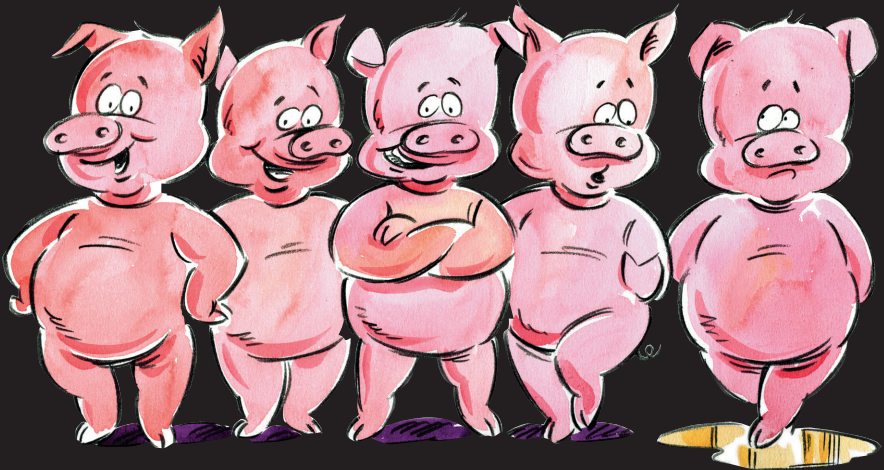


EDITED VERSION



Managing Incontinence in General Practice

Clinical Practice Guidelines



Prepared by the WA Research Unit of the RACGP with the assistance of the National Continence Management Strategy, Commonwealth Department of Health and Ageing



MANAGING INCONTINENCE IN GENERAL PRACTICE – CLINICAL PRACTICE GUIDELINES

1st Edition, 2002

Prepared by the WA Research Unit of the Royal Australian College of General Practitioners.

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1 | Foreword

This publication has been designed for the purpose of assisting GPs in recognising and managing patients who suffer from urinary and/or faecal incontinence.

Research for this publication was conducted by the WA Research Unit of The Royal Australian College of General Practitioners, with funding provided by the Department of Health and Ageing (DHA) through the National Continence Management Strategy (NCMS).

The provision of these guidelines nationally follows the successful implementation of a demonstration project within the Perth metropolitan region, also funded by DHA through the NCMS. As part of the Government's "Staying at Home" package, the Commonwealth Department of Health and Aged Care also funded two other demonstration projects: the Hunter Continence Awareness Project, and the Ovens and King Continence Care and Resource Model Demonstration Project. All three demonstration projects were evaluated by the University of Newcastle and informed these guidelines.

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2 Additional copies of these guidelines may be requested from The Royal Australian College of General Practitioners.

2 | How to use this booklet

This booklet represents an edited version of the more detailed set of guidelines and additional resources that are found in the accompanying “Managing Incontinence in General Practice” package. It has been designed as a brief, general reference for consultations with patients presenting with urinary and/or faecal incontinence.

GPs who require more detailed information regarding incontinence, particularly regarding those high-risk patient groups listed in Section 8 of this booklet, are encouraged to refer to the larger guidelines contained in the accompanying package. The package also contains useful patient information in the form of a number of pamphlets produced by the Continence Foundation of Australia. Treatment algorithms, an educational video, bladder/bowel diaries, referral links, and information on the National Public Toilet Mapping Project are also provided.

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3 | Introduction

Incontinence is largely a “hidden” condition. Patients do not readily admit to symptoms, and many doctors are unaware of their prevalence. Within the general population, up to 19% of children ⁽¹⁾ and at least 20% of women and 10% of men ⁽²⁾ may be affected by some form of urinary incontinence. Rates of faecal incontinence in the adult population are also thought to be high, with recent Australian statistics highlighting a 12-month incidence of 11.2% ⁽³⁾. These largely under-reported conditions often have a significant negative influence on quality of life and mental health ^(4,5) and are usually a major influence on decisions to place an elderly person in long-term institutionalisation ⁽⁶⁾.

A large proportion of incontinence can be cured or improved, often through simple pelvic floor exercises and other behavioural strategies such as bladder training ⁽⁷⁾. General Practitioners are ideally placed within the Australian Health System to provide and coordinate care for persons affected by incontinence. GPs are the leading providers of health-care to the Australian community, averaging 6000 consultations each per year ⁽⁸⁾. Up to 90% of Australians visit a GP each year ⁽⁸⁾.

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The cost of incontinence to patients and the wider community is difficult to estimate due to its lack of visibility. An Australian study estimated that the median personal cost per week is A\$5.61 and the total annual treatment cost of medical treatments is A\$462 on average. Total direct cost (median) was found to be A\$12.89 per week ⁽⁹⁾. Financial cost is more than matched by the social cost of the condition. Incontinence may be described as a social death, due to its debilitating effect on the ability of sufferers to travel and interact with other community members.

It is clear that a large amount of incontinence remains unmanaged. A major barrier to patients’ help-seeking behaviour is certainly embarrassment. Many patients, however, simply lack knowledge of their condition and of the available treatments ^(10,11). Others believe that incontinence is a normal part of ageing or childbirth or that it is not a “medical” condition ⁽¹⁰⁻¹²⁾. A growing body of research and clinical opinion suggests that incontinence should not be considered either normal or untreatable.

These guidelines provide sufficient information to enable GPs to feel confident in their ability to identify and manage incontinence within their own practices. Effective treatment may take time, however, and management can often be optimised by appropriate referral to other health providers such as nurse continence advisors, physiotherapists, occupational therapists, pharmacists, and specialists. Links to such professionals are provided in the package that accompanies these guidelines.

These guidelines represent a summary of the strongest available data and management recommendations for urinary and faecal incontinence, contextualised to the particular needs of Australian General Practice. Information is presented in three levels, providing detailed background, summarised guidelines, and an assessment and management algorithm that provides a convenient visual representation of the major decision points and preferred management pathways. A number of resources are also present on CD-ROM. We encourage GPs to use these resources and are confident that their use will assist in uncovering and managing a substantial amount of previously unreported incontinence.

Other practical guides that may be useful for patients and GPs include:

- “Womens’ Waterworks” by Pauline Chiarelli ⁽¹³⁾
- “Bladder care” by Prem Rashid and Vicky Hibbard ⁽¹⁴⁾
- “Simply Busting” edited by C. B. Pinnock ⁽¹⁵⁾
- “The Voice”, a free magazine produced by the Continence Foundation of Australia

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4 | Definitions

URINARY INCONTINENCE

The definitions associated with urinary incontinence presented here (see Table 1, below) are those arising from the combined work of the International Continence Society and a large number of experts worldwide ⁽¹⁾. The terms are used throughout these guidelines and are useful as guides to assessment. Clinical observation of these signs and symptoms, however, does not provide a definite diagnosis. The causes of incontinence can only be absolutely determined by urodynamic studies ⁽²⁾.

TABLE 1: TERMINOLOGY ASSOCIATED WITH URINARY INCONTINENCE

| TERM | DEFINITION |
|---|---|
| Urinary incontinence/enuresis | The complaint of any involuntary leakage of urine |
| Nocturnal enuresis | Any involuntary loss of urine during sleep |
| Urgency | The complaint of a sudden, compelling desire to pass urine, which is difficult to defer |
| Urge urinary incontinence | The complaint of involuntary leakage accompanied by or immediately preceded by urgency |
| Stress urinary incontinence | The complaint of involuntary leakage on effort or exertion, or on sneezing or coughing |
| Mixed urinary incontinence | The complaint of involuntary leakage associated with urgency and also with exertion, effort, sneezing or coughing |
| Overflow incontinence (now referred to as chronic retention of urine) | The involuntary loss of urine associated with over-distension of the bladder, or associated with poor bladder emptying |
| Chronic retention of urine (see also overflow incontinence) | A non-painful bladder, which remains palpable or percussable after the patient has passed urine. Such patients may be incontinent |
| Nocturia | The complaint that the individual has to wake at night one or more times to void |

| | |
|---------------------------------|--|
| Increased daytime frequency | The complaint by the patient who considers that he/she voids too often by day |
| Detrusor overactivity | A urodynamic observation characterised by involuntary detrusor contractions during the filling phase which may be spontaneous or provoked |
| Detrusor underactivity | A contraction of reduced strength and/or duration, resulting in prolonged bladder emptying and/or a failure to achieve complete bladder emptying within a normal time span |
| Post void residual (PVR) | The volume of urine left in the bladder at the end of micturition |
| Bladder compliance | The relationship between change in bladder volume and change in detrusor pressure |
| Bladder outlet obstruction | Obstruction during voiding characterised by increased detrusor pressure and reduced urine flow rate |
| Dysfunctional voiding | An intermittent and/or fluctuating flow rate due to involuntary intermittent contractions of the peri-urethral striated muscle during voiding, in neurologically normal individuals |
| Continuous urinary incontinence | The complaint of continuous leakage |
| Terminal dribble | The term used when an individual describes a prolonged final part of micturition, when the flow has slowed to a trickle/dribble |
| Post micturition dribble | The term used when an individual describes the involuntary loss of urine immediately after he or she has finished passing urine, usually after leaving the toilet in men, or after rising from the toilet in women |
| Detrusor sphincter dysynergia | A detrusor contraction concurrent with an involuntary contraction of the urethral and/or periurethral striated muscle. Occasionally, flow may be prevented altogether |

FAECAL INCONTINENCE

Research surrounding faecal incontinence has been hampered by the widespread use of a variety of definitions.

It is suggested that a useful definition of faecal incontinence is as follows:

An involuntary loss of anal sphincteric control leading to unwanted release of liquid or solid faeces (not flatus) at an inappropriate time or in an inappropriate place ⁽²⁾.

It remains to be seen whether this definition will continue to be used in future research. Its face validity appears good in that it defines the problem of clinically significant faecal incontinence well. It does not overestimate “serious” incontinence by including involuntary loss of flatus.

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- 1) Abrams, P., Cardozo, L., Fall, M., et al. (2002). The standardisation of terminology of lower urinary tract function: Report from the standardisation sub-committee of the International Continence Society. *Neurourology and Urodynamics*, 21 (2): 167-178.
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5 | Prevalence - General Population

ADVANCED SUMMARY

- Research has demonstrated that up to 40% of a GP waiting room population may suffer from some form of incontinence
- Urinary incontinence is thought to be present in at least 1 in 10 of the general population
- The 12-month incidence of faecal incontinence (not due to acute diarrhoea) in the wider Australian community has been reported at 11.2%
- Incontinence has been consistently identified as a major factor influencing placement of a patient in long-term-care
- Incontinence is not limited to the elderly – it can affect children, adults, sports-people, post-partum and post-menopausal women, and patients with other serious medical conditions

There are few studies of the prevalence of urinary incontinence that have included all age-groups, however the available estimates suggest that symptoms are present in just below 10% of the general population ^(eg. 1,2). It is thought that only 30% of sufferers seek health-care for urinary incontinence ⁽³⁾.

The prevalence of faecal incontinence is also likely to be both high and under-reported. A recent Australian study was able to demonstrate that during a 12-month period, 11.2% of the surveyed population experienced “involuntary loss of anal sphincteric control that led to unwanted release of liquid or solid faeces (not flatus) at an inappropriate time or in an inappropriate place” ⁽⁴⁾. Instances of acute diarrhoea were not included in this analysis. This study also highlighted that only 27% of those with faecal incontinence sought health-care for the condition and that doctor-initiated discussion was reported by 14.6% of patients in whom the condition was present ⁽⁴⁾.

Population statistics suggest that, within a General Practice population of 1000 patients, at least 100 patients may currently experience some form of urinary incontinence. A potentially distinct 100 patients may suffer from faecal incontinence during any 12-month period. Given the unique characteristics of a waiting room population however, the actual prevalence in the GP setting may be much higher. Preliminary research suggests that up to 40% of an average waiting room population may suffer from some form of incontinence ⁽⁷⁾.

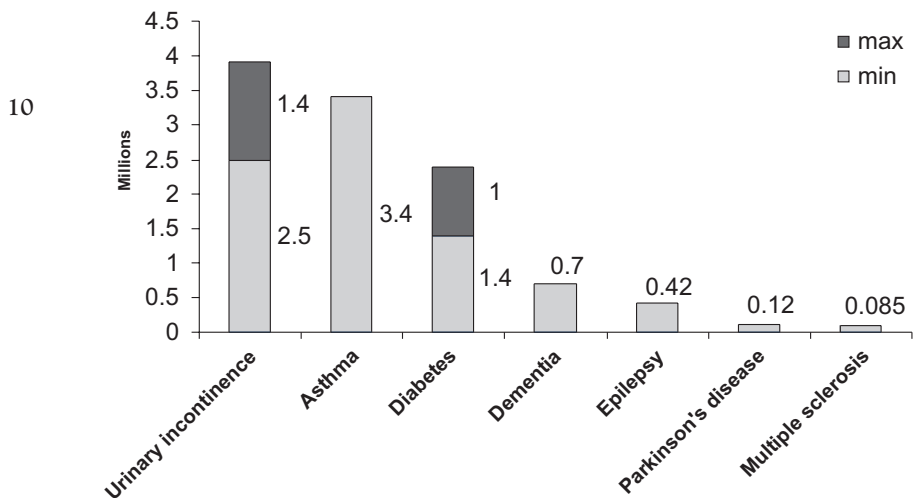
While incontinence is found throughout the general population, rates are often much higher in certain patient groups. It is unusual, for example, for studies to report urinary incontinence in less than 20% of women and most reports indicate that at least 40% have experienced symptoms ⁽⁵⁾. Rates also clearly increase with

age ⁽⁵⁾. At the extreme, incontinence is usually a major factor in the prediction of institutionalisation of the elderly ⁽⁶⁾.

Information related to high-risk groups for incontinence can be found in Section 8 of these guidelines. Specialist guidelines are available for children, post-partum and post-menopausal women, men, the elderly, and those with serious medical conditions. Reports of the prevalence of incontinence in these groups can be several times higher than that of the general population.

High rates of incontinence in the general population, combined with low rates of doctor-patient communication, suggest that screening for incontinence in General Practice should be increased. Sensitive questioning of patients during routine examination is likely to uncover previously unreported and unmanaged incontinence.

The figure below presents the prevalence of incontinence in the UK as compared to several other common conditions ⁽⁸⁾:



It is recommended that due to the potentially large number of untreated patients, screening for incontinence should be increased in General Practice.

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6 | Urinary Incontinence

6.1 PRESENTATION

In order to determine the most appropriate management strategy, it is useful to categorise incontinence according to its various clinical characteristics. Urinary incontinence can be divided into five major groups (stress, urge, mixed, overflow*, and functional). The aetiology and clinical features are briefly summarised in Table 1 (below). All information presented in this section comes from the work of the RACGP Continence Care in the Community Project ⁽¹⁾, and the work done by Millard ⁽²⁾.

TABLE 1: TYPES OF URINARY INCONTINENCE

| TYPE | AETIOLOGY | FEATURES |
|--------|--|---|
| Stress | a. Intrinsic sphincter deficiency (ISD) b. Hyper mobility of bladder neck, weakened pelvic muscles, caused by: <ul style="list-style-type: none"> • Childbirth • Menopause • Trauma/surgery | Involuntary loss of urine associated with increased intra-abdominal pressure, such as: <ul style="list-style-type: none"> • Coughing • Sneezing/laughing • Lifting • Exercise |
| Urge | a. Associated with detrusor instability that causes uninhibited bladder contractions. Causes can be: <ul style="list-style-type: none"> • CVA • Demyelinating diseases • Local irritating symptoms (UTI or bladder tumours) b. Underactive, low tone bladder, due to: <ul style="list-style-type: none"> • Drugs • Neuropathy • Spinal Cord Injury • Pelvic surgery/trauma | Involuntary loss of urine at unexpected times, associated with a strong desire to void (urgency). |
| Mixed | Combination of urge and stress incontinence | Common in women. One symptom may be more bothersome than another. |

| | | |
|------------|--|---|
| Overflow * | <p>Factors that inhibit bladder contraction:</p> <ul style="list-style-type: none"> • Bladder failure <p>Factors that obstruct outflow:</p> <ul style="list-style-type: none"> • Tumours • Benign strictures • Prostatic hypertrophy | <p>Involuntary loss of small amounts of urine from a full bladder. Patients may have a variety of symptoms including constant or frequent dribbling, or urge or stress incontinence symptoms.</p> |
| Functional | <p>Relatively normal micturition but other chronic impairment of physical or cognitive functioning. Causes include:</p> <ul style="list-style-type: none"> • Dementia • CVA • Decreased dexterity (eg arthritis) | <p>Urine loss associated with difficulty reaching a toilet when needed.</p> |

(*) Now referred to as “chronic retention of urine” – see Section 4: “Definitions”.

6.2 CLINICAL ASSESSMENT

HISTORY

A basic assessment of any patient who presents with urinary incontinence should include a detailed history such as that shown in Table 2 (below). Using sensitive questioning that utilises the patient’s own words for their condition is more likely to place them at ease and allow more accurate information to be collected. It may be appropriate to ask patients about incontinence during routine pap smear and prostate examinations. The question may be framed as an enquiry about a “surprisingly common and perhaps embarrassing condition” to allay patient concerns.

TABLE 2: KEY ASPECTS OF THE MEDICAL HISTORY

| ASSESSMENT | CONTENT |
|--|---|
| General medical and genitourinary review | <ul style="list-style-type: none"> • General Health • Co-morbidity (eg. locomotor problems) • Previous surgery/trauma |
| Characteristics of the presenting incontinence | <ul style="list-style-type: none"> • Duration • Frequency - bladder diary • Amount - bladder diary • Precipitants (eg. stress, urgency) • Impact on quality of life |
| Other related symptoms | <ul style="list-style-type: none"> • Haematuria • Nocturia • Pain (eg. dysuria, burning, stinging) • Hesitancy or abnormal stream • Constipation or faecal impaction |
| Fluid intake | <ul style="list-style-type: none"> • Caffeine, alcohol & fizzy drinks |
| Medication use (see Table 3) | <ul style="list-style-type: none"> • Include “over-the-counter” drugs |
| Environmental factors | <ul style="list-style-type: none"> • Access to toilet • Is toilet clearly identified? (esp. in dementia) • Presence of carer support |
| Cognitive status | <ul style="list-style-type: none"> • Dementia • Depression |
| Expectations of treatment | <ul style="list-style-type: none"> • Goals and motivation for treatment |

A key aspect to history-taking in patients who suffer from incontinence is medication-use. It is important to collate an exhaustive list of medications, including those available over-the-counter. As shown by Table 3 (below), there are a large number of medications that may potentially influence continence in a variety of ways. GPs should also be careful to consult the product information for each drug to establish whether drug interactions are likely.

TABLE 3: DRUGS THAT MAY CAUSE OR AGGRAVATE URINARY INCONTINENCE *

| AGENT | MECHANISM OF ACTION | TYPE OF INCONTINENCE |
|--|--|---|
| Alpha blockers Prazosin Doxazocin Phenoxybenzamine Terazosin | Decreased sphincter resistance | Stress |
| Bladder relaxants Anticholinergics Tricyclic antidepressants | Urinary retention and/or chronic constipation | Overflow |
| Bladder stimulants Cholinergic agents Anticholinesterase agents Caffeine Acidifiers SSRIs | Increased detrusor hypersensitivity | Increased urgency and frequency |
| Sedatives Early antihistamines Tricyclic antidepressants Antipsychotics Tranquillisers Hypnotics | Clouding of consciousness – less awareness of bladder sensation Anticholinergic side-effects. | Overflow and/or especially poor warning urge |
| Miscellaneous Alcohol Loop diuretics Lithium ACE inhibitors Narcotic analgesics Alpha agonists Beta agonists Calcium channel blockers | Lowers central inhibition Increases rate of bladder filling Polydipsia May induce chronic cough Urethral relaxation Retention Retention Retention | Urge, frequency Urge, frequency Urge Stress Stress Stress/overflow Stress/overflow Stress/overflow |

(*) Table compiled from ¹⁻³

NB – ANY DRUG THAT CAUSES CONSTIPATION CAN PRECIPITATE BLADDER DYSFUNCTION

PHYSICAL EXAMINATION

Together with the history presented in Tables 2 and 3 (above), a basic assessment of a patient with urinary incontinence should include a physical examination. The suggested elements to such examination are presented in Table 4 (below). Those patients who belong to any of the high-risk populations covered by these guidelines will benefit from the more detailed and specific assessment suggestions presented in Section 8 of these guidelines.

TABLE 4: SUGGESTED PHYSICAL EXAMINATION AND INVESTIGATIONS

| | | |
|-----------------------------|---------------------------------|---|
| Physical Examination | CNS | <ul style="list-style-type: none"> • Long tracts • Saddle anaesthesia • Anal tonus • Parkinson's disease • Dementia |
| | Abdomen | <ul style="list-style-type: none"> • Palpable bladder • Pelvic masses • Constipation or faecal impaction • Organ enlargement/tenderness |
| | Genitourinary | <ul style="list-style-type: none"> • Atrophic changes • Cystocele, urethrocele, prolapse • Leakage from other than urethra <ul style="list-style-type: none"> – fistula or ectopia • Obvious stress incontinence on coughing • Tenderness of urethra/bladder |
| | Perineal | <ul style="list-style-type: none"> • Strength of pelvic floor contraction • Prostate size and consistency • Determine sensation • Bulbocavernous reflex |
| Other Investigations | Post-void residual urine volume | <ul style="list-style-type: none"> • Check by ultrasound. Repeat if high (>100ml) |
| | Bladder diary | <ul style="list-style-type: none"> • Time and volume charted |
| | Urine culture | <ul style="list-style-type: none"> • Send MSU • Nitrate test not reliable • Dipstick for glucose, blood and protein |
| | Specialist referral: | <ul style="list-style-type: none"> • Urologist • IVP • Geriatrician • Cystometry, cystoscopy • Urodynamics • Urogynaecologist |

6.3 MANAGEMENT

Much urinary incontinence can be managed successfully and relatively easily within a General Practice setting. Where GPs have limited time resources, initiation of a Care-Plan should be considered. Professionals recommended to be included in a Care-Plan include nurse continence advisors and physiotherapists specialising in incontinence. Occupational therapists may also be consulted, particularly if the incontinence is functional. It is worthwhile exhausting all non-surgical options before specialist referral is considered. Specialists may include urologists, urogynaecologists and geriatricians.

Table 5 (below) presents potential management strategies for each type of urinary incontinence. Again, those patients who belong to any of the high-risk populations covered by these guidelines will benefit from the more detailed and specific suggestions presented in Section 8 of these guidelines.

TABLE 5: MANAGEMENT OF URINARY INCONTINENCE

| TYPE | MANAGEMENT STRATEGIES | RELEVANT HEALTH SERVICES |
|-----------------|---|--|
| Stress | <ul style="list-style-type: none"> • Weight reduction • Pelvic floor muscle exercises • Treat constipation or faecal impaction • Treat chronic cough • Pelvic floor electrostimulation, biofeedback • Review patient's medications (see Table 3) <ul style="list-style-type: none"> • Remove alpha-adrenergic blockers • Trial alpha-adrenergic agonists | <ul style="list-style-type: none"> • Dietician • Physiotherapist • Nurse Continence Advisor • Pharmacist • Specialist |
| Urge | <ul style="list-style-type: none"> • Exclude urinary tract infection • Treat constipation or faecal impaction • Reduce caffeine and alcohol, polydipsia/polyuria • Bladder training • Biofeedback • Review patient's medications (see Table 3) <ul style="list-style-type: none"> • Trial anticholinergic, or: • Trial tricyclic antidepressant | As above |
| Overflow | <ul style="list-style-type: none"> • Consider whether retention due to: <ul style="list-style-type: none"> • bladder outlet obstruction, or • detrusor contractile dysfunction/bladder failure, faecal impaction, spinal pathology • Confirm diagnosis by urodynamics • Remove any outlet obstruction (referral for surgery) • Review patient's medications • Discourage excessive abdominal straining • Clean intermittent self-catheterisation | As above |

| | | |
|-------------------|--|--|
| Mixed | <ul style="list-style-type: none"> • Treat presenting symptoms as above | As above |
| Functional | <ul style="list-style-type: none"> • Exclude UTI and constipation/faecal impaction • Improve access to toilet • Manage immobility • Manage dexterity, modify clothing (ie. velcro not buttons) • Consider bedside commode or urinal • Organise assistance, educate family members • Arrange chairs/beds that are easy to get out of • In cognitively impaired; <ul style="list-style-type: none"> • Prompted or timed voiding • Clearly identify toilet | As above, plus: <ul style="list-style-type: none"> • Independent Living Centres |
| All types | <ul style="list-style-type: none"> • Review regularly and titrate any medications • Referral to specialist if unsuccessful | |

References:

1. Tilbury, E, Jayasuriya, P, Taylor, J, Williams, L. (2001). Continence care in the community: Final Report, August 2001. Western Australia: The Royal Australian College of General Practitioners, WA Research Unit.
2. Millard, R. J. (2001). Tackling Incontinence in the community. New South Wales: The Hunter Continence Awareness Project.
3. Pharmaceutical Society of Australia. (2002). Medicines and urinary incontinence, in Australian Pharmaceutical Formulary and Handbook. Canberra: Pharmaceutical Society of Australia. p. 222-225.

7 | Faecal Incontinence

7.1 PRESENTATION

Faecal incontinence refers to any involuntary loss of anal sphincteric control leading to unwanted release of liquid or solid faeces (not flatus) at an inappropriate time or in an inappropriate place ⁽¹⁾. Recent research suggests that up to 11.2% of the adult Australian population suffer faecal incontinence in any 12-month period ⁽¹⁾.

Faecal incontinence may be classified into two broad groups, those with and without structural damage to the sphincter mechanism (see Table 1, below).

TABLE 1: AETIOLOGY OF FAECAL INCONTINENCE

| | |
|-----------------------|---|
| Structural | <ul style="list-style-type: none">• Obstetric-related• Damage due to surgery• Congenital anorectal abnormalities |
| Non-Structural | <ul style="list-style-type: none">• Smooth muscle degeneration with age• Neurological disease (eg. MS, cauda equina lesions)• Inflammatory bowel disease• Connective tissue disorders• Diabetes mellitus• Faecal impaction |

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7.2 CLINICAL ASSESSMENT

HISTORY

Patients should be assessed in regard to type of incontinence (solid, liquid or gas), frequency and impact on lifestyle. Questions should be directed to faecal incontinence interfering with employment and social activities away from home, the impact on sport or sexual activity and the requirement to change underwear, shower or use pads.

The patient's level of psychological stress and loss of self-esteem should be explored. A history of those conditions associated with faecal incontinence presented in Table 1 (above) should be sought. Importantly, check the patient's medication list for drugs that cause constipation or diarrhoea. Review the patient's diet (fibre and fluid) and use of laxatives.

A suggested medical history for a patient presenting with faecal incontinence is presented in Table 2 (below).

TABLE 2: KEY ASPECTS OF THE MEDICAL HISTORY

| ASSESSMENT | CONTENT |
|--|--|
| General medical and gastrointestinal review | <ul style="list-style-type: none"> • General Health • Co-morbidity (eg. locomotor problems) • Previous surgery • Presence of conditions presented in Table 1 (above) |
| Characteristics of the presenting incontinence | <ul style="list-style-type: none"> • Duration • Frequency • Amount • Precipitants (eg. Laxative use) • Consistency (gas, solid, liquid) • Level of awareness of leakage • Psychosocial impact |
| Other related symptoms | <ul style="list-style-type: none"> • Pain • Hesitancy or straining • Constipation or faecal impaction |
| Diet | <ul style="list-style-type: none"> • Fluid, fibre |
| Medication use | <ul style="list-style-type: none"> • Include “over-the-counter” drugs |
| Environmental factors | <ul style="list-style-type: none"> • Access to toilet • Is toilet clearly identified? (esp. in demented patients) • Presence of carer support |
| Cognitive status | <ul style="list-style-type: none"> • Dementia • Depression |
| Expectations of treatment | <ul style="list-style-type: none"> • Goals and motivation for treatment |

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PHYSICAL EXAMINATION

Physical examination should be guided by the likely aetiology. Neurological examination should be performed if neurological disease or diabetes is suspected. Inspection of the ano-genital region should look for surgical scars, fistulae, patulous anus and the degree of descent on straining (normally less than 1cm). Anal sensation should be tested along with the anocutaneous reflex. An assessment of the resting anal tone and squeeze pressure should be made by digital rectal examination. Faecal impaction should also be excluded. Abdominal X-Ray may be necessary to assess the degree of impaction.

7.3 MANAGEMENT

Management of faecal incontinence will depend on the likely aetiology and the severity. In women of child bearing age the cause may be obstetric related (damage to the sphincter). Such women will need further investigation that is best undertaken at specialist centres or by individual colorectal surgeons specialising in incontinence.

In patients where the incontinence is not severe, conservative management may be undertaken by the GP. Patients not responding to conservative management, or those with more serious degrees of incontinence, are best referred for specialist management.

Table 3 (below) presents a number of strategies considered useful in the management of faecal incontinence and associated conditions.

TABLE 3: MANAGEMENT OF FAECAL INCONTINENCE AND ASSOCIATED CONDITIONS

| | |
|---|---|
| Conservative strategies for faecal incontinence | <ul style="list-style-type: none">• Manipulating stool hardness• Manipulating dietary fibre• Loperamide to increase EAS tone• Encourage patients to keep rectum empty• Pelvic floor exercises• Referral to Physiotherapist, nurse continence advisor |
| Faecal impaction | <ul style="list-style-type: none">• Evacuation with enemas if extended high• Bowel regimen including dietary fibre, fluids, stool softeners, and motility agents |
| Chronic Diarrhoea | <ul style="list-style-type: none">• Full gastroenterological investigation• Ensure not caused by laxative misuse• Use antidiarrhoeal agents with caution |
| Surgery for anal sphincter weakness | <ul style="list-style-type: none">• Direct sphincter repair• Post-anal repair• Gracilis muscle transposition with functional electrostimulation• Artificial sphincter or colostomy (as last resort) |
| Correction of rectal prolapse | <ul style="list-style-type: none">• Abdominal or perineal rectopexy |
| Procedures for slow transit constipation | <ul style="list-style-type: none">• Caecostomy or appendicostomy and irrigation, or partial colectomy |

(*) Please also see the constipation management pamphlet provided in the larger “Managing Incontinence in General Practice” package.

References:

- 1 Kalantar, J. S., Howell, S., Tally, M. J. (2002). Prevalence of Faecal Incontinence and Associated Risk Factors: An underdiagnosed problem in the Australian community? Medical Journal of Australia, 176: 54-57.

8 | High-Risk Populations

This booklet represents an edited version of a larger set of guidelines available in the accompanying “Managing Incontinence in General Practice” package. Section 8 of the more detailed guidelines relates to incontinence in several high-risk populations. While incontinence is present in all strata of the general population, it is the populations presented in this section that may be most likely to suffer from it. The patient groups covered include:

- Women of child-bearing age
- Post-Menopausal women
- Men
- Children
- Elderly
- Those with serious medical conditions, including:
 - Cancer
 - Dementia
 - Diabetes mellitus
 - Intrinsic bladder disease
 - Intrinsic bowel disease
 - Multiple sclerosis
 - Parkinson’s disease
 - Spina bifida/myelomeningocele
 - Spinal cord injury
 - Stroke

This booklet represents an edited version of the more detailed set of guidelines that accompany it. It has been designed as a brief, general reference for consultations with patients presenting with incontinence.

GPs who require more detailed information regarding incontinence in the above high-risk patient groups are encouraged to refer to the larger guidelines.

9 | Additional Resources

The guideline package (“Managing Incontinence in General Practice”), of which this booklet is only part, contains a number of resources to assist GPs in their management of patients with incontinence.

These include:

- Treatment algorithms for urinary and faecal incontinence
- Edited (this booklet), and full versions of the clinical practice guidelines
- An example of a bladder diary
- An example of a bowel diary
- 13 patient leaflets from the Continence Foundation of Australia, including information on bladder training and pelvic floor exercises
- Leaflets on constipation management and autonomic dysreflexia from the WA Health Department and The Paraplegic & Quadriplegic Association of Queensland respectively
- A CD-ROM containing the clinical practice guidelines and a digital video that tackles the problem of how to approach incontinence with patients
- A Resource and Services guide template
- A Care Plan template

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Further accredited training options:

Other options exist to enable GPs to learn more about the management of incontinence. Please contact the WA Research Unit of the RACGP on (08) 9381 9684 (email: wa.research@racgp.org.au), or your local Division of General Practice to enquire as to the availability of the following:

- Clinical audit packages
- Workshops
- Small-group learning events
- Upcoming conferences

