Urinary Incontinence in Older Adults

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Background

Urinary Incontinence (UI) becomes more prevalent with aging and often goes unreported
- 15-30% of adults over 65 (and 60-70% of nursing home residents) have some degree of UI
- Aging results in decreased bladder capacity, increase in bladder contractions (detrusor over activity), and decreased ability to suppress urgency

While UI does not significantly change mortality, it has major morbidity
- Social isolation, depression, falls, UTI, and skin breakdown are all consequences
- UI is a significant underlying factor in caregiver burden and long-term care placement

Treatment

Address and modify contributing factors
- Medications leading to increased urine production (i.e. diuretics) or urinary retention (i.e. anticholinergics, narcotics)
- Excess fluids, caffeine, and alcohol

Lifestyle Interventions
- Weight loss
- Incontinence supplies (often not covered by insurance and can be costly)

Evaluation

What is the type of UI?
- Stress Incontinence: usually small volume urine loss associated with increased intra-abdominal pressure (sneezing, coughing, etc.)
- Urge Incontinence: strong, sudden urge followed by leakage of urine
- Overflow Incontinence: incomplete bladder emptying due to mechanical obstruction (BPH) or nerve damage (spinal cord injury/compression, multiple sclerosis, diabetes)
- Mixed (urge + stress) or DHIC (urge + incomplete bladder emptying)

Physical Exam
- Should generally include abdominal, neurologic, gynecologic, and rectal exam

Workup
- All patients should get a UA
- Bladder diaries and PVR testing may also be helpful in select patients
- Routine urodynamic testing is not needed
- Refer to specialist for UI with pain, hematuria, or anatomic abnormalities
Treatment Continued

Behavioral (for Urge and Stress Incontinence)
- Bladder Training: frequent voluntary voiding (begin with q2 hour) combined with urgency suppression (remaining still and defer trip to bathroom until after urgency peaks)
- Pelvic Floor Exercises (Kegels): isolated pelvic muscle contractions lasting 6-8 seconds repeated 10 times with goal of 3 sets per day, 3-4 times a week
- Behavioral methods are as or more effective than medications (but take weeks-months to have full benefit) in cognitively intact patients
- With significant cognitive impairment prompted voiding is the only proven intervention

Medications (for Urge Incontinence)
- Anticholinergic agents all have similar efficacy (mild to modest benefit)
- Side effects include constipation, dry mouth, and cognitive impairment (although very little evidence exists about the incidence and clinical impact)
- Solifenacin is generally better tolerated than oxybutynin in the elderly and studies show no changes in cognition with its use in patients with mild cognitive impairment
- Use with caution in patients with dementia, and it should not be used in combination with cholinesterase inhibitors
- Trial alpha-blocker in those with overflow incontinence

Surgery
- Potentially helpful for stress incontinence and some causes of overflow incontinence
- Proceed with caution in frail older adults, although age alone is not a contraindication

The Bottom Line

- UI is common among the elderly and has serious health and quality of life implications. Clinicians should actively screen for incontinence
- Management should include addressing modifiable contributing factors and lifestyle modifications
- Bladder training and pelvic floor exercises take persistence and relatively intact cognition, but are the first step and have good efficacy
- All anticholinergics have similar (mild to modest) efficacy for urge incontinence. There is evidence that solifenacin (Vesicare) may be a better option for patients with cognitive dysfunction

References:
4. Geriatric Review Syllabus. 9th edition