Screening and management of urinary incontinence in women

Prevalence and burden of urinary incontinence (UI) in women

- Up to 50% of women in the U.S. experience some form of urinary incontinence.[1]
  UI can lead to:
  - Lower quality of life[2]
  - Increased anxiety and depression[3]
  - Increased urinary tract and skin infections[4]
  - Increased risk of falls and fractures[5]
  - Increased caregiver burden[6]
  - Sexual dysfunction[1]

- UI risk factors[7]
  - Age – increased prevalence with age[1]
  - Multiparity and higher risk for those with vaginal births
  - Hysterectomy
  - Comorbidities (smoking, diabetes, obesity, stroke)

Because urinary incontinence is highly prevalent in women, it may be appropriate to educate in the clinical setting to help facilitate early identification and interventions.[1]

- Chronic UI can be one of a few types, and it's important to understand the cause so the condition can be treated appropriately:
  - **Stress (most common):** typically occurs with increases in intra-abdominal pressure due to urethral sphincter weakness and urethral hypermobility that is characterized by predictable loss of urine with certain physical actions (e.g., coughing, sneezing, exercising) – more common in younger women
  - **Urge (second most common):** due to detrusor overactivity resulting in urgency, frequency and nocturia, often referred to as "overactive bladder" – more common in older women
  - **Mixed:** a combination of stress and urge incontinence
  - **Overflow:** due to detrusor underactivity and/or bladder outlet obstruction that causes an overdistended bladder
  - **Functional urinary incontinence:** due to difficulties in toileting, seen in physical or cognitive impairment

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Screening

INITIAL SCREENING

- The Women's Preventive Services Initiative (WPSI) recommends annual screening for UI in women, though the quality of evidence to support the accuracy and effectiveness of screening tools is low.[1]
- If regular screening is performed, clinicians should assess whether the patient has symptoms of UI, the type and duration of symptoms and how it affects quality of life, health and activities of daily living.

Interventions

- If a patient is screened and does have positive symptoms of UI **or** presents with a chief complaint of UI, a history and physical exam should be performed to rule out acute causes, and appropriate clinical guidance should be provided.
- Women with a positive screening should get a workup or be referred for further evaluation and treatment.

Diagnosis and workup

IF UI SYMPTOMS ARE PRESENT

- First, determine if UI is chronic or transient with a full history. Common causes of reversible UI can be identified with the TOILETED mnemonic:
  - **T**hin, dry vaginal and urethral epithelium
  - **O**bstruction (stool impaction/constipation)
  - **I**nfection
  - **L**imited mobility
  - **E**motional (psychological disorders)
  - **T**herapeutic medications
  - **E**ndocrine disorders (excessive urine output)
  - **D**elirium, dementia or other cognitive impairment
- Perform a physical exam guided by the patient's symptoms and history. Consider the cough stress test in women with signs and symptoms of stress UI.[8]
- Perform a urinalysis to evaluate for urinary tract infection and exclude hematuria, proteinuria and glycosuria, and assess renal function if concern for obstruction.
- Avoid routine imaging except for bladder ultrasound if being used to measure a post-void residual or renal ultrasound to look for obstruction.

Interventions

- If determined to be a transient episode, treat the underlying cause, or refer for the appropriate workup and specialty care.
- If chronic:
  - Provide appropriate guidance about conservative management strategies (detailed in next section).
  - If patient prefers, refer to a specialist—often a urologist or urogynecologist—for additional workup and management.
- Refer to the appropriate specialist if red flag signs or symptoms are present, which include:
  - Abdominal or pelvic pain
  - Recurrent urinary tract infections (UTIs)
  - Persistent hematuria or proteinuria
  - Significant prolapse
  - Previous pelvic surgery or radiation
  - Suspected fistula
  - Elevated post-void residual
  - New neurologic symptoms

Management

GENERAL APPROACH TO MANAGEMENT

- Behavioral and lifestyle modifications about which to counsel patients include:[9]
  - Appropriate fluid intake
  - Scheduled or timed voiding
  - Reduction in caffeinated beverages
  - Smoking cessation
  - Regular physical activity and weight loss
  - Absorbent products for bladder control
- Exercise-based therapies can be recommended as an additional first-line treatment and have strong evidence for effectiveness.[10]
  - Kegel exercises to strengthen pelvic floor muscles
  - Referral to clinically guided exercises or pelvic physical therapy
- Utilize Food and Drug Administration-approved pharmacologic strategies
- If other therapies fail, bothersome symptoms persist and patients desire further evaluation, a referral to a urologist or urogynecologist can be made to evaluate for surgical management.[11]

The information in this flyer is not meant to preclude clinical judgment. Treatment decisions should always be based on the clinical judgment of the physician or other healthcare provider.

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