Urinary Incontinence in the Elderly

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Outline

1. Myths and facts about incontinence
2. Types of incontinence
3. Risk factors / causes of incontinence
4. Components of optimal continence care
5. Resources

Health Care Provider Perspectives and Attitudes are a Major Barrier to Care

- Myths:
  - Incontinence is a normal part of aging
  - Incontinence is an unavoidable result of childbirth
  - There is little that can be done to manage incontinence
  - Fluids should be restricted if someone has incontinence
  - Prompted voiding won’t work if the individual is cognitively impaired

The Canadian Continence Foundation (2007), Incontinence: A Canadian Perspective
Definition of Urinary Incontinence

“The complaint of any involuntary leakage of urine sufficient to be a problem”


Urinary Incontinence (UI) is very common

- 3.3 million Canadians (10%)
- Community:
  - 50% of women ≥ 45 years
  - 15 - 30% of seniors
- F > M (2:1) until age 80, then F = M
- Long-term care - 50%
- Home Care - 22%
- Acute care medical admissions – 20%


Patients don’t tell and Providers don’t ask

- Canadian Urinary Bladder Survey (2002)
  - Less than 50% of family physicians asked their patients about UI
  - Less than 50% of individuals report UI to their physician
  - Only 26% of individuals with bladder problem had seen a health care professional

**Incontinence – Physical, Emotional, Financial and System Burden**

- **Physical**
  - Falls, fractures, skin breakdown, infection, etc.

- **Emotional**
  - Depression, embarrassment, loss of intimacy, caregiver burden
  - Most common cause of admission to long-term care (LTC)

- **Financial**
  - Average personal cost is $1000 to $1500 / year

- **System**
  - Health care system $2.5 Billion / year (LTC $1 Billion)

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**The Bladder**

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**Age-related Changes in Urinary System: What does it mean?**

- Reduced ability to concentrate urine especially at night
  - Increased need to pass urine especially as night

- Bladder muscle hyperactivity with reduced central control so get desire to pass urine with smaller volumes and reduced ability to delay passing urine

- Males are predisposed to problems of “obstruction” because of prostate enlargement
  - Delay in starting, poor flow and dribbling

- Women because of hormone changes
  - Atrophic vaginitis & urethritis
  - Infection and flow problems
Relative Frequency of Types of Incontinence

Types of UI

- Transient (temporary)
- Established
  - Stress
  - Urge
  - Mixed
  - Overflow

Common Risk Factors to UI

- Functional
  - Impaired mobility
  - Increased "straining" or "stress" - constipation, COPD, chronic cough
  - Medications – diuretics, alcohol, caffeine, anti-depressants, psychotropics
  - Infection
- Mechanical
  - Obstruction
  - Atrophy
- Neurological Conditions
  - Central
    - Stroke
  - Parkinson’s Disease
  - Dementia (moderate to severe)
  - Peripheral
  - Diabetes
- 1/3 have multiple conditions
Medications Associated with Incontinence

- Mechanisms: Polyuria, constipating, affect awareness, retention, affecting smooth muscle
- Diuretics
- Sedatives
- Hypnotics
- Anticholinergics
- Antidepressants (Amitriptyline)
- Opioid analgesics (Codeine)


Transient or Temporary UI

- Reversible cause(s):
  - Cognitive changes / confusion / delirium
  - Urinary tract infection
  - Medications
  - Restricted mobility
  - Constipation
- 50% hospitalized elderly patients
- May include “functional” incontinence
- If untreated, can become permanent!

The Canadian Continence Foundation: www.continence-fdn.ca

Established UI

- Stress
  - Associated with abdominal pressure (e.g. cough / sneeze)
- Urge
  - Occurs soon after a strong urgency to void
- Mixed
  - Features of both stress and urge incontinence
- Overflow
  - Associated with bladder over-distention
- Functional
  - Related to a cognitive / physical / environmental cause instead of a bladder problem

Stress Incontinence

- Loss of urine with a sudden increase in intra-abdominal pressure (e.g. coughing, sneezing, exercise)
- Most common in women
- Sometimes occurs in men following prostate surgery

Urge Incontinence

- “Overactive bladder”
- Loss of urine with a strong, unstoppable urge to urinate
- Usually frequent urination day and night
- Common in women and men

Overflow Incontinence

- Bladder is full at all times and leaks continuously
- Usually associated with symptoms of slow stream and difficulty urinating (hesitancy)
- More common in men due to enlarged prostate
Optimal Continence Care

1. Screening
2. Comprehensive assessment
3. Identify contributing factors
4. Determine type
5. Management
   - Global strategies
   - Type-specific strategies


Optimal Continence Care

1. Screening
   - Do you ever lose urine when you don’t want to?
   - or
   - Do you ever lose urine and experience wetness?
   - and maybe:
     - Do you ever use pads, liners or briefs to keep you dry?

The Canadian Continence Foundation. www.continence-fdn.ca

Optimal Continence Care

2. Comprehensive Assessment
   - Incontinence history
Optimal Continence Care - Assessment

Incontinence History
- Onset
- Sudden or gradual
- Same or getting worse
- Frequency of day and night voiding
- Number and severity of incontinent episodes
- Use of containment products
- Specific questions – stress, urge, overflow
- Awareness of voiding? (cognition)
- Symptoms with voiding – hesitation, pain / burning, dribbling


Optimal Continence Care
2. Comprehensive Assessment
- Incontinence history
- Fluid intake
- Bowel function
- Medical history
- Medication
- Functional assessment
- Abilities assessment
- Physical assessment
- Contributing factors


Optimal Continence Care - Assessment
Fluid Intake and Bowel Function
- Fluid intake – amount, type, timing, restricted?
- Caffeinated beverages or alcohol
- Normal pattern of bowel movements
- Constipation
- Diet changes
- Laxatives or medications

Optimal Continence Care - Assessment

Medical History

- Surgical procedures – vaginal vs. abdominal hysterectomy; removal of ovaries? (estrogen); previous bladder repair; prostatectomy
- Parkinson’s, stroke, heart failure, COPD, recurrent UTIs
- Birth history – number of births; type of delivery; trauma to pelvic floor?
- Receiving medical treatment for incontinence?

Optimal Continence Care - Assessment

Medication

- Identify any that have an impact on bladder function
- Most cited in the literature:
  - Diuretics
  - Sedatives
  - Hypnotics
  - Anticholinergics
  - Amitriptyline
  - Opioid analgesics

Optimal Continence Care - Assessment

Functional Abilities

- Lives alone?
- Assistance in home?
- Access to bathroom
- Ability to ambulate, transfer; balance
- Arm strength, flexibility, dexterity
- Eyesight
- Ability to self-clean
Optimal Continence Care - Assessment

Physical Assessment

- Females and Males:
  - Post-void residual – scan or in/out cath
  - Send of culture / urine dipstick – if + for WBC or nitrates – send for culture to r/o infection
  - Condition of skin – irritation from leakage, product use


Optimal Continence Care - Assessment

Physical Assessment

Female:
- Atrophic vaginal changes
- Colour – pink (normal) vs. pale/white (abnormal); tissues red, thin, friable = possible atrophic vaginitis
- Vaginal discharge – swab if present
- Cough – observe for cystocele, urethrocele, rectocele

Male:
- Abnormalities of genitalia, urethral opening


Optimal Continence Care

3. Identify all Contributing Factors

- From history and comprehensive assessment
- If complex – referral to physician, geriatrician, urologist, urogynaecologist, nurse continence advisor for additional assessments
  - Cystoscopy
  - Urodynamics

Optimal Continence Care
4. Determine type of UI

- Transient (temporary)
- Established
  - Stress
  - Urge
  - Mixed
  - Overflow

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5. Management – Global Strategies

- Establish good habits
  - Routine
  - Fluids 1500-2000 ml / day
  - Minimize caffeine and alcohol use (especially at night)
- Review medications
- Optimize mobility and environment
- Address all contributory factors: constipation, atrophy, infection etc
- Select appropriate continence product – size and fit, absorbency, comfort, client ease of use, day vs. night needs


Optimal Continence Care
5. Management – Functional Incontinence

- Individualized prompted voiding schedule
  - Based on client needs and caregiver observations
  - RNAO recommends using 3-day voiding record
- Interdisciplinary team
  - OT – adaptive aids – equipment, clothing, environment
  - PT – mobility aids / enhancement
  - SLP – communication strategies (aphasia)

Health Care Provider Perspectives and Attitudes are a Major Barrier to Care

- Myths:
  - Incontinence is a normal part of aging: NO – over 50% are free from problems, and probably 75% of those affected have treatable components.
  - Incontinence is an unavoidable result of childbirth. Should be rare!
  - There is little that can be done to manage incontinence. Incorrect.
  - Fluids should be restricted if someone has incontinence: NO - just exercise common sense.
  - Prompted voiding won’t work if the individual is cognitively impaired: Incorrect.

Resources

- Specialized Geriatric Services
  - Geriatricians
  - Nurse Continence Advisors
- Other resources?

Further Resources

- RNAO Best Practice Guidelines Prompted Voiding and Managing Constipation
- The Canadian Continence Foundation www.continence-fdn.ca (for professionals and public)
- American Geriatrics Society “Geriatrics At Your Fingertips” (updated annually, online, free) www.geriatricsatyourfingertips.org
- Handouts/health information on UI
  - Women’s Health Matters www.womenshealthmatters.ca
  - Women’s Bladder Health www.womenlbladderhealth.com
  - Canadian Urological Association www.cua.org
  - Canadian Nurse Continence Advisors www.cnca.ca
  - Canadian Physiotherapy Association www.physiotherapy.ca
  - Canadian Women’s Health Network www.cwhn.ca
  - The Powder Room (overactive bladder) www.powderroom.ca