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Newsletter to Health Professionals

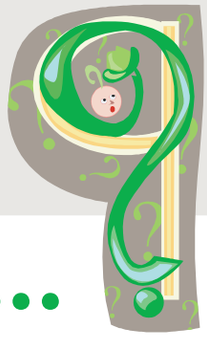
Number 6

Urinary problems in spinocerebellar disorders

Recommendations from the experts in spinocerebellar disorders by the Medical and Paramedical Committee of AFAF, CSC and ASL

Edito

Urinary problems may appear in the course of spinocerebellar diseases. Although they are not inevitable, may occur early, and may never appear at all, they should be considered by the doctor since they are not always identified by the patient himself or are often played down or even denied by him. Furthermore, a particular functional sign will not have an unequivocal cause.



Questions to be considered...

The two principal symptoms are dysuria and incontinence:

Dysuria (difficulty in urinating) may lead quietly to an effect on the upper urinary tract. As this will not cause social embarrassment, the patient will not ask about it explicitly.

Incontinence, however, is embarrassing on a functional level and is more likely to be brought up by the patient, even though it will not pose any direct threat to the kidneys.

There is therefore no parallelism between the social effect and the renal effect.

Questioning of the patient will determine:

- The frequency of micturition
- Whether it is initiated spontaneously or deferred ?
- Its quality: one stream or more

This will be complemented by a **voiding diary** to be kept over several days, recording drink times, micturition times and quantity voided.

Assessment

In the presence of a urinary disorder, whether dysuria, urge incontinence or pollakiuria (frequent voiding of small amounts of urine), the examination of choice is urodynamic assessment (UDA). This enables an accurate diagnosis to be made and appropriate treatment to be started.

A hyperactive or hypoactive bladder, striated sphincter incompetence or sphincter hypertonia, bladder instability or bladder-sphincter dyssynergia can be analysed only by means of this examination.

A **CBEU (cytobacteriological examination of urine)** will be carried out automatically to check for a urinary infection that may develop gradually and lead to neurological aggravation, in particular, of spasticity.

An **ultrasound examination of the bladder and kidneys** will complete the assessment by checking for postmicturition residue, lithiasis or an effect on the upper urinary tract.

Treatments

Treatments are pharmacological, local or locoregional.

Their aim is to reduce bladder hyperactivity and ensure complete and regular bladder emptying.

Surveillance

Long-term treatment requires caution as, although effective, it may exceed its objectives and itself become harmful.

Moreover, a satisfactory situation can rapidly be thrown out of balance. For example, renal, ureteral or vesical lithiasis, haemorrhoids, an ingrowing toenail, or cutaneous erosion can all lead to this type of imbalance and should be taken into account and treated prior to any other procedure.

It is for this reason that regular clinical, ultrasound and biological (CBEU) monitoring is required once treatment has been instituted. If bacteriuria occurs, treatment is not justified if there is a residue. The cause of the residue should be identified and an attempt made to treat it.

Drawn up by the Medical and Paramedical Committee of AFAF, ASL and CSC.
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