Key Considerations when caring for elderly women with Urinary Incontinence

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Elderly women and Urinary Incontinence

- Population studies from numerous countries have reported that the prevalence of UI ranged from approximately 5% to 70%
- UI at any age: 25–45%.
- Prevalence figures increase with increasing age, and in women aged ≥70 years more than 40% of the female population is affected.
- Prevalence rates are even higher in the elderly-elderly and amongst nursing home patients. (50 to 79%)
- There are only a few studies describing progression as well as remission of UI in the general population as well as in selected groups of the population. The mean annual incidence of UI has been reported to range from 1% to 9%, while estimates of remission are more varying, from 4% to 30%.
- The prevalence of UI is strongly related to the age of the woman

- I. Milsom & M. Gyhagen (2019) The prevalence of urinary incontinence, Climacteric, 22:3, 217-222, DOI: 10.1080/13697137.2018.154326

Frailty syndrome

- Fried and Rockwood- The Canada Frailty initiative
- Fried: The frailty phenotype: Weakness, slowness, exhaustion, low activity and weight loss.
- A biologic syndrome of decreased reserve and resistance to stressors, resulting from cumulative delclines across multiple physiologic systems, and causing vulnerability to adverse outcomes.

Frailty scales/ Screening for frailty

- Frailty screening can be useful to structure clinical team work, create awareness of frail older patients and as starting point for pro-active nursing care.
- Acute Frailty Intervention reduces LOS and re-admission rates
- Realistic Medicine- Cath Calderwood, CMO annual report 2014-5: Frailty matters.
- Frailty screening can help identify patients that would have a worse prognosis following surgical interventions

- Warnier, R.M.J., van Rossum, E., Du Moulin, M.F.M.T. *et al.* The opinions and experiences of nurses on frailty screening among older hospitalized patients. An exploratory study. *BMC Geriatr* **21**, 624 (2021). https://doi.org/10.1186/s12877-021-02586-z
- Mitchell, L, Rimer, J, Munang, L. BGS Abstract, Frailty and Urgent Care Meeting poster presentation, July 2022.
- Walston, J et al , Clin Geriatr Med. 2018 February ; 34(1): 25–38. doi:10.1016/j.cger.2017.09.004.

Patient centred care

General Considerations

History taking: “Pads and pants”

Examination: Often missed. Lichen, atrophic vaginitis, pigmented lesions.

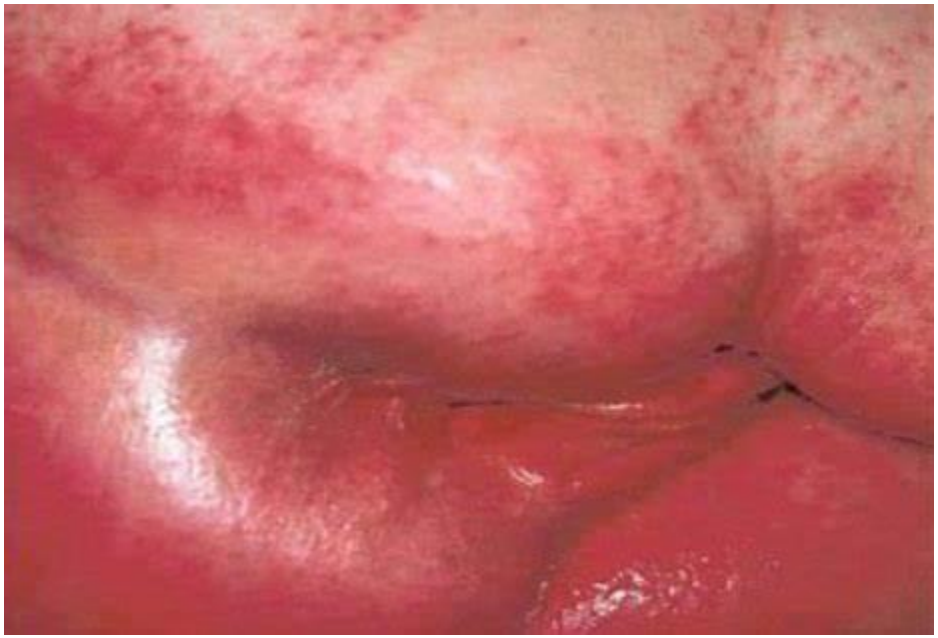
Prolapse: Poor medical teaching on how to diagnose and examine to detect prolapse.

Anal region: Signs of constipation, anal tone, any lesions, haemorrhoids.

More considerations on examination

- Skin elsewhere: Urine burn rashes in legs and sacrum.
- Delirium and cognitive impairement
- “Urine smell”- denotes incontinence rather than infection
- Frequency of positive dipsticks of urine
- Difficulties in obtaining MSU and dipsticks of urine

Urea Burns/dermatitis from poor or failed incontinence management



Previous PMH

- Vaginal deliveries/obstetric trauma
- History of prolapse/pessaries
- Propensity to UTI’s
- Constipation
- Self-evacuation
- Back pain/spinal stenosis
- Drugs***

Drugs and the Perineum

- Drugs can cause and contribute to an atonic bladder and an atonic rectum
- Hence increasing the intra-abdominal pressure through repeated or streneous Valsalva maneouvers
- Avoid stimulant laxatives (Senna), regular opiates, “incomplete” opiate prescription (always adjuvant laxative, always exit strategy), tricyclics.
- Verapamil/ antibiotics/ diabetes and candida

Continence asessment in a clinical setting (frail patients)

- Assessing continence at home: dream versus reality
- Assessing continence in hospital: Value of continence diary in in-patients often diminished
- Access to investigations (dipstick of urine, post bladder scan)
- Access to multidisciplinary discussions

Continence assessment of frail patients should be Simple and rutinary

- History
- Examination
- Continence aids
- “How do you get to the toilet”
- More specific questions: Do you toilet yourself? Do you use wet wipes? Do you use pads, which ones, how often do you change them?
- Symptoms of OAB and nocturia

“Normal in hospital” The good, the bad and the ugly

- Getting up to the toilet at night
- Distress/confusion on getting up to the toilet, requests for assistance: Need to further enquiry into cognitive problems and anxiety
- Using pads when they were not used before
- Drinking less
- Loss of trust and breakdown of relationships when accidents happen
- Depression, withdrawal
- Overtreatment of asymptomatic bacteriuria- which can have consequences (patient’s understanding, Cdiff, side effects, multi-resistant organisms)

What can help?

- Leaving the light on in the toilet
- More care in side rooms
- Adequate staffing levels
- Programmed/timed voiding
- Regular continence checks
- Promoting independence with available pads/continence stations
- Commodes at bedside/curtains
- Risk assessment decisions

Medical interventions

- Treatment of constipation
- Treatment of UTI's
- Treatment of OAB/beware of anticholinergic burden and use of anticholinergics for OAB
- Bladder retraining for long stay patients
- Adequate trial without catheters
- Catheterisation
- Psychological/social intervention

Who to offer a catheter to?

- No prospects of regaining mobility
- Distress at incontinence
- Obesity/poor skin condition
- Risks versus Benefits
- Risk of UTI's increases to at least 3 UTI's per year if none previously: What happens to this patient when they get a CAUTI?

And after the catheter?

- Catheter passport
- Consider regular clamping of catheter if short term
- Schedule and allocation of reviews
- Shared responsibility and patient information

The future?

- Prevention of incontinence
- Public health measures, education, exercise classes.
- Research on sarcopenia/nutrition: ?age 70 onwards
- Recognition of frailty and insitituting comprehensive geriatric patient centred care to all frail patients.
- Fluid care across health sectors
- Phitotherapy
- Better catheters
- Responsibility of continence products manufacturers? (environment, patient's choice, cost)

Phitotherapy

- BNO-1045 (Canephron): Herbal medicine product containing centaurii herba, lovage root powder and rosemary leaf powder: non inferior to Fosfomycin in uncomplicated UTI, could prevent post operative cAUTI.
- Antispasmodic and antiinflammatory properties, preserves gut flora.
- Horseradish powder, [ptetoa; effocacu /

Catheter innovations in the pipeline

- Antiadhesive treatments, mannoside GSK3882347 in phase 1 trial (agaisnt biofilm formation)
- Other molecules targetting pilus formation (hair like structures formed by bacteria and building blocks of biofilm)
- Malacidins (similar to penicillin, but produced by non culturable bacteria)

The Imaginary Frailty Women Association