Incontinence in older women

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Urinary incontinence in older women

> 45 % women > 65 have UI

< 35% seek treatment; < 15% frail/nursing homes are formally treated

Poor physical and mental health - poor QoL

12 - 15% faecal incontinence

75% related sexual dysfunction

Significant aggravating factors = mobility, BMI, cognitive/neurological, support , family attitude

UI is a common precipitant for admission to Nursing Homes

National Incontinence Strategy (CFI) - commissioned, never endorsed or implemented

Sequential > multidisciplinary care

Not a priority in context of current women's healthcare crises

“Perceptions & Politics” of urinary incontinence

Disease

Disorder

“Right to continence”

Natural consequence of aging

Social taboos

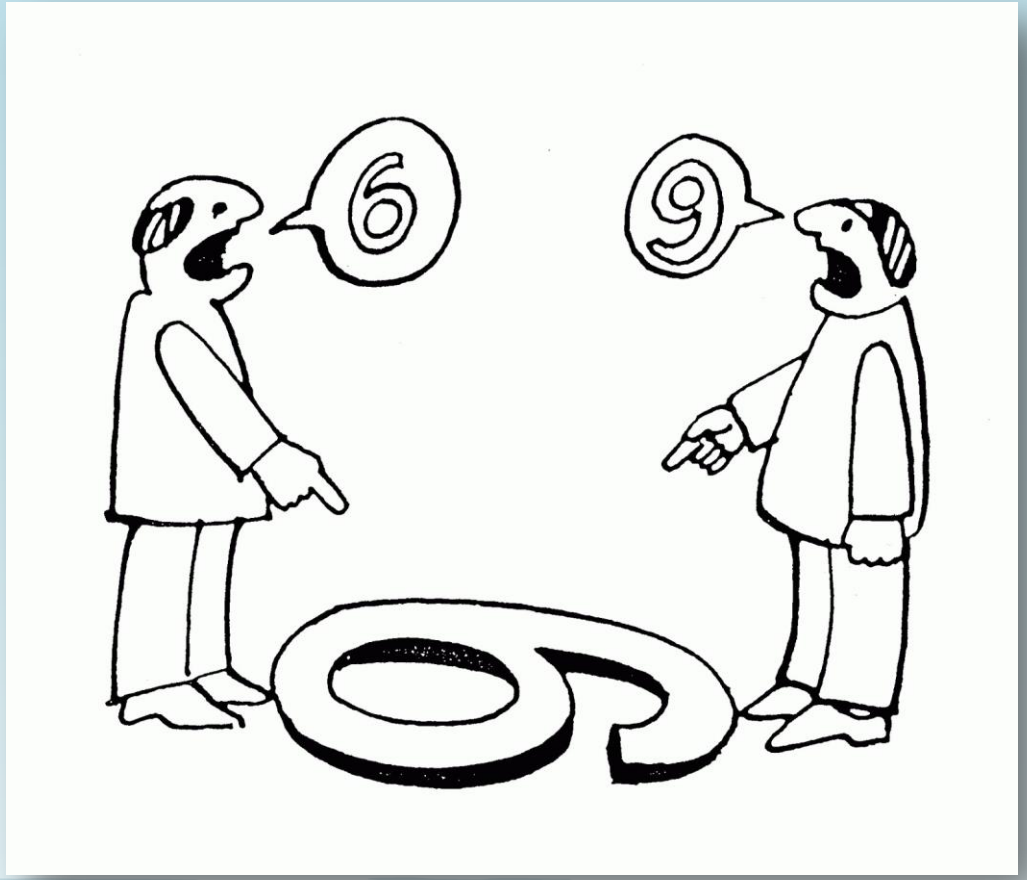
Tolerable

Nuisance

Unacceptable

Lifestyle/Health

Tip of iceberg



BBC NEWS

TENA advert criticised for 'normalising' incontinence after childbirth

05 August 2019 | UK

INDEPENDENT

News > Health

Vaginal mesh: New generation of women at risk of controversial procedure, campaigners warn

'They are so weak, they clear the way for the next generation of women to be harmed,' campaigner says

gov.ie

BETA

This is a prototype - your feedback will help us to improve it.

Publication

The Use of Uro-Gynaecological Mesh in Surgical Proecedures – Report to the Minister for Health

Published: 21 November 2018
From: Department of Health

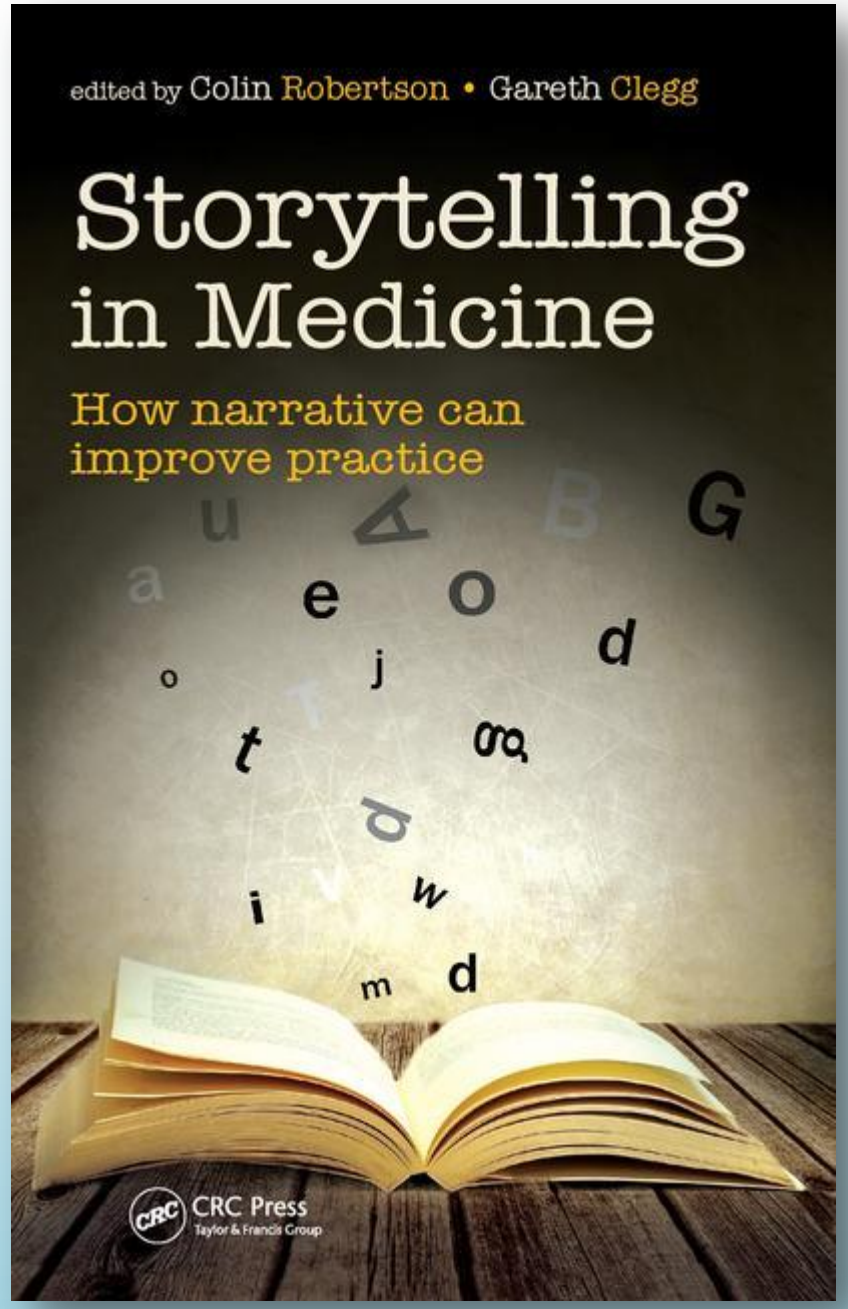

“Hell is other people.”
– Jean-Paul Sartre
June 21, 1905 - April 15, 1980
imgflip.com

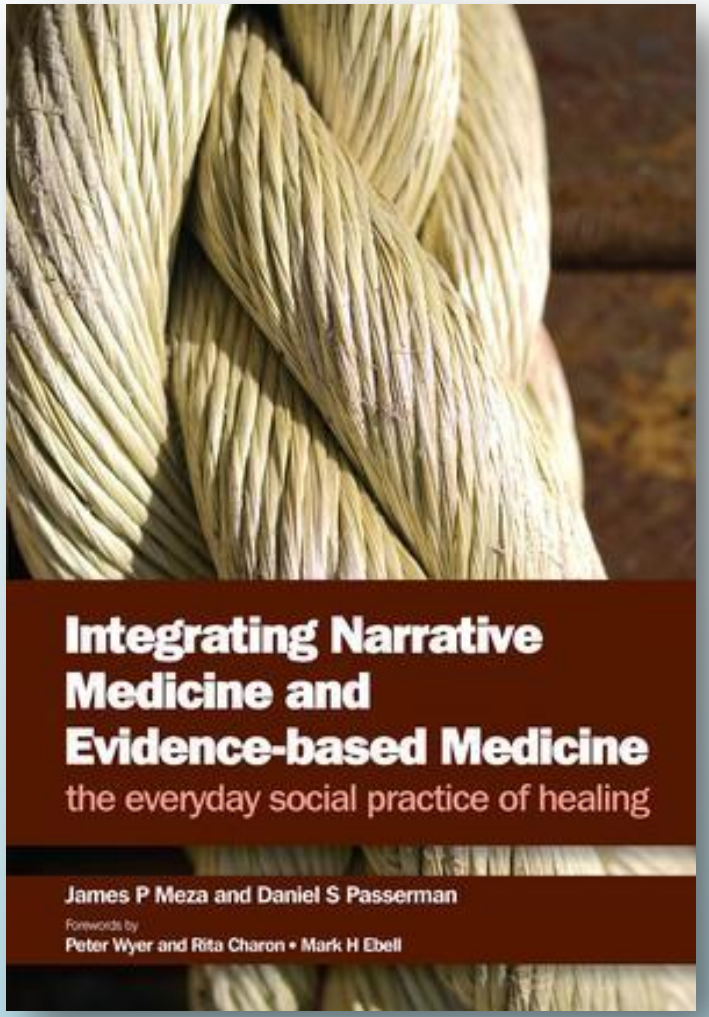

(ON SARTRE)
HELL ISN'T OTHER PEOPLE. HELL IS YOURSELF.
Ludwig Wittgenstein
Austrian-British philosopher
1889 - 1951
QUOTEHD.COM

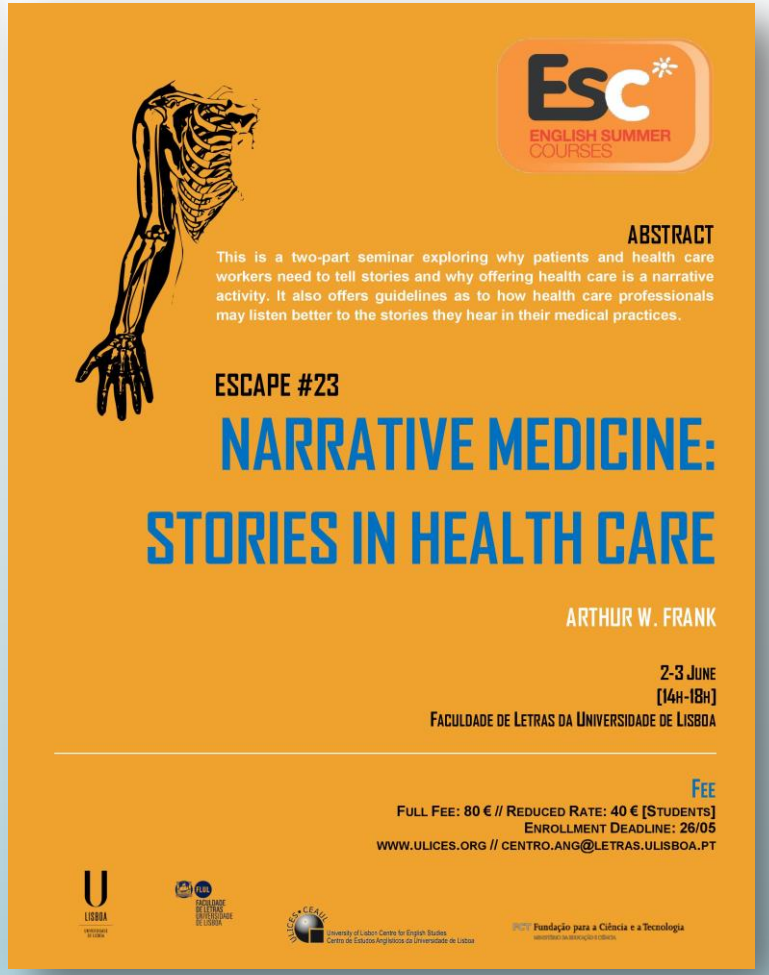
Incontinence in one older woman: narrative approach to critical review of care & services

CHRIS FITZPATRICK

COOMBE WOMEN & INFANTS UNIVERSITY HOSPITAL


edited by Colin Robertson • Gareth Clegg
Storytelling in Medicine
How narrative can improve practice
CRC Press
Taylor & Francis Group


Integrating Narrative Medicine and Evidence-based Medicine
the everyday social practice of healing
James P Meza and Daniel S Passerman
Forewords by
Peter Wyer and Rita Charon • Mark H Ebell


Esc
ENGLISH SUMMER COURSES
ABSTRACT
This is a two-part seminar exploring why patients and health care workers need to tell stories and why offering health care is a narrative activity. It also offers guidelines as to how health care professionals may listen better to the stories they hear in their medical practices.
ESCAPE #23
NARRATIVE MEDICINE: STORIES IN HEALTH CARE
ARTHUR W. FRANK
2-3 June
[14h-18h]
Faculdade de Letras da Universidade de Lisboa
Fee
Full Fee: 80 € // Reduced Rate: 40 € [Students]
Enrollment Deadline: 26/05
www.ulices.org // centro.ang@letras.ulisboa.pt

NARRATIVE MEDICINE AS A PLEA FOR PUBLIC HEALTH

On Feb. 14, 2019, *The New York Times* published an innovative essay by Eric Curran, a third-year medical student at Temple University. "I Remember the First Time I Saw a Teenager Die" combines prose and photography to tell the story of a failed attempt to save a gunshot victim. Curran includes a plea to readers to advocate for better gun control, thus demonstrating narrative medicine's potential to engage broader audiences in its social justice mission and the quest to improve public health.

Case history (35 mins SHO; 5 mins consultant)

85 years - accompanied by daughter

Referred by GP to hospital A: “urgency, dribbling, LUTIs, SCD, fullness”

Referred also to hospital B & C - on waiting list

Widow, lives alone, 7 children; 6 SVDs; CS x 1; biggest 10 ½ lbs; 1st forceps + “bad tear”

“Good health overall”; “Bladder repair” in 1980s; # dislocated humerus 2015 after “bad fall”

On Rx x 6 (solfenacin 5mg, amitripyline 10mg, nitrofurantoin 100mg)

“Good health overall; “VE not done”; no PR

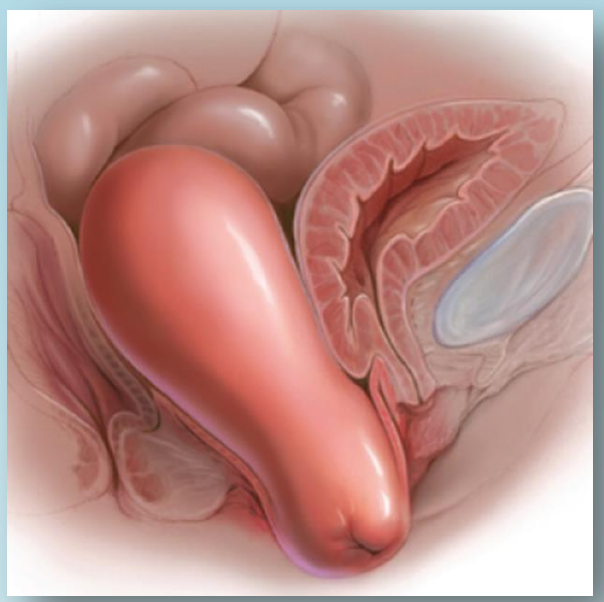
Sent appointment for 4 weeks; DNA x 2

Letter x 1 & phoned x 3 (landline only/”didn’t hear”); new appointments: 3 & 3 weeks

Had appointment for hospital B on same day; phoned - but “couldn’t get through”

“Tablets changed” - no details

GP trainee SHO - abandoned questionnaire - mainly listened



“Wet for years - since having the children/never bothered to mention”

“Worse since womb came down & infections” - few months ago

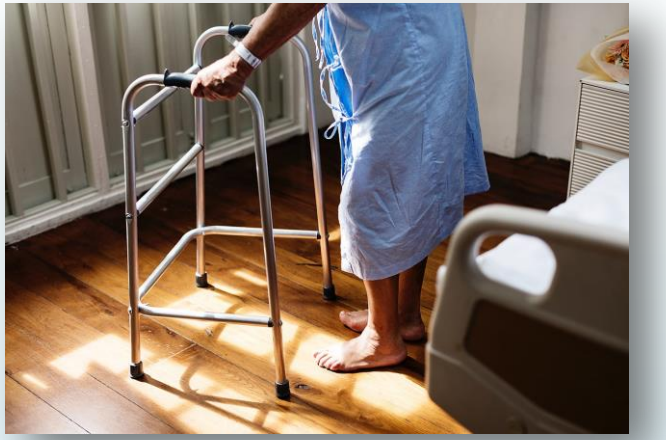
Frequency > 10/day; nocturia x 3; slow stream; incontinent ++ mainly urge/dribble

Worse in morning + at night - has “run out” of pads & incontinence sheets

Has to push up on bowel to go - no bleeding PR (no weight loss/FH of bowel ca)

Recent PVB “stains”

Rx - hasn't helped; worse with recent change of tablets (?)



Lives alone - home help 2 hours x 5 days; occasional PHN visits; sees family weekly

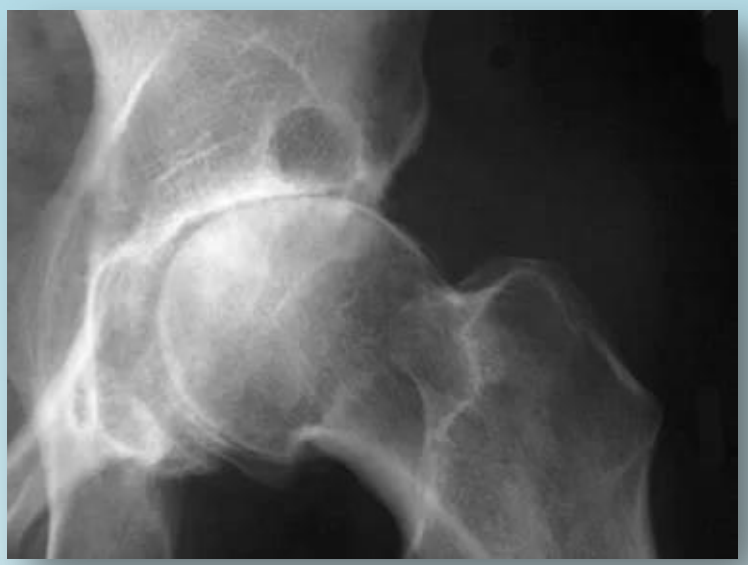
Goes out most days to shops - uses walker but has stopped going to Day Centre

Commode in bedroom; downstairs toilet

Doesn't eat dinner every day; no falls; a 'Pioneer'; non-smoker; tea+++

Flu vaccine

Examination (25 mins: HCA/midwife/consultant)



Alert, normal BMI-thin, slow, required assistance

Pulse regular, normal BP, chest clear, no oedema

Limited hip abduction - OA

CNS/PNS - normal

Wet underpants & pads

Probable previous anterior repair/Manchester repair/possible Burch/MMK

Grade IV cervical descent + large cystocoele/rectocole; normal BMPE/PR;
poor muscle tone

Atrophic mucosa + superficial ulceration

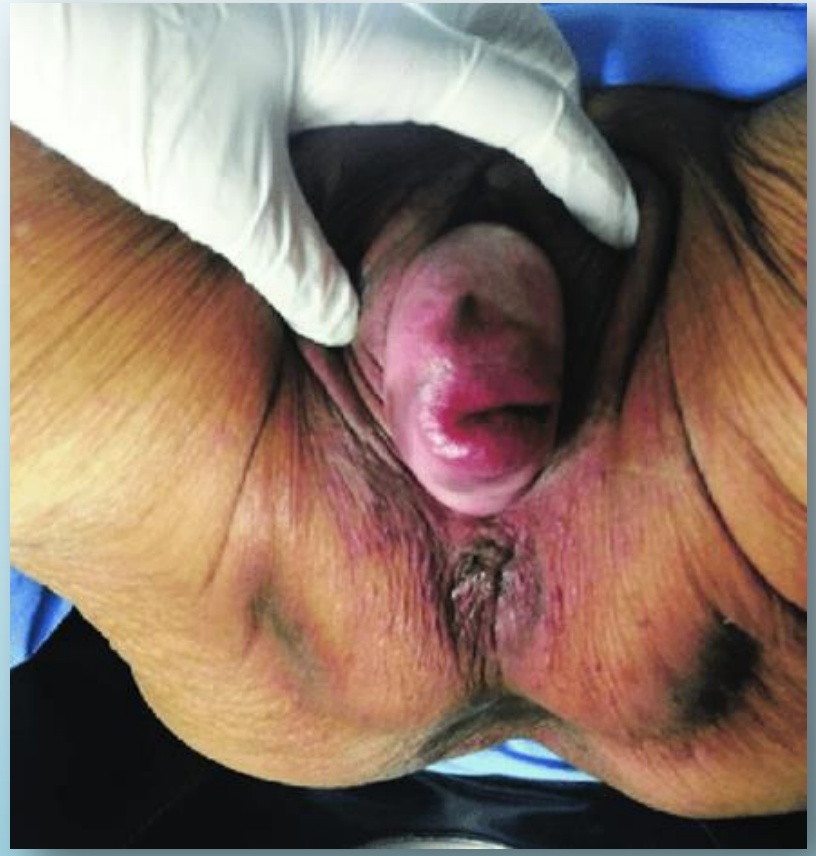
Healthy skin - Sudocrem ++

Bladder capacity on scan: 350 cc

Stress incontinence ++ on reduction of prolapse

Post-void residual: 200 cc

Urinalysis: NAD



Discussion management with patient & daughter

Pipelle - refused

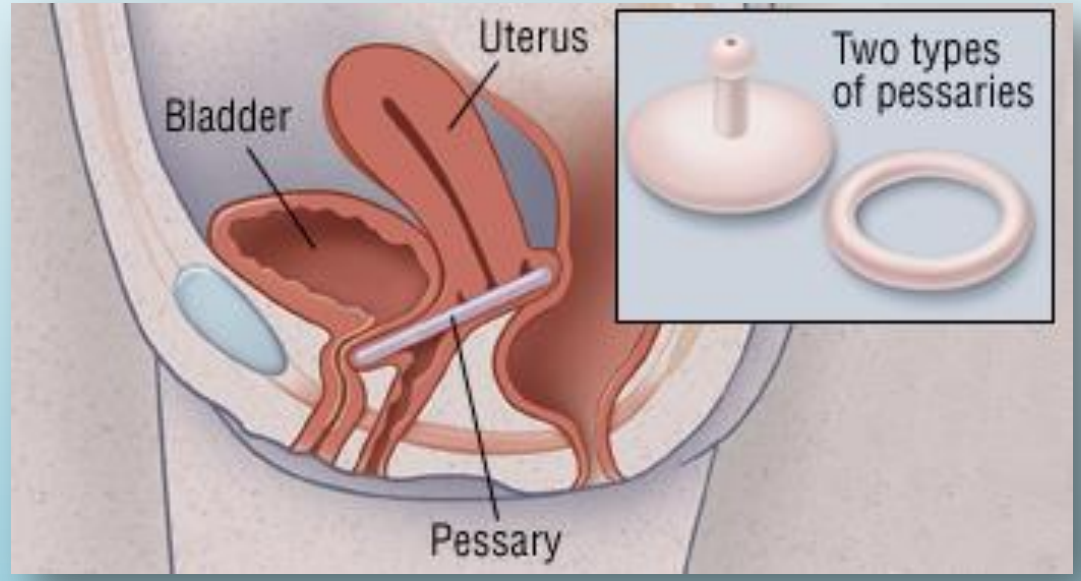
POC TV ultrasound - ‘normal’ uterus/pelvis; atrophic endometrium

Ring pessary - agreed; 75 mm + vaginal oestrogen (can’t self-administer & doesn’t want PHN/daughter to do)

Reduce tea, double voiding

Lactulose/HFD

Dinner every day



MSU & biochemistry/glucose

Department TV ultrasound (normal)

Bladder diary (didn't complete)

Review in 2 weeks

Letter to GP & hospital B & PHN

↑ urea ↓ K ↓ Na

Phoned GP - recently started on frusemide 20 mg - discontinued

Solfenacin & amitriptyline - discontinued

Daily Bladder Diary
Please fill in the appropriate blanks below.

Name:_____
Date:_____

Time	Drinks		Urination		Accidental Leaks	Strong Urge to Void? (Y/N)	Activity Prior to Void
	Type	Quantity	No. of Times	Volume (small, medium, large)	Volume (small, medium, large)		
6–7 AM	Coffee	2 cups	2	Medium		Y	Sitting
7–8 AM			1	Small		Y	Sitting
8–9 AM							
9–10 AM			1	Small		Y	Sitting
10–11 AM	Water	10 oz.					
11 AM–Noon			2	Medium	Small	Y	Walking
Noon–1 PM	Iced tea	8 oz.					
1–2 PM			1	Medium		Y	Sitting
2–3 PM	Coffee	1 cup					
3–4 PM			1	Small		Y	Sitting
4–5 PM							

FIG. 2. Example of bladder diary

Follow-up visits (4 pessaries; 2 pre-operative discussions)

"Urine pouring out of me" since ring

Vaginal tissues healthier - oestrogen applied

Post-void residual: 180 cc

Urinalysis: clear - nitrofurantoin discontinued

Lung bases clear/no oedema

5 different sizes of rings/shelf pessaries used over 8 weeks + vaginal oestrogen

Wants surgery now

Information sheet provided (didn't read)

Discussion +++ with patient +/- daughters; will stay with daughter post-op

Purpose of surgery - prolapse & incontinence

General risks & age-related risks - including death

Specific - including bladder injury (?previous Sx), urinary retention (going home with a catheter), stress incontinence (need for "injection"), UTI, ? sexual function ("waiting for me to ask")

No indication for urodynamics – wouldn't change management

Location of surgery & pre-op anaesthetic assessment

'Nutrition'

Pre-op

Pre-operative anaesthetic clinic (spinal)

Physiotherapy (post-op mobilisation)

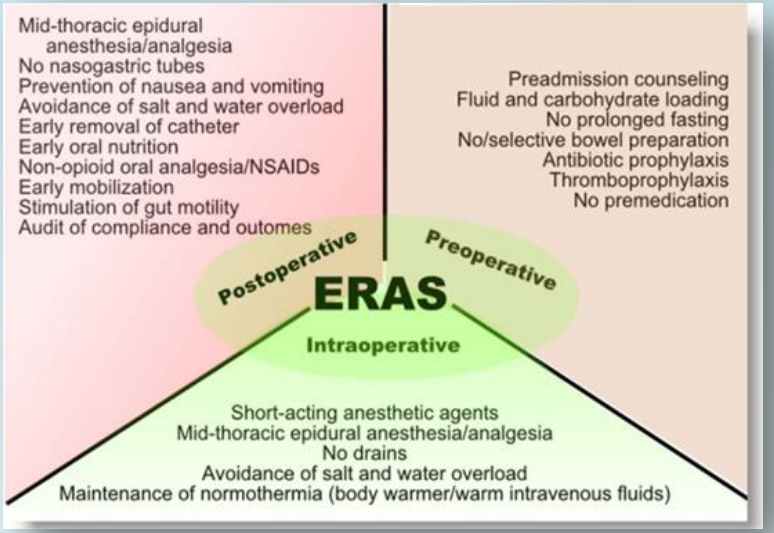
Rx reviewed by Pharmacy

Seen day before surgery

- operation discussed again
- vaginal tissues healthy
- MSU
- consent signed
- Innohep/TEDS
- suppository
- admission on morning of surgery - scheduled early on list

ASA Grading and Predictive Mortality

ASA Grade	Definition	Mortality %
I	Normal healthy individual	0.06
II	Mild systemic disease that doesn't limit activity	0.4
III	Severe systemic disease that limits activity	4.5
IV	Severe systemic disease that is constant threat to life	23
V	Moribund, not expected to survive 24hrs with or without surgery	51



Op & Post-op

Vaginal hysterectomy, anterior (loose) & posterior repair, vault suspended, cystoscopy

IV antibiotic prophylactics

Mobilised Day 1

Foley x 3 Days

Discharged Day 5

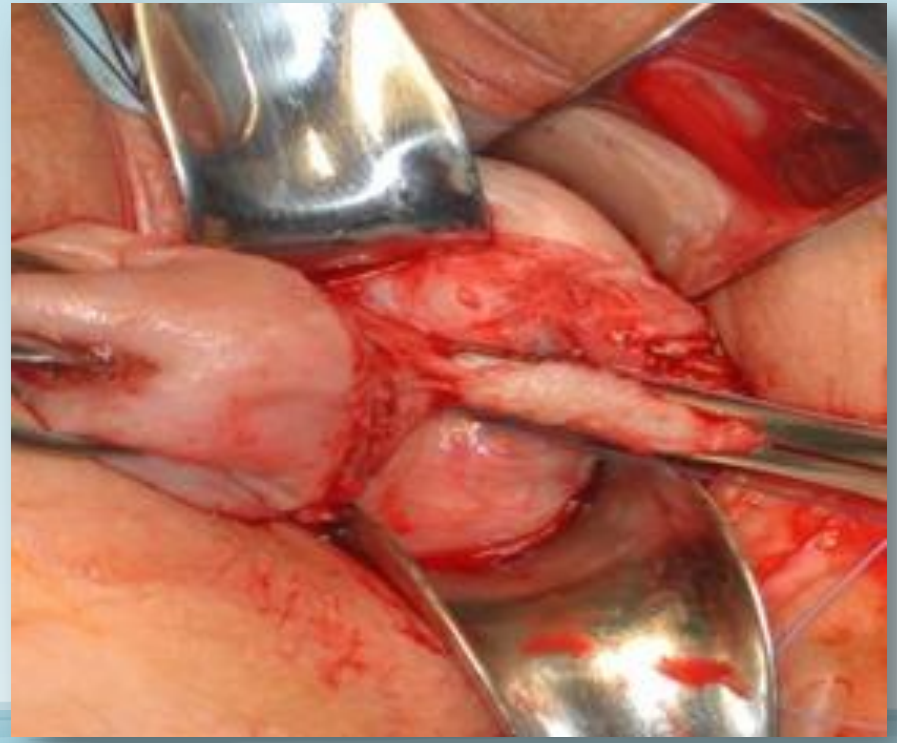
PVR 90 - 110 cc

6 bedded ward: 3 Gyn 3 Maternity

12 admissions onto ward over

“Not much sleep”

Day 7 review: PVR 110 cc MSU clear



6 weeks + 3 months + 6 months

“Have a life back”

Normal support

PVR 120 cc

Mild stress incontinence

Mild urge incontinence + nocturia x 2

1- 2 pads per day

Discussed options - wait & see - “happy”

At 3 months + 6 months: attending Day Centre again

“Wants to stay on the books” prefers 3 months to 6 (“more likely to be still around”)

History

Fit v Frail Elderly

Appropriate assessment/referral – who? where?

Need time

Need to listen

Bladder: duration, stress, urge, void, UTI, haematuria

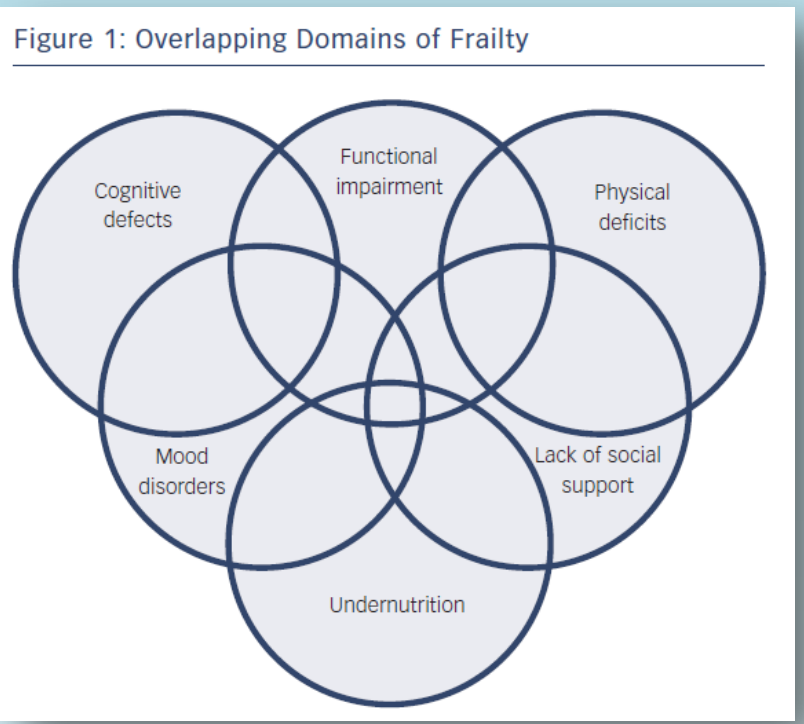
Bowels

Sexual Function

Protection & WC facilities

Co-morbidities: BMI, mobility, cardio-respiratory, DM, renal, cognitive etc

Medications

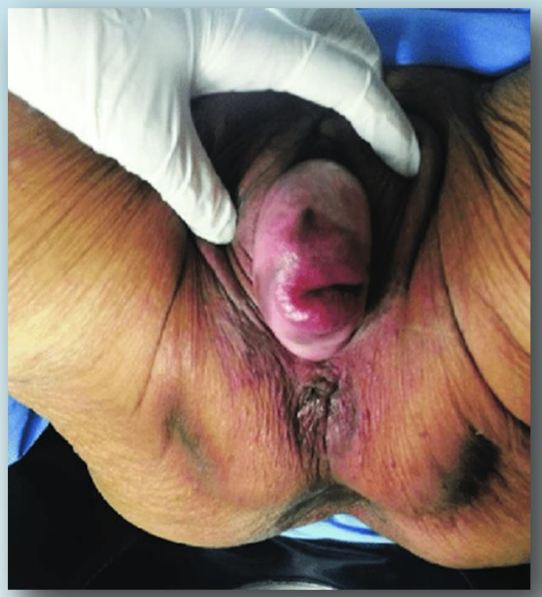


Examination

BMI, mobility, pulse, BP, chest, abdomen, oedema

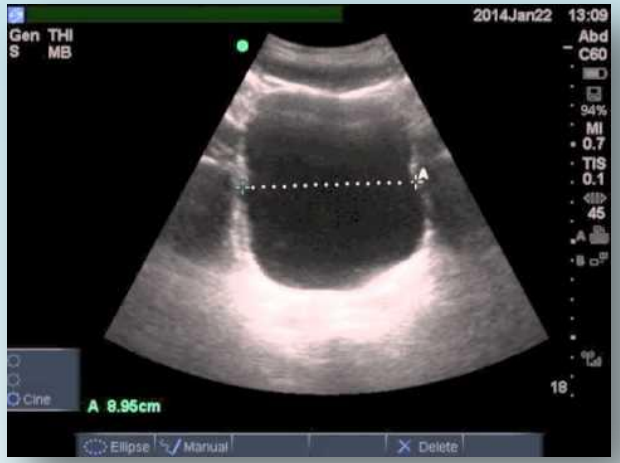
Hip abduction, prolapse, atrophy, stress incontinence, mass, PR, skin

Post-void residual



Urinalysis, MSU

Urea, creatinine, glucose



TV pelvic scan

Management

Bladder diary (?) & advice re fluids/caffeine, timed/prompted voiding

Review Rx

Treat constipation

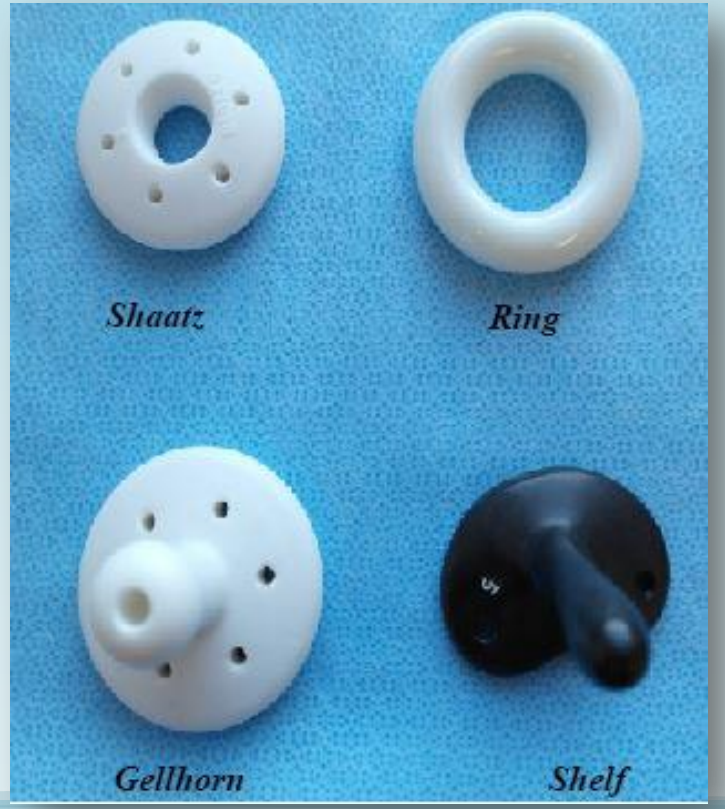
Out-rule retention

Treat UTI & atrophy

Physiotherapy: mobility & PFE

Public Health Nurse/Continence Advisor

If pessary for prolapse - advise re SUI



Management

If prolapse + actual/masked SUI - deal with prolapse first

Selective urodynamics if Sx for SUI/Botox for DO/ VD - WP

Informed consent - involve family

Physiotherapy

Dietician

Anaesthesia

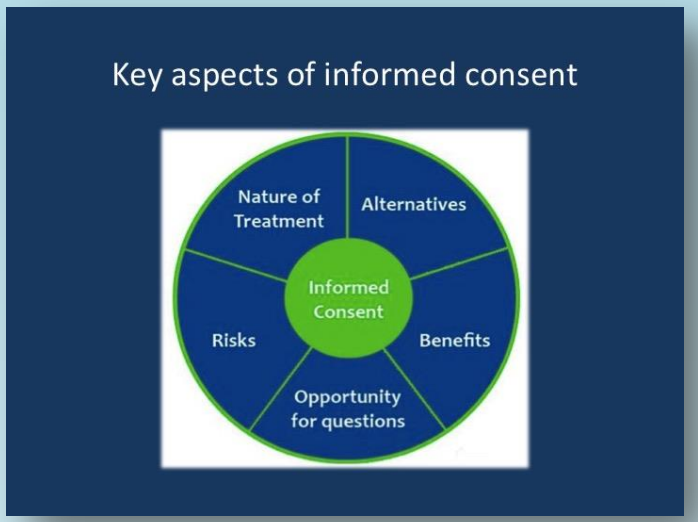
Enhanced recovery

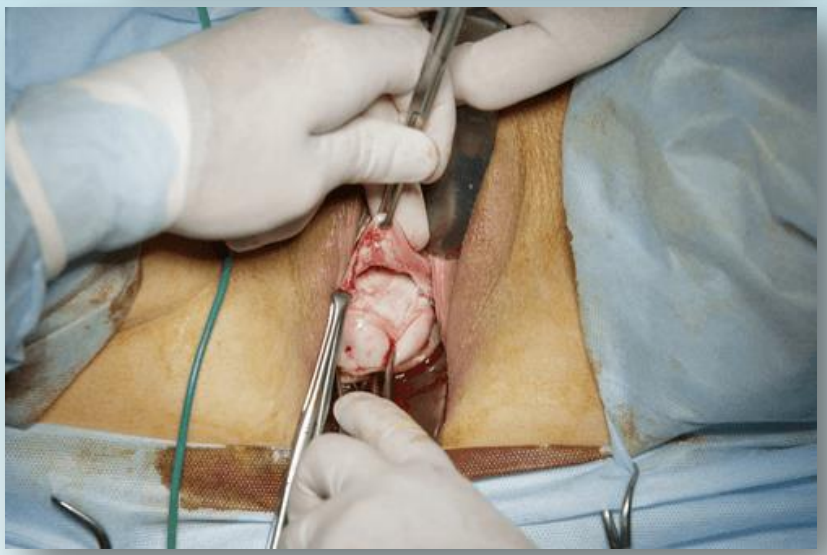
Planned discharge

Access to subspecialties

Where

Follow-up



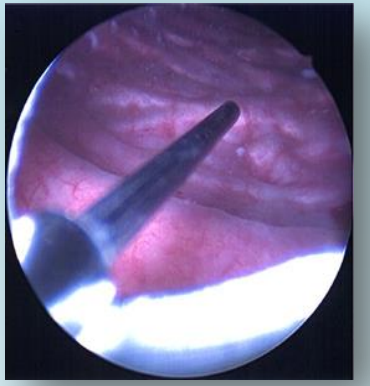


Management

Treat urge first

Out-rule voiding dysfunction

If recent/haematuria/recurrent UTIs/smoker - cystoscopy



Avoid anticholinergics as 1st line or prolonged use if can

Avoid duloxetine

Mirabegron 25 mgs - check pulse & BP

? Microdose desmopressin - haven't used

Botox - only if DO proven on urodynamics without voiding difficulty fit, can do CISC and failed Rx

Polyacrylamide gel (Bulkamid) - if SUI on urodynamics

TVT - not available @ present

"Draw" v "Win"

Difficult areas

Nocturia

Voiding dysfunction

Chronic UTIs

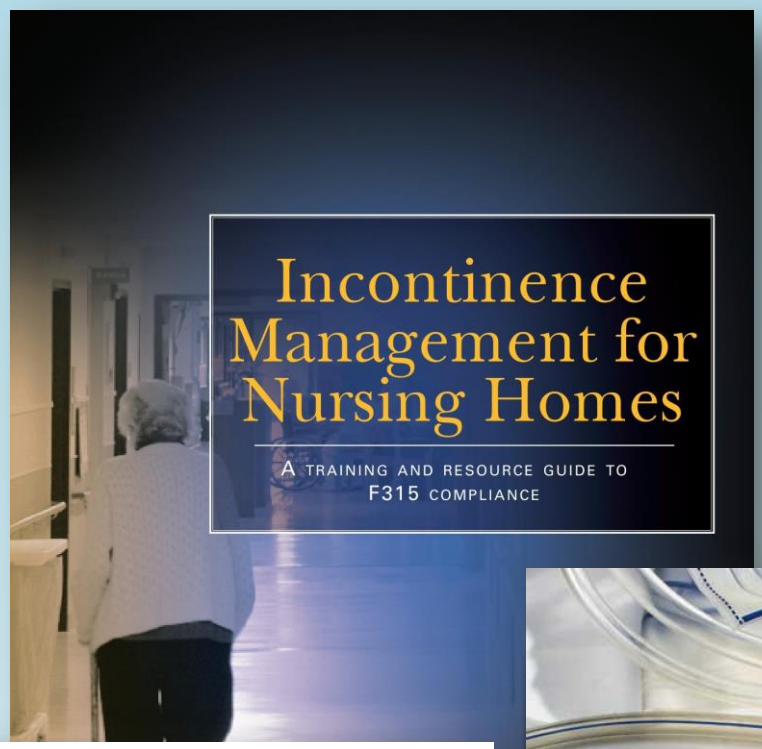
Long-term catheters

Double incontinence

Dementia

Nursing homes

Need for MDT care



Bigger Picture

TRICLOCATION