

EVALUATION OF UROGYNAECOLOGY CARE DELIVERED TO ELDERLY WOMEN IN A TERTIARY REFERRAL CENTRE.

Hypothesis / aims of study

The most recent national audit of the delivery of continence care to the elderly highlights the poor integration across acute, medical, surgical, primary care, home and community settings which results in disjointed care for patients and carers(1). We believe that the findings of this audit raise concerns about the delivery of all urogynaecology care to the elderly and not only those women suffering from incontinence. The aim of this study is to evaluate the level of community involvement in the delivery of urogynaecology care to the female elderly population in a tertiary referral university teaching hospital who also present with prolapse and other Urogynaecological diagnoses.

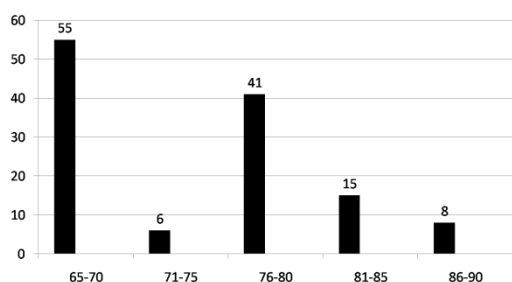
Study design, materials and methods

This is a retrospective review of case notes of 125 women aged over 65 years who were referred to the urogynaecology service over a 6 month period between January and June 2009. The source of referral, reason for referral, presenting complaint when seen, history and examination findings, investigations, management and outcome at follow-up were recorded. The co-morbidity scores were calculated using a validated ACE-27 instrument. The need for hospital based care in these patients was also assessed.

Results

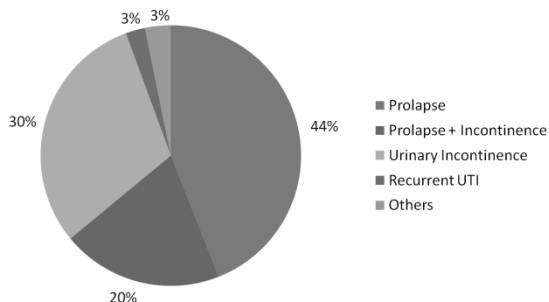
The mean age at consultation was 74 (SD 7 yrs).

Figure 1: Age distribution at referral



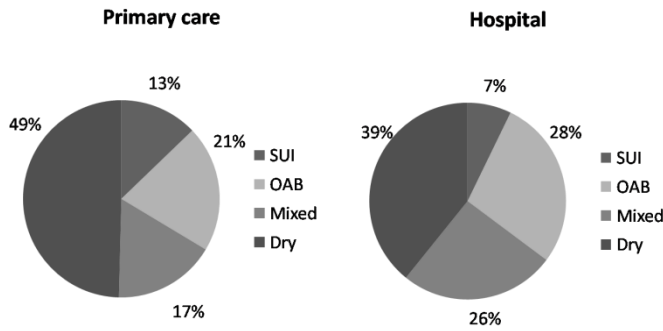
The majority of women were referred directly by their GPs (93%) with only 1% having accessed community based continence or physiotherapy care prior to referral. The main reason for referral was pelvic organ prolapse (64%) with urinary incontinence in the absence of prolapse accounting for 30% of referrals.

Figure 2: Reason for referral as stated in referral letter



The complaint of urinary incontinence was documented as the reason for referral in 63 of the 125 patients; however when these women were seen in clinic and specifically asked if they had problems with urinary incontinence 76 confirmed that this was the case.

Figure 3: Classification of incontinence in primary and hospital setting



Stage 2 or greater prolapse was documented in 75 women (60%) on examination. 33 women (26%) had undergone previous pelvic floor surgery for prolapse or incontinence with 17 women (14%) having 2 or more prior procedures. None of these women had a co-morbidity score greater than 2, which indicates that all these women were relatively fit and healthy.

Prolapse was managed with pessary insertion in 31 (25%) women. A diagnostic cystoscopy was performed in 13 women (10%) and surgical management of incontinence or prolapse was carried out in 40 women (32%). Overall 56% women did not require hospital based management and were managed with conservative treatment that could have been delivered in the community.

Interpretation of results

This study documents that the elderly population are not accessing community based care prior to being referred for hospital assessment. We believe that this finding is consistent with the findings of the recent national audit of continence care. The efficacy and benefit of conservative management with both physiotherapy and bladder retraining has been documented in the elderly population with five year follow-up after physiotherapy intervention showing sustained improvement in women who continued to perform pelvic floor exercises (2) A randomized trial of multidimensional exercises for the treatment of stress incontinence in community dwelling elderly Japanese women reported a decrease in BMI, increased walking speed and greater continence in the intervention group compared with the control group (3). It also shows that we have an elderly group of women who are medically relatively healthy. If their urogynaecological problems are adequately managed they will have a better quality of life.

Concluding message

In light of recent cuts in NHS spending it is of even greater importance to increase the use of community based conservative management of urogynaecological problems. This will be achieved by better integration between the community and hospital teams. It will also lead to a better quality of life for a growing population of elderly women who are otherwise healthy and achieve significant cost savings for the health service.

References

1. Wagg A, Harari D, Husk J et al. National Audit of Continence Care – Combined organisational and Clinical Report 2010.
2. Simard C, Tu le M. Long-term efficacy of pelvic floor muscle rehabilitation for older women with urinary incontinence. J Obstet Gynaecol Can. 2010; 32:1163-6.
3. Kim H, Suzuki T, Yoshida Y et al. Effectiveness of multidimensional exercises for the treatment of stress urinary incontinence in elderly community-dwelling Japanese women: a randomized, controlled, crossover trial. J Am Geriatr Soc. 2007; 55:1932-9.

Specify source of funding or grant	None
Is this a clinical trial?	No
What were the subjects in the study?	HUMAN
Was this study approved by an ethics committee?	No
This study did not require ethics committee approval because	This study was reviewed by the Addenbrooke's Hospital patient safety unit. As the study did not involve any patient contact and consisted of case note review of the standard care given to patients referred to the urogynaecology clinic, it was classed as a service evaluation. Hence it was registered as a service evaluation with the hospital patient safety unit and did not require formal ethics approval.
Was the Declaration of Helsinki followed?	Yes
Was informed consent obtained from the patients?	No