Urinary Incontinence

Overview

One of the greatest aging myths is that urinary incontinence (UI) is part of normal aging, when, in fact, it is not. UI is defined as the involuntary passage of urine. Older adults are often embarrassed by this problem and are reluctant to discuss this issue with their clinician.

The diagnosis and management of UI can be successfully achieved in the primary care setting and in consultation with an urologist (surgical interventions). It is highly treatable and even curable in many instances (Pompei & Murphy, 2006).

The two main UI etiologies are transient and established incontinence.

Transient incontinence (often reversible) etiologies can be summarized using the DIAPPERS Mnemonic.

Reversible Causes of Urinary Incontinence (DIAPPERS)

Delirium

Infection (UTI)

Atropic

Pharmacological

Psychological

Endocrine/excess urine output

Restricted Mobility

Stool Impaction


Established incontinence is caused by a persistent problem affecting nerves or muscles.

There are five types of incontinence:

- Stress incontinence results from abrupt abdominal pressure such as sneezing, coughing or laughing.
- Urge incontinence is characterized by uncontrolled leakage with irrepressible need to void.
- Overflow incontinence is dribbling of urine.
• Functional incontinence is related to cognitive, physical or environmental impairment.
• Mixed incontinence is a combination of any of the above types, but most commonly is a combination of stress and urge.

**Key Points**

UI is NOT a normal aspect of aging.

There is a large prevalence variation of 8-72% in community based older adults (Zurcher, Saxer, & Schwendiamann, 2011).

UI is greater in women compared to men 80 years of age or younger; prevalence is equal in both genders after 80 years (Minassian, Stewart, & Wood, 2008); Markland, Goode, Redden et al. 2010).

Approximately 35-42% of hospitalized adults are affected by UI (Ko, Lin, Salmon & Bron, 2005).

UI in older adults is treatable and often curable.

**Assessment**

Under-reporting of UI is common in older adults. UI screening is an effective method to elicit this information. The following questions will help your assessment process (DeMaagd & Davenport, 2012):

- **General Question** – Do you ever leak urine? **OR** Do you ever lose control of your urine?
- **Stress UI** – Do you leak when you cough or laugh? Do you leak on exertion or getting up from a chair?
- **Urge UI** – Is the need to go so great that you would leak if you did not get to the toilet immediately?
- **Functional UI** – Have you leaked urine because of a problem unbuttoning your pants or adjusting your clothing?
- **Overflow UI** – Do you know when you are leaking? Do you strain to pass urine? Do you find that you leak after you think you are finished?

**Management**

Successful UI management requires a stepwise approach
Step 1: Functional Management – Use assistive devices (urinals & bedside commode), medication review, eliminate environmental barriers in the path to the toilet, initiate timed voiding schedules (useful in cognitively/physically disabled patient).

Step 2: Hospitalized Older Adults - Complete a continence assessment early in the hospitalization process. Avoid unnecessary indwelling catheters and remove indwelling catheters as soon as possible. Involve interprofessional team members to assess the older adults’ functional abilities (physical & occupational therapy), home visit (nurse and social work assess home for safety and home health needs), and pharmacist (medication review to determine untoward side effects of medications that may be contributing to the older adults UI).

Step 3: Take a thorough history and implement behavioral strategies. Poor hydration causes bladder spasms & increases incidence. Obesity is well cited in the literature to increase urinary incontinence. If weight is an issue, think about a weight management program. Avoiding caffeine can reduce urine leakage 63% (Tomlinson et al., 1999). Other dietary modifications include avoiding alcohol, citrus and spicy foods (Wyman, 2000).

Step 4: Pharmacologic options are available based on the type of the diagnosed UI.

Step 5: Invasive non-surgical management includes Kegel exercises, life style modifications (smoking cessation, fluid restrictions, caffeine reduction, and alcohol reduction), intravaginal weighted cones, pessaries, pelvic floor electrical stimulation, sacral nerve stimulation, and biofeedback.

Step 6: Surgical interventions are also available. Surgical procedures will be determined based on the type of UI but include: sling procedures, other urethral suspension techniques (suprapubic arc, transobturator, and colposuspension [Burch] procedure).

References


