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## Managing urinary incontinence in primary care

Urinary incontinence is common, but underreported. This issue of *NPS News* discusses how health professionals can identify and manage incontinence in primary care, and examines the evidence for physical, behavioural and anticholinergic therapies.

### Discussing urinary incontinence

A survey conducted in Australian GP waiting rooms found that only 30% of participants with urinary incontinence had spoken to a health professional about it.<sup>1</sup> People may be reluctant to talk about incontinence because they believe that it is a normal part of ageing.<sup>2</sup> Embarrassment, lack of awareness of treatment options, fear of surgery or the doctor's gender may be important factors for some.<sup>3,4</sup>

Sensitive questioning, using everyday language, can encourage disclosure at routine cervical smear consultations.<sup>5</sup> Providing information about management options, including physiotherapy and anticholinergic therapy, may help those concerned about surgery.<sup>3,4</sup>

Screen those women who are at greatest risk of becoming incontinent. Flags include recent childbirth, being overweight, chronic conditions, and increasing age.<sup>6,7</sup> Constipation was significantly associated with urinary incontinence in a large survey of older (> 70 years) Australian women.<sup>8</sup>

### Symptomatic diagnosis determines management

Thorough assessment is important because treatment options vary depending on the type of incontinence; for example anticholinergics can exacerbate incontinence

associated with retention of urine. Clinical history-taking correctly identifies most women with stress incontinence in primary care.<sup>9</sup>

Asking when incontinence occurs — for example on exertion, coughing or sneezing, or when there is a strong urge on the way to the bathroom — will help to identify women with stress or urge incontinence.<sup>10</sup> Mixed incontinence describes a combination of these symptoms. Urgency, with or without incontinence, is called overactive bladder and is commonly associated with detrusor overactivity. Ask about hesitancy, straining and weak urinary flow if symptoms are not associated with stress or urge incontinence.<sup>10</sup>

Examination should exclude neurological conditions, cognitive impairment, enlarged bladder, pelvic mass, prolapse, constipation, urinary tract infection and urinary glucose.<sup>5,6,11</sup>

A bladder diary can help in the initial assessment of overactive bladder, and in monitoring the effects of treatment. A 3-day diary covering variations in routine (e.g. work days and weekend) may be more acceptable to people than a 7-day diary.<sup>11,12</sup> The RACGP clinical practice guideline — *Managing Incontinence in General Practice* — contains a simple bladder diary in appendix 1 (available at [www.racgp.org.au/guidelines/incontinence](http://www.racgp.org.au/guidelines/incontinence)).

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## Think about medicines and mobility

Ask about medicine use, or request a formal medicines review, to help to identify incontinence that is caused or worsened by medicines. For more information on medicines that may cause or make incontinence worse visit the NPS website at [www.nps.org.au/news\\_66](http://www.nps.org.au/news_66).

Environmental factors, reduced mobility, impaired dexterity and cognitive impairment can prevent people from getting to or using the toilet. Removing clutter and providing non-slip floor surfaces and adequate lighting may help — occupational therapists can provide further advice.<sup>5,13</sup> Height adjustment or grab rails can make the toilet easier to use.<sup>13</sup> Clearly identify the toilet for those with cognitive impairment and consider velcro fastenings or trousers with elastic waistbands if clothing or dexterity is an issue.<sup>5,14</sup>

A case study covering the causes and management of urinary incontinence is available online at [casestudy.nps.org.au](http://casestudy.nps.org.au).

### Lifestyle measures may benefit some

Recommend weight loss for overweight and obese women with incontinence. Weight reduction of 8kg during an intensive 6-month weight loss program reduced weekly incontinence episodes by nearly half (from 24±18 to 13±15 episodes [mean ± standard deviation]).<sup>15</sup>

Reducing caffeine may help those with overactive bladder.<sup>5,11</sup> Urinary urgency and frequency, but not leakage, was reduced in men and women who limited their caffeine intake to a maximum of 100 mg/day (about 2 cups of weak instant coffee).<sup>16</sup>

There is no conclusive evidence that modifying fluid intake significantly reduces urinary incontinence episodes.<sup>17-19</sup>

### What resources are available to help people with incontinence?

- **Bladder & Bowel Website** ([www.bladderbowel.gov.au](http://www.bladderbowel.gov.au)) and **Continence Foundation of Australia** ([www.continence.org.au](http://www.continence.org.au)) provide information about bladder control problems for health professionals and consumers.
- **National Continence Helpline** (1800 33 00 66) can provide information about local continence services, and public or private clinics run by continence nurse specialists.
- Details of local physiotherapists specialising in continence therapies are available from the **Australian Physiotherapy Association** ([www.physiotherapy.asn.au](http://www.physiotherapy.asn.au)) or through the National Continence Helpline.
- **National Public Toilet Map** ([www.toiletmap.gov.au](http://www.toiletmap.gov.au)) provides information about more than 14 000 public toilet facilities across Australia.

## Physical and behavioural therapies are first line

Physical and behavioural therapies promote self-management and have less risk of side effects than medicines. On referral from a GP, people with complex care needs may be eligible for Medicare rebates for services provided through the Enhanced Primary Care program.

**Pelvic floor exercises** are recommended initially for stress or mixed incontinence, and may be part of the treatment plan for urge incontinence.<sup>5,6,11</sup> Women with stress incontinence appear to benefit the most.<sup>20</sup>

Compared with standard antenatal and postpartum care, intensive pelvic floor exercises can help to reduce the risk of becoming incontinent or of existing incontinence becoming worse.<sup>21</sup> In previously continent women, 25% of those receiving standard care reported incontinence 3 to 6 months after giving birth, compared with 17.5% of women who started pelvic floor exercises during pregnancy.<sup>21</sup>

Continued support from continence exercise specialists may be needed to maintain benefits.<sup>22</sup>

## Physical and behavioural therapies are first line (*continued*)

**Bladder training** should be considered first for women with urge, or mixed, incontinence and for mentally able residents in aged care facilities with urge incontinence.<sup>5,6,11,23</sup> Bladder training encourages patients to gradually increase the interval between voiding episodes. Controlled trials suggest that it improves symptoms of urge or mixed incontinence, but better quality studies are needed to confirm this.<sup>24</sup>

Unblinded studies suggest that **prompted voiding** (carers asking regularly about the need to go to the toilet) may reduce urinary incontinence by 1 episode per day in aged care residents with or without cognitive impairment.<sup>25</sup> It is not known if the effect persists once prompting stops.

### Case review: Megan's story

Megan — a 30-year-old graduate with two young children — is attending her regular pap smear. She mentions that she is trying to regain her figure after the birth of her second child three months ago, but is having trouble getting back to her normal exercise routine.

*How might you broach urinary incontinence?*

— You could begin by asking how things have been since the birth and about the problems Megan is having with her exercise routine.

On questioning, Megan confides that she has had several embarrassing 'accidents' while at the gym. She has also leaked urine during sex.

*What further information would you need before considering treatment?*

— Confirm that the leakage occurs during exertion, and exclude underlying pathology that may contribute to incontinence.

Simple assessments suggest that Megan is a good candidate for pelvic floor exercise training and you refer her to a specialist physiotherapist. After 12 weeks of supervised exercise, Megan reports only a slight decrease in the number of leaks. You ask how Megan feels about the modest improvement, and both agree that referral to a urogynaecologist is appropriate.

## Anticholinergics for urge incontinence

Anticholinergics, combined with continued bladder training, are an option when urge incontinence does not respond to physical or behavioural therapies. About 7 people with overactive bladder need to be treated for up to 12 weeks with an anticholinergic instead of placebo for 1 additional person to report improvement or cure.<sup>26</sup>

Start with a 4–6 week trial of an anticholinergic.<sup>10,27</sup> For those who respond, reassess the balance of benefits and harms at 6 months to determine whether to continue treatment.<sup>10</sup>

Inform patients about the potential adverse effects of anticholinergics, including dry mouth and constipation, and how to manage them.<sup>10</sup> Dry mouth was reported by 31% of people taking an anticholinergic and 9.8% of those taking placebo in clinical trials.<sup>26</sup>

### Are there differences between anticholinergics or formulations?

Head-to-head comparisons suggest that anticholinergic agents have similar efficacy; however immediate-release oxybutynin is more likely to cause dry mouth than immediate-release tolterodine (available on private prescription).<sup>28,29</sup>

Differences in efficacy between extended- and immediate-release formulations are small, although extended-release formulations are less likely to cause dry mouth.<sup>28,29</sup> In people with up to 5 incontinence episodes per day before treatment, extended-release anticholinergics reduced incontinence by 1.8 episodes per day compared with 1.5 episodes per day for immediate-release formulations and 1 episode per day for placebo.<sup>28</sup>

## Anticholinergics for urge incontinence (continued)

The newer anticholinergics, darifenacin and solifenacin, are selective for the receptor that causes bladder contraction. Dry mouth may be less likely with darifenacin and solifenacin compared with immediate-release oxybutynin.<sup>28</sup> There is no evidence to suggest that they are more effective at reducing incontinence episodes than other anticholinergics.<sup>28</sup>

### Exercise caution in older people and postmenopausal women

Avoid anticholinergic agents in people with dementia because of the risk of cognitive decline and delirium.<sup>14</sup> More information about prescribing drugs used in dementia can be found in NPS News 59: *Drugs used in dementia in the elderly* ([www.nps.org.au/news\\_59](http://www.nps.org.au/news_59)).

Use anticholinergic agents with caution in frail and older people: if prompted voiding or bladder training fail start at the lowest possible dose — switch to an alternative drug if cognitive adverse effects occur.

Oral hormone replacement therapy can worsen symptoms of urinary incontinence in postmenopausal women.<sup>30</sup> However, intravaginal oestrogen significantly improved self-reported symptoms of incontinence in these women compared with placebo.<sup>30</sup>

#### What's what: Anticholinergics

darifenacin: Enablex

oxybutynin: Ditropan, Oxybutynin (Sandoz), Oxybutynin (Winthrop), Oxytrol Transdermal System

propantheline: Pro-Banthine

solifenacin: Vesicare

tolterodine: Detrusitol

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References available online at:  
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*The information contained in this material is derived from a critical analysis of a wide range of authoritative evidence. Any treatment decisions based on this information should be made in the context of the clinical circumstances of each patient.*



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