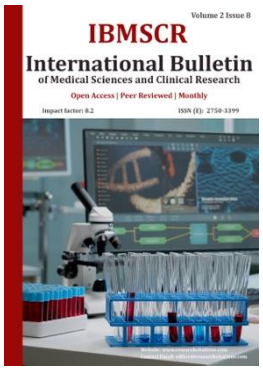

CLINICAL AND PATHOGENETIC REVIEW OF URINARY INCONTINENCE IN WOMEN WITH OBESITY

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Abstract. In women with urinary incontinence, obesity should be viewed through the lens of clinical vegetology, as it is associated with a spectrum of neurohumoral and vegeto-visceral dysregulations affecting the organism as an integrated system.

Keywords: pathology, obesity, urinary incontinence, neurohumoral mechanisms.

Relevance. Current statistical data indicate a steady increase in various neuroendocrine disorders among women, with lipid metabolism disturbances -particularly obesity- being especially prevalent. The World Health Organization's recognition of obesity as a new non-infectious "epidemic" of the 21st century highlights the urgent need for intensified attention to this health issue [1, 3, 4, 5, 8, 11, 15, 17]. Obesity is defined as a chronic, multifactorial condition that develops under the combined influence of genetic, physiological, and environmental factors [2, 3, 6, 8, 10, 13].

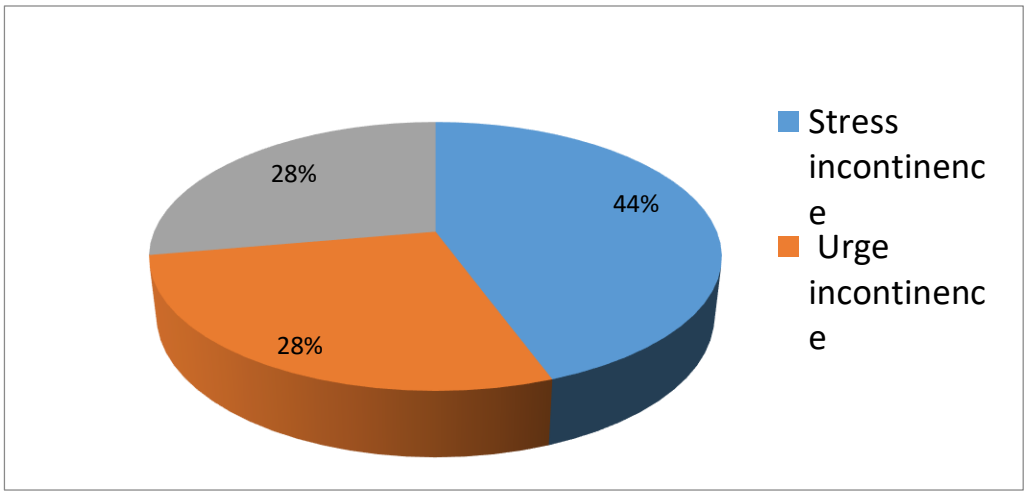

Figure 1. Distribution of types of urinary incontinence in women

In women of reproductive age, postpartum obesity frequently develops, particularly after complicated childbirth, and is predominantly related to endocrine mechanisms [1, 8, 11, 13, 14]. Excessive accumulation of adipose tissue in the anterior abdominal wall, resulting in an abdominal panniculus, not only creates aesthetic discomfort but also contributes to functional disturbances of the gastrointestinal, cardiovascular, and respiratory systems, causes back pain, and predisposes to urinary incontinence [2, 3, 7, 16, 18]. These impairments substantially limit women's working capacity, which justifies considering abdominoplasty not only as an aesthetic procedure but also as an intervention aimed at correcting functional disorders [1, 4, 5, 15, 17].

Risk factors for urinary incontinence include childbirth (especially complicated or multiple deliveries) [7, 8, 9, 18], strenuous physical labor, obesity, varicose disease, splanchnoptosis, somatic conditions associated with elevated intra-abdominal pressure (chronic cough, constipation, etc.), previous pelvic surgery, and neurological disorders.

Approximately 40% of cases represent stress urinary incontinence triggered by increases in intra-abdominal pressure; around 25% correspond to urge incontinence caused by imperative urges, and another 25% are mixed forms [3, 6, 8, 10, 12, 16, 17, 18].

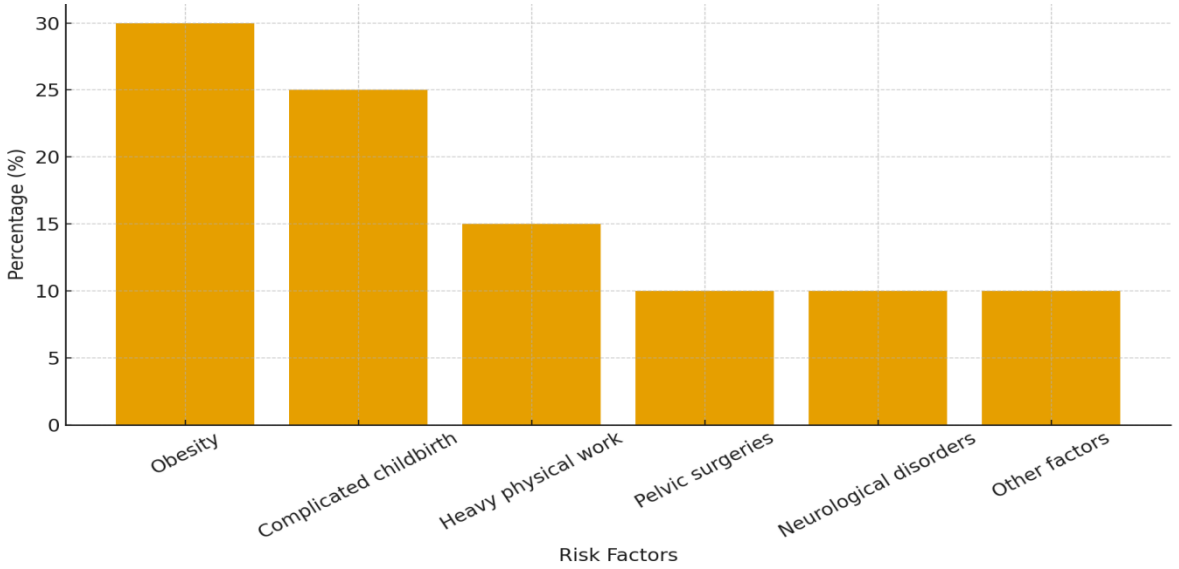

Figure 2. Distribution of risk factors for urinary incontinence in obese women.

It has been established that dysfunction of autonomic regulation of visceral organs, together with alterations in endocrine activity, plays a significant role in the development of urinary incontinence [8, 11, 14, 16]. Estrogen deficiency during the climacteric period constitutes a critical factor influencing the structure and biochemical properties of connective tissue. Recent studies, including paraurethral biopsy data, demonstrate marked differences in the connective tissue of continent women compared with those with true stress urinary incontinence—both in collagen quantity and its qualitative features. It is assumed that in women with genetically compromised connective tissue, estrogen deficiency accelerates degenerative changes, impairing urethral support mechanisms and contributing to stress urinary incontinence during menopause [5, 6, 9, 10, 12, 18].

Conclusion. From the standpoint of modern general pathology, obesity in women with urinary incontinence should be viewed as a condition associated with a constellation of neurohumoral and vegeto-visceral disturbances that affect the body as an integrated system.

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