A CLINICAL MASTER CLASS

Treat ALL Bladder Symptoms With Confidence

Overactive & stress incontinence, prolapse, GSM, bladder pain, and the vulvovaginal causes hiding behind “bladder” symptoms.

Skin, Bones, Hearts & Private Parts 2026 · Jessica Bell, PA-C, MSCP, ISSWSH Fellow · GynJess

Disclosures

Financial disclosures

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Off-label use

This presentation discusses off-label use of topical / vaginal estrogen for the urethral caruncle and for recurrent-UTI prevention.

Off-label uses are identified as such where they appear.

What we'll cover

1. Overactive bladder & urge incontinence
2. Stress urinary incontinence
3. Pelvic floor dysfunction
4. Pelvic organ prolapse
5. Genitourinary syndrome (GSM)
6. Interstitial cystitis / bladder pain
7. Vulvovaginal conditions
8. Urethral caruncle

Overactive bladder & urge incontinence

- **OAB affects about 15% of women across all ages — and drives avoidance of social activity and real quality-of-life loss.**

The vocabulary

- OAB: a sudden urge to urinate, sometimes with leaking.
- **Urgency: “gotta go right now.”**
- Frequency: “gotta go often” — ≥ 8×/day.

...continued

- Nocturia: waking ≥ 1× to void.
- **Urge incontinence (UUI): leakage with that sudden strong urge.**

OAB & urge incontinence: treatment

Conservative & medications

- Behavioral: bladder training (“mind over bladder”); cut caffeine, alcohol, carbonation, sweeteners, acidic juices. Pelvic-floor PT.
- **Beta-3 agonists (often preferred): mirabegron, vibegron.**
- Mirabegron can raise BP — monitor; avoid in uncontrolled HTN. Vibegron has less BP effect.
- Antimuscarinics: oxybutynin, solifenacin, tolterodine, trospium, fesoterodine, darifenacin.
- Trospium doesn't cross the blood–brain barrier — preferred antimuscarinic in older adults.

When to escalate

- **Botox: intradetrusor onabotulinumtoxinA (100 U) relaxes the detrusor.**
- **Nerve stimulation:**

posterior tibial (PTNS) and sacral neuromodulation

- The 2024 guideline no longer requires a rigid first→second→third-line march — match therapy to the patient via shared decisions.

Antimuscarinics add cognitive / dementia risk with anticholinergic burden — favor beta-3 in older adults; use extreme caution in narrow-angle glaucoma, impaired gastric emptying, or prior urinary retention.

AUA/SUFU OAB Guideline (Cameron et al., J Urol 2024)

Stress urinary incontinence (SUI)

What & who

- **Leakage with effort — cough, laugh, lift, exercise.**
- **Affects ~1/3 of women older than 45.**
- Risk factors: pregnancy/childbirth, constipation, obesity, smoking, aging, chronic cough, heavy lifting.

Evaluation

- **Clinical exam (cough stress test).**
- Urodynamic testing can help in select or complex cases.

SUI: treatment

Conservative

- **Weight reduction — abdominal obesity is a known driver; weight loss improves incontinence.**
- Pelvic-floor muscle exercises; pelvic-floor PT
- Bladder training
- **Topical vaginal estrogen.**

Procedural

- **Urethral bulking injections.**
- **Midurethral sling.**
- Surgery for appropriate candidates.

Pelvic floor dysfunction

Symptoms & evaluation

- **Uncoordinated muscles produce the symptoms.**
- Frequent urination, incontinence, constipation
- Low back pain; pain in pelvis, genitalia, rectum
- **Evaluate: clinician or pelvic-floor PT.**

Mimics to rule out

- **Interstitial cystitis**
- **Irritable bowel syndrome**
- **Prolapse**
- Treatment is individualized.

Pelvic floor dysfunction: treatment

- **Pelvic-floor physical therapy is the cornerstone.**
- Physician-directed exercises or formal pelvic-floor PT.
- **Help patients find a qualified therapist:**

APTA Pelvic Health PT Locator

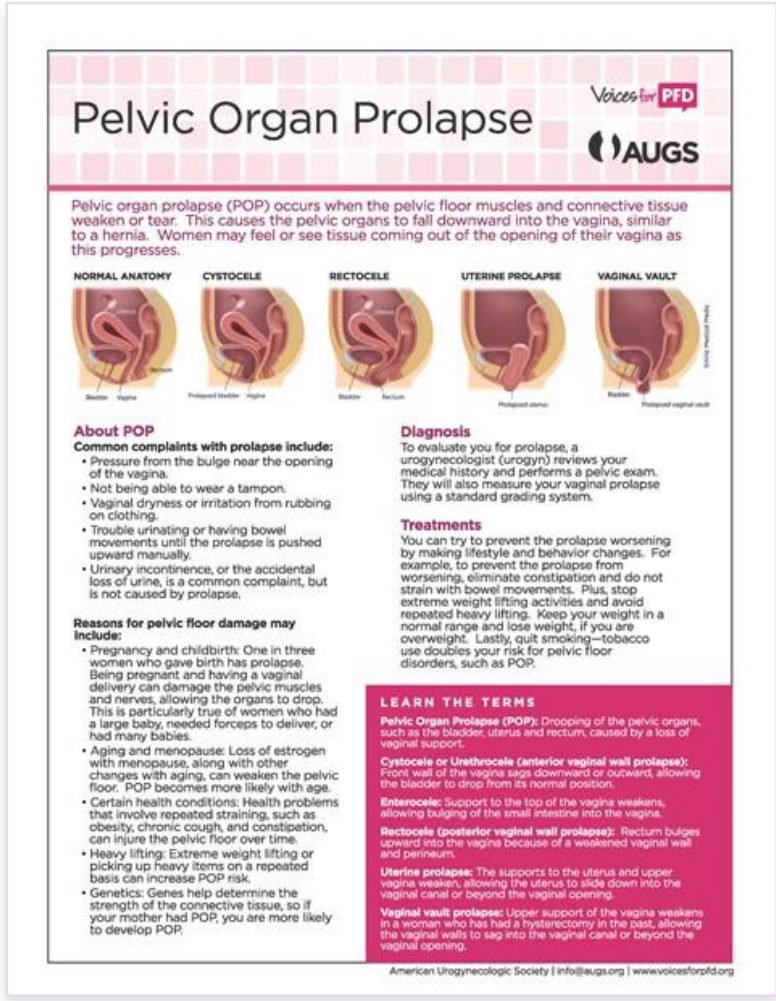
Pelvicrehab.com practitioner directory

Pelvic organ prolapse

- **Pelvic-floor muscles and connective tissue weaken or tear, and the pelvic organs descend into the vaginal canal — some patients feel tissue at the opening.**
- Symptoms: pressure, rubbing/irritation, difficulty emptying bladder or bowel, incontinence. Staged in clinic with the POP-Q.

Cystocele	Anterior wall weakens — bladder drops into the vagina.
Rectocele	Rectum bulges upward into the vagina.
Uterine prolapse	Uterine/upper-vaginal support weakens — uterus descends.
Vaginal vault prolapse	Upper support weakens — vaginal walls descend (often post-hysterectomy).

Pelvic organ prolapse: the anatomy



Pelvic Organ Prolapse

Voices for PFD

AUGS

Pelvic organ prolapse (POP) occurs when the pelvic floor muscles and connective tissue weaken or tear. This causes the pelvic organs to fall downward into the vagina, similar to a hernia. Women may feel or see tissue coming out of the opening of their vagina as this progresses.

NORMAL ANATOMY | CYSTOCELE | RECTOCELE | UTERINE PROLAPSE | VAGINAL VAULT

About POP

Common complaints with prolapse include:

- Pressure from the bulge near the opening of the vagina.
- Not being able to wear a tampon.
- Vaginal dryness or irritation from rubbing on clothing.
- Trouble urinating or having bowel movements until the prolapse is pushed upward manually.
- Urinary incontinence, or the accidental loss of urine, is a common complaint, but is not caused by prolapse.

Reasons for pelvic floor damage may include:

- Pregnancy and childbirth: One in three women who gave birth has prolapse. Being pregnant and having a vaginal delivery can damage the pelvic muscles and nerves, allowing the organs to drop. This is particularly true of women who had a large baby, needed forceps to deliver, or had many babies.
- Aging and menopause: Loss of estrogen with menopause, along with other changes with aging, can weaken the pelvic floor. POP becomes more likely with age.
- Certain health conditions: Health problems that involve repeated straining, such as obesity, chronic cough, and constipation, can injure the pelvic floor over time.
- Heavy lifting: Extreme weight lifting or picking up heavy items on a repeated basis can increase POP risk.
- Genetics: Genes help determine the strength of the connective tissue, so if your mother had POP, you are more likely to develop POP.

Diagnosis

To evaluate you for prolapse, a urogynecologist (urogyn) reviews your medical history and performs a pelvic exam. They will also measure your vaginal prolapse using a standard grading system.

Treatments

You can try to prevent the prolapse worsening by making lifestyle and behavior changes. For example, to prevent the prolapse from worsening, eliminate constipation and do not strain with bowel movements. Plus, stop extreme weight lifting activities and avoid repeated heavy lifting. Keep your weight in a normal range and lose weight, if you are overweight. Lastly, quit smoking—tobacco use doubles your risk for pelvic floor disorders, such as POP.

LEARN THE TERMS

Pelvic Organ Prolapse (POP): Dropping of the pelvic organs, such as the bladder, uterus and rectum, caused by a loss of vaginal support.

Cystocele or Urethrocele (anterior vaginal wall prolapse): Front wall of the vagina sags downward or outward, allowing the bladder to drop from its normal position.

Enterocele: Support to the top of the vagina weakens, allowing bulging of the small intestine into the vagina.

Rectocele (posterior vaginal wall prolapse): Rectum bulges upward into the vagina because of a weakened vaginal wall and perineum.

Uterine prolapse: The supports to the uterus and upper vagina weaken, allowing the uterus to slide down into the vaginal canal or beyond the vaginal opening.

Vaginal vault prolapse: Upper support of the vagina weakens in a woman who has had a hysterectomy in the past, allowing the vaginal walls to sag into the vaginal canal or beyond the vaginal opening.

American Urogynecologic Society | info@augs.org | www.voicesforpfd.org

Genitourinary syndrome of menopause (GSM)

Symptoms

- **Formerly “vaginal atrophy” — a constellation from low estrogen.**
- Urgency, frequency, dysuria, recurrent UTI
- Dryness, burning, irritation, decreased lubrication, dyspareunia
- **Up to 70% never raise it — so ask directly.**

Exam & treatment

- Labial resorption/fusion, tissue fragility, pallor, loss of rugae
- Prominent urethral meatus, urethral eversion; reduced elasticity
- **Treat with hormones and/or non-hormonal moisturizers.**

GSM: treatment

The best treatment is the one a person will use. Apply to the vulva purposefully — for creams, discard the applicator and apply with a finger.

Estradiol cream	1 g daily × 2 weeks, then 2–3×/week.
Estradiol ring	1 ring every 90 days.
Estradiol insert	10 mcg tablet daily × 12 weeks, then 2×/week.
Conjugated equine estrogen	0.5 g daily × 2 weeks, then 2×/week.
Prasterone (DHEA)	6.5 mg vaginal insert daily.

Interstitial cystitis / bladder pain

What it is

- **Chronic bladder pain without a clear etiology.**
- No clear evidence that inflammation or interstitial abnormality drives it — the name outlives the theory.
- **Bladder pain can be debilitating.**

Evaluation

- **Exam for tenderness / other causes: prolapse, diverticulum, mass.**
- Urine tests to rule out infection and hematuria.
- Rule out vaginitis and STIs.
- Cystoscopy excludes other causes — it is not diagnostic.

AUA IC/BPS Guideline (Clemens et al., J Urol 2022)

IC / bladder pain: treatment

Conservative & oral

- Diet modification; fluid management
- **Pelvic-floor PT — hypertonic floors cause pain.**
- Amitriptyline; hydroxyzine.
- **Pentosan polysulfate — warn re: pigmentary maculopathy (retinal monitoring).**
- Phenazopyridine, methenamine (symptomatic).

Procedural

- **Bladder hydrodistention.**
- **Intradetrusor botulinum toxin.**
- **Sacral neuromodulation.**

Vulvovaginal: when “it hurts to pee” isn't the bladder

“It hurts when I pee!” Raw vulvar tissue hurts as urine flows over it — the pain is dermatologic, not urinary. Lichen sclerosus is a key example.

Lichen sclerosus

- **Chronic, progressive vulvar dermatosis; highest incidence in low-estrogen states.**
- Pruritus (worse at night), perianal pain, fissures, dyspareunia, dysuria.
- Hypopigmentation; loss of vulvar architecture.

Diagnosis

- **Usually clinical: white fissures, ecchymoses, architectural change.**
- Biopsy to confirm or when uncertain.
- **“It itches right here.”**

Lichen sclerosus: treatment

- **Location of application matters — give the patient a mirror and a handout.**
- Clobetasol: a fingertip unit (~0.5 g) daily × 12 weeks to induce remission…
- …then maintenance twice weekly; once weekly in prolonged remission.
- **Treat co-existing GSM — it eases symptoms and helps distinguish active LS from atrophy.**

Urethral caruncle

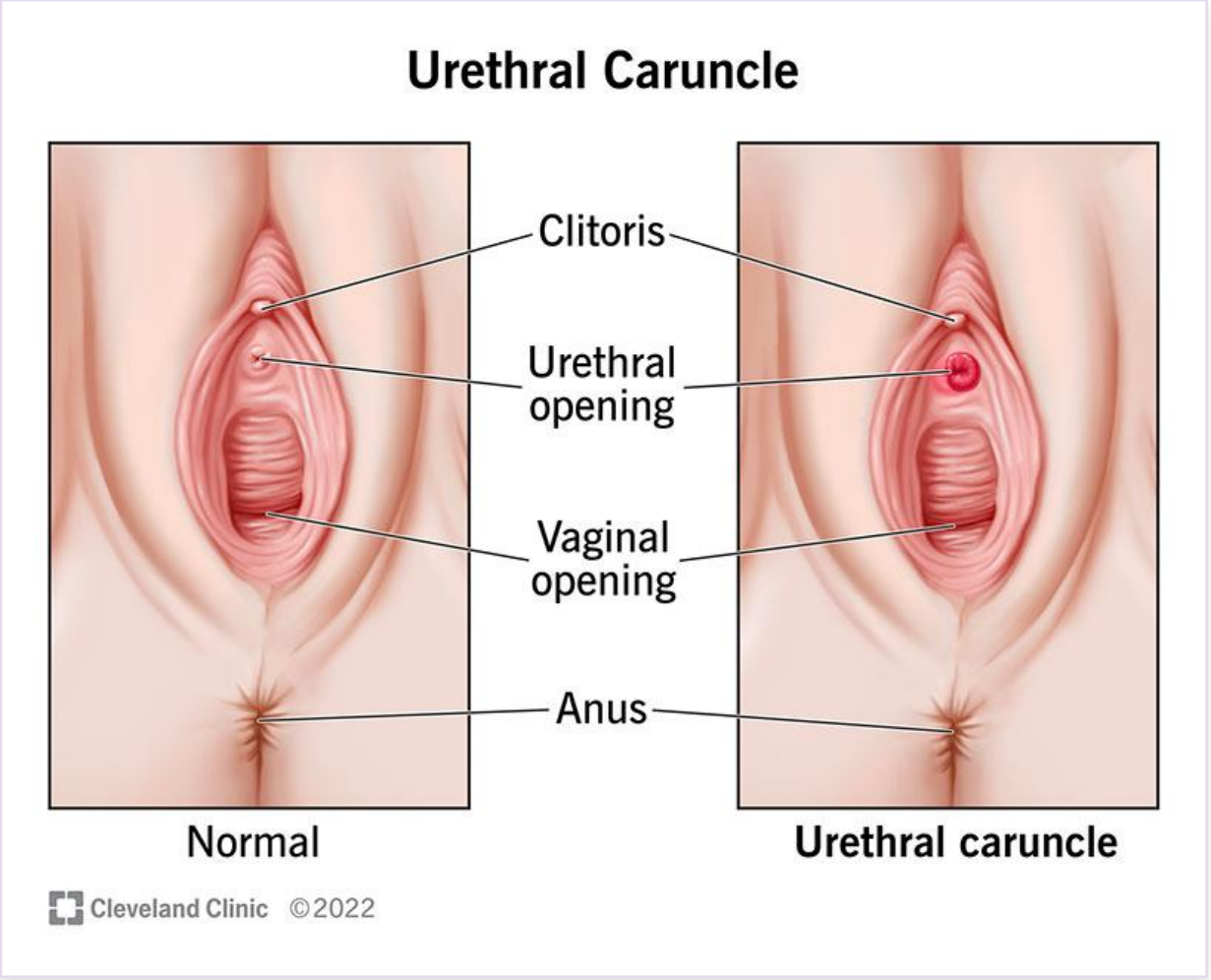
What it is

- **A benign (non-cancerous) growth at the urethral meatus.**
- **Linked to low estrogen.**
- Often asymptomatic — treat only if symptomatic.

Recognize it

- Symptoms: burning, pain, bleeding when wiping.
- **Exam: 1–2 cm fleshy red/pink lesion, often on one edge.**
- vs. urethral prolapse, which is more circumferential/uniform.

Urethral caruncle: what it looks like



Urethral caruncle: treatment

- **Treat only if symptomatic.**
- Anti-inflammatory: topical corticosteroid cream to reduce swelling and irritation.
- **Topical estrogen cream applied purposefully to the urethra — addresses the low-estrogen driver.**
- **Refractory: refer to urology for caruncle excision.**

Resources & references

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