AGING: WOMEN SEXUAL ACTIVITY, PELVIC ORGAN PROLAPSE AND URINARY INCONTINENCE

STARZENIE SIĘ: KOBIECA AKTYWNOŚĆ SEKSUALNA, WYPADANIE NARZĄDÓW MIEDNICY I NIETRZYMANIE MOCZU

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Abstract

Sex and aging are topics most older women do not want to talk about. The most obvious changes in a woman's body as she ages come with climacterium. During climacterium, decreasing estrogen levels cause physical changes that may impact sexual function. As a result of hormonal changes, menopausal women retain body fluids much more easily and experience mastalgia – painful breast swelling; it is accompanied by flatulence and swelling as another common symptom of climacterium, strongly reducing libido. Some women also complain about pain, especially within the lumbosacral spine, ostealgia and myalgia as well as migraines, dry skin and the appearance of wrinkles. Not all of the above symptoms are directly associated with menopause. Some of them can occur as a result of other circumstances, e.g. stress connected with, among other things, their life situation, or their primary disease. Climacterium brings a variety of physical and psychological changes that can have an impact on sexual performance and pleasure. Sex and aging are topics most older women do not want to talk about. Sexual activity is a natural and important part of a healthy lifestyle, no matter what women or men age. Although the amount of sexual activity generally declines with age, sexual interest and ability can remain fairly constant if not disturbed by such common problems like pelvic organ prolapse very often connected with urinary incontinence.

Keywords: women, sexual activity, pelvic organ prolapse, urinary incontinence.

Streszczenie

Seks i starzenie się to są tematy, na które większość starszych kobiet nie chce rozmawiać. Najbardziej widoczne zmiany w organizmie kobiety widoczne są w okresie klimakterium. Podczas klimakterium zmniejsza się poziom estrogenów, powoduje to zmiany fizyczne, które mogą mieć wpływ na funkcje seksualne. W wyniku zmian hormonalnych, będących wynikiem menopauzy, obserwuje się zatrzymanie płynów w organizmie. Niektóre kobiety skarżą się również na ból, szczególnie w kręgosłupie lędźwiowo, a także migreny, suchość skóry i pojawienie się zmarszczek. Nie wszystkie z tych objawów są bezpośrednio związane z menopauzą, niektóre z nich mogą występować w innych okolicznościach, na przykład w stresie związanym z ich sytuacją życiową, lub ich pierwotną chorobą. Klimakterium przynosi wiele zmian fizycznych i psychicznych, które mogą mieć wpływ na sprawność seksualną. Aktywność seksualna jest naturalną i ważną częścią zdrowego stylu życia, bez względu na to, w jakim kobiety i mężczyźni są wieku. Chociaż aktywność seksualna na ogół zmniejsza się z wiekiem, zainteresowanie seksualne może pozostać niezmienne, gdy nie będą się pojawiały takie problemy, jak wypadanie narządów miednicy mniejszej, które są bardzo często związane z nietrzymaniem moczu.

Słowa kluczowe: kobiety, aktywność seksualna, wypadanie narządów miednicy mniejszej, nietrzymanie moczu.

Aging may bring emotions that can interfere with sex. Estrogen decreases alter the thickness and size of a woman's reproductive organs [1, 2].
These changes include:

1. Loss of elasticity and a thinning of the vaginal tissue.
2. Decrease in the amount of lubrication.
3. Decrease in the size of the clitoral, vulvar and labial tissues.
4. Decreases in the size of the cervix, uterus and ovaries.
5. Pelvic organ prolapse and urinary inconti-nence.

These changes alter the experience of sex in the following ways:

- The anticipation before orgasm decreases.
- Orgasms may be less intense.
- Sexual desire may be reduced.
- However, the sensitivity of the clitoris remains the same.

For women, vaginal discomfort, dryness or pain during intercourse may occur, due to decreased lubrication, the result of hormonal changes related

to climacterium. Treatment and ways to adapt are available. Oversensitivity to breast stimulation may also occur. Anatomic and physiologic changes that accompany aging in women include reduced vaginal size, thinning and decreased elasticity of the vaginal walls, variable tendency for pelvic organ prolaps, a change in the vaginal pH from acidic to alkaline, shrinkage of the labia majora and thinning of the labia minora, decreased clitoral sensitivity and size, reduced perineal muscle tone, possible bladder prolapse, and a thinner orgasmic platform [2–4].

Pelvic organ prolapse (POP) occurs when the tissue and muscles of the pelvic floor no longer support the pelvic organs resulting in the drop (prolapse) of the pelvic organs from their normal position. POP is cause of sexual difficulties – painfull sexual contact. Protrusion of pelvic organs (uterus, bladder, rectum, small bowel) and their associated vaginal segments into or through the vagina is complicated psychosocial and medical problem (low morbidity and mortality, but has great impact on quality of life – body image, self-feeling, sexual-, sport- and work activity) [5, 6].

Epidemiology of POP:

– regarding ~12–15% of all population of women
– with aging of population POP frequency is increasing
– ~50% of women after 50 years of age have some degree of POP (if had vaginal delivery)
– ~20% have significant symptoms requiring operation
– operations due to POP have been estimated of about 16%, but after 55 years of age – 33%.

In the US 11% of women up to the age of 80 years have surgery for POP, and nearly 30% of them require repeated surgery – (vaginal vault prolapse rate after hysterectomy: 2–49%).

The bladder is the most commonly involved organ in pelvic organ prolapse. Supporting muscles and tissue of the pelvic floor may become torn or stretched because of labor or childbirth or may weaken with age. Other risk factors for POP include: genetic predisposition, connective tissue disorder, obesity, post-delivery perineal leasions, heavy lifting, frequent constipation, even chronic coughing (multifactoral etiology, which in most cases can't be prevented).

Many women have some degree of POP, although not all women have symptoms. Women who have symptoms may experience pelvic discomfort or pain, pressure and other symptoms including these descriptions:

– heaviness or fullness in the pelvis
– „something falling out"
– bulge of tissue or organs that protrudes to or past the vaginal opening
– discomfort and back pain, especially after prolonged standing, feel worse in the day and better after resting
– defecatory problems (constipations, fecal incontinence).
– sometimes: decubitus, ulceration, bleeding
– sexual difficulties; dyspareunia (painfull sexual contact)
– urinary problems (incontinence, urgency and frequency, retention.

Severity of the degree of POP and the symptoms do not correlate.

It is important for women to consult with their health care provider for proper diagnosis of POP [7, 8].

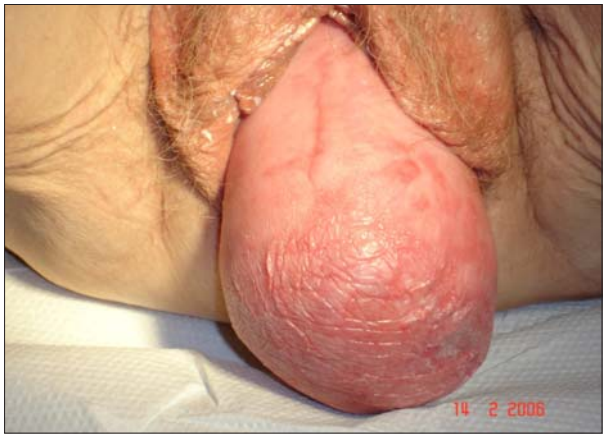
Uterine prolapse – definition

The result of poor cardinal or uterosacral ligaments and pelvic floor muscles support, which allows downward protrusion of the cervix and uterus toward the introitus.

Uterine prolapse

Enterocoele – definition

A herniation of the pouch of Douglas. Contain small bowel and is the only true herniation among the pelvic support disorders. Most occur downward between uterosacral ligaments and the rectovaginal space, but they may also occur apically, especially in the setting of a previous hysterectomy.

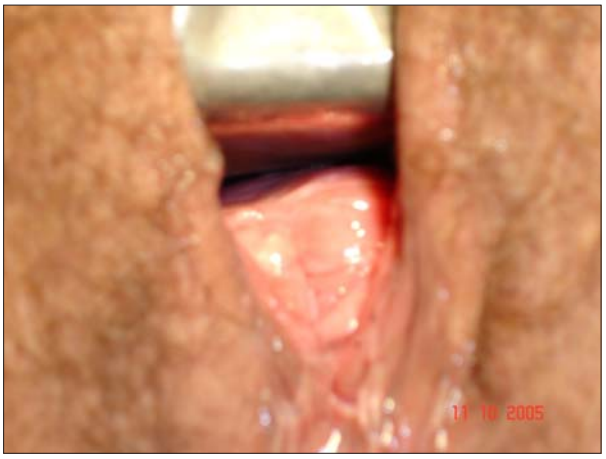


Uterine prolapse

Vaginal vault prolapse + enterocoele

Rectocoele – definition

The protrusion of the rectum into the vaginal lumen resulting from weakness in the rectovaginal fascia and the muscular wall of the rectum and the paravaginal musculoconnective tissue, which holds the rectum in place posteriorly.



Uterine prolapse

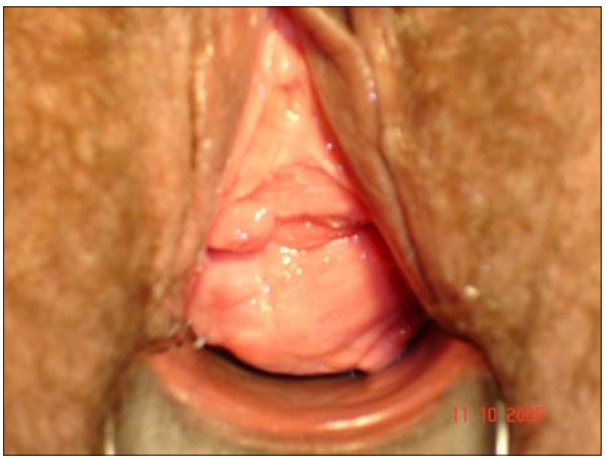
Cystocoele – definition

A herniation of the urinary bladder throught the anterior vaginal wall. Usually occurs when the pubocervical fascia tissue weak midline – central cystocoele, or detches vagina lateral from arcus tendineus pelvis – lateral cystocoele.

Cystocoele (central defect)

Recognizing symptoms early and seeing a physician right away increases the likelihood of successful treatment. Examples of nonsurgical treatment options for POP should be individualised and include:

– Kegel exercises: A type of exercise to strengthen the pelvic floor by contracting and relaxing the muscles that surround the opening of the urethra, vagina, and rectum.
– Pessary: A removable device that is inserted into the vagina to support the pelvic organ(s) that have prolapsed [5, 7, 9].
– Electrical stimulation of pelvic floor muscles.
– Massage and gymnastics.
– Estrogens.



Uterine prolapse

Not every woman with POP will need surgery. Many various surgical procedures (40 methods) and choice of appropriate techniques (hard to obtain long-lasting anatomic, postoperative effect) Surgery may be recommended for women with significant discomfort or pain from POP that impairs their quality of life. If surgery is recommended, factors to consider include:

– which kind of prolapse was diagnosed
– degree of prolapse
– desire for future children
– age
– sexual activity
– severity of symptoms
– presence of urinary (stress) incontinence.

There are many surgical options what means lack of universal one for all cases. They include restoring the normal position of the vagina, repairing the tissue around the vagina, closing the opening to the vagina with or without hysterectomy In vaginal vault prolapse there are two main categories of surgery: obliterative and reconstructive. During surgery, a procedure to prevent or decrease urine leakage may be performed. including the use of vaginal mesh implants. Some serious complications identified by the FDA and associated with the use of urogynecologic surgical mesh should be considered. Yet, urinary incontinence represents epidemiological problem: It affects an estimated 8 million women in the USA, however is not a normal part of aging (more than 75% of women older than age 80 years are continent). Urinary incontinence is a symptom for which the underlying etiology should be sought with the use of complex methods. The two most common forms of urinary incontinence in ambulatory women are genuine stress incontinence and detrusor overactivity.

Obstetrician-gynecologists can facilitate the reporting of urinary incontinence by regularly inquiring about it. The fact that approximately one of five women who experience urinary incontinence do so after a single vaginal delivery suggests that this group should be questioned as part of routine postpartum assessment.

Additionally, open-ended questions during annual examinations should facilitate reporting of bowel and bladder control disorders. Comments such as, “Let me know if you experience leaking when you cough” or “Let me know if your urine begins to come out before you reach the toilet=let me know if you start passing water before you

reach the toilet“ can be followed with an explanation that such experiences are not normal and can be evaluated and treated.

Urinary continence is a result of the normal bladder and urethral function as well as the support and function of the pelvic floor support. Involuntary escape of urine is common and may result from functional or anatomic changes in any or all of these elements. An incontinence evaluation begins with a complete history and physical examination, which will provide a list of possible etiologic factors, an impression as to the type of incontinence, and the impact of urinary incontinence on the woman's life. An assessment of the dynamics of the lower urinary tract function – urodynamics – during the storage and emptying phases will be necessary to diagnose and delineate a treatment plan. Proper utilization of urodynamic testing depends on the good understanding of its indications, techniques, and limitation.

Urodynamics is not one specific test, but a series of tests. Other tests that are a part of the urodynamic evaluation include uroflowmetry, cystometry, and the assessment of the urethral pressure profile. In some cases urodynamics may be required to establish the diagnosis e.g. if we suspect the detrusor instability. Women urinary incontinence is one of the most important health problems at the 21th century. It is considered a serious disability hindering one's life and function in society. With the number of patients affected by urinary incontinence increasing constantly not only gravids and women in confirement, but first of all menopausal women are afflicted by it. The first stage of the therapy is the non-intensive treatment. The special form of it is physiotherapy which involves kinesitherapy consisting in pelvic floor muscle training, electrical stimulation, biofeedback, magnetic stimulation and behavioral therapy. The application of a suitable therapy depends on the type of urinary incontinence. The physiotherapeutical methods are effective, but they require patience and self-control from patients. Women must be evaluated to determine the way of treatment. The whole discussion regarding treatment options needs to include information about continence and the ability to voluntarily urinate, and first of all the possibility of nonsurgical management [10, 11].

Management of sexual difficulties in older women should include local or systemic estrogen supplementation to alleviate vaginal dryness, urinary tract symptoms and dyspareunia very often connected with pelvic organ prolapse. An important predictor of how active sex life people will have in later years is their overall physical health [9, 11].

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