

# Urinary incontinence | Te mimi wewete

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## Changes with age

The maximum amount of urine that the bladder can hold tends to decline. The ability to postpone urination after feeling the need to may decrease.

The amount of residual urine increases:

- In women, the urethra shortens and its lining becomes thinner as the level of oestrogen declines during menopause, decreasing the ability of the urinary sphincter to close tightly.
- In men, the rate of urine flow out of the bladder and through the urethra slows when the prostate gland enlarges and is common when men age.

## Review history of urinary incontinence

- Medical diagnosis
- Medication
- Characteristics of voiding – frequency, timing, volume
- Previous treatment for urinary incontinence and outcome
- Importance to resident
- Bowel habits
- Use of restraint
- Use of continence products.

## General assessment

- Mental status and motivation
- Mobility
- Environment.

## Targeted physical examination

- Lower extremity oedema
- Neurological
- Abdominal
- Pelvic (women) external examination of labia, vagina for prolapse, atrophic vaginitis, skin changes.

## Tests

- Urinalysis, urine culture and sensitivity is symptomatic
- Post-void residual urine
- Stress cough test
- Supplemental blood work where indicated.

## General considerations

- Avoid caffeine – can irritate the bladder
- Maintain fluid intake – concentrated urine can irritate the bladder
- Time administration of diuretics so the resident can be close to the toilet
- Alcohol may make symptoms worse.

## Potentially reversible conditions

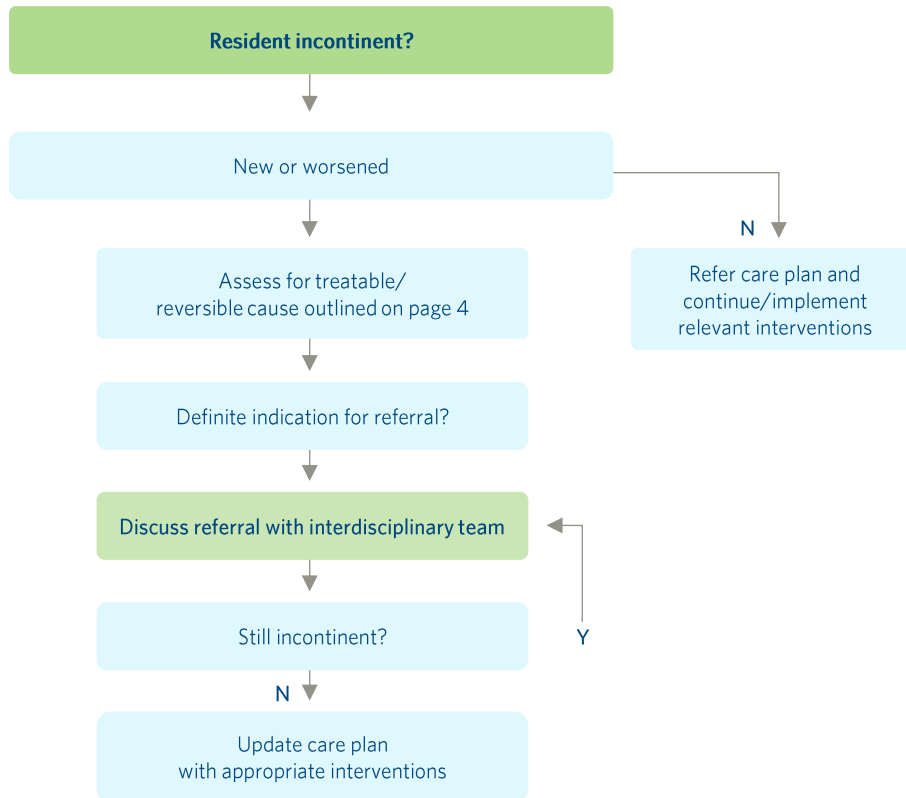
- Stool impaction
- Urinary tract infection
- Delirium
- Depression
- Increased fluid intake
- Volume overload
- Congestive heart failure
- Venous insufficiency with oedema
- Drug side effects: rapid acting diuretics, anticholinergics, narcotics, calcium channel blockers, alpha-adrenergic agonists, psychotropic drugs
- Irritation or inflammation in or around lower urinary tract
- Atrophic vaginitis or urethritis
- Metabolic (hyperglycaemia, hypocalcaemia)
- Impaired ability or willingness to reach a toilet
- Illness, injury or restraint that interferes with mobility.

## Indications for referral – always refer for these

- Microscopic haematuria
- Visible haematuria
- Recurrent or persistent urinary tract infection associated with haematuria
- Suspected pelvic mass arising from the urinary tract infection
- Symptomatic prolapse visible at or below the vaginal introitus
- Palpable bladder after voiding
- Persisting bladder or urethral pain
- Clinically benign pelvic masses
- Associated faecal incontinence – diarrhoea
- Suspected neurological disease
- Voiding difficulty
- Suspected urogenital fistulae.

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## Determine urinary incontinence



## Urinary incontinence symptoms and outcomes

<b>Stress</b>	<ul style="list-style-type: none"> <li>• Involuntary loss of urine that occurs with increased abdominal pressure, eg, coughing</li> <li>• May occur as a result of weakened pelvic floor muscles or malfunction of the urethral sphincter</li> <li>• Stress and urge incontinence often occur together in women. Known as 'mixed incontinence'</li> </ul>	<ul style="list-style-type: none"> <li>• Pelvic floor muscle exercises (3 months)</li> <li>• Scheduled toileting</li> <li>• Oestrogen cream</li> <li>• Surgery</li> </ul>
<b>Urge</b>	<ul style="list-style-type: none"> <li>• Involuntary loss of urine that occurs with sudden need to urinate due to bladder contractions</li> <li>• This occurs regardless of the amount of urine that is in the bladder</li> <li>• May result from neurological injuries, eg, spinal cord injury or stroke, MS, Parkinson's, Alzheimer's. Other causes: infection, bladder cancer, bladder stones, inflammation or bladder outlet obstruction</li> </ul>	<ul style="list-style-type: none"> <li>• Bladder training to increase capacity (6 weeks)</li> <li>• Scheduled toileting</li> <li>• Pelvic floor muscle exercises</li> <li>• Anticholinergic medicines, eg, oxybutynin to reduce bladder urge to empty urine</li> </ul>
<b>Overactive bladder syndrome (OABS)</b>	<ul style="list-style-type: none"> <li>• Where no cause can be found for repeated and uncontrolled bladder contractions, eg, not due to urine infection or enlarged prostate</li> <li>• OABS is sometimes called irritable bladder or 'Detrusor (bladder muscle) instability'</li> <li>• Symptoms include urgency, frequency, nocturia and urge incontinence</li> </ul>	<ul style="list-style-type: none"> <li>• Bladder retraining to increase capacity, anticholinergic medicines, eg, oxybutynin</li> </ul>
<b>Overflow</b>	<ul style="list-style-type: none"> <li>• Resident never feels urge to urinate, the bladder never empties and small amounts of urine leak continuously</li> <li>• Prevalent with enlarged prostate</li> <li>• Rarely seen in women</li> <li>• May be caused by weak bladder muscles, loss of bladder sensation or obstruction, eg, enlarged prostate, constipation, urethral stricture</li> <li>• Signs and symptoms include: no or rare urge to void, inability to void, continuous urine dribbling</li> <li>• Clinical findings: high residual volume of urine in bladder despite incontinence (measured with bladder scan or in/out catheter)</li> </ul>	<ul style="list-style-type: none"> <li>• Assess for high-residual volume of urine in bladder despite incontinence (measured with bladder scan or in/out catheter)</li> <li>• Consider intermittent self-catheterisation (or in/out catheter by nursing staff) or permanent IDC</li> <li>• Where overflow incontinence is present, consider creatinine level given risk of bilateral hydronephrosis secondary to incomplete bladder emptying. If creatinine deteriorating, consider catheter as above</li> <li>• A trial of alpha blocker (eg, doxazosin, terazosin) may add small benefit in men with overflow incontinence with BPH</li> <li>• Prescribe medication alongside scheduled voiding and double voiding schedule</li> </ul>
<b>Functional</b>	<ul style="list-style-type: none"> <li>• Problems with thinking, moving or communication that prevents the resident reaching a toilet, although the urinary system is normal</li> <li>• May not recognise the need to go to the toilet, where the toilet is, or get there on time. Urine loss may be large</li> <li>• Causes include confusion, dementia, poor eyesight, poor mobility, poor dexterity, unwillingness to toilet because of depression, anxiety or anger.</li> <li>• Mental confusion may prevent both recognition of the need to void and finding a bathroom</li> </ul>	<ul style="list-style-type: none"> <li>• Scheduled toileting</li> <li>• Bedside commode/hand-held urinal</li> </ul>

## Bibliography | Te rārangi pukapuka

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