Urogynecology
Treatment for “Unspoken” Pelvic Floor Disorders – Incontinence & Prolapse

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DISCLAIMER
The information contained in this presentation is not intended as a substitute for professional medical advice, diagnosis or treatment. It is provided for educational purposes only. You assume full responsibility for how you choose to use this information.
Pelvic Organ Prolapse

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What is Urogynecology?

Urogynecology

Comprehensive evaluation and treatment for female pelvic floor disorders

- Pelvic organ prolapse
- Urinary Incontinence, Frequency, Urgency etc...
  - Interstitial Cystitis
- Fecal Incontinence
  - Constipation
- Defecation Disorders
Normal Pelvic Support

Horizontal portion of pubocervical fascia supports bladder and vagina

Uterosacral ligament
Cardinal ligament
Cervix

Vertical portion of vagina

Urethra

Distal (vertical) portion of pubocervical fascia supports urethra and U-V junction and provides backstop against which urethra is compressed during straining.
Rating Scale for Kegel Muscle Strength

- **0** = No Contraction
- **1** = Flicker
- **2** = Weak squeeze with 2-second hold (no obvious lift)
- **3** = Fair squeeze with definite lift
- **4** = Good squeeze and hold
- **5** = Strong squeeze and hold - good lift easily held for 5 - 10 seconds
Pelvic floor muscle exercise (Kegels)
Normal Support
Important rule before treating prolapse.....

Don’t fix it just because it’s there
Cystocele
Rectocele
Uterine Prolapse
Enterocele
Symptoms of Prolapse

- Inability to retain a tampon
- Pressure / Bulging sensation (usually described as “heavy”)
- Need to “splint” vagina with fingers to urinate or defecate

*Pressure type*

- “Pain”
- Dyspareunia
- Back Pain
- Fecal Urgency
Risk Factors for Pelvic Organ Prolapse

**Predispose**
- Gender
- Race
- Neurologic
- Muscular
- Anatomic
- Collagen
- Family

**Incite**
- Childbirth
- Hysterectomy
- Vaginal surgery
- Radical pelvic surgery
- Radiation
- Injury

**Promote**
- Obesity
- Lung disease
- Smoking
- Menopause
- Constipation
- Recreation
- Occupation
- Medications
- Infection

**Intervention**
- Behavioral
- Pharmacological
- Devices
- Surgical

**Normal Pelvic Floor Support**

**Decompensate**
- Aging
- Dementia
- Debility
- Disease
- Environment
- Medications

References:
Epidemiology Challenges

• The aging population make the incidence and prevalence of pelvic floor disorders a moving target.

• By 2050, 33% of the U.S. population will be post-menopausal women (currently 23%)
  • U.S. Census Data (www.census.gov)
Pelvic Organ Prolapse: Non-Surgical Management
NON-SURGICAL MANAGEMENT

Pessary

Ring with Support Pessary
NON-SURGICAL MANAGEMENT

Pessary
Prolapse Surgery Decision Tree

Surgical Correction

- Reconstructive
  - Native Tissue
- Obliterative
  - Graft Augmentation
  - LeFort Or Colpectomy
Anterior Colporrhaphy (i.e. “Anterior Repair”)
Posterior Colporrhaphy (i.e. “Posterior Repair”)

- Rectocele
- Mucosal incision
- Pararectal fascia
- Excision of excess mucosa
Native Tissue Repair
Sacrocolpopexy
Vaginal Mesh
Vaginal Mesh
Sacrocolpopexy – NOT “Vaginal Mesh”
The daVinci Robot
Trocar Placement

- Camera
- Assistant
- Trocar Placement

30°
LeForte Colpocleisis (i.e. Closing the vagina)
Health and Wellness Seminar on Urogynecology:

Treatment for "Unspoken" Pelvic Floor Disorders, Incontinence and Prolapse

Bilal Chughtai, MD
Assistant Professor of Urology
Assistant Professor of Obstetrics and Gynecology
Weill Cornell Medical College
Definition

Urinary incontinence is leaking of urine that you can't control.

Is it inevitable?
URINARY INCONTINENCE

Common

Treatable

Significant Effect on Quality of Life (QoL)
Prevalence of disease in women

- INCONTINENCE: 30
- Hypertension: 25
- Depression: 20
- Diabetes: 8
Aging Changes

• Decreased bladder capacity
• Reduced voiding volume
• Reduced flow rates
• Increased urine production at night

* Nordling, J  Experimental Gerontology, 2002, 37:991
Impact on Quality of Life

- Embarrassment
- Reduced Self esteem
- Impaired emotional & psychological well-being
- Poorer sexual relationships
- Impaired social activities and relationships
Don’t Wait to Talk with Your Doctor

- 26% of women wait over 5 years to seek help
- 33% wait 1 to 5 years
- 41% seek help within 1 year

Bladder Control
How the Bladder Works

• Your body stores water (urine) in the bladder.
• The bladder connects to a tube called the urethra. Muscles and nerves help control the bladder and urethra.
• When you go, these muscles and nerves signal urine to leave the body through the urethra.

Did you know?
The urethra and vagina are separate openings.

Symptoms of Control Problems

- Problems with muscles and nerves that help to hold or release urine:
  - Loss of urine (urinary incontinence).
  - Difficulty emptying your bladder, for example, trouble starting the flow of urine.

- Symptoms vary:
  - Strong, sudden urge just before losing a large amount of urine.
  - Involuntary loss of both small and large amounts of urine with activities such as coughing or straining.
  - Slow or interrupted urine stream or sense of incomplete bladder emptying.

Types of Urinary Incontinence

- **Stress incontinence:**
  - Urine leaks with activities (coughing, sneezing, laughing, lifting, exercising).

- **Urge incontinence/overactive bladder (OAB):**
  - “Gotta go now” sensation (urgency).
  - “Gotta go now” with leakage (urge incontinence).
  - “Gotta go often” (frequency).
  - Going often during the night (nocturia).

- **Other types:**
  - Mixed incontinence (stress and urge).
  - Continuous (unpredictable) incontinence.

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SUI = stress urinary incontinence
UUI = urge urinary incontinence

Mixed Symptoms
(UUI + SUI)

Overactive Bladder

Frequency
• Daytime
• Nighttime Urgency

Bladder Control

Treatments—Urinary Incontinence

• **Find out what treatment is best for YOU:**
  – Ask your doctor about risks, potential complications, and follow-up care.

• **Diet and exercise:**
  – Lose weight (if overweight).
  – Limit alcohol and caffeine.
  – Keep pelvic muscles healthy and working well.
  – Do pelvic floor exercises (kegels).

• **Bladder diary—app or paper:**
  – Track how often you go.
  – Try to “schedule” bathroom trips.
Surgical Treatment

- Benefit
- Risk

Best long term result

Minimal complication
**Bladder Control**

**Treatments—Stress Incontinence**

- **Bulking therapy:**
  - Outpatient or office based procedure.
  - Inject gel like material around the urethra just outside of the bladder.
  - Bulk up the area to close the lumen of the urethra and help block leaking.
  - Lower success rate than surgery.
    - Goal to improve quality of life.

- **Surgery:**
  - Helps to support urethra and bladder.
  - Aims to stop or reduce urine leakage.
  - Goal to improve quality of life.
Is mesh safe?
<table>
<thead>
<tr>
<th>Disease</th>
<th>ICD-9 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grave’s Disease</td>
<td>242.0, 242.00, 242.01</td>
</tr>
<tr>
<td>Hashimoto’s Thyroiditis</td>
<td>245.2</td>
</tr>
<tr>
<td>Pernicious Anemia</td>
<td>281.0</td>
</tr>
<tr>
<td>Autoimmune Hemolytic Anemia</td>
<td>283.0</td>
</tr>
<tr>
<td>Autoimmune Thrombocytopenic Purpura</td>
<td>287.31</td>
</tr>
<tr>
<td>Amyotrophic Lateral Sclerosis</td>
<td>335.20</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>340</td>
</tr>
<tr>
<td>Guillain-Barre Syndrome</td>
<td>357.0</td>
</tr>
<tr>
<td>Myasthenia Gravis</td>
<td>358.0, 358.00, 358.01</td>
</tr>
<tr>
<td>Goodpasture’s Syndrome</td>
<td>446.21</td>
</tr>
<tr>
<td>Vasculitis</td>
<td>447.6</td>
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<tr>
<td>Celiac Disease</td>
<td>579.0</td>
</tr>
<tr>
<td>Pemphigus Vulgaris</td>
<td>694.4</td>
</tr>
<tr>
<td>Systemic Lupus Erythematosus</td>
<td>710.0</td>
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<tr>
<td>Systemic Sclerosis</td>
<td>710.1</td>
</tr>
<tr>
<td>Sjogren’s Syndrome</td>
<td>710.2</td>
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<tr>
<td>Dermatomyositis</td>
<td>710.3</td>
</tr>
<tr>
<td>Polymyositis</td>
<td>710.4</td>
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<tr>
<td>Rheumatoid Arthritis</td>
<td>714.x</td>
</tr>
<tr>
<td>Ankylosing Spondylitis</td>
<td>720.0</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>729.1</td>
</tr>
</tbody>
</table>
**Table 2. Follow-up of systemic autoimmune/inflammatory disease in mesh and control cohorts.**

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Mesh Cohort</th>
<th>Control Cohort</th>
<th>RR (95% CI)</th>
<th>Matched</th>
<th>Mesh Cohort</th>
<th>Control Cohort</th>
<th>RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>POP mesh</td>
<td>2257</td>
<td>114399</td>
<td>0.85(0.67-1.08)</td>
<td>2156</td>
<td>6645</td>
<td>64(2.9%)</td>
<td>0.94(0.71-1.24)</td>
</tr>
<tr>
<td>Vag hyst</td>
<td>2257</td>
<td>9395</td>
<td>0.88(0.68-1.14)</td>
<td>1762</td>
<td>5286</td>
<td>47(2.7%)</td>
<td>0.98(0.71-1.36)</td>
</tr>
</tbody>
</table>
## Cancer Diagnoses

<table>
<thead>
<tr>
<th>Number</th>
<th>Cancer Type</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Breast</td>
<td>888,374</td>
</tr>
<tr>
<td>2</td>
<td>Colon and rectum</td>
<td>191,620</td>
</tr>
<tr>
<td>3</td>
<td>Corpus &amp; Uterus</td>
<td>190,409</td>
</tr>
<tr>
<td>4</td>
<td>Thyroid</td>
<td>151,384</td>
</tr>
<tr>
<td>5</td>
<td>Melanoma of the skin</td>
<td>135,294</td>
</tr>
<tr>
<td>6</td>
<td>Lung and Bronchus</td>
<td>127,939</td>
</tr>
<tr>
<td>7</td>
<td>Non-Hodgkin Lymphoma</td>
<td>95,811</td>
</tr>
<tr>
<td>8</td>
<td>Ovary</td>
<td>61,283</td>
</tr>
<tr>
<td>9</td>
<td>Kidney</td>
<td>60,602</td>
</tr>
<tr>
<td>10</td>
<td>Leukemia</td>
<td>52,239</td>
</tr>
</tbody>
</table>
Mesh and Carcinogenosis

<table>
<thead>
<tr>
<th></th>
<th>POP mesh (N=1699)</th>
<th>Cholecystectomy (N=5097)</th>
<th>P value</th>
<th>RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (Mean(std))</td>
<td>60.2(13.1)</td>
<td>60.2(13.1)</td>
<td>0.97</td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>1366(80.7%)</td>
<td>4098(80.7%)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Black (Non-Hispanic)</td>
<td>93(5.5%)</td>
<td>279(5.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>146(8.6%)</td>
<td>438(8.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>88(5.2%)</td>
<td>264(5.2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>620(36.5%)</td>
<td>1860(36.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>126(7.4%)</td>
<td>378(7.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>912(53.7%)</td>
<td>2736(53.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>41(2.4%)</td>
<td>123(2.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NY resident</td>
<td>1682(99.0%)</td>
<td>5046(99.0%)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Comorbidities</strong></td>
<td></td>
<td></td>
<td>0.58</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>805(47.4%)</td>
<td>2360(46.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>544(32.0%)</td>
<td>1629(32.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+</td>
<td>350(20.6%)</td>
<td>1108(21.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cancer during FU</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-year</td>
<td>12(0.7%)</td>
<td>87(1.7%)</td>
<td>&lt;0.01</td>
<td>0.41(0.23-0.75)</td>
</tr>
<tr>
<td>2-year</td>
<td>31(2.0%)</td>
<td>162(3.2%)</td>
<td>&lt;0.01</td>
<td>0.57(0.39-0.84)</td>
</tr>
<tr>
<td>All FU</td>
<td>86(5.1%)</td>
<td>386(7.6%)</td>
<td>&lt;0.01</td>
<td>0.67(0.53-0.84)</td>
</tr>
</tbody>
</table>

Abbreviations: FU=Follow-up, RR=Risk Ratio

*Race/ethnicity information missing in 0.9% patients.

Vaginal surgery with implantation of mesh was not associated with the development of cancers

This data refutes claims against mesh as a cause of carcinogenesis
Bladder Control
Treatments—Urge Incontinence/OAB

• Lifestyle changes:
  – Retrain your bladder and learn ways to control when you go.
  – Exercise your pelvic floor muscles and make diet changes.

• Physical Therapy:
  – Biofeedback (pelvic muscle training).

• Medicines:
  – Bladder relaxant medicines.

Medications
• Surgeries:
  – Botox™ Preparation bladder injections.
  – Bladder nerve stimulator (electrical stimulator or neuromodulator).
  – Tibial Nerve Stimulation.

• Combination of treatments.
Is bladder leakage inevitable?
LOWER URINARY TRACT & PELVIC FLOOR SYMPTOMS

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Assistant Professor of Obstetrics and Gynecology
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Contents

• Urinary Tract Infection (UTI)

• Recurrent UTI

• Testing for UTI/Recurrent UTI

• Treating UTI/Recurrent UTI

• Is It Really a UTI?
Urinary Tract Infection (UTI)

- THE most common ambulatory bacterial infection in the U.S.
- 8.6 million appointments (vast majority by women – 84%)
- By early 30’s, ½ of all women would have had at least one UTI

Hooten NEJM 2012
Urinary Tract Infection (UTI)

**Uncomplicated**
- Acute cystitis (quick onset bladder infection)
  
  Or

- Acute pyelonephritis (quick onset kidney infection)

And

- In the setting of:
  - healthy non-pregnant pre-menopausal woman
  - no prior urological abnormalities

**Complicated**
- Everyone else

Used to guide:
- Choice and duration of antibiotics

But we miss:
- diversity of UTI disorders
- what about the healthy pre-menopausal woman

Hooten NEJM 2012
UTIs...Why & How Do They Happen?

- Intricate

- Bacteria from bowel and vagina

- Infection by ascending bacteria into the:
  
  urethra → bladder → sometimes even higher

Hooten NEJM 2012
UTIs…Why & How Do They Happen?

- *Escherichia coli* (E. coli) is a common bacteria (75-95% of episodes)
- Noxious inflammatory response
- Overcome our natural internal defense systems
- Pathogenesis for an uncomplicated UTI is the same for recurrent UTI

Hooten NEJM 2012
UTI Symptoms

**Likely True Symptoms**
- Frequency of urination
- Urgency of urination
- Dysuria or burning during urination
- Cannot empty bladder completely/passing small amounts of urine
- Pain or pressure in lower abdomen/pelvis
- Low back pain
- Blood in urine
- Even malodorous urine

**Likely Not Symptoms**
- Sore hands
- Sore feet
- Headache

**Controversial in <65 & healthy**
- Generalized fatigue
- Generalized malaise
- Generalized weakness

Hooten NEJM 2012
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Recurrent UTI (Definition)

• ≥ 2 infections in 6 months or ≥ 3 infections in one year

• Reinfection
  o If an infection appears after two weeks of a prior infection, even if the organism is the same

• Relapse
  o Occurs if an infection re-appears within two weeks or less

• Most recurrences are re-infection, rarely relapse
Recurrent UTI

• Majority of recurrences in healthy women (~67%) comprise the same bacteria

• Healthy young women:
  o 25% recurrence within 6 months of 1st episode
  o Recurrence rate increases with >1 previous episode

Hooten NEJM 2012
Recurrent UTI

Risk Factors
- Sexual intercourse
- Spermicides in younger women
- New sexual partner
- Women have short urethra’s
- Prior UTI
- UTI in 1st degree relative
- Persistent bladder focus (i.e. stone)
- Pelvic anatomy – perineal body, cystocele
- PVR
- Incontinence
- ABH blood group non secretor

Reasons
- Uropathogenic bacteria can stay in the bowel for years even when eradicated from the bladder
- Risk of infection increases with recent antibiotic use
- Biofilm in the bladder
- Changed barrier (atrophy), post-menopausal status, lack of estrogen

Hooten NEJM 2012
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Testing for UTI/Recurrent UTI

- Voided urine specimen
- Transurethral catheter urine specimen
- Urinalysis
- Urine culture

Steps involve Cleaning the Genital area voiding fore stream and collecting midstream
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Treating UTI/Recurrent UTI

• Empiric antibiotics

• Wait for culture (especially in the setting of recurrent UTI)

• Treatment is becoming more intricate
  o increase in multidrug resistant bacterial strains
  o C-diff (flora concerns) “ecologic adverse effects”
  o multiple drug allergies
  o side effects of antibiotics
Pennsylvanian woman with a dreaded multidrug resistant *Escherichia coli* (mcr-1 *E.coli*, resistant even to the last resort antibiotic Colistin (typically only used when all other drugs fail) found in her lower urinary tract system

This is the first time in the U.S. that an infectious bacterium has been discovered to be Colistin resistant, essentially, no cure or form of treatment
Treating UTI/Recurrent UTI

Antibiotic stewardship is KEY
Treating Recurring UTI

- Reassess symptoms
- Definitely obtain a urine culture
- Await urine culture results
- Consider broader spectrum antibiotics

Pyridium
Azo, Uristat
Flush with fluids

Hooten NEJM 2012
Treating Recurring UTI…Behavior?

Behavior Modifications

• Abstinence?
• Reduce sexual intercourse frequency?
• Urinate before and after intercourse
• Push Fluids
• Wipe front to back
• Loose underwear
• No douching

• Unfortunately no good evidence for any of these suggestions

Hooten NEJM 2012
Treating Recurring UTI... Non-antimicrobial alternatives?

Non-antimicrobials
- Cranberry
- Vaginal estrogen
- D-mannose
- Methenamine & vitamin C
- Vaccines

Non-antimicrobials
- Oral immunostimulants (heat killed E.coli)
- E.coli (avirulent) bladder instillation
- Florastor
- Femdophilus
Treating Recurring UTI…
Vaginal (Topical) Estrogen

Untreated Tissue
- Loss of vaginal ridges (rugae)
- Epithelial thinning
- Pale and dry appearance

Estrogen Treated
- Normal microflora and vaginal pH
- Thickening of epithelium
- Increased lubrication
Treating Recurring UTI...
Vaginal (Topical) Estrogen

- Evidence it works to prevent UTI
- Takes about 6 weeks to start working
- Can be used in patients with a history of prior hormone receptor positive Br Ca
Cranberry

The Cure for UTIs? It’s Not Cranberries

By JAN HOFFMAN  OCT. 27, 2016
Treating Recurring UTI

- Daily antimicrobial prophylaxis for true recurrent UTI
  - When non antibiotic treatments have failed
- Post-coital prophylaxis
- Self-treatment (intermittent)
- Sometimes we wait and watch and do not treat
  - Urinary microbiome

Hooten NEJM 2012
Treating Recurring UTI…GOAL

• Sustain an suitable standard of living and quality of life, but also reduce exposure to antibiotics

Hooten NEJM 2012
Contents

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• Is It Really a UTI?
Is It Really a UTI?

• Let’s not forget the pelvic floor
• Consider pelvic floor muscle pain
Is It Really a UTI?

- Lower abdomen pain
- Lower back pain
- Pelvic & bladder pain
  - Burning
  - Sharp
  - Pressure
  - Ache
- Feeling of recurrent UTI
- Urgency and Frequency Syndrome

- External physical therapy
- Internal vaginal pelvic floor physical therapy
- Vaginal medications
- Nerve medications
- Acupuncture
- Low dose antidepressant
- Exercise
- Yoga
- Weight loss
- Abdominal support
- Women’s health psychologist
Is It Really a UTI?

Women’s health Psychology & Pelvic Therapy

- Cognitive behavioral therapy
- Desensitization
- Relaxation before strengthening...more than Kegel’s
END
Resources
Patient Advocacy and Resources

- American Urogynecologic Society
  - http://www.augs.org/page/pop-q
Patient Advocacy and Resources

- American Urogynecologic Society
  - [http://www.augs.org/page/pop-q](http://www.augs.org/page/pop-q)
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Information For Your Patients

The following resources are available to download at no charge.

**NEW Patient Factsheets**
- Help your patients better understand their diagnoses and treatment options. Over the next year, a total of 24 topics will be developed. Currently available topics: Constipation, Mid-Urethral Sling for Stress Incontinence, Overactive Bladder/Urgi Urinary Incontinence, Pelvic Organ Prolapse, Stress Urinary Incontinence, Urodynamics

**VoicesforPFD.org**
- VoicesforPFD.org is a website and online community developed by AUGS to educate patients and caregivers about pelvic floor disorders, and to create a unique space for women to connect with other patients.

**OABCentral.org**
- OABCentral.org is an educational website designed to provide resources and education on the topic of overactive bladder (OAB) treatment. In addition, OABCentral.org offers tools and resources for your patients, such as BladderTrakHer, an iphone/ipad application that includes a bladder diary, voiding and medication reminders, and more.

**Voices for PFD YouTube Channel**
- The Voices for PFD YouTube Channel hosts a variety of educational videos for patients. The content includes informational and instructional videos on pelvic floor disorders created by AUGS members.

**Talking with Your Patients About Mesh**
- View this resource to provide your patients with talking points about transvaginal mesh, how they may be impacted, and resources that may help them.

**Primary Care Physician Toolkit (PDF)**
- This toolkit was designed by American Urogynecologic Society (AUGS) and six partner organizations as part of their Successful Strategies to Support your OAB Patients program. The purpose is to increase your patients’ knowledge of OAB and bladder control issues and facilitate a discussion between you and your patients.

**What is a Urogynecologist? (PDF)**
- This one-page fact sheet serves as a patient resource to explain the role of a urogynecologist and the treatment options available.

**Conquering IC: Identification and Management Strategies**
- Conquering IC: Identification and Management Strategies is an educational curriculum that provides an interdisciplinary audience with comprehensive continuing education on identification and management of patients with IC.

**Host a Bladder Health Week Event**
- Interested in hosting a Local Event in your area? The events will give women the knowledge and confidence they need to evaluate their own pelvic health and address pelvic health issues with their physicians. The PFD Alliance has created a Local Event Toolkit to assist you in your planning efforts.
Patient Advocacy and Resources

- International Urogynecologic Association
  - [http://www.iuga.org/?patientinfo](http://www.iuga.org/?patientinfo)