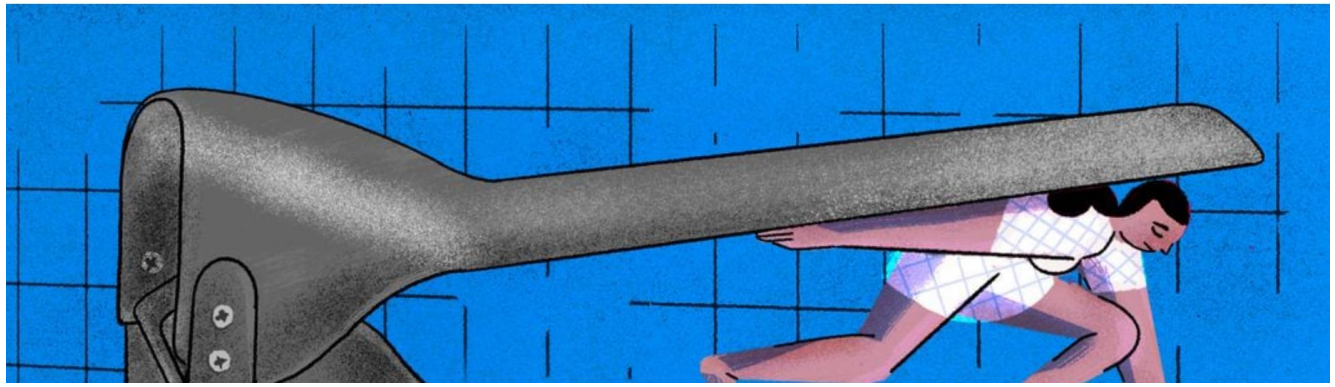
HEALTH

Pelvic exams can be ‘traumatic.’ Here’s how women and experts suggest lessening anxiety.

For many sexual trauma survivors, pelvic exams can feel intrusive and be triggering or re-traumatizing



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Trauma-informed genital exams – Best practices

- Genital examinations trigger flashbacks and increase symptoms of anxiety in about 50% of people who have experienced trauma.
- Trauma-informed examinations are performed “with” patients, ensuring that they feel safe, have control and are offered choices
- Patients may prefer to choose the timing of the examination (e.g., the current health care encounter or a future appointment), and may prefer to have a support person present during the examination. They may wish to self-insert instruments
- Practitioners should leave the room when patients disrobe and dress. This validates patient dignity and allows time for them to formulate questions. During the examination, the patient’s body should be covered, exposing only those areas it is necessary to expose and for the shortest time required. Discussions should occur when the patient is fully dressed

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Gorfinkel I, Perlow E, Macdonald S. The trauma-informed genital and gynecologic examination. CMAJ. 2021 Jul 19;193(28):E1090. doi: 10.1503/cmaj.210331. PMID: 34281967; PMCID: PMC8315200.

Goals of Pelvic Floor Surgery

- Restore normal anatomy and support
- Alleviate symptoms
- Avoid complications/harm
- Minimize risk of recurrence
- Improve quality of life

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Take home messages

- Pelvic floor problems including urinary inconteinnce are common
- *Is it bothersome and affecting your quality of life?*
- Multi-disciplinary care with subspeciality expertise
- Treatment ranges from conservative, medical, to office-based, minimally invasive, to
    - Complex surgical reconstruction

- **Important to individualize care based on patient goals:**
    - ***What matters to you?***

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Learnings of my patient-focused care journey

- Ask and listen
- Be open-minded to patient's unique viewpoints, goals, and priorities
- Believe your patients
- Meet them where they are and speak in a way that they can understand
- Give your patients choices and empower them with the understanding they need to make informed choices

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Patients define the value in health care

“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

-Maya Angelou

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Referring to Urology

Why Virginia Mason Franciscan Health Urology

At Virginia Mason Franciscan Health, your patients have access to comprehensive compassionate urologic care. We place the patient at the center of everything we do.

Conditions We Treat

We offer the full range of urologic care including general urology, multidisciplinary cancer care, men's health, sexual health, kidney stone treatment, enlarged prostate surgery, male reconstructive surgery, kidney transplantation, and women's pelvic prolapse and incontinence surgery/urogynecology.

In addition to providing general urologic care, our doctors have specific areas of expertise to ensure that the most complex problems, including cancers, are managed by experts. Our urologists have extensive experience diagnosing, managing and treating the full spectrum of disorders.

Conveniently Located

Patients can be seen and evaluated at five accredited hospitals: St. Joseph Hospital, St. Clare Hospital, St. Anthony Hospital, St. Michael Medical Center, and Virginia Mason Medical Center with clinic locations in Seattle, Bellevue, Issaquah, Lynnwood, Federal Way, Tacoma, Port Orchard, Lakewood, Silverdale, and Gig Harbor.

To refer your patients, please use the fax numbers below.

Virginia Mason Medical Center
Seattle, Bellevue, Issaquah,
Federal Way, Lynnwood
P (206) 624-1144, **F** (800) 641-9002

St. Joseph Medical Center
Tacoma
P 253-426-4101, **F** (253) 207-4285

St. Clare Hospital
Lakewood
P 253-985-1711 **F** (253) 985-6137

St. Anthony Hospital
Gig Harbor
P 253-530-2000 **F** (253) 858-4330

St. Michael Medical Center
Silverdale
P 564-240-1000 **F** (564) 240-4119

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19-2059, 8/8/23

Meet our Virginia Mason Team

(Seattle, Federal Way, Lynnwood, Bellevue, Issaquah)

Una Lee, *MD (VMFH Urology Physician Lead) Urology/ Urogynecology*

Christian Kuhr, *MD Urology/Transplant*

Nick Cowan, *MD Urology/Transplant*

Alvaro Lucioni, *MD Urology/ Urogynecology*

Paul Kozlowski, *MD Urology/Minimally Invasive Surgery*

Ksenija Stefanovic, *MD Medical Urology*

Will Fuller, *MD Urology/Male Reconstruction*

Cristi Palmer, *DO Urology/ Urogynecology*

Linda Hsu, *MD Urology/Oncology*

Christine Bunnell, *PA-C Urology*

Joseph Coyne, *PA-C Urology*

Alexis Pong, *PA-C Urology*

Brook Hanson, *PA-C Urology*

Meet our St. Joseph Team

(Tacoma)

Alex Borchert, *MD Urology/Male Reconstruction*

Jaspreet Parihar, *MD Urology/ Oncology*

Nanette Hernando, *ARNP Urology*

Rebecca Hunt, *PA-C Urology*

Meet our St. Anthony Team

(Gig Harbor)

Christopher Arroyo, *MD Urology*

Christopher Tepera, *MD Urology*

Meet our St. Clare Team

(Lakewood)

John Bak, *MD Urology*

Lucas Scott, *PA-C Urology*

Meet our St. Michael Team

(Silverdale, Port Orchard)

Manas Jain, *MD Urology*

Samay Jain, *MD Urology/Oncology*

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Every member of our team takes pride in guiding patients through their healthcare journey. On behalf of our physicians and staff, thank you for your referral. We look forward to providing your patients with exceptional care.

Thank you

- We are resources for you and your patients
- una.lee@virginiamason.org

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