

Recent studies indicate that only 32 percent of primary care providers routinely screen for incontinence, and 50 to 75 percent of the time¹ patients remain silent about their symptoms.

Underestimation of incontinence's impact 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 10 years, and 70 percent of patients who undergo treatment experience major improvements in their quality of life. For these reasons, doctors must take a more proactive role in discussing and diag-

nosing urinary incontinence in their patients and, if necessary, provide referrals to qualified urologists.

Adult urinary incontinence affects 17 million Americans, 85 percent of whom are women. Other "at-risk" groups include the elderly and those living in long-term care facilities. While prevalence increases with age, a number of younger women suffer from this 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 show the deleterious effect this condition 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.

Seeing the overwhelming gratitude of women whose incontinence has been successfully treated remains one of the main reasons I enjoy practicing in this area of urology.

Diagnosing Incontinence

The biggest challenge to assessing patient incontinence is simply engaging them in a discussion about their problem. Once a doctor — either a primary care physician or an incontinence specialist — has taken this critical first step, several techniques can be employed to help produce a more fruitful evaluation.



ADULT FEMALE INCONTINENCE

Diagnosis and Treatment Options

by Christopher Graham, M.D.

Although more medical providers are recognizing adult urinary incontinence as an abnormal but treatable condition, it continues to go undiagnosed and untreated in far too many individuals...

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, doctors should consider key history items such as the nature of incontinence, duration of symptoms, amount of leakage, pad use, previous treatment, and the impact of symptoms on lifestyle.

Physicians should focus on differentiating between the two main types of incontinence: urge urinary incontinence (UII) and stress urinary incontinence (SUI). Patients with UII and the related condition, overactive bladder (OAB), 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 and have a condition 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 almost always have 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

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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 nonurological systems can help identify comorbid 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, and examining each area as follows:

- Suprapubic region — palpate, noting scars indicating pelvic surgery
- Meatus and urethra: position and mobility — a Q-tip is often used to assess bladder neck mobility and evidence of prior surgery; check for incontinence with straining and cough, using a standing position if necessary
- Bladder — palpate for tenderness; examine for cystocele

- Vagina — assess for apical prolapse and level of atrophy; hook a finger deep to the levator floor, assessing tenderness, tone, and contraction on command
- Uterus and cervix — conduct limited exam using only one blade of a speculum, assessing for presence, prolapse, and palpable abnormality
- Rectum — check for presence of rectocele, impaction, or constipation
- Anus and perineum — check strength and presence of perineal body, sphincter tone

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, as well as a bladder scan measurement of post-void residual (PVR) urine volume. 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, had prior incontinence therapies, or 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 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. Oxybutynin and hysocamine are the commonly used generic anticholinergics. These medications require bid or tid dosing and have higher incidence of side effects (commonly dry mouth and constipation) than extended release oxybutynin (Ditropan XL[®]), oxybutynin patch (Oxytrol[®]), tolterodine (Detrol[®] LA), and trospium (Sanctura[™]). Several newer agents are in Phase III FDA trials. 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 interventions are excellent options for the elimination and improved management of chronic UUI and OAB. These interventions demand patient motivation and long-term participation in their care.

Because of the time required to manage behavioral intervention of patients effectively, doctors should consider sending candidates for this type of treatment to a specialized urodynamics center. Urology San Antonio offers a full-service pelvic

floor treatment center under the direction of Peggy Francis, RN, MSN, DNP, a bio-feedback and behavioral therapy specialist.

Stress Urinary Incontinence

Surgical treatment remains the primary means for treating bladder outlet incompetence or stress urinary incontinence. In the past, surgical urethral support operations or “sling treatments” have been plagued by poor durability, but techniques introduced in the past seven years that place a polypropylene tape under the urethra using minimally invasive approaches have proven minimally morbid, reliable, and durable. These new sling techniques and materials can be used as sole therapy or in combination with more extensive procedures to correct vaginal prolapse. They represent a quantum 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.

Another new SUI treatment that has received FDA approval and is now being studied for MUI is duloxetine, a selective serotonin/norepinephrine reuptake inhibitor.

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

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