URINARY INCONTINENCE

Definition: The involuntary loss of urine, which is unacceptable to the patient or carer.

Urinary incontinence should not be accepted as part of normal ageing and all patients deserve investigation and/or treatment. Health professionals should be vigilant and adopt a proactive approach with clients who are at greatest risk of developing urinary incontinence through factors including age, the menopause, pregnancy and childbirth, high BMI and experience of continence problems in childhood.

Clinicians should be aware of and take into consideration the potentially severe adverse effects that even mild urinary incontinence has on a patient's quality of life.

Causes

- Urinary Tract Infection.
- Genuine Stress Incontinence – often secondary to weakened pelvic floor muscles as a result of pregnancy/ childbirth.
- Detrusor Instability – with uncontrolled contractions of the bladder Detrusor muscle.
- Others – neurogenic e.g. multiple sclerosis, CVA, or anatomical e.g. vesico-vaginal fistula.

Initial Assessment

- Clinical history - include medication, bowel habit, functional status and toilet access, sexual dysfunction and quality of life. Discuss frequency/volume charting and intake of carbonated or caffeinated drinks, including tea/coffee
- Physical examination to exclude chronic retention with overflow or fistula, pelvic organ prolapse
- Urine dipstick in all women to detect presence of blood, glucose, protein, leucocytes and nitrites (see urinalysis guideline)

Assessment, treatment and referral as appropriate should be offered to all patients with urinary continence problems. If women request investigations and/or treatment, first-line management generally involves physiotherapy to assess the pelvic floor, with ongoing physiotherapy as required. The Pelvic Floor Exercises leaflet can be sent as a link via SMS to women. Many areas offer direct access physiotherapy without the need for formal referral.

Men requesting assessment and treatment should be referred to local urology services.

Alternatively, the client can be asked to attend their GP for local referral and management.

However, consider referral to the urogynaecology service at the Queen Elizabeth University Hospital for specialist advice in women with urge incontinence (urine incontinence accompanied by a sudden urge to pass urine which is difficult to delay) and also:

- Persisting bladder and/or urethral pain
- Previous continence surgery
- Associated faecal incontinence
- Suspected fistula
- Previous pelvic cancer surgery and/or radiotherapy

Urgently refer women to urology with urge incontinence who have any of the following:

- microscopic haematuria in women aged 50 years and older
- visible haematuria not associated with an acute UTI
- recurrent or persisting UTI associated with haematuria in women aged 40 years and older
- suspected malignant mass arising from the urinary tract

The GGC guidelines listed below are an excellent resource and are recommended to provide further guidance on management and onwards referral

Urogenital Atrophy

Urogenital atrophy (also known as genitourinary syndrome of the menopause or vulvovaginal atrophy) is a chronic and progressive change in urogenital tissues (vulva, vagina, bladder & urethra) due to a lack of estrogen. Although most commonly associated with the menopause, it can occur in other groups e.g. breastfeeding women.

The symptoms of this condition are often delayed and can take 3-5 years after the menopause to develop. Urinary symptoms which can be seen in these patients include urgency, dysuria, nocturia and frequency. A positive Urinalysis +/- MSSU can help distinguish between Urogenital atrophy and UTIs in these patients.

Examination findings may be minimal but can include vaginal pallor, vaginal shortening, easily bleeding tissues and change in discharge.

Vaginal estrogen is the mainstay of treatment. This can be used for as long as indicated. The amount of systemic absorption of estrogen is minimal and it is therefore suitable for most patients. Specialist opinion should be sought in the case of those patients with previous breast cancer. Potential treatment options include:

- Estradiol pessaries (e.g. vagirux or vagifem) intravaginally initially daily for 2 weeks, followed by twice weekly as necessary
- Estriol cream 0.1% intravaginally initially daily for 2 weeks, followed by twice weekly as necessary
- Estriol pessaries (imvaggis) intravaginally initially daily for 3 weeks, followed by twice weekly as necessary

In addition to the above, the following is also recommended,

- Vaginal Lubricants during sexual activity – the combination of both an oil and water based lubricant can produce a “double glide” effect (of note oil lubricants can weaken condoms)
- Vaginal moisturiser twice weekly
- Smoking cessation & regular sexual activity are also helpful.

Reference

NICE CG 123 Urinary Incontinence and Pelvic Organ Prolapse in Women: Management. April 2019 (Accessed Dec 2024)

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