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Improving Care for Women With Urinary Incontinence in Primary Care

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ABSTRACT

Urinary incontinence (UI) is highly prevalent in primary care, disproportionately impacts women, and is associated with poor quality of life related to significant psychological, physical, social, and financial burdens. UI places significant economic burden on the United States health care system. Cost-effective, first-line UI treatments improve continence and can be successfully offered in primary care. Unfortunately, UI is largely untreated, in part because health care providers fail to inquire about involuntary urine leakage and are uncomfortable with UI diagnosis and treatment. The aim of this article is to familiarize clinicians with UI risk factors and effective nonpharmacologic management strategies for primary care.

Keywords: incontinence, primary care, quality of life, urinary, women

INTRODUCTION

A 57-year-old Caucasian female presented at a family practice clinic with the complaint of sporadic urine leakage that had worsened over the previous 6 months. Because the primary care provider (PCP) was uncomfortable with diagnosing and treating possible urinary incontinence (UI), the patient was referred to a local gynecologist known to perform urodynamic studies. When questioned at a subsequent appointment in the family practice clinic, the patient conveyed the only treatment choice offered by the gynecologist was surgery, which for this patient was not an acceptable option. Thus, she decided to live with her urine leakage and changed her lifestyle to avoid public embarrassment. Unfortunately, despite the availability of evidence-based, nonsurgical and nonmedical treatments for UI, this scenario is all too common. Even when reported, UI is frequently unaddressed.[1]

URINARY INCONTINENCE

UI is the unwanted leakage of urine in any amount (even drops) and should never be considered a normal aspect of childbearing or aging.[2] UI is a prevalent health issue that disproportionately affects older women and is associated with poor quality of life (QOL) related to significant psychological, physical, social, and financial burdens.[3-6] Estimates of UI prevalence range from 30% to 64%, with advancing age being the largest predictor; women aged $\geq$ 85 years have been found to be nearly 60% as likely to experience UI than their 65- to 74-year-old counterparts.[1,7,8] Additional risk factors for UI include Caucasian race, history of pregnancy and/or hysterectomy, heart disease, stroke, type 2 diabetes, arthritis, obesity, and beyond high school education.[1,7,9] UI is a significant independent predictor of poor physical, social, and mental QOL, having a stronger association than arthritis, diabetes, and cancer with respect to psychological burden.[7] In addition, UI has been associated with social isolation, loneliness, intention to leave work, and work disability.[4,5,10,11] The condition has also been shown to be a marker of any cause mortality in frail older adults.[12,13] UI is associated with significant economic burden for both individuals and society, with the estimated total annual cost in the US for urge UI (UUI) alone predicted to be a staggering $82.6 billion in 2020.[3]

Despite the significant burden of UI, only about 3% of health care providers inquire about UI; 25%-50% of women with UI seek care, with 23%-38% receiving treatment.[1,14] Nonpharmacologic approaches (NPAs) and nonsurgical interventions

(NSIs) can be offered in primary care and have been shown to be effective at improving or achieving continence and improving QOL.[15] Due to the high prevalence and significant burden of UI in women, PCPs should be familiar with UI risk factors and on the front lines of prevention, diagnosis, and treatment with NPAs and NSIs starting with vigilant screening of adult females and other at-risk populations.[1,16] The purpose of this article is to encourage PCPs to improve screening and care of women with UI.

All women over the age of 18 can be systematically screened for urine leakage. Reuben and colleagues demonstrated that a practice process change that includes case identification through screening via phone contact prior to appointments can improve identification of UI and lead to appropriate treatment.[16] Alternatively, women can be screened at every primary care office visit with the simple question, "Do you ever accidentally leak urine?" Screening can also be done with the use of validated tools such as the 3 Incontinence Questions, the King's Health Questionnaire, and the International Consultation on Incontinence Questionnaire Short Form.[17-19] All 3 questionnaires have been found to be well suited for use in time-constrained clinical practice.[18,19]

Modifiable risk factors for UI should be determined early on with the patient and, as with all risk factors, the more a patient has the more likely they are to develop the condition.[20] Screening for urine leakage should be done by both clinical support staff and PCPs. Raising provider and support staff awareness about the problem of UI and its treatment with educational modules and pertinent lay articles may improve staff cooperation with incorporating consistent screening into their practice. Including staff in brainstorming about ways to improve patient screening for urine leakage that best fit their workflow may also be helpful. Subsequent routine staff meetings can be designed to: evaluate effectiveness of case identification for urine leakage; brainstorm for additional strategies that may improve screening rates; and celebrate successes that can lead to sustained and persistent screening of women for urine leakage over time. Displayed brochures and/or exam room signage or pamphlets targeting and educating patients about UI may serve to destigmatize the topic and promote self-report of urine leakage. Once urine leakage is identified, the PCP should conduct a systematic evaluation and develop a holistic plan of care.

EVALUATION AND DIAGNOSIS

In a busy primary care setting, a thorough investigation at the time urine leakage is identified is unlikely feasible; most patients do not present with this issue as the primary reason for scheduling an office visit. However, a preliminary diagnosis of UI can be established and follow-up (FU) should be offered when leakage is identified. A diagnosis of UI is based on assessment of incontinence type. The 3 most common types of UI are stress (SUI), UUI, and mixed (MUI).[9] SUI is the involuntary leakage of urine that occurs with increased intra-abdominal pressure, such as coughing, laughing, bending, lifting, straining, sneezing, or jumping. UUI is described as the involuntary leakage of urine accompanied or immediately preceded by a sudden uncontrollable urge to urinate. MUI is when leakage occurs with both symptoms of stress and urgency.[9] Clinicians can differentiate the type of UI by asking patients under which conditions leakage occurs, including: coughing; laughing; bending; sneezing; lifting; straining; and/or with a sudden uncontrollable urge to empty the bladder without being able to get to the toilet before leaking. Once diagnosed, patients should be educated that UI is never considered normal and that effective NSIs are available, and individuals with this condition should be encouraged to schedule a dedicated incontinence visit. Entering the appropriate diagnosis code from the ICD-10 (*International Classification of Diseases*, 10th revision) in the patient electronic health record (EHR) enables the PCP to track patients with UI for future FU.

Initial assessment includes triaging patients with complicated UI requiring referral to a specialist. Referral is indicated for patients with pain, hematuria, recurrent infections, evidence of voiding dysfunction (such as incomplete emptying or weak stream), significant organ prolapse, previous radiation therapy or pelvic surgery, possible fistula, and inconclusive diagnosis.[21]

A UI-focused history includes classifying UI as transient or persistent. Potentially transient or