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Hot topic in geriatric medicine

Consensus document on the management of urinary incontinence in older people



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ARTICLE INFO

Article history:

Received 24 February 2017

Accepted 11 April 2017

Available online 11 May 2017

Keywords:

Older people
 Incontinence
 Management
 Medical treatment

ABSTRACT

Urinary incontinence (UI), one of the geriatric giants, is a very common problem in the older person. It especially affects those with comorbidities, polypharmacy and functional impairment, physical as well as cognitive, in whom the prevalence could be as high as 70–80%. Despite its very negative effects on quality of life (QOL), UI is still largely undetected and undertreated, due to different, but incomprehensible reasons. UI produces numerous negative effects on QOL in older persons. Patients' perception of the impact of UI on their lifestyle is very important, and even mild UI could have a significant impact on QOL. Unfortunately, both detection and index consultation for UI are low, as is the percentage of older persons that receive effective treatment (about 30–50%), in spite of the valid management options available. Also, older persons are less likely than younger age groups to discuss incontinence with their physician and only about half of those with incontinence seek help for their symptoms. Geriatricians should be in the frontline of the detection and diagnosis of UI, which can be considered as the 'Frequently Forgotten Geriatric Giant'. To this effect, a multidisciplinary European group of professionals developed this scientific document in order to present the current "state of the art" on the management of urinary incontinence in the older population. The aim of this consensus document is to increase awareness, as well as knowledge of this under-recognized geriatric syndrome, and to facilitate and improve the clinical management of older people with UI.

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1. Conservative treatment of urinary incontinence (UI) in the older patient

Conservative treatment of UI is considered to be the mainstay of its management, using an individualized treatment plan, in order to address the older patient's specific needs. The main conservative strategies are as follows.

1.1. Lifestyle interventions

Patient education is crucial in managing UI. No specific data is available on lifestyle interventions in the frail older persons, nor is it clear whether any of these interventions is appropriate in this population [1]. Nevertheless, lifestyle interventions should be offered in all ambulatory vulnerable older people with UI who are cognitively intact as incontinence episodes could be decreased without significant side effects [2].

1.1.1. Weight reduction

Obesity is associated with an increased risk of stress UI [3]. Evidence for weight loss as a treatment to reduce UI among

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obese women is building. However, there is insufficient data to make a recommendation towards the older age groups [4]. It should be remembered that the health benefits of weight loss in older persons, particularly by calorie restriction, are uncertain. Any weight loss at advanced age should be recommended carefully, minimizing muscle and bone loss, and always keeping in mind that sarcopenia can also be present in the obese frail older person [5].

1.1.2. Fluid intake

In general, fluid restriction may decrease UI in frail older persons although evidence on this is very poor [1]. Advice on modifying fluid intake may be given if intake is either excessive or poor, as the latter can lead to concentrated urine with possible bladder irritation and worsening of incontinence as well as contribute to constipation, which is a risk factor on itself [3].

NICE guidelines recommend a trial of caffeine reduction in women with urge UI [6]. However, in a recent *Cochrane* review, no evidence was found of a difference in incontinence episodes between the caffeine reduction and caffeine exposure groups [4]. In daily practice, we recommend a stop or a caffeine reduction and to evaluate the effect on the individual patient.

In a survey-based study, a significant association was shown between high consumption of carbonated beverages and an increased risk of stress UI and detrusor overactivity after correction for fluid intake [7].

1.1.3. Constipation

Chronic constipation is a likely risk factor for overactive bladder and UII due to associated straining, and treatment may reduce this effect [3,8]. In frail older persons, constipation may cause difficulties in bladder emptying or result in delirium, which may precipitate or worsen incontinence. This is particularly pertinent in the acutely hospitalized older persons. Patients should be advised to avoid constipation, by responding promptly to the urge to defecate. Engaging in exercise and increasing dietary fibre are other possible recommendations, as well as providing an adequate fluid intake [8].

1.1.4. Smoking

Smoking is associated with urge UI in older people, especially in current smokers [9], so, advising smoking cessation in general is considered to be good clinical practice [4].

1.1.5. Physical activity

In 2 cross-sectional cohort studies in community-dwelling older adults, the prevalence of UI was lower in those adults with a high level of physical activity [10,11]. Due to the nature of these studies however, a causal relationship between these two variables could not be clarified.

In one prospective study, in 2355 women with a mean age of 65.9 years, increasing levels of physical activity (mainly walking) were significantly associated with a reduced risk of developing stress UI [12]. No significant relation could be found with urge or mixed UI, probably due to the small number of patients with these diagnoses. Nevertheless, given the overall health benefits of physical activity, it is highly recommended in older persons.

1.2. Behavioural interventions

Behavioural interventions can be readily incorporated into daily lives of patients of both, older men and women, who possess the necessary cognitive and functional capabilities. Non-pharmacological approaches require considerable motivation from patient and caregiver, and attrition rates may be high without adequate follow-up [8]. Therapeutic measures need to be individually tailored, taking into account patients mobility, motivation, and cognitive competence [13].

Some behavioural interventions have been specifically designed for frail older people with cognitive and physical impairments whose ability to learn new behaviours or to actively participate in self-care activities might be affected. Cognitive and/or physical impairment may nevertheless preclude the use of some of these interventions [1,14].

1.2.1. Timed voiding

Timed voiding is defined by the European Association of Urology as fixed pre-determined time intervals between toileting, applicable in those with or without cognitive impairment [15]. No attempts are made at patient education, reinforcement of behaviours or re-establishing voiding patterns [1]. It is uncertain whether timed voiding reduces urinary incontinence in frail older people [1]. The exact indication for this intervention remains unclear, mainly due to lack of consensus in terminology.

1.2.2. Pelvic floor muscle training (PFMT)

Pelvic floor muscle training is used to improve pelvic floor function, with improvement of urethral stability [15]. High quality evidence showed that PFMT is an effective first-line treatment for stress UI in women [16]. A therapeutic effect is seen in women with UII, as well as in mixed UI, though the effect in the latter is lower than in pure stress UI. In patients with overactive bladder improving pelvic floor function may help inhibit bladder contraction [15].

Two randomized controlled trials on a multidimensional exercise treatment, combining PFMT with fitness exercises, showed a higher urine leakage cure rate compared to controls, and this was proven effective in all types of UI [17,18].

BMI reduction and adherence to the intervention were consistent predictors for the effectiveness of the intervention. As with all muscle strengthening exercises, the pelvic floor requires continuous exercise to maintain the gained benefit [8]. It is recommended to implement PFMT for at least 3 months [3].

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The biofeedback guiding PFMT could improve the adherence to these exercises and the benefits in nonhomebound as well as in homebound older people [19].

In the frail older person, PFMT, both with and without biofeedback, has not been studied extensively, but in the patient with enough cognition to participate, PFMT could be implemented [1,16].

1.2.3. Bladder training

In bladder training, a progressive voiding schedule is used in combination with relaxation and distraction techniques to restore normal bladder function [3,16]. Evidence supports the use of bladder training for urgency suppression [8].

Irrespective of the type of UI bladder training should be considered for any patient as a first-line treatment for at least a short period of time [15]. However, the patient's motivation to follow the instructions as well as his capability to learn and practice the techniques are a necessary condition, which unfortunately might exclude a large proportion of the nursing home population [8].

The ideal intensity of a bladder training program remains unclear [15]. Most recent NICE guidelines recommend trying a total duration of minimum 6 weeks in women with urgency or mixed UI, before considering other treatment options [6]. A bladder diary can help identify an individual person's toileting pattern as well as urinary incontinence episodes, in order to monitor progression of treatment [1,8].

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