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 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

Reference

NICE CG 123 Urinary Incontinence and Pelvic Organ Prolapse in Women: Management. April 2019 (accessed on line Dec 2022)

The management of urinary Incontinence in Women, Nov 15 (accessed online 2016)