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BIOPSYCHOSOCIAL APPROACH TO URINARY INCONTINENCE AFTER DYSTOCIA

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Abstract: Introduction: Urinary incontinence is an involuntary loss of urine that affects biological, physical and psychosocial aspects, impairing women's quality of life and hygiene. The repercussions are also seen in work and leisure activities. There are several causes, including vaginal delivery, which can cause damage to the pudendal nerve, the levator ani and the fascial supports of the pelvic organs, as well as impairment of the urethral and anal sphincters. **Objective:** To discuss the biopsychosocial approach to women with urinary incontinence after dystocia. **Discussion:** Several authors agree when they mention in their studies the repercussions of urinary incontinence not only on a woman's physical health, but also on her emotional health, sex life and social functions. **Conclusion:** It can be seen that involuntary urine loss involves not only impacts from a biological point of view, but also in the psychological sphere and in the quality of life of those who live with this condition.

Keywords: Urinary incontinence, Coping skills, Quality of life.

INTRODUCTION

Caldeira et al (2021) explains that urinary incontinence (UI) is an involuntary loss of urine that affects biological, physical and psychosocial aspects. It directly impairs quality of life and increases the impact on work and leisure activities. It is classified according to the type of incontinence into: Stress UI, Urge UI and Mixed UI (Brasil, 2019).

Vaginal delivery can cause damage to the pudendal nerve, the levator ani and the fascial supports of the pelvic organs, as well as impairment of the urethral and anal sphincters. Therefore, vaginal delivery is a powerful determinant of stress urinary incontinence (SUI) (Jiang et al, 2009).

There are various treatments for urinary incontinence, from surgery and medication to lifestyle changes. The main focus of treatment is always to improve the patient's quality of life (Bergo et al, 2024).

Thus, therapeutic approaches should be chosen based on each patient's individual preferences and wishes (Brasil, 2018). Psychological intervention is important to improve their coping mechanisms and overall quality of life (Bergo et al, 2024).

This study aims to discuss the biopsychosocial approach to women with urinary incontinence after dystocia. The aim is to contribute to advances in this type of study and to support health actions aimed at minimizing the social and psychological disorders caused by this problem.

CASE REPORT

Patient L. R. S., female, 33 years old, cleaner, from Barras-PI, coming from Campo Maior-PI. She came to the clinic on August 30, 2024 with the main complaint of peeing when smiling, using a pad and wearing dark clothes (Sic).

HDA: the patient reported episodes of urinary incontinence during the pregnancy of her first child, with episiotomy and without the use of forceps in the first pregnancy, with worsening incontinence after the birth of her fourth child (3 years). She has continuous urinary incontinence on exertion, with no sensation of a full bladder and no dry intervals.

He also reported episodes of secondary nocturnal enuresis, which was not monosymptomatic. She uses an average of 5 pads, with quantified losses ranging from drops to cups of urine, most frequently when she spoons, as well as an association with mycosis and ammonia dermatitis in the perineal area. She reported urinary infection with a frequency of 3 to 4 episodes a year. Denies vaginal discharge, denies foul-smelling urine.

The patient has symptoms of muscle strength deficit and paresthesia in the hands and feet, headache, muscle tension in the posterior cervical region, sleep and emotional changes.

Family history: youngest daughter (3 years old) with congenital hypothyroidism.

Personal history: Systemic arterial hypertension (treated, but discontinued medication).

Obstetric history: puerperal eclampsia while taking capitolipil, G4A0P4, first dystocia and 4 eutocic deliveries.

Physical examination: BEG, eupneic, flushed, afebrile, normal psychomotor skills.

- Soft tissue enlargement in the anterior cervical region. Possible enlargement of the right lobe of the thyroid;

- Tinel (+) in carpal tunnel and tarsal tunnel;

- Globose abdomen, infra umbilical scar from tubal ligation. Presence of umbilical hernia with aponeurosis failure of less than 02 cm (approximately 0.5 cm)

- 12+/18 tender points

- Perineum: eutrophic vulva and vagina, continuous urinary leakage. Urethral meatus did not reveal urine loss. Coaptate meatus. Scar visible at 7am from the vaginal introitus to the root of the right thigh (it hurts and is deep, the right ischium can be felt very easily). Strength of the levator ani muscles is very good (normal tone and tension). Touch vaginal - no inflammatory process was identified on the anterior wall of the vagina. Diagnostic hypothesis:

- Obesity + acanthosis: metabolic syndrome?

- Obesity + Carpal Tunnel Syndrome + Tarsal Tunnel Syndrome: Hypothyroidism?

- Fibromyalgia

- Continuous urinary incontinence: URINARY FISTULA?

Conduct:

- Blood count, urea, creatine, EAS, fasting glucose, HBA1C, total cholesterol and fractions, triglycerides;
- TSH, T4L, thyroid US. B12 dosage.
- Duloxetine 30mg 01cp at the end of the day.
- Uroculture + antibiogram, CT scan of upper abdomen with contrast, CT scan of lower abdomen with contrast, urodynamic study.

DISCUSSION

Urinary incontinence (UI) consists of any involuntary loss of urine in around 50% of women during pregnancy (Bortelo et al, 2021). This problem involves multifactorial causes such as pregnancy, age, obesity, parity, types of delivery, weight of the newborn, menopause, gynecological surgeries (Mendonça et al, 2022).

The levator ani muscle and the pudendal nerve can be damaged during the cervical dilation phase in around 13 to 36% of women after vaginal delivery in their first pregnancy (Quadros et al, 2023). This event perpetuates pelvic floor dysfunction during the puerperium and thus presents a definitive picture urinary incontinence, promoting urethral hypermobility (Cabeleira et al, 2023).

The urogenital triangle is made up of superficial and deep muscles. The former is made up of the ischiocavernosus, bulbospongiosus and superior transverse muscles of the perineum. The second is made up of the urogenital diaphragm, i.e. the deep transverse muscles of the perineum and the urethrovaginal sphincter (Macedo, 2021).

After understanding the urogenital anatomy, it is important to understand the urethral support mechanism in urge urinary incontinence. In this context, Júnior and Reis (2010) explain that the levator plate is dynamic, constantly changing its tension and adjusting to changes in intra-abdominal pressure (Júnior; Reis, 2010).

Stress urinary incontinence (SUI) occurs when the loss of urine is involuntary and results from physical exertion such as exercise, coughing and sneezing, at which point the increase in intravesical pressure exceeds the urethral pressure, in the absence of detrusor contraction (Lopes, 2020).

As the patient had a dystocia, it's important to understand the subject. In the prolonged active phase or functional dystocia, dilation of the cervix occurs slowly, at a rate of less than 1 cm/hour. This dystocia usually stems from inefficient uterine contractions (lack of motor) (Brasil, 2001).

Scientific evidence shows that free movement, ambulation and the adoption of upright positions during parturition favor physiology, minimize painful sensations, increase the chances of vaginal delivery, shorten the duration of labor and correct dystocia (Costa et al, 2023).

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