

Female urinary incontinence - primary care management

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Urinary incontinence is a common and distressing condition. It is an underreported problem because of the stigma associated with the condition and many patients simply suffer in silence.

Definition

Urinary incontinence is defined as involuntary leakage of urine.

Prevalence

It has been estimated that in the United Kingdom (UK) 9.6 million women are affected by bladder problems.^{1, 2} An overactive bladder itself affects five million adults, nearly 1 in 5 of the over-40 population.³ Prevalence is estimated to be 15% among healthy older adults and 65% of old frail adults.⁴ It is twice as common in women than men. It can affect women of all ages including after childbirth. In a cross-sectional survey of adult females attending a primary care practice in the UK, nearly half had urinary incontinence but only a small minority sought help.⁵ Forty-two per cent of women affected wait up to 15 years before seeking treatment.⁶

Types

1. Stress incontinence: This is involuntary urine leakage on exertion such as coughing/laughing/sneezing or exercise. Stress incontinence is due to an incompetent urethral sphincter. It is largely caused by childbirth thus young women can develop this problem. Other causes include pelvic surgery or hysterectomy.

2. Urge incontinence: This is involuntary urinary leakage associated with urgency (a compelling desire to urinate that is difficult to defer) and is due to detrusor overactivity leading to detrusor contraction. Urge incontinence often appears later in life. Frequency or nocturia, with low volume of urine voided, are signs of an overactive bladder that can occur with or without urge incontinence.⁷ An overactive bladder affects both genders and its prevalence rises with age, affecting 16.7% of those aged 40 in North America and Europe.³ An overactive bladder should be managed in the same manner as urge incontinence.

3. Overflow incontinence

4. Mixed incontinence: This is both stress and urge incontinence.

Risk factors

The most important risk factor is being female. Others are:

- Obesity
- Pregnancy and childbirth
- Obstruction - tumours in the pelvis or impacted stool
- Hysterectomy⁸
- Neurological disease
- Cognitive impairment

Burden

In 2001 the annual estimated cost of dealing with bladder problems was £353.6 million.⁹ This included expenditure on pads. It is expected to be much higher now. Only a small proportion of the above amount was spent on drugs,¹⁰ the remainder being spent on secondary care and surgical treatment.

Bearing this in mind, it makes sense that the general practitioner (GP) is ideally placed to screen and manage these patients in primary care. It is not necessary to refer *all patients* to secondary care. With the ever-increasing pressure on GPs to reduce unnecessary referrals, there is now a scope for commissioning this service. However, management of an overactive bladder is not part of the Quality and Outcome Framework - could be one reason why GPs are not keen or enthusiastic.

Primary care management

History

A good history makes the initial diagnosis. Ask the woman whether she leaks on coughing, sneezing or exertion (stress) or whether she has an urgent need to pass urine before the leakage (urge). If she gives a history of both, she probably has mixed incontinence.

A history of nocturia or frequency with low urinary volume means an overactive bladder. This should be managed in the same way as urge incontinence. Previous surgery, or an obstetric and gynaecology history, may give further clues as to the type of incontinence.

Examination

- Abdominal examination - any palpable mass. This may be a palpable bladder, an ovarian cyst, or a large fibroid.
- Pelvic examination - Prolapse, enlarged uterus due to fibroid. Inspection of the pelvic floor may show visible stress incontinence on straining or coughing.
- Per-rectal (PR) examination if suspicion of constipation or faecal incontinence.

Investigations

- Routine urine check for sugar and protein.
- Mid-stream urine (MSU) to exclude urinary infection.
- Bladder diary for three days. Ask the woman to complete a diary of time and fluid volume - intake and output with episodes of urinary leakage and her activity at that time. The charts are available from pharmaceutical companies (keep the booklets in your examination room).
- National Institute for Health and Clinical Excellence (NICE) states that the use of cystometry, ambulatory urodynamics or video-urodynamics is not recommended before commencing non-surgical treatment.¹¹

Treatment

Treatment depends on the type of incontinence. Pregnancy and childbirth are known risk factors and there is evidence that pelvic floor exercises during pregnancy reduce the risk. The exercises should be taught by the midwife during antenatal classes.

- For stress incontinence, the first line therapy is three months of pelvic floor exercises. These should be taught by the practice nurse. An instruction leaflet on its own is not enough. There is good evidence that advising about pelvic floor exercises is an appropriate treatment for women with persistent postpartum urinary incontinence.¹²
- For urge incontinence, bladder training is the first step. The patient should be taught to gradually increase the time between voids.
- Life style advice in all with a body mass index (BMI) over 30kg/m².¹¹
- Household modifications, mobility aids, downstairs toilets can help an elderly patient struggling to reach the toilet in time.
- Regular prompting of patients, by residential or nursing home staff, to visit the toilet can make a considerable difference rather than putting a pad on.
- Patients with an overactive bladder should be advised to reduce their caffeine and alcohol intake.
- Encourage the patient to drink two litres of fluid a day. Many women reduce their fluid intake hoping that this would help the symptom control, but less fluid intake can lead to concentrated urine which can result in bladder irritation.

- Antimuscarinic drugs such as oxybutynin can be used if bladder training is not successful. NICE recommends that immediate-release oxybutynin should be given as a first line.¹¹ Transdermal oxybutynin can be given if oral oxybutynin is not tolerated. Compliance is often a problem because of side effects e.g. dry mouth, constipation, dry eyes, blurred vision, dizziness and cognitive impairment. Contraindications are acute angle glaucoma, myasthenia gravis, severe ulcerative colitis and gastrointestinal obstruction.
- NICE does not recommend duloxetine as a first or second line treatment for stress incontinence. It can be considered if there are persisting side effects with oxybutynin.
- Desmopressin or tricyclic antidepressants can be used in women with nocturia.
- The role of hormone replacement therapy (HRT) is debatable. Although oestrogens may improve atrophic vaginitis, there is no evidence that oestrogens by themselves are beneficial in incontinence.¹³
- Pads and catheters should only be issued on prescription if all treatment options have failed and the patient is waiting to see a specialist. These are coping aids.

Referral to secondary care

GPs should refer patients to a urogynaecologist or a surgeon who has experience in this field. Extra-contractual referrals are not favoured by Primary Care Trusts (PCTs) - try convincing your PCT!

Refer if there is:

- Pelvic mass
- Frank haematuria
- Symptomatic prolapse
- Suspected neurological disease
- Urogenital fistula
- Previous pelvic surgery
- Failure of conservative measures and anticholinergic drugs.

Useful patient information

www.continence-foundation.org.uk

Competing Interests

None declared

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