Inchicore Family Doctors

Inchicore Primary Care Centre

Dr. Eimear Mallon MICGP

Urinary incontinence in Primary care.. are you bothered ?

Why lack of treatment ?

Dr. Dmochowski: There are multiple factors, both patient- and physician-related, leading to a significant lack of treatment of incontinence. Let me review the main ones.

Perception: It's a "natural part of aging." There is an assumption, especially among women, that incontinence is a natural part of the aging process, and that there is nothing that can be done about it. Incontinence can cause embarrassing situations. Patients may not want to admit that they are experiencing incontinence, and, if it occurs, they do everything they can to try to forget it.

New, more effective pads. Absorbent and external padding devices have greatly improved over the last several decades. Many patients rely on these devices to help them manage their urinary incontinence.

Comorbidities. Incontinence often occurs with comorbidities. It is not uncommon to see a patient with incontinence as well as an element of dementia or chronic obstructive pulmonary disease, cardiac disease, or other chronic medical conditions. These other conditions may preclude the use of certain types of interventions for the incontinence, such as surgical or device procedures.

Level of bother. For each individual, incontinence presents a unique level of bother. For example, one person who experiences one incontinent episode per week may be very bothered by the symptoms, while another person who has multiple episodes a day may be less bothered. Gaining an understanding of each individual patient's experience and distress associated with the incontinence must occur early in the discussion of it, to help direct therapy. The level of bother plays a very important role as a motivational stimulator for patients to modify their behaviors. It needs to be carefully taken into account when assessing a patient's likelihood of success with any therapeutic modality that is introduced for incontinence.

Role of primary care

- GPs/ PHNs/Practice nurses are best placed to screen for UI
- Longstanding relationship with patient /family/carers
- Can assess in home environment
- Frequent encounters for opportunistic screening

Barriers

- Embarrassment leads to silence.
- Time constraints lead to inadequate attention
- Knowledge limitations lead to patient acceptance
- Limited access to services
- Limited resources lead to inadequate management

Why screen

UI - common, generally benign condition but…

QOL impact

- UI said to have a stronger influence on psychological quality of life than cancer, DM or arthritis.
- UI is a major indication for nursing home placement.
- Annual nursing home admissions related to UI – 6 billion dollars (Morrisson 2006)

Incidence

- 30 – 60% of older females
- 10 – 35% of older males
- Greater than 50% of institutionalized older adults

- Only 20% of these present to healthcare professional

Type

Stress	• Leakage of urine on coughing/sneezing/rapid movement/walking. • More common in parous or post menopausal women
Urge	• Sudden intense urge followed by involuntary loss of urine. • Maybe related to co-morbidities e.g. DM, dementia, Parkinson's or CVA
Overflow	• Leakage of urine when bladder is full e.g. BPH
Functional	• Difficulty toileting due to impaired mobility or cognitive impairment
Mixed	• Often a combination of above

Contributing factors

- Changes in urinary system – childbirth, ageing, depleting oestrogen
- Altered cognition, brain injury
- Physical disability
- Infection
- Co-morbidities – constipation, CCF, venous insufficiency

Exacerbating medications

- Diuretics
- Caffeine
- Anticholinergics
- Anticonvulsants
- Hypnotics
- Antipsychotics
- Antidepressants

Presentation

Patient discloses issue

Doctor picks up on clues in history or exam

Carer/PHN report issue

Careful History...are you bothered ?

- Frequency day/night
- Have you trouble getting to the toilet on time ?
- Do you have leakage of urine when you cough or sneeze?
- Feeling of something coming down/pressure
- Continuous leakage
- Hesitancy, post micturition dribbling- male
- Haematuria
- Discharge PV/ itch
- Fluid intake, caffeine, sweetners, c2h5

Hx continued..

- Ask about protection
- Ask about impact on quality of life
- Explore functional ability/access to bathroom/ambulation/transfer aids/environment

OAB V3 score

How bothered have you been by..	Not at all	A little	somewhat	Quite a bit	a great deal	Very great deal
Frequent urination in day	0	1	2	3	4	5
Sudden urge to urinate with no warning	0	1	2	3	4	5
Urine loss with strong desire to urinate	0	1	2	3	4	5

Exam

- **Abdomen** – palpable bladder or suprapubic mass, ? POCUS for post void residual volume
- **Pelvic** - Female

Posterior wall bulkiness/ laxity, Rectocoele

Anterior wall laxity –bladder neck mobility, cystocoele

Uterine descent

Urine leak on coughing/Valsalva

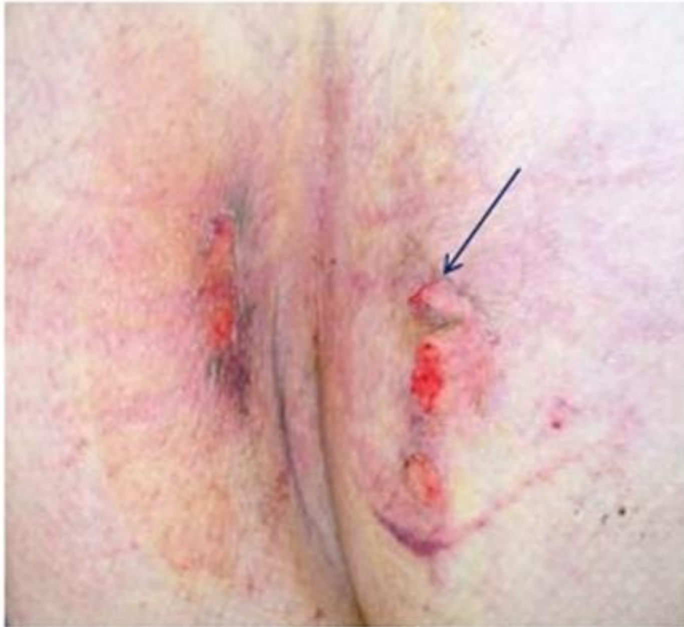
Evidence of vaginal atrophy/ oestrogen depletion

Vulval dermatitis/excoriation/moisture lesions

Examine on standing

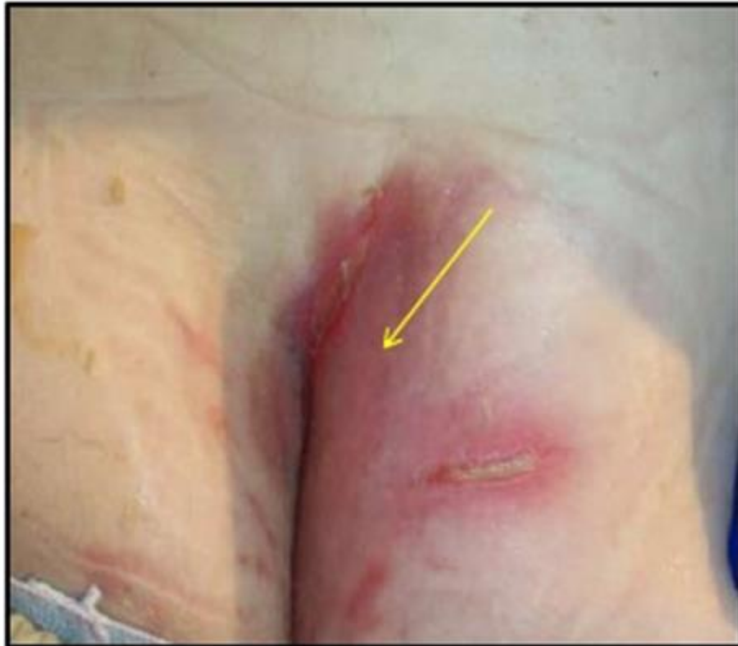
- Male – DRE
- Urinalysis

Shear & Friction



Erosion of the skin occurs frequently and probably attributable to friction created by moving moist or saturated pads or clothing over irritated skin; or to damage from digestive enzymes present in liquid or solid stool.

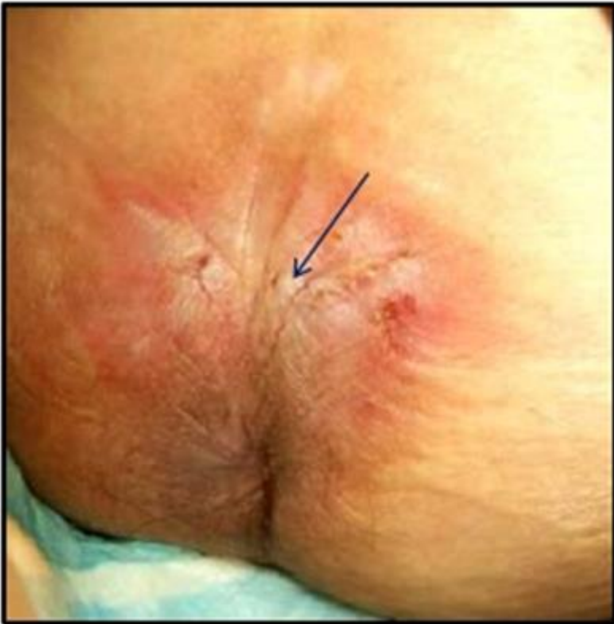
Incontinence Associated Dermatitis



Skin condition commonly associated with incontinence. Skin irritation and inflammation related to exposure to urine and feces. Additional risk factors:

- Diaper use
- Bed bound / immobility

Moisture Associated Skin Damage



Skin maceration is a sign of increased moisture exposure. Skin maceration leads to skin breakdown. This condition is also referred to as Moisture Associated Skin Damage (MASD).

Management

1. Behavioural

- Bladder retraining – increasing time between voids- Patient information leaflet, Refer PHN. Refer to www.iscp.ie and www.baus.org.uk
- Limitation of fluid intake – 2l
- Pelvic rehabilitation – Kegan exercises – refer physio , 3/12 trial – www.iscp.ie
- Carer advice – prompted voiding
- Manage bowels to prevent constipation
- Decrease caffeine , sweeteners, c2h5

2. Mechanical – non-surgical

- Pessaries- ring, shelf, gel horn
- POP/ stress UI
- Measure symphysis pubis to posterior fornix
- Assess for vaginal atrophy – use oestrogen cream
- Change every 6/12.
- Complications – abrasions/ulceration

3. pharmacological

- **Oestrogen cream**

Vagifem 10mg PV daily x 2 weeks and then twice weekly ongoing

- **Antimuscarinics**

Oxybutin/tolterodine,solfenacin – 4/12 to full response, caution re risks ++

Anticholinergic burden – falls, increased confusion, constipation etc

- **Selective beta agonist**

Mirabegron

Combination therapy with mirabegron and antimuscarinics
European journal Urology 2016 70;146

RCT 2000 patients OAB with incontinence who remained incontinent after 4 weeks solifenacin 5mg

Combination mirabegron 50mg and solifenacin 5mg was superior to higher dose solifenacin.

PSA or no PSA ?

- Recent reviews BMJ May 2018 and BJGP Nov 2018
- .. No significant evidence to suggest that men with self reported LUTS are at increased rick of advanced or potentially fatal prostate cancer when compared to men without LUTS
- But studies are heterogenous and incomplete- need for further studies but BMJ authors didn’t identify any ongoing relevant studies

Recommended – ‘do not routinely offer PSA testing in men with LUTS and no risk factor for prostate ca’

Refer if ..

- Haematuria
- Recurrent UTIs
- Difficulty emptying bladder
- Constant leak ? Fistula

- Consider Ca 125 if new onset OAB > 50 yrs
- Consider PSA in Male but only based on risk and patient preference - not for LUTS alone

Main points

- Patients slow to present
- Clinicians should increase screening
- Careful history important to ascertain urge/stress/mixed
- Non pharmacological first line can be effective
- Life style advice , Patient information leaflets, involve PHN and carers
- Refer physio for pelvic floor exercises offer PIL Kegal exercises
- Involve OT – home safety issues
- Role of E2 cream
- Meds- marginal effect – continue only if clear benefit
- PSA – not routine with LUTS in men, only if other significant risk

Case Studies

Dr. Mary Short

- Director of Women’s Health ICGP

Patient A

- 69 yr old female
- 1st presented added 41 (10 yrs after the birth of her last child)
- Para 3 + 3
- 2nd / 3rd labour -- epidural
- 2 operations
- ?Stamey/ Raz 10 yr later incontinent
- Birch colposuspension 10 yrs later incontinent
- No coffee / tea / alcohol --
- Flooding / leaking ??

Patient B

- 94 yr old woman
- Para 8
- No continence issues through reproductive life and beyond
- Living at home with supports
- Urinary problems surfaced with immobility
- Suffers form constipation – takes laxatives
- Recurrent cystitis with significant suprapubic pain
- Now wears pads

Patient C

- 84 yr old woman
- Para 4
- Complaining of leakage worse on coughing
- Symptoms surfaced aged 60 yrs
- Treated with 3 month course of anti biotics on 3 occasions
- UTI returns from time to time– urine odour is offensive.
- Not always infected