

WHAT TREATMENTS FOR URINARY INCONTINENCE AND LOWER URINARY TRACT SYMPTOMS ARE ACCEPTABLE AND WHAT OUTCOMES DESIRABLE TO OLDER PEOPLE?

Hypothesis / aims of study

Urinary incontinence in older people has a significant impact on not only quality of life, but also can lead to adverse outcomes such as depression, urinary tract infection, falls, and an increased rate of institutionalization. Older people often delay health care seeking for their incontinence [1]. Awareness of the many treatment options available to help cope with the issue appears to be low. In terms of treatment and cure, the dictionary definition does not adequately consider the feelings of the observer, whether patient or clinician. As patient reported outcomes from medical treatments become increasingly important in assessing quality of care and service provision, it is important to understand to what degree patients' expectations are met as part of assessments of the overall patient experience. Likewise, an understanding of those interventions which patients might find unacceptable would allow clinicians to counsel patients regarding realistic expectations, or cater to their preferences.

There are no data, which examine expectations and acceptability of treatments in older patients. The aims of this study were therefore to determine what degree of improvement in UI was desirable for older persons with UI, what treatments older patients found acceptable and what symptoms they would be willing to tolerate following treatment.

Study design, materials and methods

Consecutive older outpatients over 65 years of age referred to a secondary care multi-professional incontinence clinic were assessed using a validated three-part questionnaire, which included the Leicester Urinary Symptom Questionnaire [2], an attitude questionnaire used in studies of younger patients, and the King's Health Questionnaire [3]. The Leicester Urinary Symptom Questionnaire (LUSQ) is a validated ten-item questionnaire, reliable in establishing a diagnosis based on symptoms of bladder problems in both men and women. The attitudes questionnaire consisted of 28 questions divided into five different categories, including: acceptance of current problems, willingness to modify lifestyle, willingness to undergo various treatments, frequency of hospital visits, and acceptability of side effects. A glossary of terms defining terms used in the questionnaire was provided to patients. The King's Health Questionnaire (KHQ) is a well validated and reported condition specific health related quality of life questionnaire. The questionnaires and definitions were handed to patients following explanation of the study along with a reply-paid return envelope. As a descriptive, observational study, no *a priori* sample size could be calculated, a group of 150 individuals was hypothesised to provide robust data on the primary outcomes of interest, degree of desired improvement in symptoms. In addition to descriptive and summary statistics, relationships between quality of life, diagnosis, and acceptability items were analysed using Pearson's correlation coefficients. Differences in proportions between groups were analysed using the chi-squared test. Length of time with bladder problems was categorized into three groups: less than one year, between one to five years and over 5 years.

Results

Of 150 questionnaires distributed, 121 patients, 91 women and 28 men, returned surveys. The mean (SD) age of the participants was 77.5 (7.9) years (65-95 years, N= 117) and the mean (SD) length of time with bladder problems was 8.2 (9.7) years (range 3 months - 46 years, N= 109). Ninety-six patients (81%) provided sufficient data to allow categorization into mixed incontinence (59.1%, N= 58 (male= 8, female= 50)), stress incontinence (26.5%, N= 26, male= 5, female= 21), urgency incontinence (14.2%, N= 14, male= 5, female= 9). UI was the most bothersome symptom for 96 patients with evaluable data (n= 41, 42.7%), followed by urinary urgency (n= 21, 21.9%), nocturia (n= 19, 19.8%), and frequency (n= 9, 9.3%). Expectations of cure are shown in the table. Short-term lifestyle modifications and clinical procedures with no long-term risk were more popular options than long-term lifestyle modifications, catheterization, and surgical procedures (Table 5). The majority of respondents (n= 56, 85.5%) identified short-term medication as being the most acceptable treatment to them, followed by a clinical procedure with no long-term risk (n= 47, 72.5%). The least popular option was long term catheterisation, which only 6.2% (n= 113) of participants were willing to accept, followed by undergoing a major surgical operation (n= 112, 12.6%). In terms of residual symptoms, patients were less prepared to tolerate frequent nocturia, persistent stress incontinence, and frequent pad use. Infrequent nocturia, and using pads only when necessary were more acceptable as residual "problems" (Table 4). Least desirable outcomes were having an occasional large leak on coughing or sneezing and frequent small leaks on coughing or sneezing, 10.3% and 21.4% acceptability, respectively. Overall 75.4% of participants were prepared to accept one nocturia episode per night.

Women were much more accepting of small leaks on sneezing or coughing and on strenuous exercise post treatment ($X^2=.001$, $p < 0.01$, $X^2=.003$, $p < 0.01$, respectively) and having to wear pads ($X^2=.0004$, $p < 0.01$) than men. Men reported that leaking during sexual intercourse after having treatment ($X^2=.002$, $p < 0.01$) was less acceptable to them than women. Men reported a clinical procedure with risk of catheterization more acceptable to them than women ($X^2=.0005$, $p < 0.01$). Patients with a longer duration of symptoms were statistically significantly more likely to report lower expectations of treatment compared to those with shorter durations of symptoms ($X^2=.008$, $p < 0.01$). There was no statistically significant association between reported quality of life and acceptability of different treatment types, acceptability of outcomes, or expectations of cure.

Which of these treatments would you find acceptable to treat your bladder problems?	Yes	Percentage (%)	No	Percentage (%)
Pelvic floor exercises for 6 months	75	67.0%	37	33.0%
Pelvic floor exercises for the rest of your life	41	38.7%	65	61.3%
Regular medication (pills) for the rest of your life	58	50.4%	57	49.6%
Medications (pills) to take just when you need them	94	85.5%	16	14.5%
Major surgical operation	14	12.6%	97	87.4%
Minor surgical operation	23	20.9%	87	79.1%
Clinical procedure (60% improvement, no long term risk)	79	72.5%	30	27.5%
Clinical procedure (80% improvement, 12% risk of having to catheterize yourself)	16	14.8%	92	85.2%
Long term catheter in your bladder	7	6.2%	106	93.8%
Learning to catheterize yourself	15	13.3%	98	86.7%
FOR WOMEN: wearing a pessary and removing/cleaning yourself	18	22.5%	62	77.5%
FOR WOMEN: wearing a pessary and having a physician or nurse remove/clean at regular intervals	28	35.4%	51	64.6%

Interpretation of results

Patients in this study appeared realistic in their expectations of cure. This is a similar finding to that previously reported in middle aged women regarding overactive bladder and prolapse. Patients with the longest duration of symptoms (>5 years) were more likely to accept any improvement, no matter how small, than those with problems of a lesser duration, regardless of the associated impact on quality of life. This may be explained by previous treatment experience leading to reduced expectations or simply that any improvement in bladder symptoms may have greater significance to this group. Frequent pad use was viewed as unacceptable by all patients, regardless of their reported impact on quality of life. In other studies, likelihood of pad use was correlated with worsening quality of life. Overall, frequent nocturia and stress urinary incontinence were viewed as the most unacceptable post-treatment symptoms across all groups. Frequent nocturia has severely adverse effects on quality of life and sleep quality; the degree of both increasing in association with its frequency.

Concluding message

Older patients with UI express preferences for less invasive treatments for their UI and have reasonable expectations for cure and improvement in their symptoms.

References

1. Fam Pract 2004;21(6):689-96
2. BJU Int 2002;90(3):205-15
3. Br J Obstet Gynaecol 1997;104(12):1374-9

Disclosures

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