

**Urology and Parkinson's  
with Arun Mathur**  
Davis Phinney Foundation

Melani Dizon (Director of Education, Davis Phinney Foundation):

Hi, my name is Melani Dizon. I'm the director of education at the Davis Phinney Foundation and I am here today with Dr. Arun Mathur, and he is a urologist and he's gonna talk to us about a lot of the urinary dysfunction that some people with Parkinson's experience. So, thank you so much for being with us today.

Arun Mathur, MD (Urologist and Medical Director of Surgical Program, Lake Ridge Health):  
Thank you very much, Melani, always glad to help and enjoying a nice conversation.

Melani Dizon:

Awesome. So first, can you just tell us a little bit about yourself, your work, and your relationship to Parkinson's?

Arun Mathur:

So as many people might know the last name looks a little bit familiar, and if you Google Mathur you're gonna find my wife all over the place. So Soania, my wife, was diagnosed with prostate, prostate, sorry, that's my urology side coming out, Parkinson's disease back at least 23, 23 plus years ago. And we had just started our family together, had our first kid, and she got the diagnosis and she was just starting a practice, she's also a family doctor. So that diagnosis and the journey over the last 20 plus years has done a couple things. It shaped my practice as to how I practice medicine as a whole, but it also, how should I put it? It has resulted in a lot of the primary care physicians in the area, sending their patients to me. And even though my basis was mostly oncology and stone disease and some in incontinence I started picking up a huge neurogenic bladder practice, which is diseases like MS, Parkinson's, Alzheimer's, stroke that are susceptible to urologic problems.

Melani Dizon:

Do those diseases typically have a similar manifestation around urinary dysfunction?

Arun Mathur:

Yes and no, the symptoms can overlap quite a bit and the type of disease they have, but there are some differences. For example, Parkinson's is a progressive neurodegenerative disorder. So, every step of the way you're kind of moving along the journey as the brain changes. MS is different. So multiple sclerosis is more of a relapsing remitting type of disease. So, depending on where the injury is in the nerve sheets and the nerves going from the brain to the bladder, you can go from the extreme of something we call overactive bladder where you're going to the bathroom, a lot, a lot of frequency and urgency to completely shutting down. So, there are

some differences, and stroke and these types of illnesses depends on where the injury is. So, there is some variability.

Melani Dizon:

Interesting. Okay. So, I'd love to get started by digging into some of the general information about urinary dysfunction. So, when people say urinary dysfunction, what are they talking about? What are the different things having to do with it?

Arun Mathur:

So, let's break it down to a really simple level. And I like to talk in simple terms because I'm basically a plumber. So, in plumbing, you have two parts of the urinary system. You have the pump, and you have a pipe. The pump pushes water through the pipe, the pipe being the urethra in the women and the urethra plus prostate in the men, the pump being the bladder. So anytime we see any problems with the lower urinary system, anything to do with the urination, either it's a problem with a pipe or it's a problem with the pump, that's the basics. And then when you break it down further, it's either you're peeing too much or you're not peeing enough. So not peeing enough means your bladder is slowing down. The pump's not working well, and it can't push the urine through, or not peeing enough could be the pipe's starting to close down. And that could be prostate enlargement. Which you often see with men and women can have also narrowed urethra.

The other side of the coin is peeing too much. Peeing too much can have a number of reasons. A lot of us have heard of things like urinary tract infections. And we get, when we get a UTI, particularly in women, you go to the bathroom a lot, but the system requires wiring and that wiring comes in the brain in spinal cord. If that wiring has any trouble or any issues, you can get too many signals going into the bladder, which then cause the bladder to contract inappropriately when you don't want it to. And you could be sitting there watching TV and all of a sudden it's like, oh my God, I go to the bathroom badly or take that to an extreme, you barely have seconds to feel that symptoms of going to the bathroom and then woosh, the urine comes out, you drain, which is incontinence. So, urgency is that sudden desire to pee and if the urgency goes too far, too fast, you can't make it to the bathroom in time and you leak. And that can be related to problems with the wiring into the bladder. Now what's Parkinson's disease or any of these neurological conditions. They mess with the wiring a little bit. And that's where the problem occurs.

Melani Dizon:

Okay. So, when somebody is not going to the bathroom enough is it like a urinary tract infection, that feeling of, in pain? Like, I feel like I have to go, and I can't go. Or are they just not going?

Arun Mathur:

So, when you feel that have a sensation that I can't go to the bathroom, I want to go to the bathroom, but I can't go to the bathroom. There's a number of things that can cause that. It can be a wiring problem or a plumbing problem. The plumbing problem is something's blocking the tube. And usually that could be in men, at least a prostate enlargement or a wiring problem where if the wiring's being affected by some neurological condition, the bladder can't generate enough pressure. It's trying, but it just can't push the urine out. We call that a weak bladder or technically a hypotonic bladder. So, a hypotonic or low tone bladder, low electrical bladder means it just can't push the urine out, but more commonly the issue, especially where Parkinson's is often seen in the elderly, is prostate problems.

So, prostate enlargement can give symptoms of going to the bathroom a lot. Prostate enlargement can give symptoms of getting up at night to pee. When you get the urge to pee, I can't make it in time. My stream's a little bit weak. I don't have a lot of pressure behind it. When I go to the bathroom, I have some difficulty in starting the stream, I'm standing there for a few seconds to get the stream going. Well, guess what? Parkinson's can have all those symptoms. I gotta go to the bathroom a lot, more frequently. Sometimes I can't make it in time and I leak on the way there. I get up at night, multiple times to pee. I go to the bathroom. I don't have a good, solid, strong stream. So huge overlap. The challenge is completely different treatments, like completely different. One will require drugs that work on the prostate to open it up to the extreme form where you have surgery and you see on TV, a lot of these surgeries where you can open up your prostate. With the Parkinson's side, it's all electrical. It's not as much obstruction. So, with the electrical side, you need to work on the electrical activity to the bladder and that's drugs that play with those, that wiring. So, we have medications that can help there, both men and women that have urologic issues.

Melani Dizon:

Okay. So, kind of tangentially related. I know constipation is one of those things, a prodromal symptom, like lots of people look back and they say, oh, well, gosh, I had that for a really long time. Obviously didn't know it was Parkinson's at the time. Is this something that they often look back on? Or is that not a...

Arun Mathur:

Yes. A lot of patients will do that. So, I don't hear it as much in Parkinson's, but I hear it occasionally, but more so, for example, in MS. 10% of MS patients are diagnosed with urinary problems first and the urologist or somebody in the urological field will say, you know, that's little odd that your symptoms and they'll notice some other like tremor or some other symptom. It's like, you know, you should get checked for neurologic problems like MS. And I've had a number of patients where I've picked up their MS or Parkinson's because they've been sent to me primarily their biggest concern is urinary problems. You know, it's, if I send you somebody with high blood pressure, what's gonna be their symptoms. Nothing. Who knows when their pressure's up, you know, unless a doctor measures it and tells you, even though it's a very serious life threatening condition, nobody really senses high blood pressure.

So, people don't have much regard for it, except, oh, I gotta take the pills because my doctor told me, or cut back on salt. Urinary problems may not be life threatening, but they are massive when it comes to quality-of-life issues. And they have huge impact to the individual, to the point that people start watching where they go, watching what they wear, black outfits particularly the women, because you don't want that stain showing because you have that sudden urge to pee, you can't make it, and you leak especially the Parkinson's patients. So, where you go, what you do, what you eat and drink is modified. And all these people are often dehydrated chronically because they don't wanna have the urinary issues. So, the impact on QL scores and quality-of-life scores is traumatic. It's beyond diabetes, depression, high blood pressure, many illnesses, which we all think of very serious illnesses, incontinence and urinary issues sits above them. Cause you pee every day, multiple times a day.

Melani Dizon:

Yeah. I was talking to one woman, and she said my first job ever, where I travel is where are all the bathrooms? I map it out. I've got it with me. Like I never go somewhere without knowing, and I know how much time I'm gonna be in between. And I'm like, oh gosh, like that just seems like a, that's a lot. Right? That's a lot to have to worry about when they're already doing the other things anyway. Right?

Arun Mathur:

Exactly. And you know, watching what you eat and drink, where you go, the mapping out is you know, you don't need Google maps. These people map everything out. They tell you exactly where the bathroom entrance is, timing, and you have to, because you know, there there's the visual side of it. When you see that, oh, I leaked a little bit or something I have incontinence and the smell side of it that people are extremely aware self-aware of the smell if it leaks, even when you have pads on. Then there's the financial cost. I mean, there's a huge cost in pads. People don't realize how expensive incontinence pads are and especially the elderly, which may be on a limited budget, it really starts adding up. So, we really do need to spend more time at you know, some of the non-motor symptoms, particularly the incontinence side, which is kind of just brushed under the table, well you're getting older.

Oh, you're a male. It's probably your prostate. You know, maybe you get a chance to go see a urologist or some other excuses are used to kind of just brush it aside because we focus on the motor symptoms a lot. And some of the higher profile non-motor symptoms. You know, incontinence and urinary issues, it's not a hot topic. But one thing I do talk to people about when it comes to this, when you look at treating it is expectation management and that's really important. Too many people watch TV and they see the ads of some fancy new drug and this wonderful couple walking down the street and life is perfect. Drugs don't work like that. And so, people come in with the expectation like they're gonna be peeing like they're 20 years old again. It can't happen. But if I have somebody going to the bathroom six times at night, and

that's very common for Parkinson's patients, five or six times a night, I may not get them to sleep through the night.

But if I can go from five to six down to once or twice, you'd be shocked at how less tired there in the daytime, how much more bright and more energetic they are. And as we all know, a lot of the dopamine is regenerated through sleep, REM sleep, you don't hit REM sleep long enough, you're not regenerating what limited dopamine reserves you have. And so, it's important to get that sleep. So, if you can even go from six times down to three or four times, to me, that's a win. And I tell people, manage your expectations, make sure you get the treatment. And if you have reasonable expectations, you'll be happy with the results.

Melani Dizon:

Yeah. You said, you know, it's not the hottest topic. It's interesting, right? It's not, unless it's your problem, and it's the only thing you think about. I mean, I just have some people that that is the thing they email me about all the time. So, let's talk a little bit about when, so people with Parkinson's are dealing with a lot of issues. When does it make sense for them to say this is, you know, this is beyond normal dysfunction, normal incontinence, when should they go see a doctor?

Arun Mathur:

So, I think the important thing there is to realize there is no exact normal, your normal Melani will be different than my normal. And so that's first realization. So then is any of this dangerous? There are a few select circumstances where there can be problem if it's a significant prostate issue and maybe you want to get it checked a little sooner, but check with your family doctor. But the biggest thing is when your quality of life is being compromised. So, I have patients that come in, I'll give you a great example. I have younger patients that come in and they'll say to me, you know, doc I get maybe once every four or five days, I get a little squirt of urine in my underwear and pad. And it's horrifying. I'm a lawyer or I'm a dentist or I'm a teacher and I'm afraid somebody's gonna smell it.

So, you gotta fix this. You really have to fix it. Then the opposite, somebody, 80 years old, home, bedridden, maybe have some arthritis. They don't go out much. Bathroom's right down the hall. And they say, yeah, I get up eight times a night. I go right back to sleep. I nap in the daytime. It really is not a big deal for me, bathroom down the hall. I don't travel much. I've got a lot of arthritis, two completely different scenarios where one person, it didn't affect them enough to justify getting treatment. The other one you would definitely say, well, that's not really very much leakage, but it's enough in their quality of life. They wanna get a change. So, when you are, when it's really affecting you and what you're doing day to day, whether it's your clothes you wear, the food you drink or the amount of fluid you drink or the traveling you're doing and you're not happy with it, get it checked, get it fixed.

Melani Dizon:

Right. That brings up another question. In your practice, have you seen that this issue is more prevalent in people who may have early onset Parkinson's versus later onset? Does there seem to be any pattern?

Arun Mathur:

More later onset. So, younger individuals one, they have more compensatory capability. Their bodies are younger, so their bladders can compensate. They're also more active, more spry, and they themselves can manage their life a little bit easier. Older individuals are dealing with, like I suggested an older prostate or an older bladder. So aging, male or female, can give a lot of these urinary symptoms. I see people without Parkinson's coming in with the same symptoms. So, when you have somebody coming in at 65 or 70 years old with these urinary symptoms, it won't be a hundred percent aging and it won't be a hundred percent Parkinson's, it'll be a mixture of both. So, both are interacting. So, they tend to notice it more. It bothers them more and it's hard for them to compensate. You know a younger individual can manage a little bit better with it.

Melani Dizon:

I read somewhere that around 30 to 40% of people with Parkinson's have some sort of urinary dysfunction. How does that compare to the general population?

Arun Mathur:

So, it's, these particular type symptoms, it is higher than the general population. But that is also what's reported. You have to also realize incontinence is not a sexy disease. You know, heart disease, people tell you right away their issues, diabetes and stuff like that. Hot news. It's a topic that's discussed quite a bit, but I find a lot of people, you know, sweep these symptoms under the bed and just don't wanna, under the carpet, and don't wanna talk about it until things get really, really bad. So, I think those numbers are actually quite a bit under reported. And we see that also in the general population, not just Parkinson's patients. We're still just starting to get more clinicians and the multidisciplinary teams that are starting to recognize as you know, Melani, the non-motor symptoms have been kind of put on the wayside for the longest while, as we've been struggling with dealing with the motor symptoms and finding cures in that area. And it's only recently in the last five to 10 years, we're placing more emphasis on non-motor. So yeah, we didn't pay a lot of attention to it, but we are now realizing how impactful it is to quality of life for these patients.

Melani Dizon:

Right. So, can we talk a little bit about some of the treatments, whether pharmacological or non-pharmacological for people?

Arun Mathur:

So, you know, the first thing right off the bat, you go non-pharmacological right off the bat, and that would be lifestyle issues. The list is massive. Right off the bat, alcohol and caffeine, two

things that really irritate the bladder and they really accentuate these symptoms. So, I tell people alcohol and caffeine, switch over to decaffeinated products and then alcohol, try to cut back as much as you can. Other things is trying to work your schedule a little bit, try to cut back on fluid intake late in the evening. So, after about 5, 6, 7 o'clock drink up a lot earlier in the day when you can easily get to the washroom so that you're not getting up through the middle of night going to the washroom. So, there's a lot of these types of lifestyle changes that I tell people they should look at trying to improve their quality life. Many people...

Melani Dizon:

Does exercise help with urinary dysfunction?

Arun Mathur:

Huge. So, let's throw that into the mix, especially in females. So, in females, as you know, many women can get stress incontinence having had previous children, as we get older things kind of sag a bit, and as the tissue sags and having previous children, you get leakage from coughing, sneezing, these activities. We know in men and women, by tightening up the pelvic floor, you can tighten up the musculature down there and helps with the incontinence component, thus, so the urgency component, but the leakage component and there's these things called kegel exercises. You can Google it anywhere. People have a lot of crazy ideas, what part they move. And it's hard to point to say, that's the muscle you gotta move. But you know, if I could be a little bit blunt, if I wanna help people, if anytime you have to pass wind or have a bowel movement or pee, and you wanna stop either of those three things, the muscle you use to stop it, that's the muscle. We want you to squeeze and we recommend squeeze and let go 10 times every hour on the hour, while you're awake. Just sitting there, watching TV, having popcorn, squeeze and let go 10 times. And that's called kegel exercise and that tightens up the pelvic floor. So, exercise is definitely, is very important.

Melani Dizon:

Great.

Arun Mathur:

And the next level is medication. And then we have a level above that which gets into, let's call them surgical treatments or other treatments. The way in more extreme cases, we can even stimulate the nerves ourselves. So, you know, you hear about DBS where we stimulate the nerves in the substantia nigra of the brain. So, we have pacemakers that we can actually put underneath the skin, near the bladder and send a wire to our spinal cord and stimulate the nerves going to the bladder to control how much overactivity is happening. We kind of shut it down and we can control it with a little app or whatever in your phone. So, there's a lot of technology in how far we can go with controlling this.

Melani Dizon:



Does DBS tend to have any impact on people's urinary dysfunction because it is impacting their signals?

Arun Mathur:

It can, in some cases...

Melani Dizon:

I mean, obviously it's not gonna be a reason you get it, but...

Arun Mathur:

So, there've not been enough big clinical trials, more anecdotal and case report type data out there. So, it can anything that affects the nerves up there. But Parkinson's has two levels. It's more of an upper motor neuron lesion. So, it's up in the higher end. Bladder also has its own little pacemaker down in the lower part of the spinal cord. So, people, for example, have spinal cord injuries, they can still empty their bladder and their system's still functioning. You think, well, the wiring for the bladder for the brain's gone, because it's been cut because an injury, but there's almost like a second brain, the bottom part of the spinal cord is autonomous and works on its own. But DBS in very select cases can improve. But as we've seen with DBS, there's a handful of things that it definitely improves. And there's a list of things that it's dependent, person to person, depending on where those electrodes are sitting and this person might notice, wow, that symptom really improved dramatically. And the next 10 people, nope. Didn't notice any improvement with it.

Melani Dizon:

Okay. So, questions about medication. So, one of the questions that I received from one of our readers is that it was, she had really bad incontinence and there were several things going on, but under the supervision of her movement disorder specialist, he took her off the carbidopa levodopa and her symptoms got better. Her urinary symptoms got better. The reason why he took her off though was because she was actually re-diagnosed with atypical Parkinsonisms, not Parkinson's so that wasn't sort of helping her in the way that it needed to help her anyway. But she said, the also result was that her urinary incontinence was better. So, is that a common thing with carbidopa/levodopa?

Arun Mathur:

No. It's not common with it, but you're mixing two things. So, you've got an atypical situation. So that in itself is a problem. So, the atypical Parkinsonism type situation, which is not true, Parkinson's in the sense that we think of it. So that's affecting the wiring very differently than your classic Parkinson's where it's the substantia nigra and dopamine and all that sort of stuff. And you can get, and that also you have the vascular Parkinsonism type situations and so on. So, in that circumstance, her urinary symptoms were probably not directly tied to that like you would have it tied to a Parkinson's patient. And then you couple that by taking a drug, which is not gonna help that condition. So yeah, you can get some abnormal side effects. So, you are



playing with dopamine, which is a very powerful neurotransmitter. So, I think the key point there is that probably was not the right diagnosis and then therefore having the wrong treatment.

Melani Dizon:

Okay. So, let's talk a little bit about medications. What are some of the first line medications that you use as maybe people are on just sort of Sinemet or they're on a dopamine agonist, is there a difference in what you try first?

Arun Mathur:

So, you mean for bladder issues?

Melani Dizon:

Right.

Arun Mathur:

So there are two major classes of drugs and one is a more tried and proven class called anticholinergics. And these drugs play with a certain set of nerves that actually go down into the bladder. And what they do is those nerves when they fire too much will cause the bladder to contract. So, when you and I go to the bathroom to pee, those nerves are firing up, the bladder contracts and pushes the pee out. In Parkinson's patients, these nerves are firing inappropriately when they shouldn't be. And so, what happens is we use a drug called an anticholinergic drug, which shuts those nerves down. Problem is, is that same set of nerves goes through multiple parts of the body, in particular, our eyes, our stomach, and our mouth, for example, salivary gland.

So, the drugs we use will then start affecting those areas. So, they can cause blurred vision, dry mouth, and stomach upset, okay, and dry eyes, to name a few things. So, when it starts to have these side effects, that can be a little bit problematic. So, be a little bit cautious, but they're very potent drugs. The second class plays with a different set of nerves. So, it doesn't affect those body parts. So, the side effect profile's really good, probably not as strong as the first ones I mentioned. So, I will usually start with that second one, not as powerful, but virtually no side effect. They're called beta-3 agonists. If I get good control, fantastic. If I don't, I'll add one of the other drugs at a lower dosage. So, I get less side effects combined with this one that has no side effects at higher dosage and mix the two of them together and try to get the symptoms under some degree of control.

Melani Dizon:

Okay.

Arun Mathur:

We also have above that, something called Botox injections. So, it's classic Botox, which you think of for wrinkles and whatnot, exact same Botox we can inject into your bladder. And what we do is, the bladder's a muscle, with a lot of muscles in it, and we'll shut down a certain percentage of the muscles and let the rest of the muscles contract. But by doing that, we can cut down a lot of those overactive bladder urgency and incontinence symptoms. And that works for about nine months. So, every nine months you have to come in and get another shot in your bladder. But it's a quick procedure through a scope. It only takes about five minutes.

Melani Dizon:

How successful is it? Do you usually use medication in conjunction with that? Or are you trying that on its own?

Arun Mathur:

You mean the Botox? Yes. So, Botox is kind of second line. So, you really want to go with the drugs. Botox works really well, but the problem is it could be too well. So, if I shut down too many of the muscles, what's gonna happen? You go into retention, you stop peeing. And as I mentioned, it takes nine months for the Botox to wear off. Like when you get Botox in your face, you have to get every six to nine months. Same with the bladder. If I give too much or the bladder's overly sensitive to the Botox, you can't pee. Then we have to put a catheter in or teach you how to catheterize yourself to empty your bladder for the next nine months. Because the Botox wears off. So, some patients are like, whoa, even though it's a really rare side effect, I don't feel comfortable with that. And they don't wanna go down that pathway, but the people that do go down, like in 23 years in practice, I honestly can't remember a single patient that's gone into retention, maybe one over the years. It's pretty rare.

Melani Dizon:

That's great.

Arun Mathur:

The key is not to put too much in there. That's the key. But the effect, the improvement is dramatic. But we do that Melani, after we've tried the drugs, if the drugs don't work, that's kind of the next tier up.

Melani Dizon:

Yeah. So, let's go back to that catheterization, because some people have talked to about self-catheterization that they actually were trying before drugs. So, can you talk a little bit about that? What does that involve and what stage do you ever recommend something like that?

Arun Mathur:

Well, self-catheterization is more for the individuals that's having trouble emptying the bladder. So, if you can't empty the bladder yourself, we will use self-catheterization, teach you how to catheterize yourself. Both male and female do it, a little bit easier in the female population. And

essentially you carry like these disposable catheters in your purse. We have a nurse that comes to your house. She'll teach you how to do it. It's literally like half hour, an hour teaching. Sounds kind of ickier than what it really is. Most people that when they get used to it, they're happy with it because it empowers them to have control of their bladder. The biggest thing is if you can't empty your bladder, you're either relying on other nurses to help you. You have to have a nurse come in to catheterize you a few times a day, which means you're stuck in the house or you're not too bad most of the time and then suddenly one day things are plugging up or not working very well.

Oh God, I gotta go to an emergency department. I gotta wait X number of hours for a doctor to see me and et cetera, et cetera. This empowers you to go out and do whatever you want. And if you get in any trouble, you can take care of your trouble where you can slip into the bathroom because in your purse or your handbag or in your pocket, you have a catheter in the supplies, you zip in, empty your bladder, and you carry on with your day. Particularly people who travel, you know, and we know a lot of people sitting for 6, 7, 8 hours on a transatlantic flight can get into urinary trouble like that. It allows them to control their bladder themselves if they have to.

Melani Dizon:

So, they do what they need to do. They go to the bathroom and then they dispose of that right away.

Arun Mathur:

Yeah. You can buy, there's two ways. Some people find the cost prohibitive. You can clean the catheters. They can be reused. They're designed for being disposable.

Melani Dizon:

They're designed for a one-use kind of thing.

Arun Mathur:

One use type of thing. But you know, it's just a piece of plastic. So, if you clean it properly, you're perfectly fine to use it again if you do it properly.

Melani Dizon:

Okay, great.

Arun Mathur:

But it gives, brings control back in your hands. When you have a disease that is all about losing control, anything we can do to bring that control back into the patient's hands, any aspect of their lives, not just incontinence, but other aspects I think is empowering and very important.

Melani Dizon:

Yeah, absolutely. Is there anything I haven't asked about that I should, or that your patients are asking about that?

Arun Mathur:

The biggest thing I think is, it's very easy, a lot of the neurologists don't have a lot of background in urinary issues. So, they'll often refer them to the urologist and say, you know, go see the plumbing guy and get it looked at. The important thing is the men, the male population, we have another variable on the side, that's your prostate. So, you can have a number of prostate problems. All the guys that will be watching this video know about that. Cause you see prostate issues on the news all the time or on TV commercials and whatnot for new drugs. So prostate issues can mix with Parkinson's issues. And then you're stuck with similar symptoms saying, okay, which one is it, and they're completely different drugs. So, people sometimes get one drug for one of those issues and it's the opposite issue.

And they're being treated for that, treated for that, and they're getting zero improvement in their quality of life. And they're getting frustrated with their urinary symptoms, and nobody thought about, oh, maybe it's the other, so prostate patients, well maybe it's the Parkinson's causing all this, or Parkinson's patients, hey, maybe we should look at your prostate, that might be causing the issues. And in a lot of them it's both. I've had a lot of patients in men where I've gotta treat their prostate, use drugs to shrink the prostate that's causing issues, part of their is symptoms improve, but not complete. And then I think, okay, that remaining 50% of symptoms left behind is from the Parkinson's. I gotta deal with that side too, with a different set of drugs.

Melani Dizon:

Yeah. So, part of that is just being proactive and saying, wait, I'm trying these things, I'm getting some treatment, but I'm not getting relief, I need to go another step. I need to figure out if it's really what I think it is.

Arun Mathur:

Exactly. Especially when it comes to incontinence because incontinence, unlike, you know, tremors are basically Parkinson's, you know, there's nothing else really causes tremors of that type, but incontinence, millions and millions of people around the world have incontinence, urgency, and urinary symptoms on regular basis, especially when you get above 45, 50 years of age. So, it's a very common disease out there anyways, so in that circumstance, you can't assume that it's something else or you can't assume it's just Parkinson's only and just chalk it off to, oh, it's just your Parkinson's and we've tried your drugs, live with it, right. Or maybe something else like the prostate or other issues. So, it's worth sending them off to a urologist.

Melani Dizon:

Okay, great. And the last question I forgot. How long might somebody expect if they are doing the non-pharmacological interventions, they're exercising, they're cutting off their liquid intake,

they're stopping caffeine and alcohol, doing kegel exercises. How long does something like that take to be able to see a difference?

Arun Mathur:

So, each of them, it depends. So, the fluid intake, alcohol...

Melani Dizon:

Let's pretend they're doing all of them. Let's pretend they're doing all the things.

Arun Mathur:

If they're doing all them, very quick, so fluid intake and the cutting back caffeine, alcohol, all that sort of stuff, that stuff will kick in within a few days, you'll notice an improvement. Kegels take time. It's a muscle. It's no different, the pelvic floor muscles are no different than your biceps. So, you think you're going to the gym to notice a new improvement on your arms, working out, you're talking weeks, and same thing with the kegels. You've gotta go for weeks with it and stick with it. But we'll put it this way. All these things I mentioned on the non-pharmacologic side, they're cheap, because there's no cost to them, they're healthy anyways. You know, who should be drinking lots of Coke with caffeine or coffee, you know, cutting caffeine out of your diet is not a bad thing anyway you look at it. Cutting out alcohol is not a bad thing. So, all these things are healthy anyways. And any muscle, I don't care what muscle it is in body, if you can make it stronger, it's good for you. So do it, just do it anyway, you have nothing to lose out of it. It's not like taking a drug where there may be side effects or whatever. So yeah, I really push the non-pharmacologic side.

Melani Dizon:

And also they're gonna have better symptoms all around if they do those things, right?

Arun Mathur:

Yeah, just general, your general wellbeing and health is gonna be better. So yeah, I would push all that stuff right off the bat.

Melani Dizon:

Okay, great. Well, I really appreciate you talking to us. I know everyone's gonna love hearing all of this great information and actionable things that they can do right away to start feeling better hopefully.

Arun Mathur:

Anytime Melani, I'm happy to come out and talk to you guys. You guys have a fantastic organization, a lot of respect for your group. Thank you. Hope to see you sometime down in Colorado sometime soon.

Melani Dizon:



Yeah, absolutely.

Arun Mathur:

Thank you. Thank you.

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