

LEARNING TO HELP PEOPLE WITH INCONTINENCE

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About 5% of the population suffers from urinary incontinence, and the proportion is much higher among the elderly. This means that in a city region of 2 million people there are about 100,000 people with this problem—probably about 100 new cases every week (figure 1,). Most of these people receive no help because it is not offered and they do not ask for it, although half of them would like it. How can all these people be cared for? How can they possibly receive urodynamic assessment, the newest medications, and the latest type of surgery? This problem—getting people the incontinence care they need—is even more intractable in rural areas

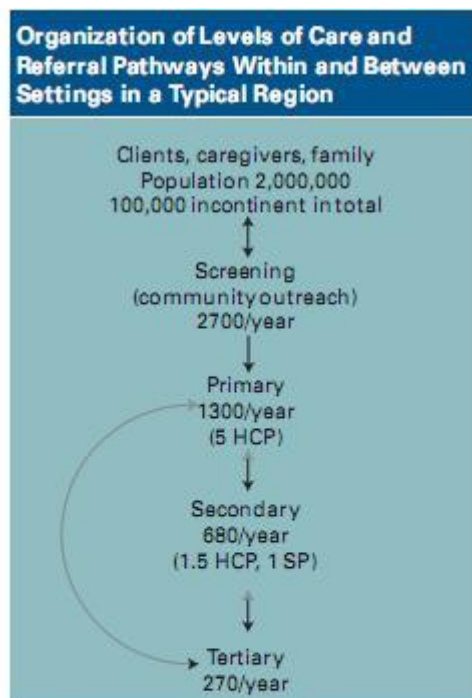


Figure 1

Referral and return pathways within and between different levels of continence care. For simplicity, all clients/patients have been shown as first coming to screening care, but some may self-refer directly to the primary level. Estimated numbers of new clients/patients requiring care at each level every year are shown. Estimated numbers of full-time healthcare professionals (HCP: family physicians, continence nurses, trained physiotherapists) and surgical specialists (SP: urologists, gynecologists, urogynecologists) are indicated (adapted from Canadian Continence Foundation').

Types of management needed

It is fortunate that high-tech assessment and care are not necessary, and not even desirable, in most cases. National and international authorities agree that the first-line approach to incontinence should be simple assessment and conservative management, including lifestyle interventions and techniques such as pelvic-floor muscle exercises and urge suppression (figure 2) and shows the recommendations of the Third International Consultation on Incontinence for initial assessment and management of incontinence in women; there are similar algorithms for men and the frail elderly. For simple uncomplicated incontinence, this algorithm suggests that noninvasive assessment and nonsurgical treatment are appropriate initially, with trial of medication as a last resort (see penultimate line of algorithm). Only if these measures prove inadequate, or if the incontinence is complicated by other factors, should more sophisticated assessment and specialized management such as surgery be considered. Consequently, in spite of the large number of incontinent people in the community, relatively few require management by specialist physicians.

What lifestyle and behavioral techniques are recommended? At the simplest level they include advice on good bladder habits (table 1), especially dealing with constipation and fluid intake management. They may also include advice on the best incontinence products to use while the incontinence is being brought under control. At the next level, training in pelvic-floor muscle exercises (Kegels) is provided. This usually requires some sort of check (biofeedback, for example) that the exercises are being done correctly. Although often considered as a treatment for stress incontinence, pelvic-floor muscle exercises also form the foundation for urge-suppression techniques used to manage urgency and urge incontinence. In a current University of Pittsburgh research project (led by Dr. Neil Resnick), we are trying to improve this type of treatment. The aim is to streamline therapy by discerning which parts of a complicated protocol, involving biofeedback-assisted pelvic-floor muscle exercises, are critical for successful treatment of urge incontinence. So far the project confirms that biofeedback can be a successful treatment, even in older women with quite severe urge incontinence. Relearning the ability to suppress urgency and urge incontinence gives patients the sense that they are once again in control of their bladders.

Who should provide management?

The majority of people with incontinence require, first, identification by a screening process; and second, simple advice on lifestyle measures, with referral only if necessary. A proportion of these people need assessment and conservative management at the primary care level, either by a knowledgeable family practitioner or by a trained continence nurse or physiotherapist. A still smaller proportion require secondary- or tertiary-level assessment by a specialist or an academic medical centre. Figure 1 shows estimates by the Canadian Continence Foundation of the numbers involved. In a hypothetical city region of 2 million people, 2700 patients per year might be identified by screening, but fewer than 1000 per year would require attention by a specialist physician, and fewer than 300 of those would be treated in an academic center offering advanced techniques such as full videourodynamic assessment

Table 2. Three basic questions suggested by the International Consultation on Incontinence	
1. How often do you leak urine?	<ul style="list-style-type: none"> • <i>never</i> • <i>about once a week or less often</i> • <i>two or three times a week</i> • <i>about once a day</i> • <i>several times a day</i> • <i>all the time</i>
2. How much urine do you usually leak? (whether or not you wear protection)	<ul style="list-style-type: none"> • <i>none</i> • <i>a small amount</i> • <i>a moderate amount</i> • <i>a large amount</i>
3. Overall, how much does leaking urine interfere with your everyday life?	<ul style="list-style-type: none"> • <i>score from 0 (not at all) to 10 (a great deal)</i>

Who should identify the incontinent people in the community and provide advice about behavioral measures? Primary-care providers (family physicians or continence nurses) do not have the time or resources. Specialized continence units staffed by trained nurses or physiotherapists are at present too thinly scattered. The Canadian Continence Foundation suggests that front-line health professionals who come into contact with incontinent patients on a daily basis (e.g., community nurses and pharmacists) are in the best position to do this. Figure 1 shows how they can “catch” patients so that relatively few will need to filter through to secondary- or tertiary-care centers, where urodynamic

assessment and treatment with suitable medications or sophisticated surgery are available for those who really need them. One way of screening for incontinence is to use the short-form questionnaire (known as ICIQ-SF) of the International Consultation on Incontinence, which covers the 3 main aspects of incontinence: How often? How much? How troublesome? These 3 main questions are shown in table 2, but the copyrighted form (see reference 3 for ordering) should be used for screening.

Training in continence care

How are front-line healthcare professionals to receive training in continence care? Existing programs in incontinence management are excellent but are aimed at nurses who want to devote the time and effort necessary to become a professional continence advisor—for example, the Certified Continence Care Nurse program in the USA, and the Nurse Continence Advisor program in Canada. Front-line professionals are not specialists, and they require much shorter training to give them insight into incontinence assessment and management techniques. This training should be widespread and accessible to the large number of professionals who could potentially be involved.

A useful side-effect of short training programs of this type is that, by promoting much wider awareness of incontinence management among healthcare professionals, they will inspire such professionals to undertake more advanced training, allowing large numbers of specialized continence units to be set up and more continence care to be provided at the primary level by continence nurses and physiotherapists (figure 1). In busy incontinence practices, nurses with advanced training can undertake initial assessment and conservative management, allowing the physicians to concentrate on difficult cases. Table 3 provides a quick self-test to determine if you could benefit from more education in this area.

Table 3. Self test: If you are uncertain about the answers to these questions, you need more training.
A 34-year-old mother of four tells you she occasionally leaks urine when she coughs, sneezes, laughs, or picks up her youngest child.
1. What type of incontinence is she most likely to have?
a. urge
b. stress
c. reflex
d. overflow
2. You ask her to keep a bladder diary. It should include the timing and other details about all of the following except:
a. urine output
b. type and amount of fluid ingested
c. episodes of leakage
d. food intake
3. The following therapies might all be recommended except:
a. pelvic-floor muscle exercises
b. physiotherapy/biofeedback
c. propanteline 7.5 mg TID
d. pessary
Answers: 1. b; 2. d; 3. c

Based on our own experience in advising patients and researching the causes of incontinence, we have developed a short course (Nursing the Incontinent Patient) that requires about 4 hours study, with a post-study test. It is open to any healthcare professional who desires insight into simple incontinence assessment and conservative management techniques. SUNA (Society of Urologic Nurses and Associates) has approved it for 4 continuing education contact hours. You do not have to be an incontinence nursing expert to take it, but if you are interested in brushing up your knowledge of incontinence so that you can advise patients—or if you know someone else who might be interested—you can get further details at our website www.learncontinence.com, or send us an email at info@learncontinence.com or a fax at (780) 438-2341.

A similar course for pharmacists who want to give their customers simple but authoritative advice about incontinence is provided through the University of Alberta. It offers 2 pharmacy continuing education credits. For information go to www.pharmalearn.ualberta.ca/conted and click on "print courses". For family physicians, the Canadian Continence Foundation (www.continence-fdn.ca) co-hosts a day-long accredited course.

References

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