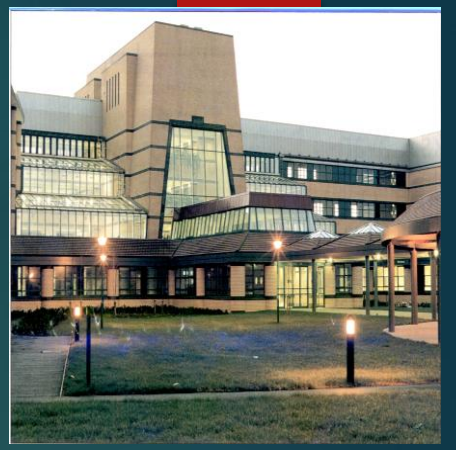
Incontinence



"*Giant* of Geriatric Medicine"

But why do we leak as we age ? .

DR RÓNÁN COLLINS

CONSULTANT PHYSICIAN IN GERIATRIC AND STROKE MEDICINE

Definitions:

URINARY INCONTINENCE: (UI):

"THE OBJECTIVE INVOLUNTARY LOSS OF URINE ".

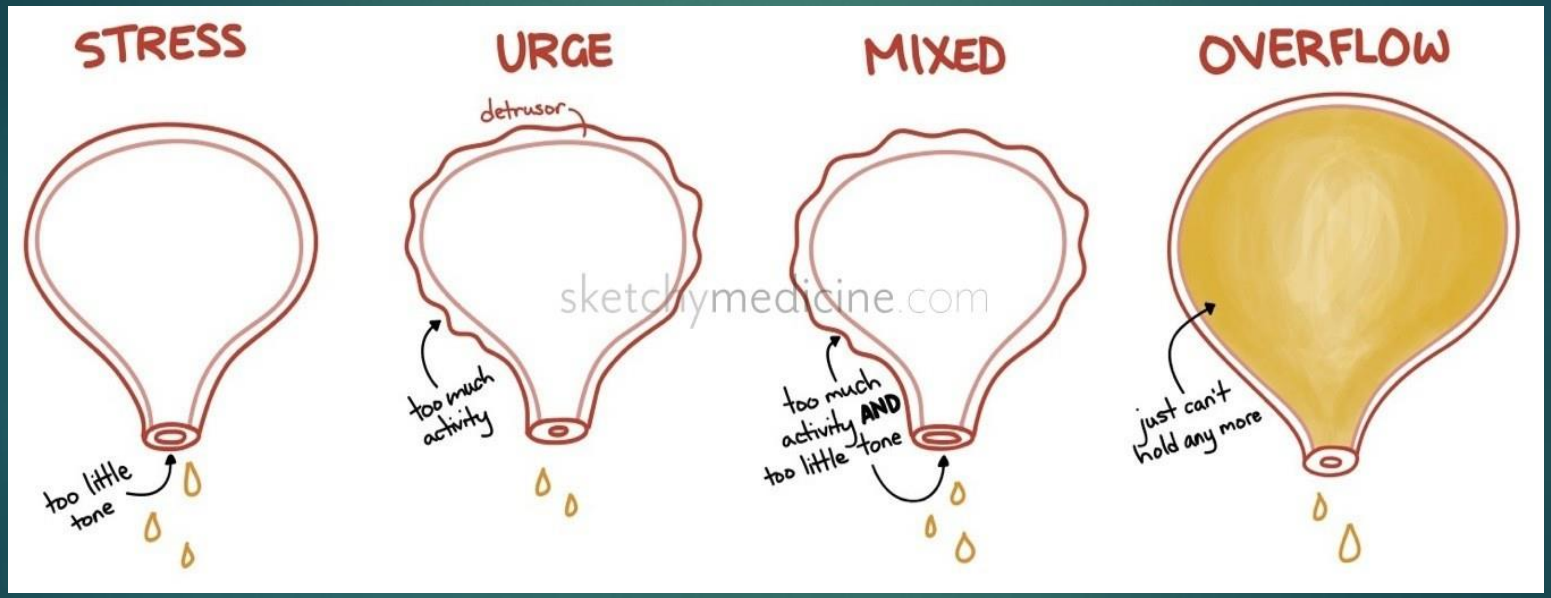
Abrams et al. Neurourol Urodyn 2002

FAECAL INCONTINENCE:

"INVOLUNTARY LOSS OF LIQUID OR SOLID FAECES"

Perry C et al. Gut 2002

Types of Continence



Stress incontinence

Most common type that mainly affects women but can effect men if they have had prostate surgery

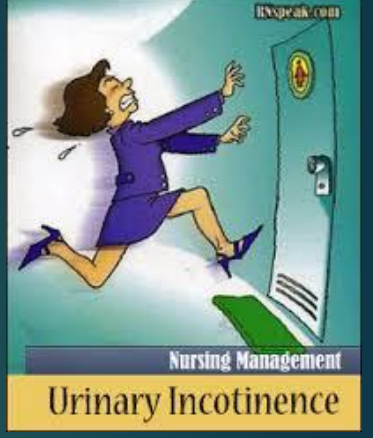
Caused by:

weakened or damaged to muscles or nerves to the Pelvic flo

Characteristics:

- leaking (cough, sneeze, jump , run or laugh) 20-50mls
- Always know when they leak
- Leak without having had a feeling that they need to go to the toilet
- Nocturnal enuresis absent

Urge Incontinence



Overactive Bladder results involuntary incontinence accompanied or immediately preceded by urgency

Caused by :

- Can be unknown
- UTI most common cause
- Neurological e.g. PD, MS (failure to inhibit detrusor contraction)

Characteristics

- Sudden strong urge to Pass urine and quickly
- Leak moderate to large amounts of urine before they reach the toilet
- Frequency
- Nocturia- at least twice

(Milsom et al 2001, Stewart et al 2003)..

Mixed Incontinence

Complaint of involuntary loss of urine associated with urgency and also with effort or physical exertion or on coughing or sneezing

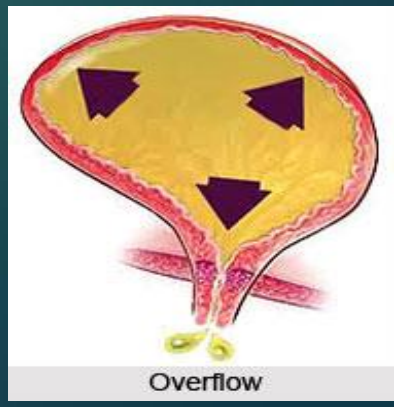
*Firstly treat the type that is dominant *

Overflow Incontinence

Difficulty emptying bladder due to obstruction, infection, constipation , enlarged prostate mainly effects men

Characteristics

- Hard to pass urine
- Push or strain
- Slow or weak stream not emptying bladder



Functional Incontinence

- Impaired mental state
- Immobility
- Impaired dexterity
- Unsupportive environment

Characteristics

- Unable to recognise signals of need to toiilet or interpret them wrong i.e need to walk or tidy drawers
- May be recognise the signals but physically incapable of getting there without help
- May experience problems with dexterity i.e MS or Parkinsons

Assessment
1. History

- Establish the impact on their life
- History of Urinary Symptoms
- Mobility and Manual Dexterity
- Bowel Pattern
- Medical problems that has direct effect on continence i.e number of pregnancy , BPH, surgeries
- Medications
- Diet& fluids

(Mangnall et al 2010)

Part 2 Observation and exam

- Physical Examination
- Mobility, manual dexterity
- Communication- how they communication
- Urinalysis
- Continence aids – prior
- Home Environment

Part 3

- MDT Treatment plan
- Reassessment date

Why is Incontinence important

- Because it is so common and distressing
- Because it is so badly neglected and managed by healthcare
- A cause of social isolation and embarrassment
- A cause of falls
- A cause of depression
- Costly to manage
- Often the ***'straw that breaks the camels back'*** in home care

In reality However

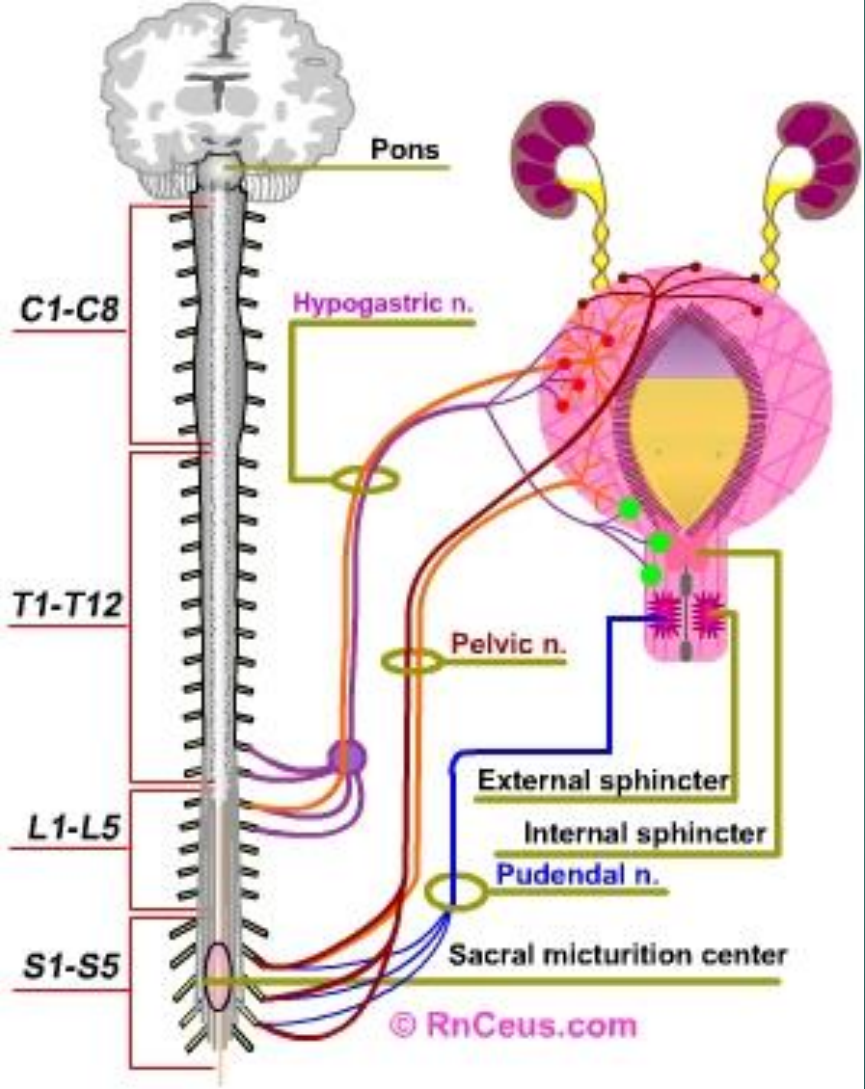
- **No Irish National Audit Data**
  - √ Stroke
  - √ Dementia
  - √ Hip Fracture / falls
  - x **Continence**

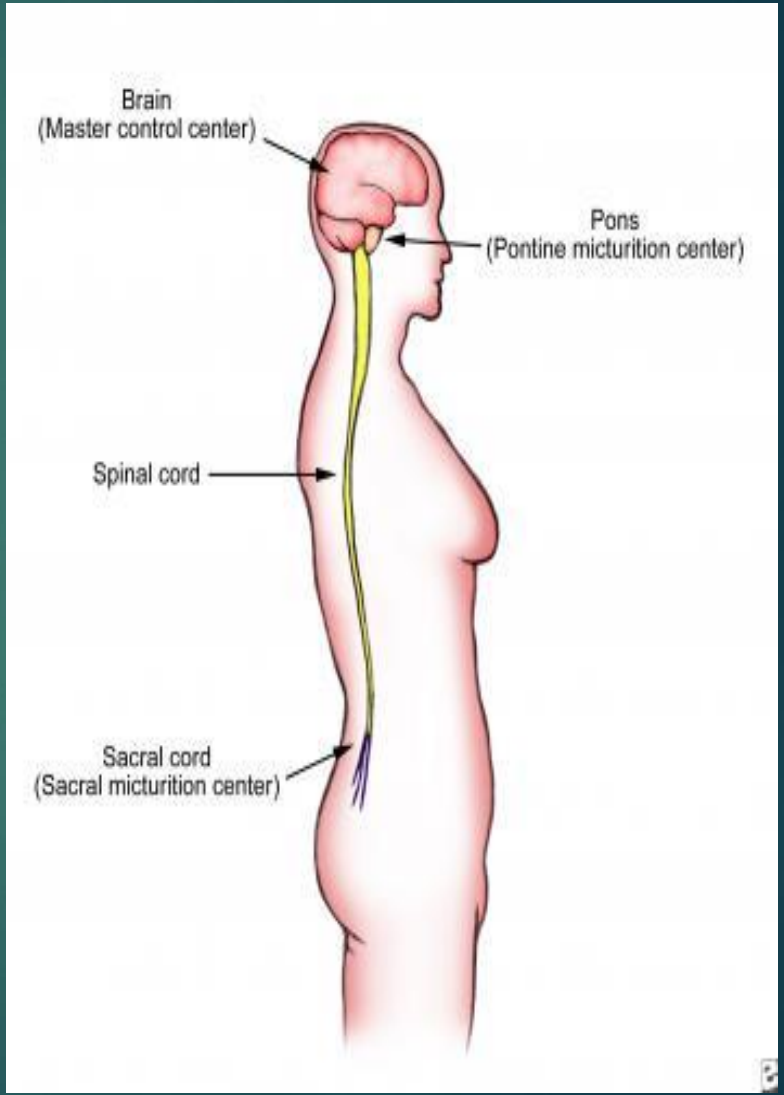
- **Most Hospitals have very limited if any access to**
  - Specialist continence Advice
  - Continence Clinics (interdisciplinary)
  - Urodynamics

The British Geriatric Society recognises continence care as a key part of ensuring privacy and dignity in care for older people and encourages members to take an active role in its "Behind closed doors" campaign

Time For Enhanced Action in Ireland ?

Controlling Bladder Function





Urinary Incontinence- strongly Age Related

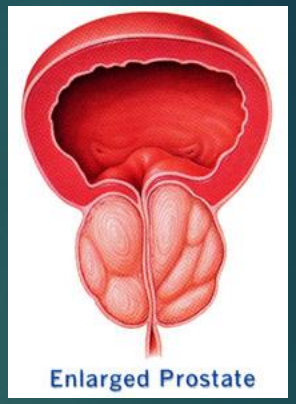
Age Related changes

To urological tract

- Detrusor overactivity
- Reduced bladder capacity
- Pelvic floor weakness
- Oestrogen loss
- Prostatic enlargement

- Urge and stress incontinence in women
- LUTS , urge and overflow incontinence in men.

LUTS in men



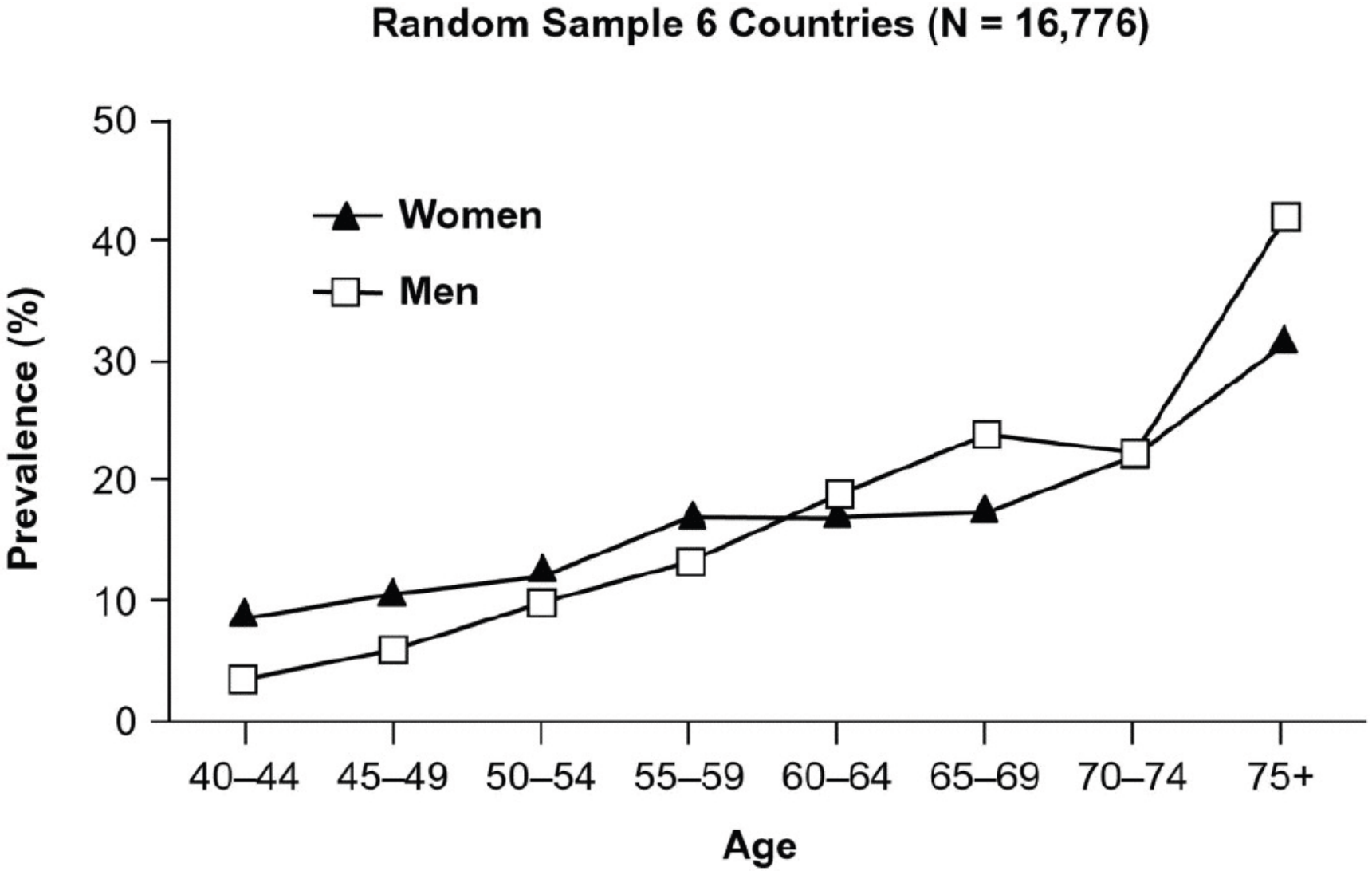
Voiding dysfunction:

- Hesitancy
- Straining to void
- Intermittent stream
- Dribbling
- "Pis en deux"
- Incomplete emptying
- Post micturition dribble

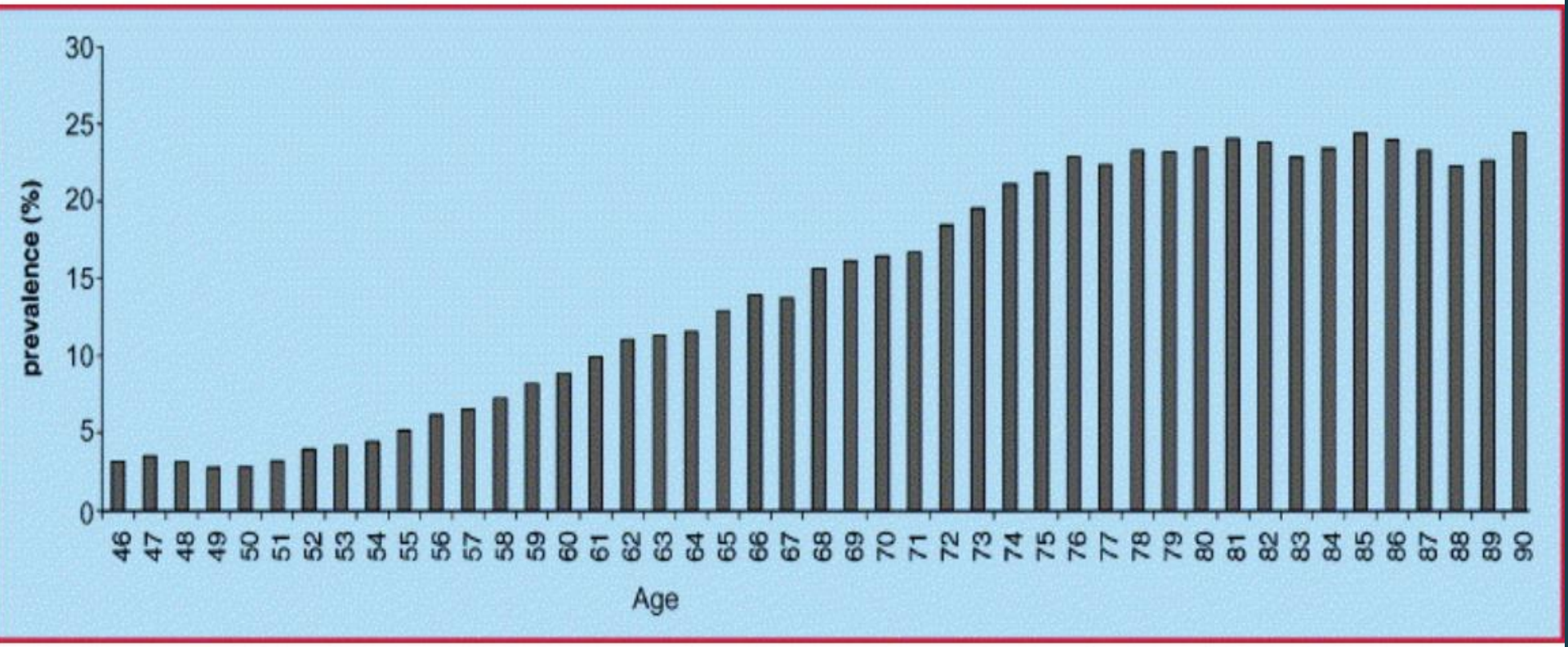
Storage Dysfunction:

- Frequency
- Nocturia
- Urge
- Incontinence
  - Urge
  - Stress
  - mixed

OAB symptoms and age



Age specific prevalence of LUTS



Mixed LUTS (voiding & storage dysfunction)

Prevalence

- 24% women and 15% men > 65 suffer UI
- 4-6 % >65 suffer faecal incontinence incidence is highest in Institutional care
- **Huge cause of**
  - Embarrassment and Social Isolation
  - Depression
  - Falls
  - Expense
  - Breakdown in care structures and need for residential care
-

Promotion of Continence in Hospital – poor ?

Fracture patients HIP n=3184 / Non-Hip n =5642

Hips:

- 63 % assessed
- 41% reported a continence problem.

Non Hip

- : 21% assessed
- 27% reported a problem

- **Only half** got any referral to continence service or intervention

Edwards R et al Maturitas 2011.

UK National Audit of Continence Care

- 43% PCTs and 81% hospitals responded.

- Integrated Continence Services
  - 58% PCTs
  - 48% hospitals
  - 74% care homes

.....I fear we would be worse

ISPGM surveys and developing a strategy for Incontinence

R COLLINS, R O CAOIMH, I NOONE, P HARKINS, M CONDON , D MCCARTAN, E MANNION ET AL.

Noone et al. St Vincents University Hospital - 2007

- **Title:** "An Audit of the Prevalence of Incontinence in the Acute Hospital Setting"
- **Type:** Point prevalence study
- **Methodology:** verbal consent and patient Survey questionnaire
- **Population:** all acute hospital patients n =442
- **Results:**
  - 141(32%) were incontinent.
  - 80 (18%) were incontinent of urine, 61 (14%) were incontinent of faeces .
  - 5% patients had urinary catheters inserted.
  - 55% of the total patients were female with 32% patients >80 years.

Condon et al. University Hospital Galway 2017

- **Title:** Urinary and Faecal Incontinence: Point Prevalence and Predictors in a University Hospital
- **Type**: Point prevalence cross sectional – consecutive sample acute adult admissions
- **Methodology:** verbal consent-Interview & Review of medical & nursing notes - verbal consent – ethics approval-
- **Results:**
  - 435 eligible inpatients.Median age was 72±23 years and 53% were male.
  - median CFS score was 5±3 and CA-CCI 5±4.
  - Overall Point prevalence of UI was 26% versus 11% for FI.
  - ≥ 85 35.2% and 21.1% respectively for UI and FI.
  - **Age** was not an independent predictor.
  - **Frailty;** CFS scores were independently associated with both UI (p=0.01) and FI (p=0.05)
  - Patients on orthopaedic wards had highest prevalence
  - Continence assessments were available for 11 (2%) patients.

Harkins et al . Tallaght University Hospital 2018

- **Title:** A Hospital Wide Point Prevalence of Adult Urinary Incontinence and Audit of Continence Care.
- **Type:** Point prevalence study of UI
- **Methodology:** Audit medical & nursing notes adult in-patients – hospital audit committee & ethics approval
- **Results:**
  - N= 358 – point prevalence of 31% (112) urinary incontinence
  - equal numbers of males and females (n=56 each)
  - 6 patients (1.6%) had a continence care plan in place.
  - 40% with UI had diagnostic type with evidence of relevant investigations.
  - 26.7% were on medication used to treat urinary incontinence
  - 77% were on medications that could exacerbate urinary incontinence.

McCartan et al: Tallaght University Hospital 2017

- **Title:** "Urinary Catheter Use and Care in the Acute Hospital Setting"
- **Type:** A Point Prevalence Study
- **Methodology** Hospital Audit of acute in patients – medical & nursing notes review
- **Results:**
  - n= 386
  - 14.5% (56 /386) had an indwelling catheter 75% ≥65 years, and 64% were male.
  - 86% were newly inserted.
  - 14% (9/56) no indication recorded
- other indications
  - urinary retention 19.6% (neurological 7%)
  - haemodynamic stabilisation protocol 12.5% .
  - Only 14.5% new UC had a trial-without-catheter(TWOC) 4% had formal urology input.

Summary Irish Hospital Audits

- 18-31% are incontinent of urine
- 11-14% are faecally incontinent
- 5-14% have urinary catheters in place 75% of which are newly inserted
- 1-2% of non-catheterised patients had a continence plan
- Majority if patents are older (2/3 over 75)

What should happen in Continence care ?

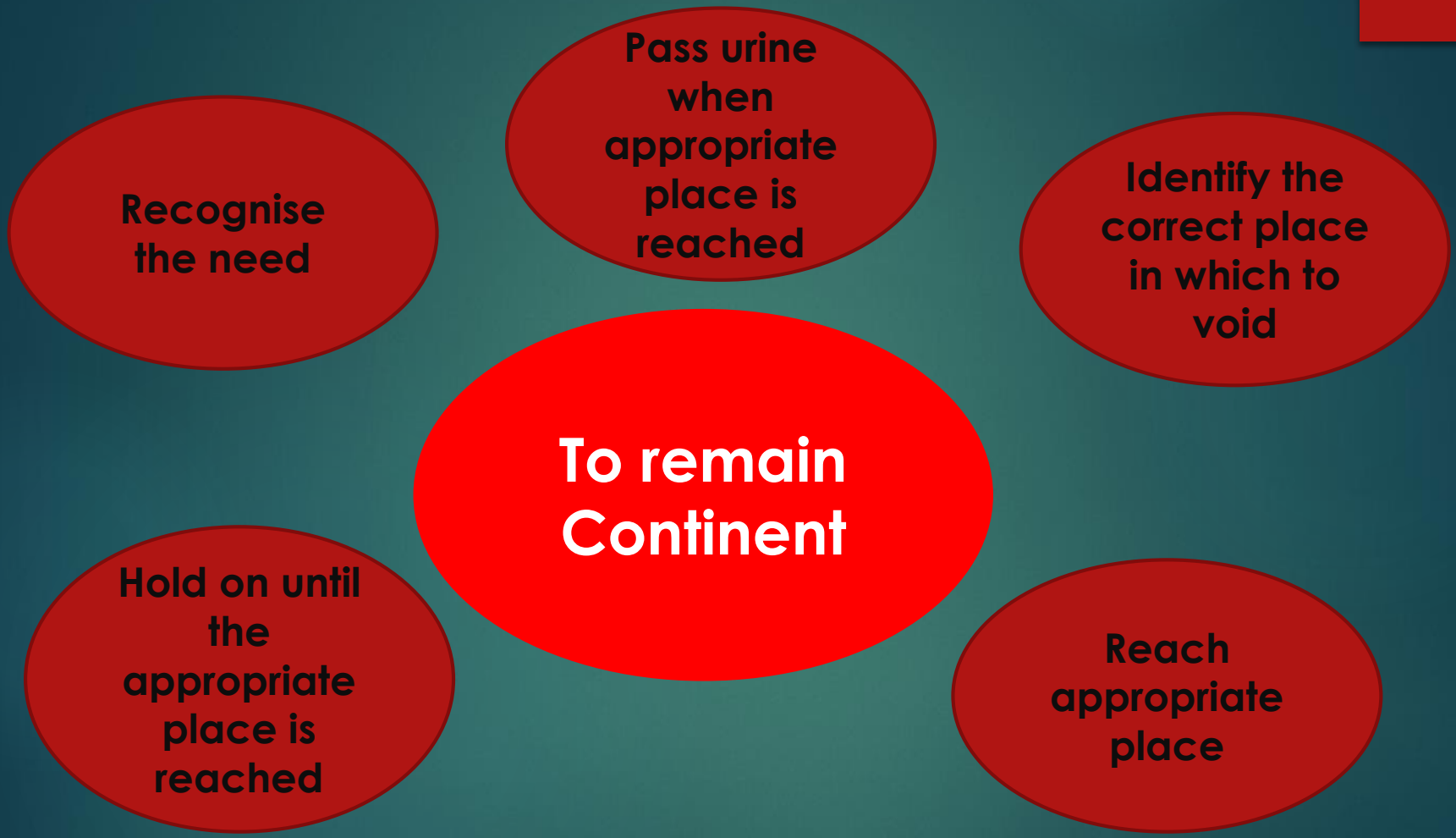
Encourage patients

- **Prompt leaflets**
- **Awareness posters**

What should happen in Continence care ?

Encourage yourself to…

- 'Listen' with your eyes
- 'Hear' with your nose
- Prompt and reassure patient
- Prompt and reassure carers where appropriate


Recognise the need
Pass urine when appropriate place is reached
Identify the correct place in which to void
To remain Continent
Hold on until the appropriate place is reached
Reach appropriate place

Clear signs on toilet doors

Why is Incontinence Age Related

Why is UI age related ?

Urological issues

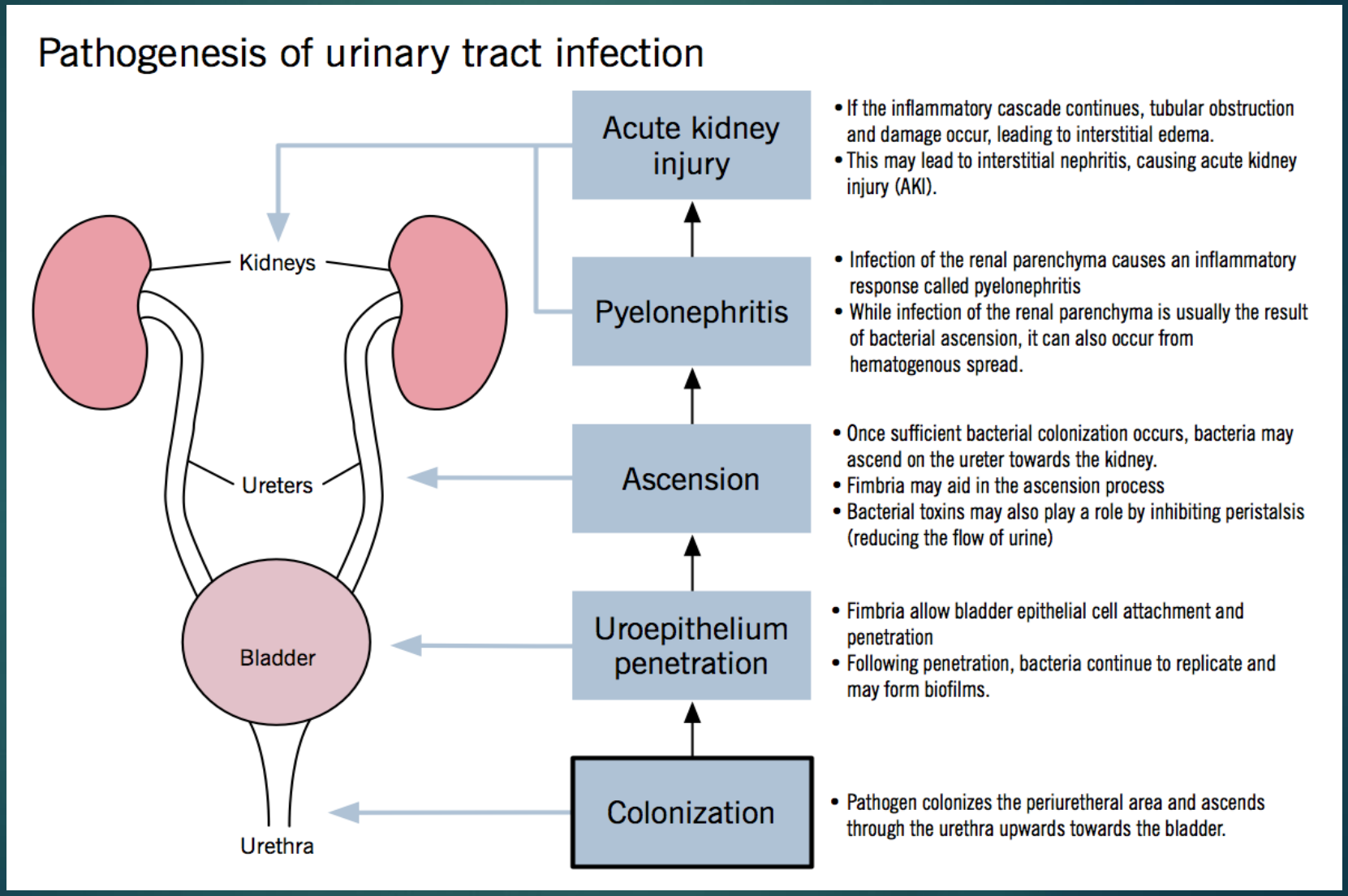
Direct:

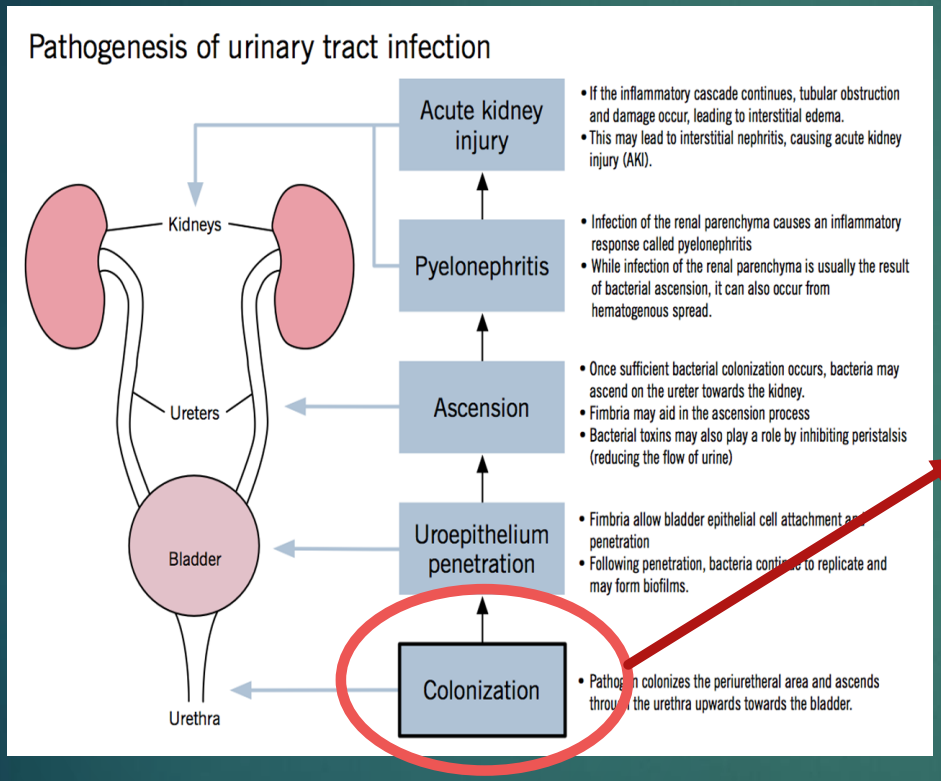
- Detrusor Over-activity
- Reduced bladder capacity
- Prostate enlargement
- Pelvic Floor weakness

Indirect:

- Oestrogen deficiency
- Polypharmacy
- Immobiltiy
- Constipation

Infection – ***stagnant water goes off***





♀ Changes

- oestrogen level
- vaginal PH
- Normal flora

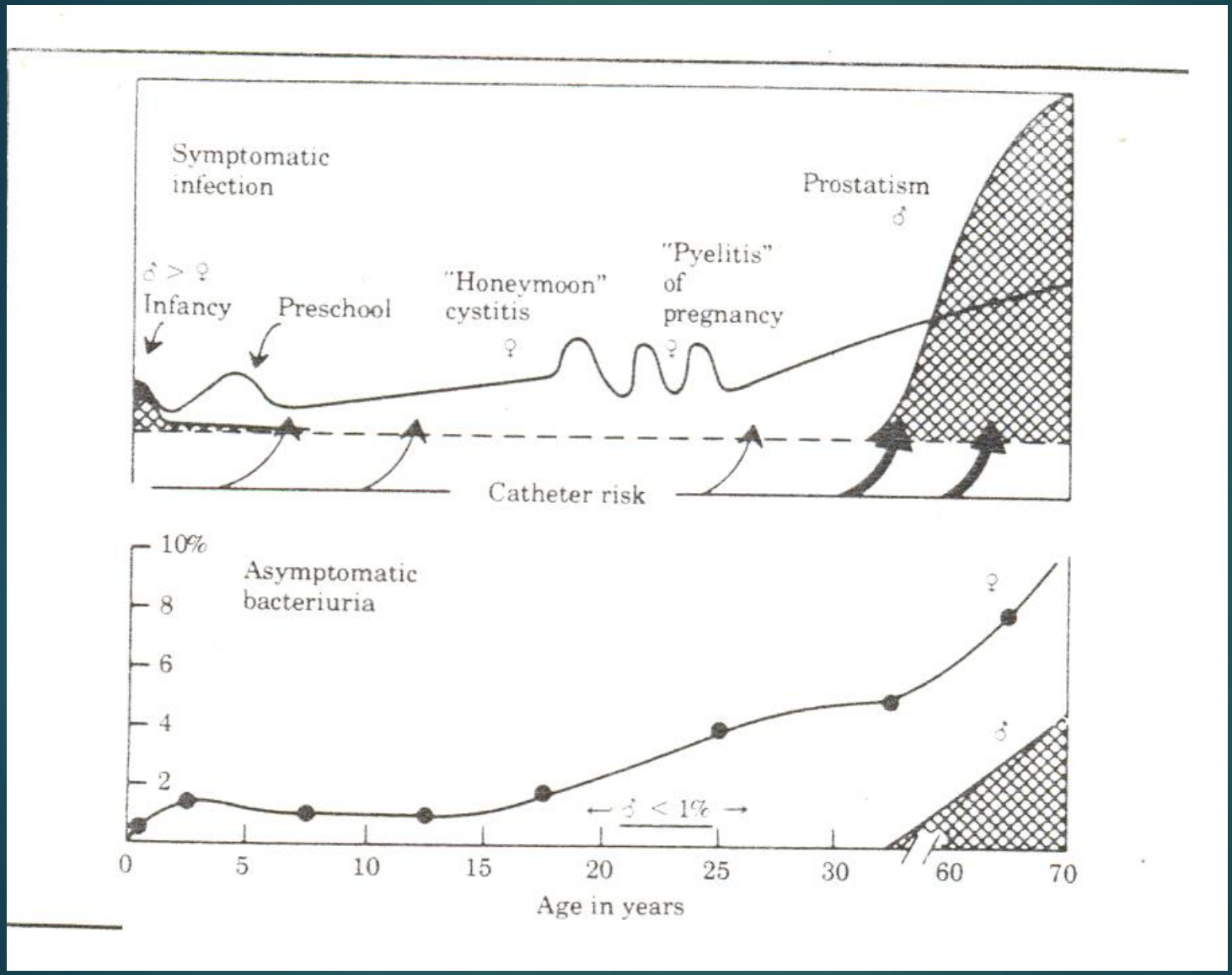
♂ changes:

- Prostatic secretions

Common factors

- Poor hygiene
- Increased antibiotics
- Instrumentation
- Structural abnormalities

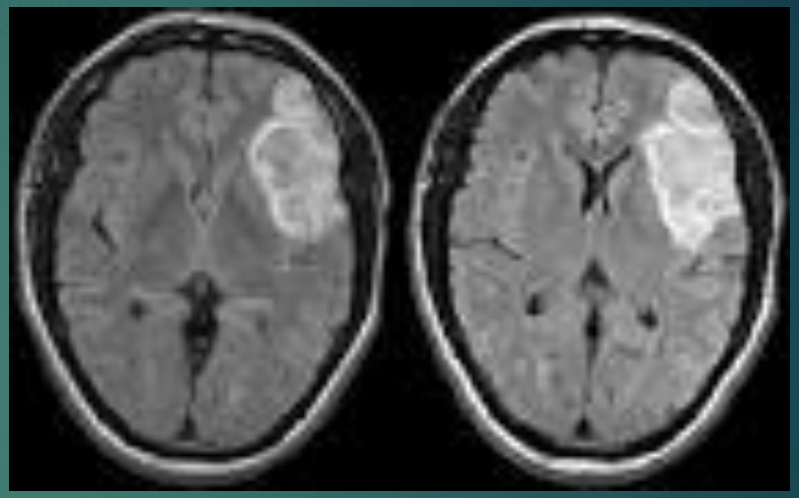
Incidence of UTI with age



Staykova S. NEPHROLOGY 2013;4(1):

Why is Incontinence Age related ?

Neurological issues



- Agnosia
  - Dementia
  - Frontal lobe disease
  - Stroke

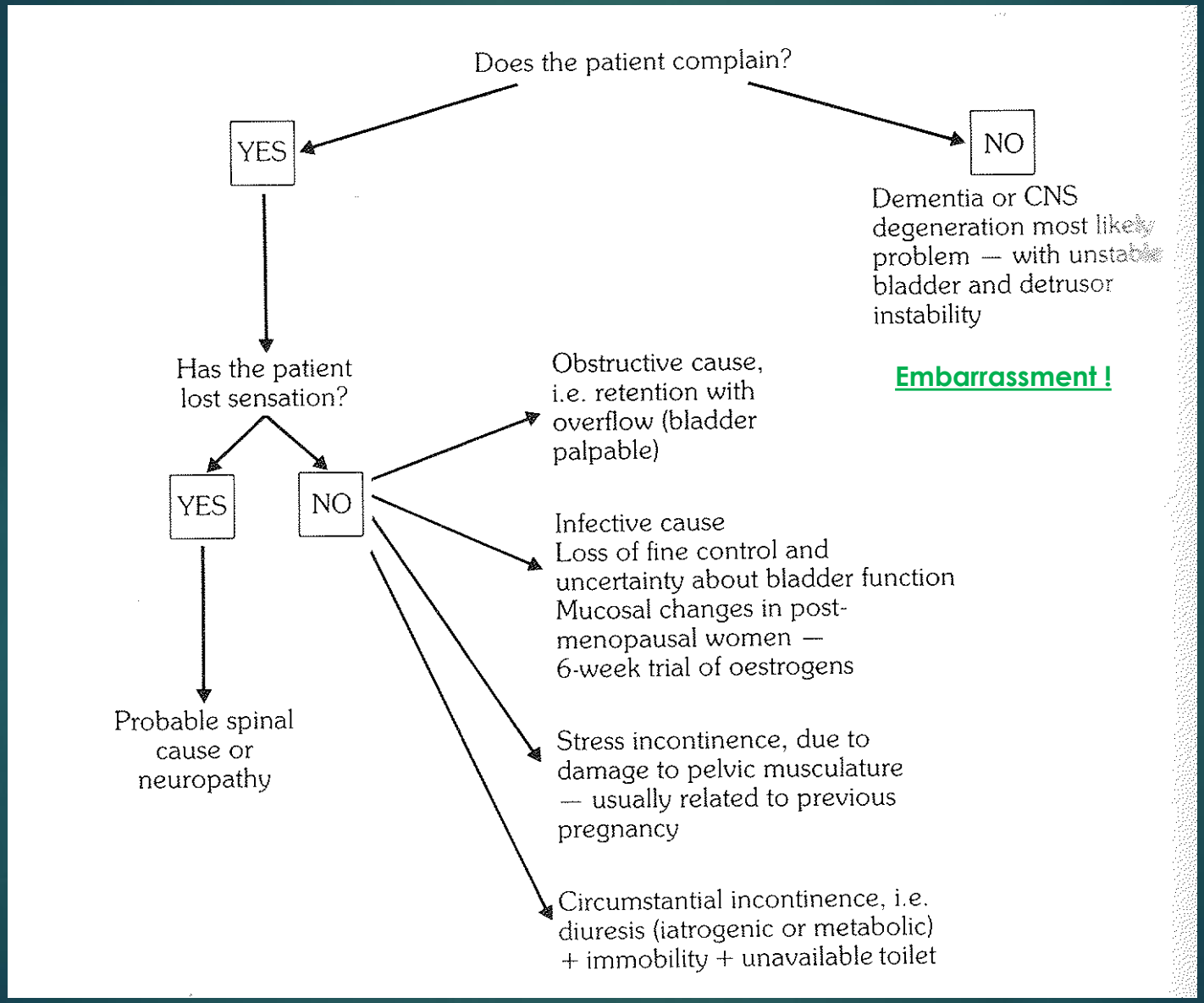
Why is Incontinence Age related ?

- **Overactive Bladder**
  - Parkinson's disease
  - Demyelination

Why is Incontinence Age related ?

other Age-Related Issues

- **Poor Mobility**
  - Stroke, Arthritis, Parkinson's etc.
- **constipation ?**
  - "Behind every full bladder lies a full rectum" !
- **Medication ?**
  - - diuretics,
  - paradoxical with anticholinergics,
- **Is it due to heart failure ?**
  - Nocturia, Oedema , tachycardia, creps


Does the patient complain?
YES
NO
Dementia or CNS degeneration most likely problem — with unstable bladder and detrusor instability
Embarrassment !
Has the patient lost sensation?
YES
NO
Obstructive cause, i.e. retention with overflow (bladder palpable)
Infective cause
Loss of fine control and uncertainty about bladder function
Mucosal changes in post-menopausal women — 6-week trial of oestrogens
Probable spinal cause or neuropathy
Stress incontinence, due to damage to pelvic musculature — usually related to previous pregnancy
Circumstantial incontinence, i.e. diuresis (iatrogenic or metabolic) + immobility + unavailable toilet

What should happen in Continence care ?...at the GP

- **Baseline examination:**
  - Palpate abdomen for bladder /constipation
  - Evidence of heart failure?
  - Neurological/ cognitive impairment ?
  - ?? PR **(But ONCE Please)**

- **Baseline investigations:**
  - Dipstick and MSU
  - FBC, Renal-liver function
  - Glucose/ HbA1C / Calcium / PSA

Full History of symptoms -Continence-Symptom Diary

- Past urology and Obs/ Gynae history
  - Is it mainly stress or urge ?
  - **Is it typical male LUTS pattern ?**
    - Older
    - Nocturia, hesitancy, poor stream, incomplete voiding dribbling
  - **Is it typical female stress pattern: ?**
    - Post partum
    - Multiparous, post menopausal
    - Hx instrumentation, repair surgery
    - sneezing, coughing , laughing. **"I nearly wet myself "**

What should happen in Continence care of older people ?....at the Hospital

A multidisciplinary assessment

- Always Geriatrician -**comprehensive geriatric assessment**
- Usually a Urologist
- Often a Gynaecologist
- *Physiotherapist
- *Nurse specialist
- *Occupational therapist.

Extra Investigations:

- Post micturition bladder scan +/-Urodynamics
- Cystoscopy / renal ultrasound

General overview of approaches to Urinary incontinence

- **Treatment is keyed to the type of incontinence**.

- **Stress incontinence**
  - Surgery
  - pelvic floor physiotherapy (KEGEL)
  - medication 2nd Line (?? Topical oestrogens, Duloxetine)
- **Urge incontinence**
  - **Changes in diet & behavioural modification**
  - **pelvic-floor exercises**
  - **Medications (anticholinergics/antimuscarinics, adrenergic agonists)**
  - **Intravesical treatment (botunlinium)**
  - **surgical intervention**
  - **sacral nerve stimulation**

General overview of approaches to Urinary incontinence II

- **Mixed incontinence**
  - - Anticholinergic /anti-muscarinic drugs
  - ? surgery
- **Overflow incontinence**
  - alpha agonists & alpha reductase inhibitors (men)
  - Catheterization regimen or diversion
  -
- **Functional incontinence**
- Treatment of the underlying cause

First Surgery needed is "Operation Transformation"

- **Curiosity and empathy from US**
- **Weight loss**
- **Change diet** – factors that aggravate urge
  - Spicy foods e.g. cayenne pepper, mustard
  - Citrus fruits and juices
  - Chocolate
- **Physiotherapy (KEGEL)** for all stress and mixed incontinence in women and post prostate surgery in men
- **Behavioural modification** programme in Overactive Bladder

Safety First -*Primum Non Nocere*

Pharmacology Principles

NICE- UK

- **1.7.1 When offering drugs to treat OAB always take account of:**
  - existing conditions (e.g.poor bladder emptying)
  - Existing meds –total anticholinergic load
  - risk of adverse effects.
- **1.7.2 Before OAB drug treatment starts, discuss with patients**
  - likelihood of success
  - common adverse effects, **and**
  - the frequency and route of administration
  - may not see the full benefits until for 4 weeks.
- ***1.7.3 Prescribe the lowest recommended dose when starting a new OAB drug treatment.***
- **1.7.4 If a woman's OAB drug treatment is effective and well-tolerated, do not change the dose or drug.**

" IF it's not broke don't fix it"

Pharmacology principles II

ACP – Ann Int Med 2014

- **Clinicians should choose pharmacologic agents by:**
  - Tolerability
  - Adverse effect profile
  - Ease of use
  - Cost of medication.
- What about Efficacy ??!!

Geriatric med principles

- It will likely work
- It will NOT make the person worse
- Will improve quality of life
- Easy to take
- Flexible ‘go low and slow’ dosing
- Won’t break the bank

Overactive bladder - NICE Pathways - Windows Internet Explorer

http://pathways.nice.org.uk/pathways/urinary-incontinence-in-women/urinary-incontinence-in-women-overview#path=view%3A/pathways/urir

File Edit View Favorites Tools Help

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Overactive bladder - NICE Pathways

Page Safety Tools

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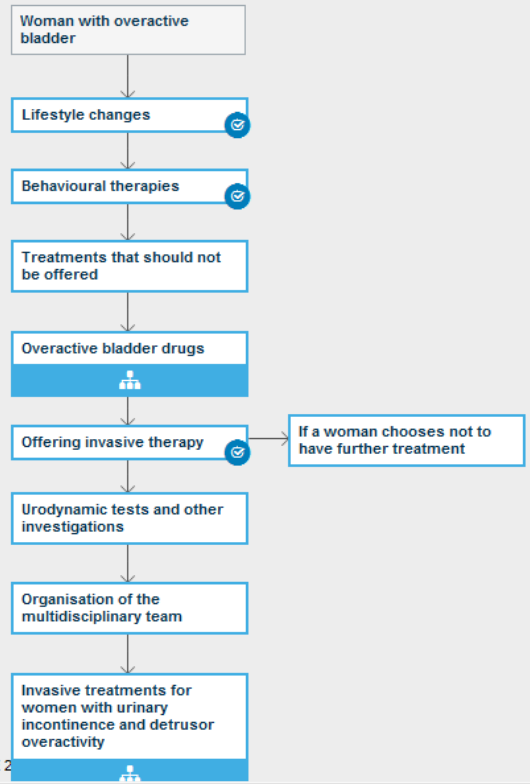
Overactive bladder



Urinary incontinence in women overview

About | Resources | Information for the public | Quality standards

These are the paths in the *Urinary incontinence in women* pathway:

- Urinary incontinence in women overview
- Initial assessment and investigation of urinary incontinence
- Stress urinary incontinence
- Surgery for women with stress urinary incontinence
- **Overactive bladder**
- Overactive bladder drugs
- Invasive treatments for women with urinary incontinence and detrusor overactivity

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09:44 25/02/2016

On-Line Resources

British Geriatrics Society:

http://www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/377-continenceBritish Geriatrics Society:

- Advocates Integrated Continence services

NICE Guidelines:

- http://pathways.nice.org.uk/pathways/urinary-incontinence-in-women

Raise awareness in Staff

Attention ALL Staff !

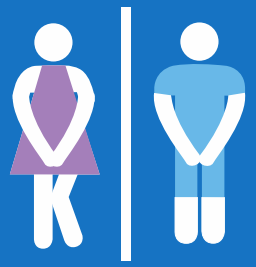
Tallaght University Hospital
Ospidéal Ollscoile Thamhlachta
An Academic Partner of Trinity College Dublin

Continence Awareness

Urinary incontinence isn't a disease, it's a symptom.

Ask yourself the following questions each time you empty a catheter, bring a commode, or attend to the personal care of each patient...

- Q1 Does my patient really need catheterisation?
- Q2 Is my patient really incontinent?
- Q3 Do they really need incontinent wear?
- Q4 Is the patients incontinent wear the correct type, size?
- Q5 How often is your patient being toileted?
- NB REPORT discreetly to the Nursing or Medical staff



How do you know what's Normal?

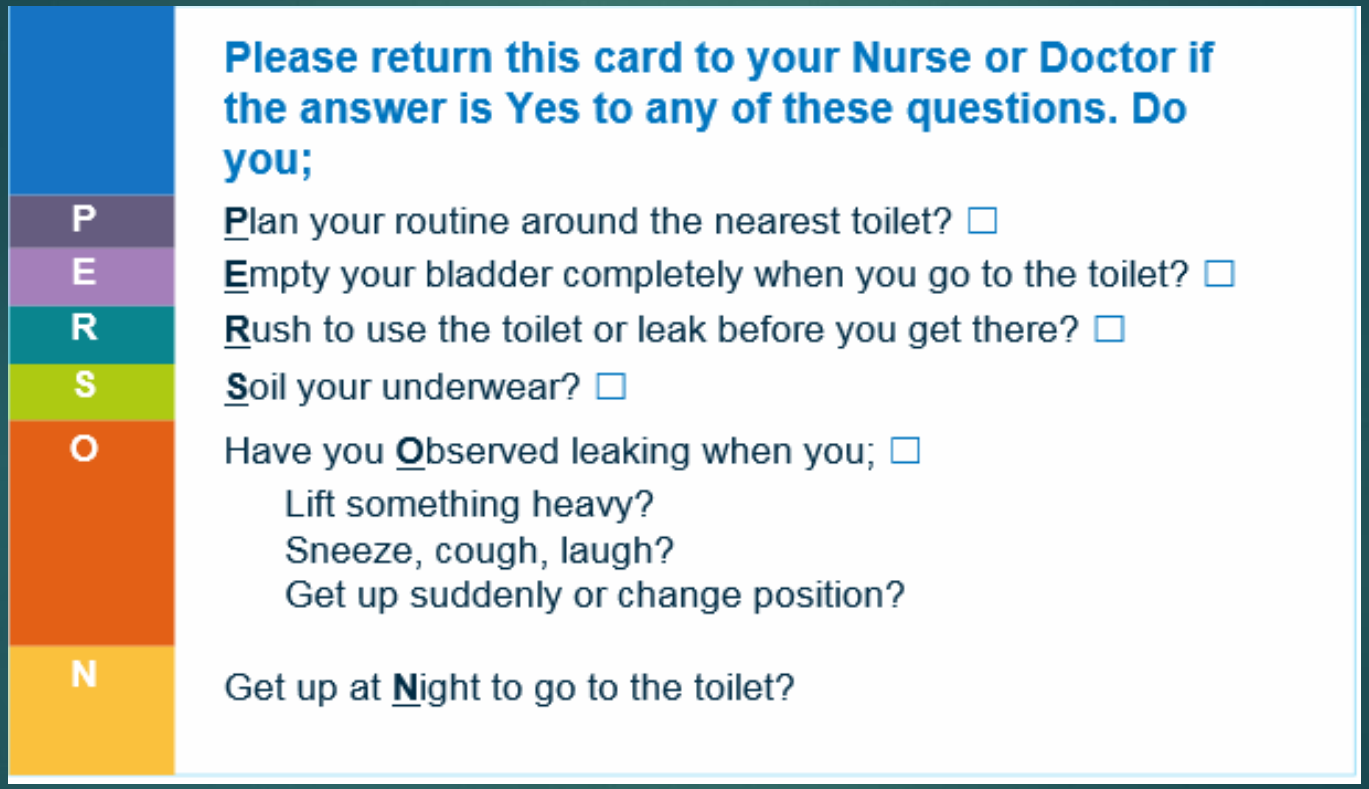
A Healthy Bladder

- ✓Does not leak, you feel when it is full and you have time to go to the toilet
- ✓Can hold to up 400-600mls
- ✓Empties between four to eight times a day
- ✓Can wake you up once a night to go to the toilet (twice if older)
- ✓Completely empties each time

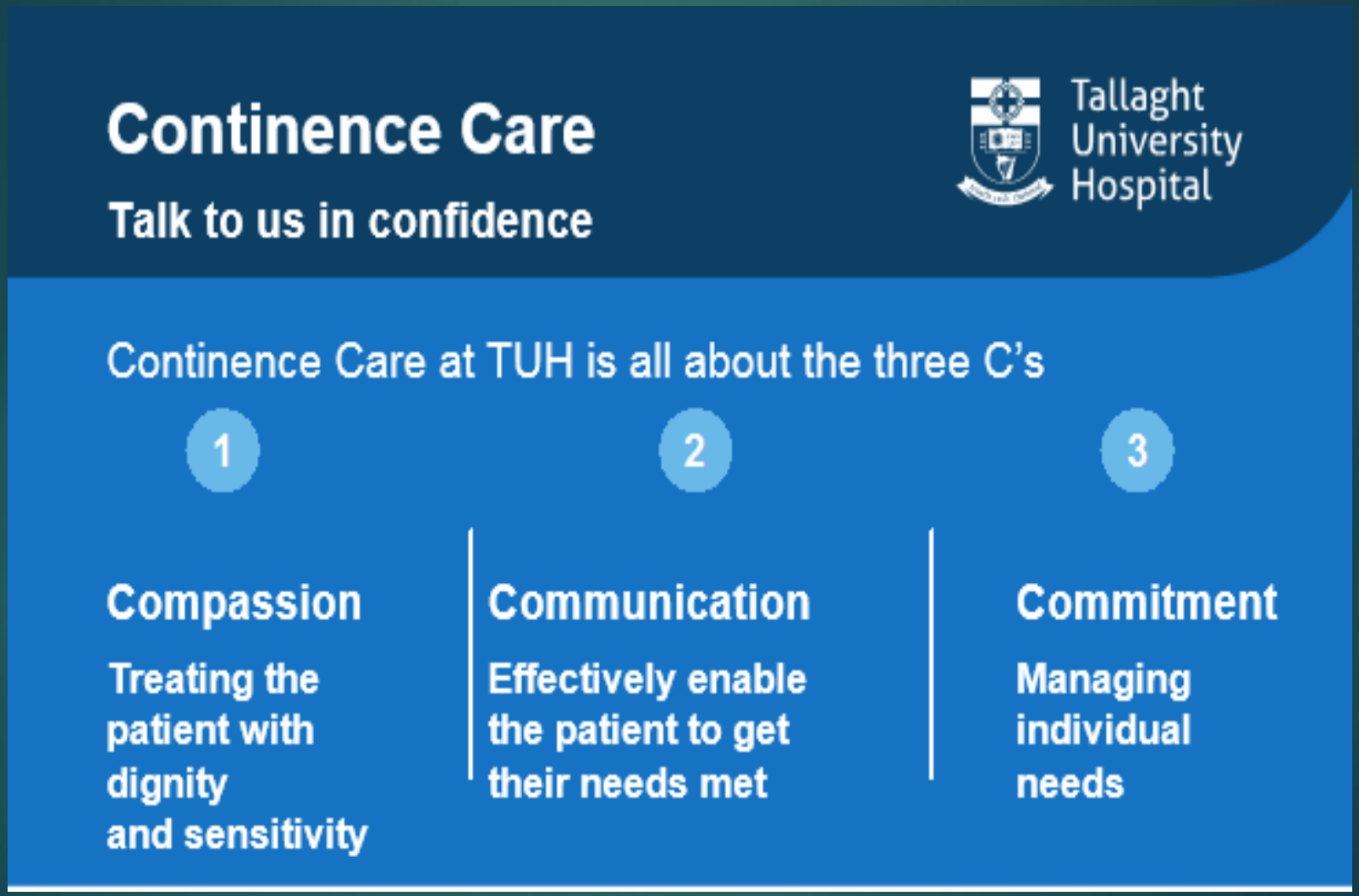
A Healthy Bladder

- XLeaks urine with coughing/sneezing/lifting
- XCan only hold 300mls or less
- XEmpties more than eight times a day
- XHas you up more than twice during the night
- XDoes not completely empty after passing urine
- XBurns or stings when passing urine
- XGives a strong urge to get to the toilet and you may not always make it in time

Empower patients



Remind Us All



A Charter for Continence ?

1. All patients have the right to have their continence maintained in hospital & community.

2. Hospitals have duty to provide clean toileting facilities with appropriate privacy suitable for all ages and all levels of physical and cognitive impairment .

3. Patients needing help to toilet are entitled to have physical assistance provided in a sensitive and private manner that maintains their dignity and aims to have them using normal toileting facilities

4. Loss of continence (pre-existing admission or new) requires a multidisciplinary and often interdisciplinary assessment to which patients are entitled.

Charter for continence

5. Bedside toileting by pan or commode should be a last resort of toileting in patient care and not dictated by staffing levels .

6. Use of continence pads on patients should not be routine and should only be put on patients after careful nursing review and with patients or their carers involved in the decision

7. Insertion and use of urinary catheters should only be for documented medical reasons and with the consent of patients or their carers. Catheters should have a daily care plan and be removed as soon as possible.

To achieve proper continence care we need….

- At least one continence nurse specialist in each acute hospital and every CHO
- Appropriate toilets and continence aids in our hospitals
- Making continence a core part of nursing plans again
- Interdisciplinary continence clinics for each acute hospital and CHO
- Appropriate level (? Mandatory) training for all doctors at BST and SPR level and at RGN/ CNM level in continence care

Next steps….?

- Overview paper of Irish audits of incontinence in preparation
- Media campaign ? Agree suggested charter
- Liaise with Institute Obs and Gynae / Irish urology society
- Address training issues with RCPI / RCSI and training within geriatric medicine

A New PANTS For Continence!

Tallaght University Hospital
Ospidéal Ollscoile Thamhlachta
An Academic Partner of Trinity College Dublin

P	**P**roactive about continence
A	**A**wareness of what it is
N	**N**othing to be ashamed of
T	**T**alk to your patient
S	**S**olve the problem