URODYNAMICS
PATIENT INSTRUCTIONS

PATIENT NAME:_____

APPOINTMENT:_____ **ARRIVAL TIME:**_____
DATE **TIME** **15 minutes before appt.**

You have been scheduled for a Urodynamics study. This test is to help your doctor determine how your bladder and pelvic muscles may be working inappropriately.

If you take Enablex, Detrol, Ditropan, Sanctura, Vesicare, Oxytrol or their generic equivalent stop taking 2-3 days before Urodynamics study, or call the office if you have questions or are unsure of medication.

Directions for the day of the procedure:

- Empty your bowels before coming to the office - use one Fleets enema the morning of your test
- Bring your completed questionnaire and bladder diary
- Unless otherwise directed by your doctor, you should take your normally scheduled medications*
- Bring an extra pair of socks
- Do NOT wear lotion on your legs
- Empty your bladder 1 ½ hours prior to your appointment time
    - then begin drinking water frequently until your appointment – you should arrive in the office with a comfortably **FULL** bladder
    - you may eat before your appointment

The procedure will begin with you undressing from the waist down. We will review the bladder diary and questionnaires with you and then you will empty your bladder on a special chair. A small catheter is inserted into your bladder; and another catheter will be inserted into the rectum. Two patches (like EKG electrodes) will be placed next to your rectum. We will attach all of the catheters and electrodes to a small computer and start filling your bladder with sterile water. You will be asked about the sensations you are having while your bladder is filling. There are no right or wrong answers to these sensations. **Do NOT be afraid to leak urine** – we want to determine which specific muscles are not working by **causing you to leak during this test.**

We will explain everything to you as it happens. The only discomfort you may have will be a stinging sensation when the catheter is inserted in the bladder. This sensation will disappear after a few minutes.

The series of tests typically takes about one hour. You will be able to resume all previous activities, including driving, upon completion of the Urodynamics studies.

If you have any questions, please call the office 918-747-9641. If you need to reschedule your appointment, please call at least 24-hours before your appointment.

URODYNAMICS DIAGNOSTIC PROCEDURE

WHAT IS URODYNAMICS?

Urodynamics refers to a series of diagnostic tests that evaluate the function of your bladder and urethra. These tests may be recommended if you have urinary incontinence (leakage of urine), recurrent bladder infections, a slow/weak urinary stream, incomplete bladder emptying, or frequent urination. Urodynamics testing provides valuable information to aid in the accurate diagnosis of your urinary problems.

HOW TO PREPARE FOR URODYNAMICS

Prior to your appointment you will be asked to complete a bladder diary and questionnaire. Please bring these with you to the appointment.

Unless otherwise directed by your doctor, you should take your normally scheduled medications. You may eat and drink prior to the study. ***If you take Enablex, Detrol, Ditropan, Sanctura, Vesicare, Oxytrol or their generic equivalent stop taking 2-3 days before Urodynamics study, or call the office if you have questions or are unsure of medication.**

The series of tests typically takes about one hour. You will be able to resume all previous activities, including driving, upon completion of the Urodynamics studies.

Your physician will decide which of the following procedures are appropriate for you.

UROFLOWMETRY

This study measures your urinary flow rate. You should come to the test feeling as though you need to urinate. Try not to empty your bladder one hour before your test is scheduled. You will be asked to urinate into a special commode that allows a computer to measure your urine flow rate and voided volume.

EMG

This study measures how well you can control your sphincter (outlet) muscles and helps determine if they are working in coordination with your bladder. "Sticky patches" (electrodes) will be placed near the rectum to record sphincter muscle activity.

CYSTOMETROGRAM

This study measures your bladder capacity, evaluates how your bladder holds urine, and determines how well you can control your bladder muscle.

One very small catheter will be placed in your bladder, and another will be placed in your rectum. These catheters will measure both the pressure inside your bladder, and the pressure your body exerts on your bladder.

You will be asked to report the sensations you feel as your bladder is filled (such as when you first feel the need to urinate and when that feeling intensifies).

You will be asked to cough or bear down during the test to check for leakage of urine. Do NOT be afraid to leak urine – we want to determine which specific pelvic muscles are not working by causing you to leak during the test. At the end of the study, you will be asked to urinate again.

PRESSURE FLOW STUDY

This study measures how well the bladder muscles, the sphincter, and the urethra work together. This test may be done sitting or standing. Your bladder will be filled until you feel that your bladder is completely full. You will then be asked to urinate. The computer will measure the strength of your bladder muscles and sphincter, as well as the urinary flow rate and voided volume.

URETHRAL PRESSURE PROFILE

The Urodynamic catheter is placed in the urethra and it will calculate the urethral closure pressure and the bladder pressure simultaneously. this result will be documented by the computer and provide additional information for your diagnosis.

TREATMENT OPTIONS

BIOFEEDBACK & PELVIC FLOOR THERAPY

This non-surgical form of therapy is used to retrain the pelvic floor and/or bladder muscles. Typically, pelvic floor therapy consists of weekly sessions for six weeks. The first session will last about one hour, but the remaining sessions will be shorter.

Using biofeedback and electrical stimulation techniques, a therapist will evaluate your muscle strength and instruct you on how to properly isolate and exercise these pelvic floor muscles. A computer can be used to guide you and monitor your progress. You will be educated in these techniques so that you can continue the exercises at home.

MEDICATION

Some prescription medication options may be available. Your doctor will discuss the results of your testing and if there are any prescription options right for you.

SURGERY

Your doctor will discuss any surgical options that are appropriate for you, based on your study results.

Tulsa OB-GYN Associates, Inc. Physician: _____

Name:_____ Age:_____ Date of Birth:___/___/___

Height:_____ Weight:_____ Age of Menopause:_____

# of Pregnancies:_____ # Vaginal Births:_____ # C-Sections:_____

Do you smoke?.....	Yes	No	# of packs daily:_____
Do you drink alcohol?.....	Yes	No	# of drinks daily:_____

Ethnicity:
Caucasian/White ☐ African American ☐ Hispanic ☐
Asian/Pacific Islander ☐ Other ☐_____

URINARY INCONTINENCE- leakage of urine

	YES	NO
Do you have accidental loss of urine?	☐	☐
How many months/years have you had leakage of urine? ___months ___years		
Do you use pads to absorb lost urine?	☐	☐
How many pads to you wear in a day? ___		
About how many trips to the bathroom do you make during the day? ___		
Does the sound, sight or feel of running water cause you to lose urine?	☐	☐
Do you lose urine during the act of intercourse?	☐	☐
Do you lose urine during orgasm?	☐	☐
Does an uncomfortably strong need to pass urine wake you up?	☐	☐
How many times do you urinate during the night, after going to bed? ___		
Which best describes the severity of urine loss with activity (*choose one*)		
1. I lose urine during coughing, sneezing, running or heavy lifting ☐		
2. I lose urine with changes in posture, standing or walking ☐		
3. I lose urine continuously, I am constantly wet ☐		
Have you seen a physician for complaints of urine loss?	☐	☐
Have you taken medicine to prevent urine loss?	☐	☐
If yes, name the medication_____		
Have you had surgery to prevent urine loss?	☐	☐
If yes, was surgery done through the vagina or abdomen_____		
Date of operation ___/___/___		
Result of the surgery was: helped temporarily ☐		
no difference ☐		
made it worse ☐		
Do you notice any dribbling of urine when you stand after voiding your urine?	☐	☐
Do you usually have difficulty starting your urine stream?	☐	☐
Have you ever required catheterization for the inability to pass urine?	☐	☐
Do you always feel your bladder is NOT empty after going to the bathroom?	☐	☐

BLADDER PROLAPSE

	YES	NO
Do you have a bulge or mass in your vagina?	☐	☐
How many months or years have you noticed this bulge or mass? #____mon ____yrs		
Have you seen a doctor for the bulge or mass in your vagina?	☐	☐
Have you worn a device called a pessary for this problem?	☐	☐
If yes, how long have you worn a pessary # ____mon ____yrs		
Have you ever had surgery for this bulge or mass in the vagina?	☐	☐
If yes, was it done through the vagina or abdomen (circle one)		
Date of operation ___/___/___		

FECAL INCONTINENCE

Do you have accidental loss of solid stool?	☐	☐
Do you have accidental loss of liquid stool?	☐	☐
Do you have accidental loss of gas?	☐	☐
How long have you had accidental loss of stool or gas? #____mon ____yrs		
Have you seen a doctor for this problem?	☐	☐
Have you had surgery for this problem?	☐	☐
Date of operation ___/___/___		
Did the problem with accidental loss of stool begin after childbirth?	☐	☐
Do you wear protective pads for this problem?	☐	☐
How many pads do you wear each day? #____		
Are you unable to sense the need to have a bowel movement?	☐	☐
Are you unable to tell the difference between solid stool/liquid stool/and gas?	☐	☐
Do you have a frequent desire to have a bowel movement?	☐	☐
Do you feel that your bowels are never completely empty?	☐	☐
Has there been a change in your bowel habits recently?	☐	☐
Have you noticed any bright red bleeding with your bowel movements?	☐	☐
Have you noticed black or "tarry" stools?	☐	☐
Are your bowel movements painful?	☐	☐

CONSTIPATION

Do you have constipation?	☐	☐
Do you excessively strain to pass stool more than 25% of the time?	☐	☐
Do you have less than 3 bowel movements each week?	☐	☐
Do you pass hard, small stool?	☐	☐
How many months or years have you had constipation? #____mon ____yrs		
Have you seen a doctor for this problem?	☐	☐
Have you ever used over the counter medication for this problem?	☐	☐
If yes, name the medication_____		
Have you had surgery for this problem?	☐	☐
Date of operation ___/___/___		
Have you ever placed your hand in your vagina or between your vagina and rectum to help have a bowel movement?	☐	☐

QUALITY OF LIFE

Circle one number for each question

	NOT AT ALL	A LTTLE BIT	SOMEWHAT	QUITE A BIT	VERY MUCH
Urine leakage has affected:					
Ability to do household chores (cooking, cleaning, laundry)	0	1	2	3	4
Physical recreation (walking, swimming, other exercise)	0	1	2	3	4
Entertainment activities (movies, concerts, etc.)	0	1	2	3	4
Ability to travel by car or bus more than 30 minutes from home	0	1	2	3	4
Participating in social activities outside your home	0	1	2	3	4
Emotional health	0	1	2	3	4
Causes frustration	0	1	2	3	4

Do you experience and if so, how much are you bothered by:					
Frequent urination(I)	0	1	2	3	4
Urine leakage related to the feeling of urgency(I)	0	1	2	3	4
Urine leakage related to physical activity, coughing or sneezing(I)	0	1	2	3	4
Small amounts of urine leakage(S)	0	1	2	3	4
Difficulty emptying your bladder(OD)	0	1	2	3	4
Pain or discomfort in the lower abdominal or genital area(OD)	0	1	2	3	4

VOIDING DIARY

PHYSICIAN NAME: _____

REFERRING PHYSICIAN: _____

PATIENT:

ADDRESS:

TEL.:(W):

TEL.:(H):

DAY 1 DATE: _____

DAY 2 DATE: _____

DAY 3 DATE: _____

	TIME	VOL mL/S/A/L	LEAK S/A/L	PROTECTION
day				
night				
TOTAL				

	TIME	VOL mL/S/A/L	LEAK S/A/L	PROTECTION
day				
night				
TOTAL				

	TIME	VOL mL/S/A/L	LEAK S/A/L	PROTECTION
day				
night				
TOTAL				

T = total **S** = small **A**= average **L** = large

SEE REVERSE FOR INSTRUCTIONS

The form can be folded, but most importantly, remember to return it to your doctor.

INSTRUCTIONS

VOIDING DIARY

This voiding diary is one of the most important tools to help you and your doctor better define your condition and therefore choose the best possible treatment. Please complete this voiding diary as accurately as possible for 3 consecutive days (day and night). Return the completed sheet at your next appointment.

HOW TO COMPLETE THE DIARY

1 Record the time you went to the bathroom and amount of urine voided in mL (or oz). (Any graduated container can be used to measure the amount of urine output).

2 In some situations, for example when shopping or at a movie, it may not be possible to measure the amount of urine output. In these circumstances, record the time you emptied your bladder and specify whether the volume was small (S), average (A), or large (L).

3 If you lose control of your bladder involuntarily (incontinence), record the time that the incident occurred and mark in the appropriate column whether the volume leaked was small (S), average (A), or large (L).

4 If you experience leakage and need to change your protective product or your underwear, mark an X in the protection column and record each time you have to change protective product or underwear.

EXAMPLE

DAY 1 DATE:_____

	TIME	VOL mL/S/A/L	LEAK S/A/L	PROTECTION
day	6:45 am	200		
	8:30 am	300		X
	10:00 am		S	
	10:30 am		S	
	11:00 am	175		X
	12:00 pm	S		
	12:30 pm		A	
	1:10 pm			X
	2:00 pm	250		
	2:30 pm		S	
	3:20 pm	200		
	4:50 pm		S	
	5:50 pm	200		X
	9:00 pm	150		
night	1:00 am		L	X
	4:15 am	125		

Printed in Canada