

GIBS NEWSLETTER

Exploring The Relationship Between Overactive Bladder & Pelvic Organ Prolapse

Latest Updates

GIBS PERIODIC CASE BASED DISCUSSION

Presented by

URO DEPT, TUTH, NEPAL

- **Dr. Manish Pradhan as
Organizing Chairperson**



Date: 8th May 2025



**Time: 7:30 PM – 8:30 PM IST |
7:45 PM – 8:45 PM NPT**

DECADE Celebration!! 10th Annual Congress on IC/BPS - GIBS 2025

Date: 23rd & 24th August 2025

**Venue: Kokilaben Dhirubhai Ambani
Hospital, Mumbai**

**Theme: Decode, Demystify, Drive
IC/BPS**

**CALL FOR ABSTRACT
Last Date for Submission
EXTENDED : May 31 ST, 2025**

**CALL FOR BEST VIDEOS
Last Date for Submission
EXTENDED: May 31 ST, 2025**

Overactive Bladder (OAB) is a condition with physical, emotional and social consequences. It can affect all gender and ages, but this article is focused for people with uterus. OAB is characterized by urgency, frequency, nocturia and urge urinary incontinence (UUI). Traditionally, patients with OAB have been offered antimuscarinics or B3 agonist or behavioral modification, some might have been offered pelvic therapy &/or PTNS.

A large-scale, prospective study done by Jalkanen, et al in 2021, looked at 2,933 women undergoing surgery for pelvic organ prolapse (POP) to assess the relationship between compartment of prolapse and severity of pelvic organ prolapse. They used PFDI-20 to look at urinary urgency and urge urinary incontinence at baseline (pre-surgery), 6 months and 24 months. They found that people with anterior and apical prolapse had more severe UUI and urinary urgency symptoms. At baseline, 40% of participants reported bothersome OAB symptoms (score ≥ 3 on PFDI-20). After anterior/apical surgery, 82% saw resolution in bothersome urinary frequency and 75% saw resolution in bothersome UUI. In contrast, among those undergoing posterior-only repair, 63% had resolution of urinary frequency and 61% had resolution of UUI.



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References:

1. De Boer TA, Salvatore S, Cardozo L, et al. Pelvic organ prolapse and overactive bladder. *Neurourol Urodyn*. 2010;29(1):30–39.
[doi:10.1002/nau.20858](https://doi.org/10.1002/nau.20858).
2. Karjalainen PK, Tolppanen AM, Mattsson NK, Wihersaari OAE, Jalkanen JT, Nieminen K. Pelvic organ prolapse surgery and overactive bladder symptoms—a population-based cohort (FINPOP). *Int Urogynecol J*. 2022;33:223–234.
[doi:10.1007/s00192-021-04920-w](https://doi.org/10.1007/s00192-021-04920-w).

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Study done by De Boer et al in 2010, looked at several theories for pathophysiology of OAB in women with POP.

-Mechanical Bladder Outlet Obstruction

Severe POP, particularly cystocele, can obstruct bladder emptying, leading to reduced urinary flow (Qmax), especially in women with detrusor overactivity (DO). Flow rates and OAB symptoms often improve post-surgery, supporting this mechanical link.

-Bladder Denervation

Chronic obstruction may cause partial autonomic denervation, resulting in hypersensitivity to acetylcholine. Ischemia and hypoxia from overdistension contribute to nerve damage and detrusor instability.

-Detrusor Muscle Remodeling

Obstruction alters detrusor function—decreasing contractile response, disrupting electrical conduction, and increasing membrane instability—leading to hyperresponsiveness and OAB symptoms.

-Altered Spinal Reflexes

Prolonged outlet obstruction induces neural plasticity, with increased NGF expression and dominance of short-latency spinal reflexes, making the bladder more reflexively active.

-Urothelial/ Suburothelial Activation

Bladder distension triggers release of ATP, Ach, and P2X3, activating sensory pathways and initiating involuntary detrusor contractions.

-Urethral Traction

A large cystocele may pull open the urethra, allowing urine to enter prematurely and reflexively triggering detrusor contractions, leading to urgency or incontinence.



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These theories highlight how mechanical obstruction can possibly contribute to the emergency of OAB in women with POP. And understanding these mechanisms is essential for selecting appropriate treatment strategies, whether conservative (e.g., pessary) or surgical.

The findings from these studies closely align with my clinical observations in pelvic health physical therapy practice. A comprehensive evaluation of patients presenting with overactive bladder (OAB) symptoms often allows us to not let pelvic organ support issues go undetected, guiding us toward more targeted and effective interventions.

Clinical Evaluation: Bridging the Gap Between Symptoms and Structural Causes

To avoid missing the critical link between OAB and pelvic organ prolapse, a thorough pelvic floor assessment should be part of the standard evaluation for individuals presenting with urgency, frequency, or urge incontinence — especially in those with a history of childbirth, chronic constipation, or pelvic surgeries.

A comprehensive evaluation may include:

- **Subjective history:** Focused questioning about urinary symptoms, bowel habits, pelvic pressure, bulging sensations, and sexual function.
- **Pelvic floor muscle examination:** A comprehensive assessment of the pelvic floor should include evaluation of resting muscle tone, strength, coordination, endurance, and the ability to voluntarily contract and relax the musculature. Importantly, performing the examination in a standing position—in addition to supine—can yield more accurate information regarding the extent & functional

impact of pelvic organ prolapse, particularly in cases of stage I or II prolapse. Upright assessment better reflects gravitational forces and functional demands, offering a more realistic appraisal of symptom provocation and pelvic support dynamics.

- **POP-Q (Pelvic Organ Prolapse Quantification):** An objective staging system to identify and localize the compartment(s) involved (anterior, apical, or posterior).
- **Dynamic Ultrasound Assessment Under Increased Intra-Abdominal Pressure (IAP):** Performing transabdominal or trans perineal pelvic floor ultrasound during activities that elevate intra-abdominal pressure (e.g., Valsalva maneuver, coughing, or positional changes) allows for real-time visualization of pelvic organ descent, urethral mobility, and the functional integrity of pelvic floor support structures. This dynamic imaging can be a valuable adjunct to the physical exam in identifying occult or position-dependent prolapse, assessing levator ani function, and guiding appropriate clinical management.

Incorporating this type of evaluation can help providers recognize underlying prolapse contributing to OAB symptoms, ensuring that treatment is not only symptom-focused but also addresses the root mechanical or neurological contributors. This proactive approach can reduce treatment failures and improve long-term outcomes. Supported by this information, we can tailor our treatment plans to include behavioral modifications, bladder retraining, pelvic floor muscle down-training or up-training as indicated, and, when appropriate, pessary fitting to support pelvic structures and alleviate symptoms.



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DRUG SNIPPET FOR TREATMENT OF ICBPS



Amitriptyline

Mechanism of Action

Amitriptyline is an Antidepressant.

It is a neurotransmitter (especially norepinephrine and serotonin) reuptake inhibitor; elicits anticholinergic effects.

Pharmacokinetics

Onset of action: up to 6 weeks

Half-life: 9-27 hr

Peak serum time: 4 hr

Metabolism: metabolised by Hepatic CYP2C19, CYP3A4. Metabolites: Nortriptyline

Excretion: Urine (25-50%); bile (small amounts)

Dosing

To be started at 25 mg at bed time.

May be increased up to 75 mg or as decreased to 10 mg/day depending on the response and side effects.

Contraindications

Depression of the central nervous system from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines);

Presence of evidence of bone marrow depression

History of hypersensitive to phenothiazines, amitriptyline, or excipients.

Within 14 days of taking a monoamine oxidase inhibitor.

Acute recovery phase following myocardial infarction.

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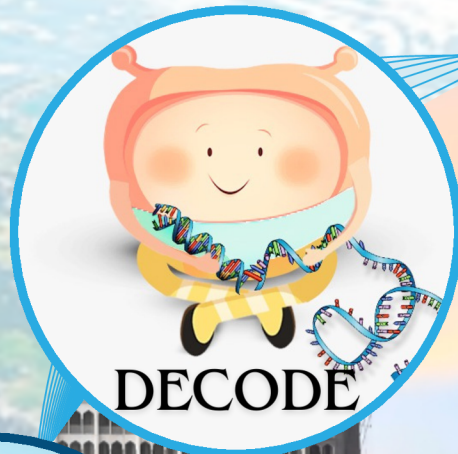
AUGUST 23rd & 24th, 2025

HIGHLIGHTS

- ✓ Advances in IC/BPS
- ✓ Workshops
- ✓ Orations from Subject Expert around the Globe!

 Kokilaben Dhirubhai Ambani Hospital, Mumbai, India

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- ✓ **Presentation Format: In Person**
- ✓ **Date: 24th August 2025**
- ✓ **Time: 09:00AM - 10:30AM IST**
- ✓ **Finalist Announcement: By 10th May**
- ✓ **Limited Slots Available!**
- ✓ **Registration: Mandatory!**

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