Urinary Incontinence In Primary Care

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November is National Incontinence Awareness Month!

The Canadian Continence Foundation
Learning Objectives

By the end of the session participants will be able to:

1. Describe the prevalence of **Urinary Incontinence (UI)** in community-dwelling individuals.
2. Discuss the impact of UI on the individual/family, health care system/society.
3. List risk factors for UI:
   - Predisposing (age-related),
   - Intrinsic,
   - Extrinsic
4. List 5 types of established UI and their associated causes.
5. Name the 9 possible causes for transient incontinence and the associated acronym.
Learning Objectives Cont’d

7. Name 3 patient/client tools that can be used to prepare for the evaluation process (Prepare).
8. State 4 components of the basic evaluation of UI in primary care (Evaluate).
9. Describe 6 conservative lifestyle / behavioural interventions that are effective in the management of UI. (Action).
10. Describe situations in which you would refer for secondary / specialist management. (Action).
11. List 3 professions involved in the multidimensional management of UI and their roles (Action).
Outline

- Definition of Urinary Incontinence
- Prevalence and significance
- Causes and risk factors
- Types
- Assessment and management strategy for primary care: “Identify, Prepare, Evaluate, Action”
- Case studies
Definition of UI

“The complaint of any involuntary leakage of urine”

(International Continence Society)
Prevalence of UI in Canada

By population:
- 3.3 million Canadians (10 % of population)
- Gender proportion F > M (2:1) until age 80, then F = M

By location:
- Community:
  - More than half of women ≥ 45 years
  - 15 - 30% of persons ≥ 65
- LTC or housebound elderly: up to 50%
- Home Care population: 22%
- Acute care medical admissions: 20%

UI – Putting it in a Canadian Perspective

† 1 in 5 community-dwelling women reported that UI affected normal daily activities
† UI is the most common cause of admission to Long Term Care facilities
† Compared to continent individuals:
  ▪ More frequent visits to physicians
  ▪ Spend more time in hospitals and nursing homes

The Costs of UI in Canada

Individual

- Physical/Psychological – “reduced wellness”, depression, embarrassment, social isolation, side effects from drugs
- “Consequence costs” – falls, fractures, skin breakdown
- Financial Cost
  - UI supplies not covered by health insurance or private insurance - $1,000-$1,500 per year (seniors fixed incomes)

The Costs of UI in Canada

**Individual**

**Spouse / caregiver / family**
- Share the burden - social isolation, financial
- High caregiver demand - burnout
- Main cause of admission to LTC – guilt
- Loss of intimacy, sexuality

The Costs of UI in Canada

Individual

Spouse / caregiver / family

Society

- Loss of productivity, absenteeism, presenteeism
- Professional and diagnostic expenditures
- Drug expenditures
- Surgery expenditures – increasing cost
- Hospital and LTC expenditures – nursing, supplies, laundry
- LTC - $3000-$10,000 per person per year for supplies and nursing care
- LTC total: $1 Billion per year

UI in Canada – Future Crisis

- Total direct and indirect costs presently $2.5 Billion / year.
- With Canada’s aging population and an increasing prevalence of UI with age - incontinence likely to become an increasing burden.
- Can be better managed!
  
  “Urinary incontinence can be resolved, better managed, or better contained in 100% of people affected.” (Borrie, M.J. & Valiquette, L. (2002). Managing adults with urinary incontinence: clinical practice guidelines. Canadian Family Physician. 48, 1.)
UI – Barriers to Receiving Care

✦ Under reported
  - Survey of Canadian family physicians (2002):
  - Fewer than half asked their patients about UI
  - Fewer than 50% of individuals report UI to their physician
  - Canadian Urinary Bladder Survey (CUBS): only 26% with bladder problem had seen a health care professional.

✦ Underfunded – health plans (drugs, supplies)

✦ Lack of access to resources/information

✦ Lack of access to skilled clinicians (Survey 2002)
  - Only 46% reported clear understanding of UI
  - Only 38% had organized plan for UI
  - Only 35% felt very comfortable dealing with UI
  - Long wait time to see specialist (> 6 months)
The Bladder

UI Causes

+ Not a normal part of aging
+ Loss of urine control due to a combination of
  - **Predisposing factors:**
    - Age-related changes
  - **Intrinsic factors:**
    - Genitourinary pathology
    - Comorbid conditions
  - **Extrinsic factors:**
    - Lifestyle and behaviours
    - Medications
    - Environmental obstacles

UI Causes: Age-Related Predisposing Factors

↑post-void residuals
↑nocturia:
(↑ urinary output later in day, ↓ ability to postpone void, ↓ time between voids)
↓ urine concentrating ability
↑ involuntary detrusor contractions
↓ detrusor contractility

↓ bladder capacity
↓ urethral compliance
↓ maximal urethral closing pressure
↓ flow rates
↓ estrogen loss – weakness of pelvic muscles

↑ urethral resistance

UI Causes – Intrinsic Risk Factors

Genitourinary conditions:
- Atrophic vaginitis & urethritis (inflammation of the vagina and outer urinary tract due to the thinning and shrinking of the tissues, as well as decreased lubrication – all due to a lack of estrogen).
- Benign Prostatic Hypertrophy

Comorbid conditions (1/3 have multiple conditions):
- Depression
- Stroke, Parkinson’s Disease, TIA, or other neurological injury or disease
- Dementia (moderate to severe)
- Arthritis or impaired mobility
- Diabetes, Obesity, CHF, COPD, Chronic cough
- Constipation
- UTI
UI Causes – Extrinsic Risk Factors

**Lifestyle:**
- Insufficient fluid intake
- Excessive caffeine
- Alcohol
- Smoking
- Physical activity - high impact, heavy lifting, straining
- Poor bowel habits

**Medications:**
- Diuretics, etc

**Environmental:**
- Bathroom obstacles / mobility issues
Types of UI

- Transient
- Established
  - Stress
  - Urge
  - Mixed
  - Overflow
  - “Functional”
Transient UI

- Precipitated by reversible factor (may include functional causes)
- 1/3 community dwelling individuals
- 1/2 hospitalized aged patients
Transient UI - Causes

- D Delirium
- I Infection
- A Atrophic Vaginitis & Urethritis
- P Psychological
- PP Pharmacologic agents
- E Endocrine, Excessive U/O
- R Restricted mobility
- S Stool impaction
Transient UI - Pharmacological Mechanisms

- Reduced awareness
  - Sedatives
- Polyurea (large volumes)
  - Diuretics, Alcohol, Caffeine
- Depressed detrusor activity with urinary retention and overflow incontinence
  - Opioids
  - Calcium channel blockers, Anti-Parkinsonians, Anti-cholinergics
  - Prostaglandin inhibitors
- Increased detrusor activity
  - Cholinergics (donepezil)
- Altered urethral tone
  - Increased leading to retention and overflow (alpha-agonists)
  - Decreased leading to stress incontinence (alpha-antagonists)
Prevalence by Type of Established UI

Stress Incontinence

- 50% of female and 25% males with UI have Stress UI
- Impaired urethral closure due to insufficient pelvic support, sphincter opens during bladder filling
- Leaking associated with ↑ intra-abdominal pressure: cough, sneeze, etc.
Urge Incontinence

- Detrusor overactivity with uninhibited bladder contractions
- Unpredictable, abrupt urgency, frequency, variable volumes lost, Post Void Residual usually normal
Mixed Incontinence

- Features of both urge and stress UI
- Common in older women
Overflow Incontinence

- Detrusor under-activity and/or outlet obstruction
- Continuous small volume leakage
- Dribbling, weak stream, hesitancy, nocturia
- Outlet obstruction = 2nd most common cause of UI in males (elderly men with enlarged prostate)
- Detrusor under-activity → urinary retention & overflow incontinence in 12% F; 29% M
Functional Incontinence

- Unable or unwilling to toilet due to physical impairment, psychological or cognitive dysfunction, environmental barriers
- No underlying GU dysfunction
- Diagnosis of exclusion
Principles of UI Management in Primary Care

- Establish type/cause of UI and treatment plan
- Identify complex cases or serious conditions for specialist referral
- Allow sufficient time for education in lifestyle modification and behavioural techniques in order to have impact on symptoms (may require referral to another professional)
- Lifestyle and behavior modifications alone may completely resolve UI or significantly improve it and the individual’s quality of life
Framework for UI in Primary Care

“An adequate evaluation [of UI] may take 2 to 3 visits. The first visit may involve a full history [PREPARE], the second a physical examination (including a pelvic examination for women and a measurement of post-void residual urine volumes with a catheterization) [EVALUATE] and … a third visit to review management strategies [ACTION].”

Case Finding

Identify

“Do you have any problems with involuntary loss of water/urine?”

If “yes”:

- Discuss evaluation process
- Discuss goals / expectations of treatment
- Give “Prepare” forms to complete for return appointment
Patient Self-Report Tools

Review at follow-up visit:
- **International Consultation on Incontinence Questionnaire (ICIQ-UI) or Incontinence Impact Questionnaire (IIQ)**
  - Baseline measure of impact on quality of life
- **Incontinence Patient Information Form**
  - Lifestyle, habits, symptoms, medications, medical history
- **Bladder diary (7 days)**
  - Frequency, timing, and amount of voids and accidents, associated activity, amount and type of fluids, associated urgency
ICIQ - UI

<table>
<thead>
<tr>
<th>Section</th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Please write your date of birth:</td>
<td></td>
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<tr>
<td>2</td>
<td>Are you (tick one):</td>
<td>Female</td>
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<td></td>
<td></td>
<td>Male</td>
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<td>3</td>
<td>How often do you leak urine? (Tick one box)</td>
<td>never</td>
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<td>1</td>
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<td>5</td>
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<td>4</td>
<td>We would like to know how much urine you think leaks.</td>
<td>none</td>
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<td></td>
<td>How much urine do you usually leak (whether you wear protection or not)?</td>
<td>1</td>
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<td>5</td>
<td>Overall, how much does leaking urine interfere with your everyday life?</td>
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<td>Please ring a number between 0 (not at all) and 10 (a great deal)</td>
<td>0</td>
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<td>1</td>
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<td>10</td>
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<tr>
<td>6</td>
<td>When does urine leak? (Please tick all that apply to you)</td>
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<td></td>
<td>Never - urine does not leak</td>
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<td>Leaks before you can get to the toilet</td>
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<td>Leaks when you cough or sneeze</td>
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<td>Leaks when you are asleep</td>
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<td></td>
<td>Leaks when you are physically active/exercising</td>
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<td>Leaks when you have finished urinating and are dressed</td>
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<td></td>
<td>Leaks for no obvious reason</td>
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<td></td>
<td>Leaks all the time</td>
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</tbody>
</table>

Thank you very much for answering these questions.
**Patient Incontinence Impact Questionnaire**

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage.

How much has urine leakage affected your:

**Ability to do household chores (cooking, housecleaning, laundry)?**
- Not at All
- Slightly
- Moderately
- Greatly

**Physical recreation such as walking, swimming, or other exercise?**
- Not at All
- Slightly
- Moderately
- Greatly

**Entertainment activities (movies, concerts, etc.:)**
- Not at All
- Slightly
- Moderately
- Greatly

**Ability to travel by car or bus more than 30 minutes from home?**
- Not at All
- Slightly
- Moderately
- Greatly

**Participation in social activities outside your home?**
- Not at All
- Slightly
- Moderately
- Greatly

**Emotional health (nervousness, depression, etc.):**
- Not at All
- Slightly
- Moderately
- Greatly

**Does leakage have you feeling frustrated?**
- Not at All
- Slightly
- Moderately
- Greatly
# Bladder Diary

## Bladder Diary DAY 1

<table>
<thead>
<tr>
<th>TIME</th>
<th>AMOUNT URINATED</th>
<th>URGENCY?</th>
<th>LEAKAGE</th>
<th>DRINKS</th>
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<tbody>
<tr>
<td></td>
<td>How many times</td>
<td>How much</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>EXAMPLE:</td>
<td>3 times</td>
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<td>6-8 am</td>
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<td>8-10 am</td>
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<td>10-12 pm</td>
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<td>12-2 pm</td>
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<td>12-2 am</td>
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<td>2-4 am</td>
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<td>4-6 am</td>
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</tbody>
</table>

Evaluation of UI in Primary Care

- Review self-report – history, medications, impact, habits, precipitants, environmental factors
- Vitals and physical exam – general physical, abdominal, neurologic, musculoskeletal, genitourinary, assessment for fecal impaction
- Labs
  - Urinalysis with Culture and Sensitivity
  - Blood tests (Blood, urea, nitrogen (BUN), creatinine, glucose, and calcium) only if compromised renal function suspected and/or polyuria without diuretic use. ?Prostate Specific Antigen
- Other tests:
  - Post-Void Residual (bladder scanner or referral for pre/post void Ultrasound)
  - Clinical urinary stress test or provocative tests (cough, stand, heel bounce, running water)
Post Void Residual

- Volume of urine left in bladder after voiding
- Bladder scan preferred vs catheter
- < 50 - 100: Normal
- 100 - 400: Monitor until consistently less than 200cc.
- > 400cc: Needs intermittent catheterization
  - Consider referral for secondary management - cystometry, cystoscopy, and further urodynamic studies
1. Initial management – primary care
2. Secondary management - specialists
Interprofessional Treatment Options in Primary Care

- Conservative (alone may effectively resolve UI)
  - Lifestyle modifications – healthy bladder habits
  - Bladder retraining – scheduled voiding and urge control techniques
  - Pelvic muscle exercises - Kegel’s

- Pharmacological
  - discontinue or initiate drugs

- Containment devices, skin care, toileting aids
  - Pessaries, pads, disposable briefs, liners, catheters
  - Skin hygiene – liquid soap, barrier creams
  - Commodes, urinals, bedpans

- Supportive devices
  - Pessaries

- Other – referral to other professionals:
  - Social Work – financial, social and emotional impact
  - Occupational Therapy – home safety – nocturia
  - Continence Nurse or Physiotherapist – education and exercise
All UI Types – Initial Conservative Management

+ Lifestyle interventions
  - Increase fluid, decrease caffeine, alcohol and cigarettes, weight loss, diet, scheduled toileting, bowel management

+ Pelvic Floor Muscle Training
  - Individuals need instruction
  - Physiotherapist or Continence Nurse
  - Biofeedback or electrical stimulation may help technique

+ Bladder Retraining and Bladder Diary
  - Schedule and tracking of voids, accidents, pads used

+ Devices for Containment

+ Education +++
Stress UI – Management in Primary Care

- Previous conservative strategies PLUS:
- Medications – estrogen, alpha-stimulation, tricyclic antidepressants
- Referral to specialist for further evaluation if req’d
Urge UI – Management in Primary Care

- Previous conservative strategies PLUS:
- Medications – with caution in elderly
  - oxybutinin
  - flavoxate
  - tolterodine
  - TCA’s
- Referral to specialist for further evaluation if req’d
# Drugs Prescribed to Treat Urge Incontinence

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug Type</th>
<th>Typical Dosing</th>
<th>Adverse Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxybutynin ( Ditropan &amp; generics)</td>
<td>Anticholinergic/Spasmytic</td>
<td>2.5 mg twice or three times daily</td>
<td>• Dry mouth</td>
</tr>
<tr>
<td>Extended Release (Ditropan XL)</td>
<td></td>
<td>Once daily</td>
<td>• Sensitivity to light</td>
</tr>
<tr>
<td>Skin Patch (Oxytrol)</td>
<td></td>
<td>Apply patch every 3 to 4 days</td>
<td>• Blurred vision</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Dry eyes</td>
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<td></td>
<td></td>
<td></td>
<td>• Decreased sweating</td>
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<td></td>
<td></td>
<td></td>
<td>• Flushing</td>
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<td></td>
<td></td>
<td></td>
<td>• Drowsiness</td>
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<td></td>
<td></td>
<td></td>
<td>• Constipation</td>
</tr>
<tr>
<td>Tolterodine (Detroil)</td>
<td>Anticholinergic</td>
<td>2 mg twice daily</td>
<td>• Dry mouth</td>
</tr>
<tr>
<td>Prolonged Release (Detroil LA)</td>
<td></td>
<td>(4mg daily for LA)</td>
<td>• Abnormal Vision</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Sensitivity to light</td>
</tr>
<tr>
<td>Imipramine (sometimes prescribed in combination with oxybutyn or tolterodine)</td>
<td>Anticholinergic/Antidepressant</td>
<td>25-75 mg daily</td>
<td>• Gastrointestinal effects</td>
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<td></td>
<td>• Drowsiness</td>
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<td></td>
<td>• Weakness/tiredness</td>
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<td>• Dry mouth</td>
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<td></td>
<td>• Excitement/anxiety</td>
</tr>
<tr>
<td>Flavoxate (Urnspas &amp; generics)</td>
<td>Anticholinergic/ Antispasmodic</td>
<td>2.5-5.0 mg Up to four times daily</td>
<td>• Dry Mouth</td>
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<td></td>
<td></td>
<td>• Nausea &amp; Vomiting</td>
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<td></td>
<td></td>
<td></td>
<td>• Headache</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Drowsiness</td>
</tr>
<tr>
<td>Oxybutynin CR (Uromax)</td>
<td>Anticholinergic, Antispasmodic</td>
<td>10-15 mg once daily</td>
<td>• Dry Mouth</td>
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<tr>
<td>Darifenacin (Enablex)</td>
<td>Anticholinergic (selective M3 blocker)</td>
<td>7.5-15 mg once daily</td>
<td>• Pharyngitis</td>
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<tr>
<td>Solifenacin (Vesicare)</td>
<td>Anticholinergic</td>
<td>5-10 mg once daily</td>
<td>• Dry mouth</td>
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<td></td>
<td></td>
<td></td>
<td>• Constipation</td>
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<td></td>
<td></td>
<td></td>
<td>• Blurred vision</td>
</tr>
<tr>
<td>Trospium (Trosec)</td>
<td>Anticholinergic</td>
<td>20 mg twice daily</td>
<td>• Dry mouth</td>
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<td>• Constipation</td>
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<td></td>
<td>• Dyspepsia</td>
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<td></td>
<td></td>
<td></td>
<td>• Headache</td>
</tr>
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</table>
Mixed UI – Management in Primary Care

- Treat both etiologies or the dominant one
- Previous conservative strategies PLUS:
  - Medications – estrogen, tricyclic antidepressants
- Referral to specialist for further evaluation if req’d
Overflow UI – Management in Primary Care

- Previous conservative strategies PLUS:
  - Crede maneuver (men)
  - Catheterization – intermittent or indwelling

- Medications –
  - Terazosin
  - Finasteride (men)
  - Bethacoline

- Referral to specialist for further evaluation if req’d.
Specialist referral:

- Continence specialist from a variety of disciplines: Urology, Gynecology or Geriatrics, Continence Nurse
- More invasive urologic and urodynamic investigations
- Further management options when refractory to initial management in primary care:
  - Further trials of medications
  - Devices
  - Bulking agents – periurethral collagen
  - Surgery
Case Study - Helen

- 76 years old
- Healthy and active
- No chronic conditions
- Comes in for periodic health examination
Helen’s Periodic Health Evaluation Form

Identify

“Do you have any problems with involuntary loss of water/urine?”
- Yes

- Helen is interested in receiving treatment for her UI and schedules a return appointment for an assessment.

- What forms should she take with her to complete prior to her next visit?
Helen’s “Prepare” Forms

- ICIQ
- Incontinence Patient Information Form
- Bladder Diary
Helen’s Return Visit: ICIQ - UI

- Leaks a small amount of urine several times daily
- 8/10 rating of “interference with every day life”
- Urine leaks “before she can get to the toilet” and “for no obvious reason”
Helen’s Return Visit – Incontinence Form

**Goals:** “reduce daytime accidents” and “reduce night bathroom visits”

- Urine leakage for 1 ½ years, never treated
- Uses pads
- Leaks when rushing to toilet, running water, washing hands
- Once bladder full, can hold less than 1-2 minutes
- Night voids >4 times
- Feels that bladder does not completely empty
- Drinks 2 cups of coffee per day and about 4 glasses of water
- Drinks 4 oz fluid before she goes to bed
- Vaginal delivery of one child
- Does not take estrogens
- Vaginal hysterectomy and ovaries removed 24 years ago
Helen’s Return Visit – Bladder Diary

- Tracked for 7 days
- 11 accidents
- 43 voids
- 19 pad changes
Helen’s Evaluation

Medication review
- Uses 3 meds per day, none of special note

Vitals and physical exam:
- Mild OA in hands
- GU exam – atrophic vaginitis, no uterus palpated

Other tests:
- Post-Void Residual - 50 ml by bladder scan
- Urinary stress test - normal
- Provocative tests – incontinent with running water

Labs - normal
- Urinalysis with C&S
Helen’s Evaluation

What is the likely etiology?

- Stress
- Urge
- Mixed
- Overflow
- Functional
Helen’s Evaluation

What are the factors contributing to her incontinence?

- Predisposing (age-related)
- Intrinsic (co-morbidities)
- Extrinsic (lifestyle, medications, environment)
Helen’s Management Plan

Identify  Prepare  Evaluate  Action

- Helen’s goals and treatment preferences
- Lifestyle / behavioral (coffee, night fluids)
- Education
- Containment
- Follow-up / Interprofessional Care Plan
- Medication
Summary and Take Home Messages

- UI is common, treatable, and NOT a normal part of aging.
- It has an enormous impact on quality of life for the individual and family, and will have an increasing impact on Canadian society as our population ages.
- Several barriers exist to receiving effective care including underreporting to health care professionals and a lack of access to skilled continence practitioners.
- It is important to determine the type of incontinence as well as the contributing factors.
- A bladder diary is a helpful tool to assist with identifying the type of incontinence.
- In most cases, a history, physical exam, and simple tests done in primary care can identify the cause of incontinence.
Summary and Take Home Messages – Cont’d

- Although most cases of incontinence can be effectively treated with conservative approaches – lifestyle modification, pelvic exercises, and bladder retraining – pharmacologic interventions are used about 50% of the time.

- Specialists – urologists, gynaecologists, geriatricians – can provide secondary management for cases refractory to initial management. This may include further urodynamic evaluations, drug interventions, and surgical evaluations.

- Continence nurses and physiotherapists are able to provide specialty management for incontinence including further evaluation, counselling, and exercise.

- Other interprofessional team members have a valuable role in the management of UI: financial impact/adjustment counselling (SW) and remediation of environment (OT).
Resources available on www.sagelink.ca

- Algorithms for Primary Care
- Patient Forms
- Clinician Assessment Forms
- Handouts / Educational Material
- Quick Reference Materials
- Links to Other Resources
Further Resources

- The Canadian Continence Foundation [www.continence-fdn.ca](http://www.continence-fdn.ca) (guidelines, professional tools, facts, downloadable handouts, contact info for UI professionals)
- Society of Obstetricians and Gynaecologists of Canada [www.sogc.org](http://www.sogc.org) (clinical practice guidelines, articles)
- Incontinence chapter of American Geriatrics Society’s annually updated publication “Geriatrics At Your Fingertips” (online, free) [www.geriatricsatyourfingertips.org](http://www.geriatricsatyourfingertips.org)
- Practicing Physician Education in Geriatrics Toolkits - [http://www.gericareonline.net/tools/index.html](http://www.gericareonline.net/tools/index.html)
- Handouts/health information on UI
  - Women’s Health Matters [www.womenshealthmatters.ca](http://www.womenshealthmatters.ca)
  - Women’s Bladder Health [www.womensbladderhealth.com](http://www.womensbladderhealth.com)
  - Canadian Urological Association [www.cua.org](http://www.cua.org)
  - Canadian Nurse Continence Advisors [www.cnca.ca](http://www.cnca.ca)
  - Canadian Physiotherapy Association [www.physiotherapy.ca](http://www.physiotherapy.ca)
  - Canadian Women’s Health Network [www.cwhn.ca](http://www.cwhn.ca)
  - The Powder Room (overactive bladder) [www.powderroom.ca](http://www.powderroom.ca)
What is the Diagnosis?

References


