Geriatric Urinary Incontinence

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KEYWORDS

• Geriatric • Women • Aging • Urinary incontinence • Mixed incontinence
• Stress incontinence • Urge urinary incontinence • Management

KEY POINTS

- Urinary incontinence (UI) is a prevalent problem for all people internationally, peaking in the geriatric population.
- UI is often classified as the context in which urine is involuntary lost and can be correlated with other urinary, bowel, or pelvic symptoms.
- UI screening should be implemented across all stages of health care in an effort to identify those who suffer in silence with UI symptoms.
- A thorough history, comprehensive examination, and thorough analysis of other diagnostic tools can help identify the type of UI with which the patient suffers.
- Once the type of UI has been identified, conservative measures, such as pelvic floor muscle training or bladder training, may be implemented along with lifestyle modifications. Various medications and other electronic forms of treatment are available to help decrease symptoms of UI.

INTRODUCTION

Urinary incontinence (UI), or involuntary urine loss, is a lower urinary tract symptom resulting from impaired bladder storage.[1,2] UI can result from a variety of causes ranging from transient infections to structural abnormalities to pelvic floor dysfunction. UI persists as a significant disease of morbidity in the United States and worldwide affecting men and women across the lifespan with peak prevalence in the geriatric population. Though the extent of symptoms and impairment may vary, evidence continues to show the effects of UI on a woman's quality of life include limitations of physical activity and psychological burdens. This article provides a general review of current evidence on nontransient presentations of UI, including stress, urge, and mixed incontinence, and implications for health care providers caring for geriatric women with UI.

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OVERVIEW

UI is often concurrent with aging of the lower urinary tract, infections of the urinary tract, and also non-genitourinary causes including chronic conditions such as diabetes mellitus, cognitive impairment, neurological conditions, and obesity, and is not considered normal in the aging process.[2–7] Continence requires optimal cognitive functioning, appropriate structure and functioning (contracting and relaxing) of the detrusor muscle and urethra, appropriate support of the pelvic floor from muscles (levator ani complex) and connective tissue, and appropriate innervation from the peripheral nervous system.[2,3,7–9] UI is the one of the most common pelvic floor disorders resulting from pelvic floor dysfunction and frequently occurs concomitantly with other pelvic floor disorders, such as fecal incontinence or pelvic organ prolapse.[10] Unintentional urinary leakage can occur when pressure inside the bladder increases above the pressure within the urethra.[2] Alteration of the pressures within the bladder and the urethra can occur from various underlying pathologic conditions.[2] The numerous risk factors for UI include age, childbearing, type of obstetric deliveries, obesity, diabetes, poor physical function, and poor cognitive function and memory loss.[3,4,6,11–13] If structural or neurologic abnormalities are present, individuals may experience a variety of other urinary storage or sensory symptoms, including frequency, urgency, and decreased bladder sensation.[1] Possible factors leading to UI include delirium, infection, atrophic urethritis and vaginitis, pharmaceuticals, psychological disorders, excessive urine output, restricted mobility, and stool impaction (DIAPPERS). These criteria are frequently used in evidence to highlight transient and reversible causes of UI,[3,14] all of which should be considered and ruled out when a geriatric patient presents with UI.

Specific to women, a lack of estrogen production from the ovaries characteristic of menopause can precipitate bladder symptoms such as UI.[15] This lack of estrogen to the female pelvis, formerly known as atrophic vaginitis or vulvovaginal atrophy, is known as Genitourinary Symptom of Menopause, and should be considered as a precipitating cause or influence of UI and is highlighted in the acronym DIAPPERS as a transient cause of UI.[3,15]

Specific types of UI are categorized based on symptoms.[1] Stress UI (SUI) occurs during a physical stressor and increase in intra-abdominal pressure (coughing, sneezing, laughing, or physical exertion) in which support or mechanical closure of the urethra is compromised, as with hypermobility of the urethra or intrinsic sphincter deficiency.[1,9,16–18] Urge UI (UUI) occurs along with a sudden, compelling urge to urinate and can be attributed to multiple causes of detrusor instability and overactivity.[1,9,17,18] Mixed UI (MUI) is the combination of SUI and UUI in which leakage occurs in the presence of a physical stressor and with an intense urge to void.[1,2,18,19] The SUI and UUI symptoms experienced with MUI are not required to occur at the same time; instead, the patient may experience episodes of isolated SUI and isolated UUI. SUI is commonly seen in younger and middle aged-women, and UUI and MUI is commonly seen in geriatric women.[18] Additional UI symptoms include postural incontinence, continuous incontinence, insensible incontinence, and coital incontinence.[1]

PREVALENCE

Prevalence rates for UI in the general population and across the world can vary based on cultural differences, types and frequency of symptoms, perceptions, reporting inconsistencies, and research-based differences.[3] True prevalence rates are most likely higher than what is recorded due to the underreporting of symptoms from patients and