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Continence Management

Lunch with the Professors
Geriatrics Update Course
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Discussion Topics

- Age Related Changes in the Lower GU Tract
- Assessment
- Types of U I
- Reversible Causes of U I
- Drugs Causing Acute Changes in Mental Status in Elderly Persons
- Management Options

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Age Related Changes

- Increased nocturnal urinary output related to change in levels of arginine vasopressin and atrial natriuretic hormone
- Reduction in urethral closing pressure and urethral length resulting from estrogen loss
- Reduced ability to delay voiding
- Reduced bladder capacity

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Age Related Changes

- Reduced sensory awareness of filling
- Reduced urinary flow rates
- Elevated post void residual (PVR)
- Elevated risk for bladder outlet obstruction secondary to prostatic hypertrophy
- Increased frequency of sensory and motor urgency

- Data from Miller M; Nocturnal polyuria in older people., J Am Geriatr Soc 48:1321-1329, 2000; Naeem M, Naeem L, Morey JE Aging urinary bladder. In Morley JE, Ambrecvht HJ, Coe RM, Vellas B, editors: Science of geriatrics, vol !!, New Your, 2000, springer-Verlag, pp 659-667; and Wagg A,Malone-Lee J: The management of urinary incontinence in the elderly, Br J Urol 82(suppl):11-17, 1998. In Doughty, D, Urinary and Fecal Incontinence: Current Management Concepts, Third Ed.2006, p56.

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Assessment

- Lower Urinary tract symptoms
- History
- Physical exam
- Environmental assessment
- Symptom severity, effect and quality of life
- Voiding diary
- Lab studies/endoscopy/imaging

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Types of Urinary Incontinence

- Stress
- Urge
- Mixed
- Overflow
- Functional

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Stress Incontinence

- Involuntary leakage on effort or exertion (sneezing or coughing, laughing, movements)

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Urge Incontinence

- Involuntary leakage accompanied by or immediately preceded by urgency Overactive Bladder Syndrome – urgency and frequency (day and/or night)

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Mixed Incontinence

- Leakage associated with urgency and also with exertion

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Overflow (now referred to as chronic urinary retention)

- Involuntary loss of urine associated with over-distension of the bladder, even after voiding.
- If acute, it is painful and the person may not be able to void at all

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Functional Incontinence

- Loss of urine and/or stool caused by factors outside the urinary and/or GI tract that interfere with the ability to respond in a socially appropriate way to the urge to void or defecate

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Reversible (Transient) Causes of U I

- D Delirium, Dehydration, Dietary Irritants
- I Infection of urinary tract, symptomatic
- A Atrophic urethritis and vaginitis; acute urogenital prolapse
- P Pharmaceuticals
- P Psychological, especially depression
- E Excess urine output (endocrine disorders, CHF, overhydration, sleep apnea)
- R Restricted mobility, Retention
- S Stool impaction

- Adapted from Resnick NM: Geriatric incontinence, Urol Clin North Am 23:55-74, 1996, . In Doughty, D, Urinary and Fecal Incontinence: Current Management Concepts, Third Ed.2006, p57.

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Drugs Causing Acute Change in Mental Status in Elderly Persons

ACUTE

CHANGE

IN

MS (MENTAL STATUS)

- Adapted from Flaherty JH: commonly prescribed and over the counter medications: causes of confusion, Clin Geriatr Med 14:101-108,1998, In Doughty, D, Urinary and Fecal Incontinence: Current Management Concepts, Third Ed.2006, p58.

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ACUTE

Initial	Drug Class
A	Antiparkinsonian drugs
C	Corticosteroids
U	Urinary incontinence drugs
T	Theophylline
E	Emptying drugs (e.g. metoclopramide)

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CHANGE

- C Cardiovascular drugs
- H H2 blockers
- A Antimicrobials
- N Nonsteroidal anti-inflammatory drugs
- G Geropsychiatric drugs (e.g.. tricyclic antidepressants, SSRIs, benzos, antipsychotics, anticholinergics)
- E ENT drugs (e.g.. Decongestants, antihistamines, expectorants, antitussives)

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IN

- I Insomnia drugs
- N Narcotics

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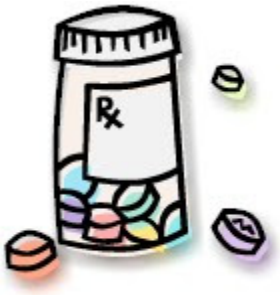
MS (MENTAL STATUS)

- M Muscle relaxants
- S Seizure drugs



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Management Strategies

- Remember: success may be measured as a reduction in incontinent episodes, such as 50%
- Results may not be immediate – perseverance and encouragement are key

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Management of Stress Incontinence

- Kegels (if willing and/or able):
- Pelvic muscle rehab for slow-twitch and fast twitch muscles (with or without cones, biofeedback)
- Limit diuretic fluids , spread fluid intake throughout the day (restricting fluids can increase frequency and UI), limit fluids after supper
- Timed toileting (to prevent excessive bladder distension)

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Management of Stress Incontinence (cont'd)

- Prompt voiding
- Pharmacologic: alpha-adrenergic agonists, tricyclic antidepressants, topical estrogen
- Surgery – (if organ prolapse)
- Pessaries (if organ prolapse)

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Management of Urge Incontinence

- Weight reduction - target BM<30
- Smoking cessation
- Reduce carbonated drinks
- Reduce/eliminate caffeine/alcohol
- Reduce or eliminate other bladder irritants
- Increase mobility/nighttime commodes
- Eliminate environmental barriers

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Management of Urge Incontinence (cont'd)

- Easier clothing (snaps, elastic, Velcro)
- Manage reversible causes
- Bladder/fluid diaries
- Scheduled voiding regimens – gradually increase time to toilet between voids
- Urgency suppression training (pelvic floor ex)
- "Freeze - squeeze – breathe"

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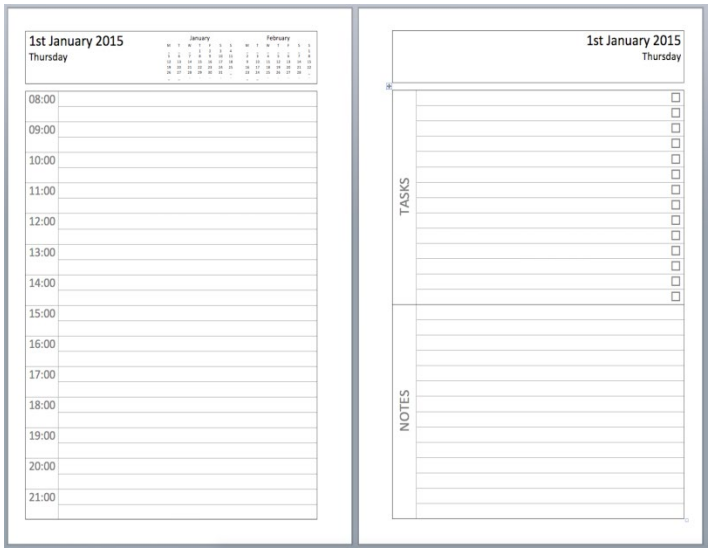
Management of Mixed Incontinence

- Use strategies used for stress and/or urge incontinence



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Management of Chronic Urinary Retention (Overflow) Incontinence

- CIC versus Foley, unless extremely resistant
- Look at meds as a cause
- Men – BPH – meds, surgery
- Assess kidney function

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Management of Functional Incontinence

- assess for cognitive, motivational, mobility/coordination/manual dexterity and environmental factors-Kegels usually not indicated
- look for underlying depression
- manage energy requirements
- managing urgency and UI can reduce falls
- promote toileting versus use of briefs alone
- look for changes in continence patterns (and delirium) and address underlying causes

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Management of Functional Incontinence (cont'd)

- Ease of clothing and/or assistance
- Accessibility –location, lighting, equip, hazards
- Prompt toileting (may need prompting for each step in process)
- Maintain bowel regularity
- Fluid prescriptions
- Signs on bathrooms doors (or a picture of a toilet)

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Role of Medications in UI

- Estrogens
- Antimuscarinic drugs if detrusor overactivity is suspected
- Alpha-adrenergic antagonists (alpha blockers) if bladder outlet obstruction is suspected
- Other

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Acknowledgements/Resources

- Doughty, Dorothy B., Urinary and Fecal Incontinence: Current Management, Third Edition, 2006.
- Getliffe, K. and Dolman, M., Eds., Promoting Continence, A Clinical and Research Resource, 2007.

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