

Diagnosing and Treating Incontinent Women



Improving
quality of life

By Gregory R. Wahle, M.D

Although more medical providers are recognizing adult urinary incontinence as an abnormal but treatable condition, it remains undiagnosed and untreated in far too many individuals. Recent studies indicate that only 32 percent of primary care providers routinely screen for incontinence, and patients remain silent about their symptoms 50 to 75 percent of the time. Underestimation of the impact of incontinence on patient quality of life, frustration with past treatment options, and insufficient time to screen for problems during office visits all contribute to inadequate treatment.

The fact is, however, that urinary incontinence treatments have improved dramatically over the last ten years, and 70 percent of patients who undergo treatment experience major improvements in their quality of life. For these reasons, doctors should take an active role in discussing and diagnosing urinary incontinence in their patients and, if necessary, refer these patients to qualified urologists and urogynecologists.

Adult urinary incontinence affects at least 17 million Americans, 85 percent of which are women. Other "at risk" groups include the elderly and those living in long-term care facilities. While prevalence increases with

age, incontinence is not necessarily a natural function of aging. Younger women suffer from the condition as well. In fact, recent consumer research reveals that one in four women over the age of 18 experiences episodes of involuntary urine leakage.

Those unfamiliar with incontinence often underestimate its effect on quality of life, but incontinence studies, which now routinely employ quality-of-life measures, consistently reveal the deleterious effect it has on daily living. Many people affected by the loss of bladder control suffer emotional as well as physical discomfort. They may isolate themselves for fear of ridicule and may find

employment impossible or compromised.

DIAGNOSING INCONTINENCE

The biggest challenge to assessing patient incontinence is simply taking the time to engage them in a discussion about their problem. When a medical provider -- either a primary care physician or an incontinence specialist -- has taken this critical first step, several techniques can be employed to expand and enhance evaluation.

Obtain Detailed Patient History

Having a detailed history of the incontinence is critical to determining the direction of further evaluations. For this reason, it is often wise for doctors who uncover incontinence symptoms as a part of routine examinations to invite their patients for a separate visit to specifically evaluate their incontinence. By doing this, they allow adequate time for the evaluation and can also determine how motivated their patients are to participate in their care.

During the second meeting, key history items such as the nature of incontinence, duration of symptoms, amount of leakage, pad use,

¹ D.S. Chutkan, K.C. Fleming, M.P. Evans, et al., "Urinary Incontinence in the Elderly Population," *Mayo Clin Proc* 71, 1996, pp. 93-101.

previous treatment, and the impact of symptoms on lifestyle, should be considered.

The focus should be on differentiating between the two main types of incontinence: urge urinary incontinence (UII) and stress urinary incontinence (SUI). Patients with UII and the related overactive bladder (OAB) condition exhibit symptoms of frequency, nocturia, urgency, and incontinence. Patients with SUI experience incontinence when they engage in activities such as laughing, sneezing, coughing, or exercising that put pressure on the abdomen. These patients may or may not feel urgency before leaking. Most women exhibit symptoms of both UII and SUI, which is called mixed urinary incontinence (MUI); in these cases, physicians must employ careful questioning to help patients determine which symptoms are dominant.

When evaluating a patient's history, doctors should be aware that many women with incontinence have already tried at least one anticholinergic medication. In addition, they may have developed atrophic vaginitis after stopping estrogen supplementation in light of recent data questioning its efficacy. Some women who have had hysterectomies are unsure if they have also had surgical therapy for prolapse or incontinence. Women who have had pelvic radiation generally have symptoms of OAB.

In addition to understanding the common medical treatments that can cause incontinence, doctors must also be familiar with the concurrent conditions that contribute to the condition. Frequent infections (self-diagnosed or documented), constipation, neurological disease (stroke, multi-infarct dementia), diuretic use, sedatives, and poorly controlled diabetes are examples of such problems.

Conduct a Physical Examination

A quick assessment of non-urolurgical systems can help identify co-morbid conditions that affect bladder function. For example, changes

in mental status, limitations of mobility, and evidence of heart failure can lead to incontinence. A brief neurological exam concentrating on the lumbo-sacral nerves can also prove helpful. When evaluating urologic systems, it is easiest to work systematically, moving across the pelvis, anterior to posterior.

Conduct Diagnostic Testing

According to the results of the patient's history and physical exam, certain diagnostic tests may be appropriate.

For straightforward SUI documented during the exam or for OAB without incontinence, physicians can limit testing to a urinalysis of the blood, glucose, and leucocytes and a bladder scan measurement of post-void residual urine volume (PVR). In cases where OAB patients are vague about their symptoms or when symptoms are predominantly nocturnal, a voiding log may also be helpful. The log can be as simple as recording the time and volume of each void for a 24-hour period.

Because successful treatment depends so heavily on diagnosing the correct cause of a woman's incontinence, those who have mixed symptoms, have had prior incontinence therapies, or have had pelvic surgery should undergo urodynamic testing (UDS) of bladder function during both filling and voiding. UDS provides the most information when performed in a consistent manner by someone extensively trained in this field and when the interpreting practitioner is familiar with the test and its limitations.

TREATMENT

Urge Urinary Incontinence

Anticholinergic medicines have become the mainstay for treating OAB and UII symptoms. While some patients, especially the elderly, may be required to take these medicines indefinitely, doctors should always look for other treatments that could rectify the cause of symptoms.

Either as sole therapy or in combination with drugs, behavioral modification is an excellent option for the elimination and improved management of chronic UII and OAB. These modifications require patient motivation and long-term participation in their care. Because of the time required to manage behavioral modifications effectively, doctors should consider sending these patients to a specialized center for the treatment of incontinence and bladder control symptoms. UroPoint Bladder Control Centers are a division of Urology of Indiana. There are five centers located in central Indiana and each offers full-service pelvic floor treatment by a team of providers who specialize in surgical and non-surgical treatment of urinary incontinence.

Stress Urinary Incontinence

Surgical treatment remains the primary means for treating bladder outlet compromise resulting in stress urinary incontinence which is refractory to conservative therapies. In the past, surgical urethral support operations or "suspension treatments" have been plagued by poor durability, but more recently developed techniques ("sling" procedures) have proven minimally morbid, reliable, and durable. Slings may be used as sole therapy or in combination with more extensive procedures to correct vaginal prolapse. They represent a significant improvement in incontinence treatment.

For SUI associated with a fixed urethra, periurethral bulking agents work well; however, durability remains a problem, and new materials studied to overcome the need for repeated periurethral injections are being evaluated.

These advances in medical and behavioral treatment in incontinence have dramatically improved the management of this common female disorder and should motivate professionals to help their patients regain their quality of life.



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