CONTINENCE FAILURE

Loss of continence is common in older people. 24% of community dwelling older adults are affected by urinary incontinence and 1-4% have faecal incontinence. In continuing care facilities between 30-60% of people will be incontinent of urine and up to one quarter of will be faecally incontinent.

Loss of continence causes much distress and loss of dignity for the older person and their carers. It is often a major factor in breakdown of social support necessary to continued living at home. It is also a major societal burden: $1.1 billion/year spend on disposable pads alone in the US.

For individual:

- Reduced Quality of Life
  - Embarrassment
  - Social isolation
  - Depression
  - Avoidance of sexual contact /intimacy
- Potentially Serious Health Effects
  - Limitation /cessation of physical
  - Poor Hygiene, UTI, fractures

Problems with continence are often not volunteered by patient, tolerated (although with increased stress) by carers and poorly detected by healthcare staff. Where a continence problem is identified, assessment and management of the root cause is vital rather than a reliance on compensatory incontinence aids.

- Innervation
  - Higher centres
  - Spinal centres
  - Sphincters – sympathetic
  - Detrusor – parasympathetic

Types of incontinence

Often multiple types at once!

Transient

Delirium, drugs, infection, reduced mobility, constipation

Urge

Little/no warning
Reduced ability to retain
Associated with detrusor instability (no other neurological signs) or detrusor hyperreflexia

Stress

Coughing/sneezing/laughing
Obstetric history
Structural abnormality
- Urethral hypermobility
- Intrinsic sphincteric deficiency

Neuropathic

MS, PD, stroke
spinal cord injury

Overflow

Incontinence associated with poor bladder emptying.

Clinical approach

History

1. Do you leak urine when you cough, sneeze, or laugh?
2. Do you ever have such a strong need to urinate that if you don't reach the toilet you may leak?
3. If yes to #2, do you leak before you reach the toilet?
4. How many times during the day do you urinate?
5. How many times do you void at night after you've gone to bed?
6. Have you wet the bed in the last year?
7. Do you develop an urgent need to urinate when you are under stress, in a hurry, or are nervous?
8. Do you leak during or after sex?
9. How often do you leak?
10. Do you have to wear a pad?
11. Have you had bladder, urine or kidney infections?
12. Any pain or discomfort with urination?
13. Any blood in your urine?
14. Do you find it hard to begin urinating?
15. Do you have a slow stream or have to strain to pass your urine?
16. After you urinate, do you have dribbling or feel that your bladder is still full?

Full medical, obs/gyn, neuro, surgical and drug history:
DM, CVA, Lumbar disk dis
COPD/chronic cough
Constipation
Hysterectomy, vaginal repair, retropubic surgery, or radiation
Sedatives, diuretics, anticholinergics, α-blockers, α- or β-agonists, calcium channel blockers

Urinary diary

Record volume and frequency of fluid intake and voiding for 1-7 days
Record episodes of incontinence
Record Nocturia/Enuresis
Record max volume voided (approximates bladder capacity)

Examination

MMSE
Neurological
Urological + gynaecological
PR: constipation, prostate, anal sensation, anal tone

Investigation
Blood glucose
Urinalysis
MSU
Urea and creatinine
Postvoid residual
± Urodynamics
± Cystoscopy and cytology (if hematuria or acute onset irritative symptoms in absence UTI)

Urodynamics
– Cystometry – study of bladder fxn
– Pressure-flow study – bladder fxn during void
– Videourodynamics
– Uroflowmetry (study of flow rates)
– Electromyography (EMG)
– Urethral Pressure Profilometry
– Ambulatory Urodynamics

Management strategy
Rectify aggravating factors
Delirium
Review drugs
Mobility
Infection
Constipation
Atrophic vaginitis

Stress incontinence
Pelvic floor exercises (Kegel) ±biofeedback: 16% cure, 54% improvement
Gynaecological evaluation will direct potential candidates towards surgical intervention

Urge incontinence
Bladder training
to resist or inhibit the sensation of urgency
to postpone voiding
to urinate to a timetable rather than according to the urge to void

Oestrogen supplementation

Anticholinergic therapy
Oxybutynin
Tolterodine
Trospium
But not for everyone…constipation, dry mouth, blurred vision

NEW!! Botox, Bladder Pacemaker

Overflow
Men usually prostate
Watch for precipitating factors: eg, behind every full bladder lies a full rectum
Plan: urology review re Rx

If above strategies not successful,
When patient stable: continence charting
If continence < 2 hourly: compensatory measures
If continence > 2 hours: toileting as per the chart

Compensatory strategies
Continence advisor – key aid!

Pads (now a large range)
Condom catheter
Intermittent self-catheterisation
Indwelling catheters
- Demeaning and dangerous
- Reserved for non-operable prostatic obstruction, pressure sores
- Remember leg-bags