

RECOMMENDATIONS FOR MANAGEMENT OF STRESS AND URGE URINARY INCONTINENCE IN WOMEN

INTRODUCTION:

- Definition:
Urinary Incontinence: The involuntary loss of urine resulting from pathologic, anatomic, or physiologic factors (1, 2)
 - Stress (SUI): small losses of urine during an increase of intra-abdominal pressure produced from activities such as coughing, sneezing, laughing or exercising; also known as outlet incompetence (3)
 - Urge (UI): urine loss due to abnormal detrusor muscle contractions and is sometimes associated with some degrees of urinary retention; characterized by an abrupt and strong desire to void; a major component of “overactive bladder” syndrome (3)
 - Overflow: urine loss due to over-distension of the bladder; symptoms vary and may include urgency, frequent urination, constant dribbling, and both urge and stress incontinence (3,4)
 - Total: continuous loss of urine with minimal activity, usually seen in women with severe stress UI (3,4)
 - Functional: urine loss due to acute or chronic impairment of both physical or cognitive function (3,4)
 - Mixed: symptoms of both stress and urge incontinence (3,4)
- Epidemiology:
The prevalence of urinary incontinence is difficult to determine for several reasons. Variations in etiology and different definitions of incontinence impair consistent reporting. Definitions of urinary incontinence may range from specifying the occurrence of at least one episode within the last 12 months to specifying incontinence on a daily basis. (1,5)
 - Urinary incontinence is more common in women than men, although the difference narrows as patients’ age. (1,2,5)
 - The type of incontinence – urge, stress, or mixed, varies proportionately by sex and age. (5)
 - In a study of postmenopausal women (mean age 67 years), 56 percent reported urinary incontinence at least weekly. (6)
 - Stress and urge incontinence are common in postmenopausal women and have different risk factors, suggesting that approaches to risk-factor modification and prevention also might differ and should be specific to the type of incontinence. (6)
 - Stress incontinence accounts for most incontinence in women younger than 60 years but for only half the cases in older women. (5)
 - Two recent summary analyses of the prevalence of urinary incontinence yielded similar estimates: the median prevalence of urge and mixed incontinence was about 11 to 13 percent in women aged 30 to 60 and 19 to 24 percent in women older than 60. (5,7)
 - Several population based studies in the United States found a higher prevalence

- of urinary incontinence among white women than among African Americans. (5)
- A survey of women at a medical school based clinic in 2000- 2001 found that more white women reported urinary incontinence than did black or Hispanic because of their higher stress incontinence symptoms. The percentage of urge incontinence was similar among the three groups; more black and white women reported mixed incontinence; more black women reported frequency and nocturia. (7)
- Another study comparing white and Hispanic women found urge incontinence twice as common in whites. (5)

The high prevalence of incontinence symptoms among women of different races and ages illustrates that health care providers should routinely screen all women for urinary incontinence. (7)

PATHOPHYSIOLOGY:

- Continence, control of bladder function, is maintained by voluntary and involuntary mechanisms. The external urethral sphincter and pelvic floor muscles are under voluntary control. The detrusor muscles of the bladder and internal urethral sphincter are under the autonomic nervous system control, which may be modulated by cerebral cortex connections. (2,8)
- Factors contributing to urinary continence include adequate estrogen, which may help maintain bladder sphincter tone; adequate bladder capacity, elasticity, and smooth muscle tone; and maintenance of an acute urethrovesicular angle to support the bladder neck and urethra. (2)
- Variables shown to be associated with urinary incontinence include age, parity, urinary tract infections, body mass index (BMI), constipation, psychological well-being, lifestyle factor, hysterectomy, and some types of gynecological surgery. (2,8)
- Incontinence in women can result from defects in urethral sphincter incompetence, detrusor over-activity or hyper-reflexia, or both. (2,4,6)
 - Urethral Sphincter Incompetence
 - associated with weak pelvic ligaments, resulting in loss of support to urethral and bladder neck can contribute to loss of sphincter tone
 - weakened ligaments allow the urethra to rotate downward during stress which overloads the sphincter causing urethral hypermobility
 - increases in intra-abdominal pressure with poor ligamentous support and poor sphincter tone may result in involuntary loss of urine
 - conditions contributing to poor ligamentous support include obstetric trauma and loss of pliability and turgor of the urethral tube through atrophic changes associated from estrogen deprivation
 - advanced age, inadequate estrogen, previous vaginal surgery, and certain neurological lesions are associated with poor urethral sphincter function
 - Detrusor Over-activity and Hyper-reflexia
 - associated with inappropriate contraction of the detrusor muscle during urine storage phase
 - detrusor muscle contractions causes pressure to rise in the bladder and the patient often perceives a subjective sense of urgency
 - if pressure rises sufficiently to exceed urethral pressure, leakage results

SUBJECTIVE ASSESSMENT:

1. HISTORY

1. Past medical history obtain a complete, detailed medical history with focus on contributing factors such as: (1,2,4,9,10,11,12)
 - Diabetes
 - Hypercalcemia
 - Congestive heart failure
 - Hypoalbuminemia
 - Drug induced edema associated with NSAIDs or calcium channel blockers
 - Chronic lung disease
 - Fecal impaction
 - Neurological conditions (e.g. multiple sclerosis, stroke, spinal cord injuries, lumbar disc disease, Parkinson's disease)
 - Cognitive impairment
 - Immobility
2. Obstetric and gynecologic history should include: (2,4,9,10,11,12)
 - Gravity and parity
 - Number of vagina, instrument-assisted and cesarean deliveries and complicating factors (eg. degree of lacerations, episiotomy breakdown)
 - Estrogen or menopausal status
 - Presence of leiomyomata, endometriosis or pelvic pain
 - Previous gynecological surgeries, hysterectomy and/or vaginal or bladder surgery
 - Pelvic radiotherapy trauma
3. Urologic history should include key questions related to: (1,2,4,11)
 - Number and frequency of UTIs
 - Urogenital abnormalities
 - Nature of symptoms and duration (dysuria, frequency, post void dribbling, incomplete emptying, nocturia, hematuria)
 - Use and number of pads to protect from urine leakage.
 - Presence of urine leakage without awareness
 - Stress incontinence
 - Presence and frequency of leakage of urine
 - Triggers which increase abdominal pressure (cough, lifting, exercise, sneezing)
 - Urge/overactive bladder incontinence
 - Leakage of urine in relationship to urge and frequency
 - Number of times bladder is emptied during 24 hours
 - Number of times person empties bladder during night and if it is associated with urge
 - Mixed incontinence
 - Symptoms associated with both stress and urge
 - Overflow incontinence
 - sensation of being unable to completely empty bladder
 - frequent or constant dribbling
 - Behavioral changes made to compensate for incontinence
4. Diet History (11)
 - Amount of fluid consumed in a 24 hour period

- Intake of bladder irritants such as caffeine, alcohol, acidic fruits, tomatoes, sugar, spicy foods, carbonated beverages
 - Behavioral changes made to compensate for incontinence
 - Previous attempted therapies and the degree of their success
2. MEDICATION REVIEW (1,2,4,9,10,11,12)
 - Current prescription medications
 - Any and all over the counter medications including alternative medications or herbal treatments
 3. REVIEW OF FAMILY HISTORY
 - Any positive history for DM or urological, neurological, or gynecologic pathology
 4. PSYCHOLOGICAL HISTORY
 - Evaluation of coping skills
 - Evaluation of availability of support systems
 - Evaluation for signs and symptoms of depression, anxiety, social isolation, low self esteem related to incontinence
 - Patient goals for treatment

OBJECTIVE ASSESSMENT:

1. PHYSICAL EXAM (3,10)
 - General Appearance: include mobility/dexterity and cognition
 - Vital signs: including height and weight
 - Neurological: Focus on lower extremities for strength, DTR's and perineum by testing with a sharp instrument and noting sensation around the thighs above the knee, and evaluate for anal wink
 - Abdomen: evaluate for bowel sounds, tenderness (especially suprapubic), masses, rigidity, guarding, and rebound tenderness
 - Genitals: note any masses, irritation, discharge, and lesions. Inspect vulva and vagina for estrogen deficiency, cystocele, rectocele, enterocele, or uterovaginal prolapse, vaginal moisture, strength of pelvic floor contraction
 - Pelvis: speculum visualization of cervix, including bimanual to evaluate for uterine enlargement, uterine tenderness, cervical motion tenderness, adnexal tenderness/abnormality
 - Rectum: evaluate for masses and assess for point tenderness as well as pelvic floor strength, fecal impaction
2. RECOMMENDED LABORATORY EVALUATION (10, 13)

It is recommended that a urinalysis and if appropriate, a urine C&S and post void residual (PVR) be performed to evaluate for bladder dysfunction. A PVR can be elevated in infection and mechanical obstruction from uterine prolapse. See the attached reference tool "*Evaluation and Monitoring of Urinary Incontinence*".

DIAGNOSIS: (10)

Diagnosis	Etiology	Age	Typical symptoms	Other comments

Stress incontinence	Anatomical changes that lead to urethral hypermotility and sphincter weakness	Most common in any age women except the elderly	Loss of small amounts of urine associated with cough, sneezing, and/or physical activity	Diagnosed by history should R/O urinary tract infection
Urge incontinence	Abnormal detrusor muscle contractions and sometimes associated with urinary retention	Most common in the elderly	Characterized by an abrupt and strong desire to void, often cannot make it to the toilet in time	Consider cystocele, rectocele, enterocele, or uterovaginal prolapse and tumors
Mixed incontinence	Traits of both stress and urge incontinence	As above	50-60% commonly presented form of incontinence: one set of the symptoms is most bothersome to the patient	Consider cystocele, rectocele, enterocele, or uterovaginal prolapse and tumors
Complex history of incontinence	Associated with spinal cord trauma, neurological disorders, multiple sclerosis, etc	Any age	Symptoms associated with etiology	These patients should be referred to a urologist for evaluation and management

NONPHARMACOLOGIC THERAPY:

- **Diet Counseling-** should receive diet counseling to limit caffeine intake, such as coffee, tea, colas, and chocolates. Caffeine can overload the bladder causing stress and urge incontinence. Spicy foods and carbonated beverages are bladder irritants. Other diet issues include adequate fluid intake. Dehydration can cause constipation, concentrate urine and increase irritative effects of dietary materials. Limit fluids at bedtime if nocturia is of a particular problem. The recommended fluid intake is 1500-2400 mls. (3)
- **Behavior Modification-** includes bladder training, prompted voiding, and scheduled toileting. A voiding diary should be kept by patient to document each void and episode of incontinence on a daily basis (see the attached sample voiding diary). The diary should be reviewed at each clinic appointment. (3,10)
- **Pelvic floor exercises-** daily kegel exercises can increase strength, control, and coordination. As muscle strength improves, the patient should be taught to increase time of contraction to ten seconds. These can be done in conjunction with auditory and visual biofeedback. Clinical trials of pelvic floor exercises have shown 80-85% improvement of incontinence. These are most effective in women with stress incontinence. (14)
- **Environmental-** evaluates living area, ease of getting to toilet, physical limitations that

may impair ability to get to toilet and modify as appropriate for patient. May consider bedside commode. (10)

- **Social factors-** in order to attend social functions such as church, family gatherings, may need to consider use absorbent of products. (3)
- **Obesity-** maintaining optimum weight may decrease urinary incontinence secondary to a decrease in pressure on the bladder and greater urethral mobility (3)

PHARMACOLOGIC THERAPY: (*Should be used in conjunction with non-pharmacologic therapy*)

1. **Pharmacologic options for urge incontinence:** (4, 10,12,15)

- a. Anticholinergics are recommended as first-line pharmacotherapy. Tolterodine and Oxybutynin are considered standard therapy. Tolterodine can be considered for use first as a muscarinic receptor antagonist as it has a higher selectivity to bladder receptors and a lower incidence of adverse effects such as headache, fatigue and symptoms involving the GI tract and CNS. It has not been associated with significant changes in ECG, BP, standard clinical chemistry or hematologic variables.

Table 1

Generic Name	Recommended Dose	Contraindications
Tolterodine (Detrol, Detrol LA)	PO: 1-2mg BID PO 2-4mg/d (Detrol LA) <i>* Lower doses should be given in elderly and in hepatic and Renal failure.</i>	Known hypersensitivity, narrow angle glaucoma, GI or Urinary obstruction,
Oxybutynin (Ditropan, Ditropan XL)	PO: 2.5-5mg BID to TID <i>Titrate: increase by 2.5 mg increments every 1-2 d as needed</i> PO: 5mg/d (Ditropan XL)	Known hypersensitivity, narrow angle glaucoma, GI or Urinary obstruction,
Flavoxate	100-200mg TID	GI Bleed, achalasia
Propantheline	15mg ac, 30 mg HS	Myasthenia gravis, GERD, angle closure glaucoma

- b. bladder relaxants (for urge incontinence):

Table 2

Generic Name	Recommended Dose	Contraindications

Imipramine	10-75 mg q HS <i>Max. 300mg/d</i> <i>Max 100mg/d in elderly</i>	Known hypersensitivity to TCAs recovery phase of myocardial infarction Use with caution in cardiovascular disease.
Dicyclomine	10-20 mg QID <i>Max 40mg QID</i>	Obstructive uropathy, obstructive GI disease, severe ulcerative colitis, myasthenia gravis
Hyoscyamine	0.375 mg BID	Glaucoma, Obstructive uropathy, obstructive GI disease, severe ulcerative colitis, myasthenia gravis, autonomic neuropathy

2. **Pharmacologic options for Stress Incontinence** (16, 17, 18, 19)

- a. Alpha-adrenergic antagonists : Pseudoephedrine 15-30 mg TID
- b. Localized estrogen replacement therapy

Table 3

Generic Name	Recommended Dose	Contraindications
Vaginal estrogen ring	Insert into vagina every 3 months	Caution in thromboembolic disorders, pregnancy, estrogen dependent Ca, Breast Ca, undiagnosed vaginal bleeding, impaired liver function
Vaginal estrogen cream	0.5 –1 gm, apply in vagina q HS	

Drug therapy should be initiated at the smallest recommended dose and slowly titrated upwards, based on patient response and tolerance.

FOLLOWUP:

Stress incontinence:

Follow up in one month after initial conservative interventions are initiated and diagnostic testing is completed. If symptoms improve continue current interventions and have patient return in one month. If no improvement or sub- optimal improvement as evidenced by severity scale consider pharmacological intervention with pseudoephedrine.

Urge incontinence

Follow up in one month after initial conservative interventions are initiated and diagnostic testing is completed. If symptoms improve continue current interventions and have patient return in one month. If no improvement or sub- optimal improvement as evidenced by severity scale consider pharmacological interventions (See Tables 1,2,3)

Mixed Incontinence

Follow up in one month after initial conservative interventions are initiated and diagnostic testing

is completed. If symptoms improve continue current interventions and have patient return in one month. If no improvement or sub-optimal improvement as evidenced by severity scale consider pharmacological intervention with Imipramine (see Tables 1,2,3)

REFERRAL:

Referral is indicated for patients who have failed initial management and for those with a complex history of urinary incontinence. Complex history includes uncertain diagnosis, hematuria without infection, comorbidities such as recurrent UTI's, severe symptoms of voiding difficulty, severe pelvic organ prolapse, elevated PVR volume or neurologic conditions. Complex urodynamic testing should be performed prior to surgical referral. Any patient with voiding difficulty.

The algorithm for "Recommendations for the Management of Stress and Urge Urinary Incontinence in Women" is available on request from the guideline developer.

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Urinary Incontinence Evaluation Tool

History

Dates of occurrence	Date	Date	Date	Date	Other comments
Recurrent UTI					
Pelvic Mass/radiation					
Pelvic Surgery/fistula					
Diabetes					
Neurological disorders					
Impaired cognition					
Impaired mobility					
OB history					Gravida__ Para__ Vaginal or C-section

Symptoms

	Yes	No	Other Comments pertinent to symptom
Incontinence noted with cough or physical activity			
Urgency or frequency			
Difficulty voiding/retention			
Dysuria/BOU			
Impaired quality of life			
Medications precipitating incontinence			

Diagnostic Work-up

	Date completed	Results	Further diagnostics, if indicated
U/A and Urine C&S			
Urine Cytology, if UA abnormal			
Pelvic/Prostate exam, if indicated			
Complete metabolic panel			
PVR			
Ultrasound of abd/CT scan or abd, etc			
Urology or GYN referral			

Plan for Diagnosis of _____

	Date tried	Successful	Failed	Other comments
Bladder training (scheduled voids) with void diary using severity scale				
Pelvic floor exercises, if indicated				
Complementary strategies such as biofeedback/acupuncture				
Diet consult/Fluid monitoring for adequate intake				
Environmental issues addressed				
HRT, if indicated				
Medication trial of _____				

Signature _____

Date _____

Urinary Incontinence Patient Screening Tools

Sandvik Severity Scale

- I. How often do you experience urine leakage (incontinence)?
 - 0 - never
 - 1 - less than once a month?
 - 2 - one or several times a month
 - 3 - one or several times a week
 - 4 - every day/night
- II. How much urine do you lose each time?
 - 1 - drops/little
 - 2 - more
- III. Total score (*multiply question 1 by question 2*).
 - 0 - dry
 - 1 - 2 slight incontinence
 - 3 - 5 moderate incontinence
 - 6 - 8 severe incontinence

Incontinence Quality of Life (IQOL)

Patient should complete the following prior to visit, if possible. Patient is to rank on a scale as follows: 1- very much, 2 moderately, 3-a little, 4 not at all. Then total all the scores and the higher the score, the better the quality of life.

1. _____ I worry about wetting myself.
2. _____ I worry about coughing and sneezing because of my incontinence.
3. _____ I have to be careful standing up after sitting down because of my incontinence.
4. _____ I worry about where toilets are in new places.
5. _____ I feel depressed because of my incontinence.
6. _____ Because of my incontinence, I don't feel as free to leave my home for long periods of time.
7. _____ I feel frustrated because my incontinence prevents me from doing what I want.
8. _____ I worry about others smelling urine on me.
9. _____ Incontinence is always on my mind.
10. _____ It's important for me to make frequent trips to the toilet.
11. _____ I avoid laughing because of my incontinence.
12. _____ Because of my incontinence, it's important for me to plan every detail in advance.
13. _____ I worry about my incontinence getting worse as I grow older.

14. _____ I have a hard time getting a good night's sleep because of my incontinence.
15. _____ I worry about being embarrassed or humiliated because of my incontinence.
16. _____ My incontinence makes me feel as if I am not a healthy person.
17. _____ My incontinence makes me feel helpless.
18. _____ I get less enjoyment out of life because of my incontinence.
19. _____ I worry about not being able to get to the toilet on time.
20. _____ I feel like I have no control over my bladder.
21. _____ I have to watch what I drink because of my incontinence.
22. _____ My incontinence limits my choice of clothing.
23. _____ I worry about having sex because of my incontinence.

_____ total score

Sample Voiding Diary

Name: _____

Date: _____

Instructions:

Place a check in the appropriate column next to the time you urinated in the toilet or when and incontinence episode occurs. Note the reason for the incontinence and describe your liquid intake (for example; coffee, water) and estimate amount (1 Cup).

Time Interval	Fluid intake-amount and type	No incontinence;Urinated in toilet	Small incontinence episode	Large incontinence episode	Activity at time of incontinence	Did you feel a strong urge to go? Yes or No	Any urine leakage between urinating? How much?
6 - 8 a.m.							
8 - 10 a.m.							
10 - noon							
noon – 2 p.m.							
2 - 4 p.m.							
4 - 6 p.m.							
6 - 8 p.m.							
8 - 10 p.m.							
10 - midnight							
overnight							

number of pads used							
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time of last drink of fluid before going to bed _____

**Adapted from National Institute for Health
UI Project: Dixon, Koneski, Roberts*