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شبكة المعلومات الجامعية

التوثيق الالكتروني والميكرو فيلم

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التوثيق الالكتروني والميكروفيلم



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بالرسالة صفحات

لم ترد بالأصل

BA901

**URODYNAMIC STUDIES OF
POST-MENOPAUSAL
FEMALES TAKING HORMONAL
REPLACEMENT THERAPY**

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Contents.

	Subject	Page.
I	Introduction	1
II	Aim of work	3
III	Anatomy.	4
IV	Physiology .	12
V	Etiology & Pathology of S.U.L.	18
VI	Diagnosis	21
VII	Treatment	40
VIII	Hormonal Replacement Therapy	83
IX	Patients & methods .	88
X	Results.	91
XI	Discussion.	110
XII	Summary ,	115
XIII	References.	119

INTRODUCTION

Introduction :

Normal continence in the female results from delicate balance of several forces including the closing pressure of the urethra, the critical functional and anatomic urethral pressure at the time of stress and the proper anatomic location of the sphincteric unit. Normally anatomic support of the bladder neck and proximal urethra allows for proper transmission of intra-abdominal pressure increases this area of continence.

Together with an intrinsically intact urethra with its coapting muscosal surface and reflex pelvic contraction at the time of strain, a leak proof mechanism is achieved. Failure of one of these components of this delicate balance will not produce leak because of the compensatory effect of other components.

This balance explains why many patients with urethral and bladder prolapse can be totally asymptomatic and only a small percentage have S.I.

Obstetric trauma and resulting anatomic displacements usually occurs at 20 to 30 year but anatomic incontinence is found mainly at menopause suggesting that hormonal changes (e.g Atrophy of the urethral tissue) are superimposed on the anatomic displacements producing the resulting leakage.

(Raz, et al 1992).

Incontinence is one of the most distressing symptoms that may have a social and hygienic implications (International Continence Society I.C.S., 1977). Stress Incontinence or sphincteric incontinence as named by (Youssef, 1956, Cardozo and Stanton, 1980) may be a symptom, a sign or a condition, the symptom S.U.I. denotes that the patient experiences leakage of small amount of urine instantaneously upon exercising physically.

The sign S.U.I. denotes an observation of leakage immediately upon raising the intra-abd. pressure.

The condition named genuine S.U.I. is defined as involuntary loss of urine when the intra vesical pressure exceeds the maximal urethral pressure in absence of detrusor contraction S.U.I. is one of the most distressing disabilities to which women and especially parous are liable. The intermittent escape of small amounts of urine makes the vulva and perineum sore and necessitates frequent changes of under wear or else, the wearing of sanitary pad. The woman life become a misery on this account and in several cases consciousness of the urinary odour makes her shun so that she may refuse to go out doors and from sheer lack of exercise, she is apt to become obese, which only serves to aggravate the condition. (Dwyer PL; Lee ET; and Hay DM, 1988).

Some authors feel that a thorough history and ex. are sufficient to make the diagnosis in the majority of cases,

(Beck, 1978) but because of many possible etiology of urinary incontinence and the necessity to avoid unwarranted surgical procedures, a need for accurate preoperative evaluation of the lower urinary tract. Urodynamics is a technique that evaluates urethral and bladder function both statically and dynamically during different kinds of stress.

Aim of Work :

The aim of this study is to evaluate uses of urodynamics in cases of S.U.I. to allow careful and rational selection of patients for suitable surgical and/or medical management.

ANATOMY

ANATOMY

EMBRYOLOGY :

The uro-genital system develops from a longitudinal ridge of mesoderm known as the nephrogenic ridge or cord on either side of the root of the mesentery.

Cloaca : Latin (Sewer)

Is a cavity common both to the urogenital and alimentary systems into which open in the early stages of development the allantois and hindgut. Its lumen is separated from the amniotic cavity by a thin cloacal membrane which is a small area into which mesoderm from the primitive streak does not penetrate, so that the endoderm and ectoderm come into direct contact in this area. Later on, the cloaca begins to be partitioned into a smaller dorsal part which forms the lower end of the hindgut and a larger ventral part, which merges into the allantois, becoming the primitive urogenital sinus. This process is produced by the growth of a spur of tissue called the urorectal septum, which grows caudally till it reaches the cloacal membrane which is divided at this

stage into a ventral urogenital membrane and a dorsal anal membrane. The primitive urogenital sinus is subdivided into a vesico-urethral canal above the level of opening of the mesonephric ducts and a definitive urogenital sinus below these openings. Last, (1984)

The bladder and whole female urethra develop from the endodermal vesico-urethral canal and from the mesodermal lower ends of the mesonephric ducts. As development proceeds, the mesonephric ducts shorten because of the absorption of their distal extremity, containing the ureteric buds, into the wall of the vesico-urethral canal. The latter process continues with the result that the ureters open separately and laterally to the openings of the mesonephric ducts. At this stage, a well-defined trigone is distinguished. The ureters open into its cranio-lateral angles, whereas the mesonephric ducts, which remain closely opposed to each other, open into the definitive urethra, on either side of a midline elevation called the Müllerian tubercle produced by the fused Müllerian ducts. In the absence of actively secreting testes, the mesonephric ducts regress to form the vestigial Gartner's ducts. Last (1984)