kidney news

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Introduction

Urinary incontinence is this newsletter's theme.

Incontinence is either due to a weak bladder outlet sphincter (stress), or blockage to the outlet (obstruction), or either an overactive (urge) or under-active bladder.

There are three main types of urinary incontinence:

STRESS

Stress incontinence is associated with increased intra-abdominal pressure, such as coughing, sneezing, laughing. This problem is common in woman, especially woman who have given birth. A study from Wellington did show, however, 27% of *nulliparous* women polled in a survey reported urinary incontinence. *[Lara & Nacey. NZJ Med 28 Sept 1994].*

URGE

Urge incontinence ("unstable bladder") is from a disinhibited bladder. It sends the message to be emptied when there is an only small volume of urine to be voided. Often the volume lost is large, and symptoms include frequency and nocturia.

OVERFLOW

This is often seen in older men, and maybe associated with obstruction and/or detrusor muscle weakness. Two thirds of men with overflow incontinence have detrusor instability. The lost volume is usually small.

A good history and examination will usually point to which of these three types is the culprit, and therefore therapeutic option(s).

Incontinence pads or intermittent urinary catheterization are last resorts and should be considered only after all the suitable therapeutic options have been exhausted, which may include surgery.

The rule of thumb for management is: try the option(s) for the type of incontinence, and if these fail, refer to the urologists for further management. When these have all failed, or no further therapies are possible, the assistance of the continence nursing service [eg.

HISTORY POINTS:

Duration of the incontinence.
Frequency of the incontinence and provoking symptoms.
Intake of fluids, especially diuretics (eg. Caffeine-containing drinks and alcohol).
Bowel and sexual function (faecal impaction or sexual dysfunction/erectile dysfunction (ED)).
Medications, including OTCs. And especially diuretics.
Parity - the more children, the more likely incontinence is to occur.
Bladder diaries are invaluable.

EXAMINATION POINTS:

Mental state – is there a limited mental capacity for continence education? Multi-infarct dementia? Recent CVA?
Scars from previous back surgery or major abdominal/pelvis surgery?
Mobility (?limited leading to "not getting to toilet on time"), peripheral neuropathy (eg. diabetes mellitus with ED, autonomic dysfunction, eg. postural hypotension).
Rectal tone for intact neural pathways, and ?faecal impaction.
External genitalia for excoriation, balanitis, para/phimosis, vaginal atrophy.
Perianal sensation (sacral nerves intact).
Assess post-void volume – either by pre and post-micturition ultrasound scan; or post-micturition in-out urinary catheterisation (volume >200ml suggests detrusor weakness/obstruction = overflow incontinence).

WHAT'S IN HERE THIS TIME?

THERAPIES:

STRESS INCONTINENCE

Remove precipitants. And use pelvic floor exercises/strengthen pelvic floor muscles before exacerbating factors, eg. coughing, laughing, sneezing.

Vaginal ring pessaries, especially in prolapse.

Oestrogen creams (in vaginal atrophy). Oestrogens increase the number of α-receptors, which are necessary for the sphincter tone.

Terazosin as an α-adrenergic receptor stimulant (1mg to 5mg is usually adequate) or imipramine (75mg nocte).

Referral for surgical repair is worth considering if all the above fails.

THERAPIES:

URGE INCONTINENCE

Common in older people, and when there is a bladder irritant – therefore look and treat these: eg. urinary infections, bladder stones, non-bacterial irritation/cystitis, and neoplasia.

Hard dedicated work at retraining the bladder by the patient – to "hold on a little longer" so less frequent trips to toilet. But go when necessary, so as not to be "caught short". Double voiding, and regular toileting/schedules.

Oxybutinin 2.5mg to 5mg bd to tds. The dry mouth often leads to polydipsia, and exacerbation of the urine volume/incontinence.

Tolterodine 1 to 2mg bd (NSS, approximately $100 per month, but much less anti-cholinergic side-effects).

THERAPIES:

OVERFLOW INCONTINENCE

Exclude impaction, and pelvic masses pressing on bladder.

Exclude obstruction (ultrasound scan).

Avoid detrusor relaxants, as these often make the bladder volume increase exacerbating the overflow.

Double voiding or Valsalva when micturating may help complete emptying.

Intermittent clean-catheterisation with or without bladder retraining – often allows the bladder to reset itself after all the stretching.

Where do I get bladder retraining information from?

Continence nurse services at Middlemore Hospital.
Patient information pamphlets are also available.
Physiotherapists for pelvic floor exercise training.

What does a bladder diary look like?

Date/Time	Urine Volume	Clothing wet (W) or dry (D)	Comments
07:30	150ml	D	
09:10	200ml	W	Sneezed
10:40	120ml	W	Soaked clothes

Etc.

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Qualifications

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Interests

Investigation of renovascular disease and hypertension
Management of urinary tract infections
Investigation of urinary calculi
Investigation of proteinuria and haematuria
Investigation and management of impaired renal function.
Renal nutrition.

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