

GER-E-NEWS

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Urinary Incontinence in Older Adults

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<u>Background</u>	<u>Evaluation</u>
<p>Urinary Incontinence (UI) becomes more prevalent with aging and often goes unreported</p> <ul style="list-style-type: none"> • 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 <p>While UI does not significantly change mortality, it has major morbidity</p> <ul style="list-style-type: none"> • 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 	<p>What is the type of UI?</p> <ul style="list-style-type: none"> • <i>Stress Incontinence</i>: usually small volume urine loss associated with increased intra-abdominal pressure (sneezing, coughing, etc.) • <i>Urge Incontinence</i>: strong, sudden urge followed by leakage of urine • <i>Overflow Incontinence</i>: incomplete bladder emptying due to mechanical obstruction (BPH) or nerve damage (spinal cord injury/compression, multiple sclerosis, diabetes) • <i>Mixed</i> (urge + stress) or <i>DHIC</i> (urge + incomplete bladder emptying) <p>Physical Exam</p> <ul style="list-style-type: none"> • Should generally include abdominal, neurologic, gynecologic, and rectal exam
<p><u>Treatment</u></p> <p>Address and modify contributing factors</p> <ul style="list-style-type: none"> • Medications leading to increased urine production (i.e. diuretics) or urinary retention (i.e. anticholinergics, narcotics) • Excess fluids, caffeine, and alcohol <p>Lifestyle Interventions</p> <ul style="list-style-type: none"> • Weight loss • Incontinence supplies (often not covered by insurance and can be costly) 	<p>Workup</p> <ul style="list-style-type: none"> • 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:

1. Wagg A, Gibson W, Ostaszkiwicz J, Johson T, Markland A, Palmaer M, Kuchel G, Szonyi G, Kirchner-Hermans R. Urinary Incontinence in Frail Elderly Persons: Report From the 5th International Consultation on Incontinence. *Neurology and Urodynamics*. 2015; 34:398-406.
2. Sink KM, Thomas J, III. Xu H, et al. Dual use of bladder anticholinergics and cholinesterase inhibitors: Long-term functional and cognitive outcomes. *J Am Geriatr Soc* 2008;56:847-53.
3. Wagg A, Verdejo C, Molander U. Review of cognitive impairment with antimuscarinic agents in elderly patients with overactive bladder. *Int J Clin Pract* 2010;64:1279-86.
4. Geriatric Review Syllabus. 9th edition

