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Sullivan M, Yalla SV

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**Functional Studies to Assess Bladder Contractility**

M. Sullivan, S. V. Yalla


Bladder contractility refers to the intrinsic property of bladder smooth muscle to contract at a given length and intuitively represents not only the strength of the detrusor contraction, but the ability to adequately sustain a contraction. Suitable methods of measuring bladder contractility and approaches to quantifying these measurements are essential to accurately characterize voiding dysfunctions. Numerous techniques for functionally assessing bladder contractility, based on established biomechanical principles, have been described and thus the choice of methodological approach should be determined by the goals of the evaluation. 

**Introduction**

Contractility is a broad physiologic term used to describe muscle performance and generally refers to the intrinsic property of smooth muscle to contract at a given length. In relation to the bladder, the concept of contractility intuitively represents the strength of the detrusor contraction, as well as the ability to adequately sustain a contraction. Numerous physiologic and pathophysiologic alterations modulate bladder contractility, including neurologic, biochemical, biomechanical, behavioral and hormonal factors. Thus evaluation of ensuing voiding abnormalities requires suitable methods of measuring bladder contractility and approaches to quantifying these measurements in order to accurately characterize voiding dysfunctions prior to initiation of appropriate management strategies.

**Bladder Contractility Assessed During Voiding**

During urination, contraction of the bladder generates both detrusor pressure and urinary flow. Accordingly, the strength of the bladder contraction is a function of the complex interplay between pressure and flow. Several clinical methods of analyses that are based on Hill’s force-velocity relationship are used to assess the ability of the detrusor to contract during a pressure-flow (PQ) study. The Hill equation describes the biomechanical hyperbolic relationship between the active force of muscle contraction and the velocity of shortening, such that any muscle contraction can be described by two fundamental parameters – the maximum velocity of shortening and isometric force. For the bladder, an analogous relationship between the circumferential shortening velocity and the isometric force. For the bladder, an analogous relationship between the circumferential shortening velocity and the isometric force. Thus WF is considered a useful clinical research tool.

Many other contractility parameters derived from pressure-flow studies have been described. Schafer introduced a simplified approach to classify contractile strength using linearized bladder output relations on pressure-flow nomograms in which the peak of the passive urethral resistance relation indicates detrusor contraction strength [4]. The Schafer nomogram can also be used to approximate the maximum isovolumetric pressure by projecting the point defined by $p_{\text{det}}$ and $Q_{\text{max}}$ towards the y-axis at an angle parallel with the linearized bladder output relation. Using the slope of this line (established to be 5 cm H₂O/ml/s), this projected isovolumetric pressure (PIP) can be calculated as $p_{\text{det}}Q_{\text{max}} + 5Q_{\text{max}}$ in men. However, this slope may need to be adjusted for different populations, since a slope of 1 cm H₂O/ml/s appears to better approximate isovolumetric bladder pressure in older women [5], and in men can vary considerably depending on the type of dysfunction [unpublished observations].

**Bladder Contractility Assessed by Isometric Techniques**

The above types of analyses require PQ studies which sometimes cannot be easily obtained, especially in the non-ambulatory frail and elderly population. Special table and equipment are required to acquire accurate PQ data in such disabled patients. Other simpler methods advocated involve isometric testing techniques in the mid-voiding phase, with interruption of flow by either voluntary contraction of the external sphincter or by sudden occlusion of the bladder neck with a balloon. Also, the velocity of detrusor contraction before voiding has been used to determine the detrusor performance. These non PQ methods have not been adequately standardized or extensively validated and are known to have certain drawbacks. The isometric detrusor contractions generated from voluntary interruption are not entirely isometric since reflex detrusor inhibition induced by voluntary contraction of the striated sphincter can result from these maneuvers. Further, this technique may be unsuccessful in certain demented patients who are unable to effectively interrupt urinary flow or cannot comprehend the commands of the
investigator and in those with myeloneuropathies who are unable to voluntarily contract their striated sphincter. While mechanical occlusion of the bladder neck during voiding may avoid the problem of sphincter induced reflex detrusor inhibition, other disadvantages are evident. For example, the timing of the occlusion of the outlet during bladder contraction has not been optimized and the potential effects of sudden discomfort to the patient that may cause contraction of periurethral musculature resulting in reflex detrusor inhibition have not been addressed. Furthermore, neither of these isometric methods provides information regarding the duration of detrusor activation.

Efficient urination requires a detrusor contraction of appropriate strength that can be rapidly attained and adequately sustained. Thus, any assessment of detrusor contractility must ideally include a characterization of each of these contraction phases. A modified method of inducing an isovolumic contraction has been introduced that involves occluding the outlet with a balloon catheter positioned at the bladder neck prior to the initiation of a voiding contraction and challenging the detrusor throughout the period of its activation [6] (fig. 1). This continuous occlusion test is applicable to the evaluation of many types of voiding dysfunction in both males and females. The maximum isovolumetric pressure ($P_{isv}$) obtained from this method has been shown to increase with bladder outlet obstruction in men (fig. 2) and with detrusor overactivity in both men and women [6–8] and to decrease with impaired voiding efficiency [9].

This method of bladder contractility assessment allows consideration of the duration of detrusor activation, an important parameter that complements isovolumetric pressure in the evaluation of detrusor contractile performance. Adequate activation of the detrusor, reflected by the duration of bladder contraction, is essential for efficient emptying of the bladder. Thus, elevated post-void residual volumes are associated with unsustained isometric bladder contractions, despite the generation of high maximum isovolumetric pressures. Previous studies have demonstrated that the duration of isometric contraction, though well correlated with voiding efficiency, is poorly correlated with maximum $P_{isv}$ [6], indicating that these two parameters characterize independent aspects of detrusor contractile performance.

Although in vitro and in vivo experimental studies in animals indicate that $P_{isv}$ decreases with increased bladder volume [10, 11], detrusor contractions are better maintained at higher bladder volumes, suggesting that bladder efficiency improves at larger volumes (approaching capacity) by generating sustained contractions of lower magnitude. In humans however, the dependence of isovolumetric detrusor pressure on bladder volume is relatively minor over a limited range of bladder volumes encompassing bladder capacity [1, 6, 12].

**Figure 1.** Schematic diagram of isometric pressure generated during the continuous occlusion test. Foley catheter is inserted into the bladder for simultaneous bladder filling and measurement of bladder pressure. From the detrusor contraction that is generated, the maximum isovolumetric pressure ($P_{isv}$), the slope of the contraction ($\Delta P/\Delta T$) and the duration that the isometric contraction remains above 50 % of its maximum ($T_{50}$) can be determined. Top tracing demonstrates strong bladder contractility while bottom tracing reflects contraction that attains a similar maximum isovolumetric pressure but is phasic and poorly sustained.

**Figure 2.** Maximum isovolumetric pressure ($P_{isv}$) in patients with voiding dysfunction. $P_{isv}$ is significantly higher in patients with detrusor overactivity (DO) and/or bladder outlet obstruction (BOO).

**Relationship between $P_{isv}$ and WF**

Assessment of bladder contractility based on pressure-flow studies have been compared with those derived from isometric testing. $P_{isv}$ has been shown to be highly correlated with maximum WF [6] and is approximately equal to 10 x WF [2]. Moreover, the behavior of these parameters with various types of voiding dysfunction has been compared. Like $P_{isv}$, WF is positively correlated with bladder outlet obstruction [13]. However the relationship between voiding efficiency and WF is less clear than with the duration of isometric contraction. WF was not shown to be correlated with post-void residual (PVR) volumes in men with bladder outlet obstruction, but WF was negatively correlated with PVR in diabetic patients [14]. In men with bladder outlet obstruction, PIP and WF were increased in those with detrusor overactivity [15], and WF in women with overactive bladder is greater than in those with normal bladder, similar to the results reported with $P_{isv}$. The diagnostic correspondence in these approaches to contractility assessment points towards the accuracy and suitability of each technique; thus the choice of approach can be determined by patient needs and the urodynamic environment.

**Non-invasive Measurement of Bladder Contractility**

To develop appropriate methods of non-invasively evaluating men with voiding dysfunction, several techniques for estimating $P_{isv}$ without urethral catheterization have been devised. This can be achieved either by placing a flexible cuff around the penis which is automatically inflated to interrupt flow [16, 17], or by using the condom catheter method in which a modified incontinence condom is fitted to the penis and attached to variable outlet resistances controlled by a pneumatic valve [18]. The concept underlying these techniques is that the pressure transmitted to the measurement site during
occlusion of urinary flow reflects the isovolumetric bladder pressure generated against a closed outlet. To measure this pressure, the bladder neck and proximal urethra must remain open with fluid in continuity from the bladder to the site of pressure measurement and the external sphincter should be in a relaxed state. Under these conditions, both of these methods have been shown to produce quantitative measures of bladder contractility that closely approximate maximum isovolumetric detrusor pressures measured invasively and represent promising approaches to the practical assessment of bladder contractile function.

Bladder Contractility Assessed Experimentally by Force and Velocity

Bladder contractility is assessed in the clinical setting using mechanical variables that are accessible and easily measured: pressure, flow, and volume. Bladder contractility has also been experimentally defined by the relationship between bladder wall force and velocity. In vitro force-velocity measurements have confirmed that bladder smooth muscle can generally be approximated by hyperbolic Hill equation derived from striated muscle. Examination of this relationship under various conditions demonstrates that increasing the stretched muscle length up to an optimum length increases maximum isometric force and alters the curvature of the hyperbolic force-velocity relationship, whereas the degree of activation of bladder smooth muscle affects the maximum isometric force, maximum shortening velocity as well as the shape of the hyperbolic curve [19].

Assuming that the bladder has a spherical shape, is incompressible and stretches equally in all directions throughout all regions, force (tension) can be related to incompressible and stretches equally in all directions

References:

Dr. Maryrose Sullivan

Dr. Maryrose Sullivan is Assistant Professor in the Department of Surgery, Brigham and Women’s Hospital, Harvard Medical School and Director of Urology Research at the VA Boston Healthcare System, West Roxbury, MA. She received a Ph.D. in Biomedical Engineering (Systems Physiology) from the University of Virginia and postdoctoral training in neurourology and urodynamics at the VA Boston Healthcare System. Dr. Sullivan’s research is funded primarily by the Department of Veterans Affairs Medical Research Service and focuses on basic science and clinical aspects of bladder and voiding dysfunction. She has authored or co-authored numerous peer-reviewed publications and chapters, and has received several awards including the Lapidus Award for Urodynamic and Neurourology Research. She also serves as a reviewer for several urology and physiology journals and is a member of the American Urological Association and Society for Urodynamics and Female Urology.

Dr. Maryrose Sullivan
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