Ob.Gyns. Key in Identifying Urinary Incontinence

BY DOUG BRUNK

Ob.gyns. and other primary care providers play a major role in helping women identify and manage symptoms of urinary incontinence, a condition estimated by the American Urogynecologic Society to affect 30%-50% of women, but that notion appears to be lost on some generalist clinicians.

"Since we know it's such a problem, maybe we should be asking our patients more about it and have them 'fess up, but we don't, because we only have 15 minutes of managed care time where we're assessing risks for heart disease, cancer, and other medical conditions," said Dr. Cheryl Iglesia, who directs the Section of Female Pelvic Medicine and Reconstructive Surgery at Washington (D.C.) Hospital Center. "Urinary incontinence is a quality of life issue that's not going to kill you, but it really does take away your quality of life."

Some physicians take a fatalistic view of the condition, she continued, telling women "there's nothing that can be done about it. There's where we go wrong. It's a highly prevalent condition, and we have a growing Medicare population," said Dr. Iglesia, who is also associate professor of obstetrics and gynecology and urology at Georgetown University in Washington. "In fact, 80% of women by the time they're 80 have some form of incontinence. At the same time there's a misconception that incontinence happens as a normal part of aging, [the notion of] 'What do you expect? You're getting older. Just deal with it. Wear the incontinence pads.' That message is always wrong."

Then there are the patients who avoid discussing the issue during office visits. "A lot of patients are so embarrassed by the situation that they become reclusive, or it's affecting their quality of life but they don't want to bring it up with their physician because of the shame factor," she said. "They become more isolated, not wanting to be physically active, wearing pads, or bringing along changes of underwear, so coping in a way, but they don't want to talk about it."

The Problem

According to a recent review from the Agency for Healthcare Research and Quality, some degree of involuntary urine loss is experienced by 25% of young women, 44%-57% of middle-age and postmenopausal women, and 75% of elderly women in nursing homes. It went on to note that in 2004, annual costs associated with treating the condition averaged $19.5 billion.

The two main types of incontinence are stress incontinence and urge incontinence, although most women have a mix of each, said Dr. Linda Brubaker, who directs the division of Female Pelvic Medicine and Reconstructive Surgery at Loyola University Chicago, Maywood, Ill. "It's kind of like height and weight: You can be tall and fat, short and skinny, or tall and skinny. You can have any combination of stress incontinence or urge incontinence."

In stress incontinence, women experience loss of urine during physical activities that increase abdominal pressure, such as sneezing, coughing, or exercising. In this form, the urinary sphincter "may not be doing its job well because it's lost some of its normal function or it's lost some of its normal anatomic positioning," explained Dr. Brubaker, who is also interim dean of medicine at Loyola University Chicago. "The function doesn't usually get restored, but what we do with surgery is add a material that is a secondary mechanism, which helps the sphincter do its job. So while the sphincter itself isn't any better, the backup team is on board now. That usually will bring a patient to have resolution of stress incontinence."

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Urge incontinence, also known as overactive bladder, is more common with advancing age. It is characterized by a sudden need to urinate with or without urinary leakage. This form is generally treated behaviorally by decreasing intake of caffeine and other known bladder irritants, and by strengthening the pelvic floor muscles, but some patients require treatment with medications that impact the muscarinic receptors in the bladder. Pregnancy commonly contributes to incontinence, as can chronic constipation and disorders associated with chronic cough.

"There is also an increasing relationship between obesity and urinary incontinence," said Dr. Dee Ellen Fenner, professor of obstetrics and gynecology at the University of Michigan, Ann Arbor. "It's been shown that even modest weight loss in women who have urinary incontinence and obesity can greatly reduce their symptoms. Losing 10 or 15 pounds for a patient who is morbidly obese can help reduce her symptoms."

According to the American Urogynecologic Society, other causes of urinary incontinence include pelvic radiation, occupations that require heavy lifting or exertion, medications taken for other conditions, and stones or tumors in the bladder.

Keep the Initial Workup Simple

Step one is to ask women whether they're experiencing urinary incontinence symptoms. Dr. Fenner recommends including a focused question on your intake questionnaire and in person during routine office visits such as, "Are you having difficulty holding your urine?" Or, "Is urinary incontinence a bother?"

Dr. Brubaker offered the following phrase to use during visits with patients: "Women experience urinary incontinence commonly. If you do, let me know, because there are things we can do to help." This approach creates "a safety net so the woman can talk about this without feeling humiliated, or embarrassed, or alone."

If a patient informs you of urinary incontinence symptoms at the end of an office visit, Dr. Brubaker recommends ordering a urine culture to rule out a urinary tract infection. Then ask her to schedule a follow-up visit by saying something like, "I'm so glad you raised this. I'd like to order some basic urine tests today, but I'd like to set up a dedicated time in the near future so that we can investigate what's going on."

Experts interviewed for this story emphasized that most women do not require a complex evaluation such as a multichannel urodynamic study to make a diagnosis of stress, urge, or mixed urinary incontinence. "A lot of what we recommend is based on her symptoms: when she leaks, what promotes her incontinence," said Dr. Fenner, who is also director of gynecology for the University of Michigan Health System. "That can help direct your therapy. In addition, we recommend looking for prolapse and testing to see how well she can squeeze and perform a Kegel contraction. That gives you an idea of whether physical therapy may be of benefit or not."

Dr. Fenner recommends post-void residual testing in symptomatic patients, "to make sure that women are emptying their bladder completely, that they don't have a more complex neurologic etiology. You can do that with a catheter or with an ultrasound." Full bladder stress testing also can be helpful. For this test, have the woman lie down with a full bladder. "If she doesn't leak lying down, we have her do three strong coughs," she said. "Have her stand up and see if that makes her leak."

Workups should include consideration of potentially reversible factors. In 1985, geriatrician Dr. Neil M Resnick, chief of the division of geriatrics at the University of Pittsburgh, proposed the mnemonic DIAPPERS for the following treatable causes of urinary incontinence: delirium, infection, atrophic urethritis and vaginitis, pharmaceuticals, psychologic disorders, excessive urine output (such as from heart failure of hyperglycemia), restricted mobility, and stool impaction (N. Engl. J. Med. 1985;313:800-5).

"Defining etiology directs therapy," Dr. Fenner said. "There are things that can go wrong with the bladder. There are things that can go wrong with the urethra. There are things that can irritate the bladder. There can be systemic problems like diabetes, Parkinson's or multiple sclerosis that can impact urinary incontinence."

If you'd like to get a more detailed sense of how symptoms are impacting your patients, Dr. Iglesia recommends two validated questionnaires. One is called the Medical, Epidemiological, and Social aspects of Aging, "which tells you more about stress and urge incontinence symptoms," she said. Another is the Incontinence Impact Questionnaire, which measures the impact of urinary incontinence on activities, roles, and emotional states (Neurourol. Urodyn. 1995;14:131-9). Other questionnaires to consider using, she said, include the Incontinence Severity Index (ISI) and the six-item Urogenital Distress Inventory–6 (UDI-6).

Support and Education Efforts

Consumer groups such as The Accidental Sisterhood (www.accidentalsisterhood.com) and the National Association for Continence (www.nafc.org) offer online information, support, and chat forums for patients. In addition, the American Urogynecologic Association sponsors online information and a chat room called "Take the Floor: Voices for Pelvic Floor Disorders" (www.voicesforpfd.org). "Women are using social media a lot for conversations about urinary incontinence," Dr. Iglesia said. "Education is important. We also need to do a better job with physician training, so they can deal with the increased demand for treatment of this in the near future."

Progress is being made on that front. In April of 2011, the American Board of Medical Specialties accredited the new subspecialty of female pelvic medicine and reconstructive surgery. According to Dr. Fenner, the American Board of Obstetrics and Gynecology and the American Board of Urology are working together to develop board testing and certification, which is expected to be available in 2013. "The purpose is to have subspecialists for complex surgical procedures and for the complex patients who have failed initial treatment," Dr. Fenner said. "With the increase in the population and the growing number of healthy women who want to live very active lives, urinary incontinence is only going to be increasing. There won't be enough providers to care for this population. It will be very important that general ob.gyns. and other primary health care providers ask patients if they're having issues with urinary incontinence. They certainly can care for many of these women."

Dr. Fenner disclosed that she receives research support from American Medical Systems and that she receives honorarium from UpToDate. Dr. Brubaker and Dr. Iglesia said that they had no relevant financial conflicts to disclose. ■