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MEDICATION FOR URINARY INCONTINENCE IN OLDER WOMEN: IS USE PREDICTED BY BOTHER, SEVERITY OR IMPACT ON QUALITY OF LIFE?

Hypothesis / aims of study

Urinary incontinence is associated with considerable morbidity and a reduction in quality of life of older people [1]. Conservative measures and pharmacological treatment for the condition is effective and, for drug treatment, usually well tolerated. The England and Wales NICE guidelines for the management of incontinence in women suggest that conservative therapies are tried before pharmacological therapy and thus it might be expected that drug therapy might more often be prescribed for those with more bothersome or severe incontinence, or that which has greatest impact upon quality of life. This study examined the use of medication in women with urinary incontinence with respect to these variables. We hypothesised from previous data that these would have no effect on whether or not a drug was prescribed.

Study design, materials and methods

Data came from the Prospective Urinary Incontinence Research (PURE) Study, a prospective, observational study of women either presenting for or involved in treatment for UI [2]. Data from the UK/RoI baseline and six month follow up were analysed. Patients were recruited by 124 healthcare providers of whom 122 were general practitioners. 399 women of 65 years or over were observed and were eligible for inclusion in the analysis. Symptomatic diagnosis of UI was made according to the S/UIQ and severity of incontinence assessed according to the Sandvik index [3]. Quality of life was assessed using IQoL. Ethical committee approval was obtained for those centres where it was deemed necessary for an observational study and informed consent was gained for all subjects.

Where applicable, chi-squared for trend was used to examine differences in proportions

Results

There were 1124 observations in 399 women, mean (SD) age 74.9 (6.5) years. For 76 women the baseline observation was made at their first presentation. Table 1 shows the proportion of women receiving medication for their urinary incontinence by subtype (S/UIQ) at baseline and six months. The proportion of women receiving medication increased after 6 months. Increased severity of UI was not associated with an increased likelihood of receiving medication (p=NS). There was no association between perceived bother of UI (Likert scale) and likelihood of receiving medication (Table 2) (p=NS).

	Baseline		6m	
	N	%	N	%
Any UI Medication	153/392	39.3	202	53.6
Stress UI	15/58	25.9	18/56	32.1
Mixed UI	82/207	40.0	108/201	53.7
Urge UI	34/71	48.6	48/67	71.6

Table 1. Proportion of women receiving medication for UI

Bother and medication	**6 months**	
(n=160)	N	%
None	23	14.4
slight	40	25.0
somewhat	19	11.9
moderate	32	20.0
Very much	35	21.9
extreme	11	6.9

Table 2. Bother and medication use

Table 3 shows the distribution the relationship of medication use versus other treatment modalities related to quality of life (IQoL) at baseline. There was no relationship between quality of life and the probability of receiving medication for the treatment of incontinence. There was a non-significant trend for those with a higher quality of life score to receive no treatment.

I-QoL score & Treatment Cohort (/100)	**N**	**Mean**
Drug	153	55.5
Conservative only	76	54.8
No Treatment	160	59.9

Table 3. Quality of life and medication use

Interpretation of results

The prescription of medication for older women presenting for care for their urinary incontinence was not predicted by a higher impact on quality of life, subjective bother of UI and associated symptoms or severity of incontinence over a six month period. More women were prescribed medication for their UI at six months than at the baseline observation. Increased medication use was greater for those women with either mixed UUI/SUI or pure UUI, as might be expected, at the time of this study there was no available medication for SUI. There was however, a high proportion of women receiving antimuscarinic medication for pure SUI. These data suggest that medication use for older women with urinary incontinence is driven by other factors than those studied here.

The data which suggest that older women receive less drug treatment for their condition than younger women might suggest that considerations such as drug-drug interactions or the increased likelihood of adverse effects play a role in the use of drugs for this condition.
Additionally, this study could not take into account the perceived success or failure of non-drug treatment, the choice of women to receive drug therapy for their condition or the prescribing preferences of the individual primary care physician, which may substantially influence care received over the study period. Whether the newly published NICE guidelines for the management of UI bring some uniformity or consistency to this pattern remains to be seen

Concluding message

Medication use for older women with UI in primary care is not governed by severity of condition, bother or impact upon quality of life

References

1. BJOG. 2004 Dec;111 Suppl 1:15-9.
2. *Value in Health* 2004; **7**(3):366.
3. Neurourol Urodyn. 2000;19(2):137-45.

FUNDING: Boehringer-Ingelheim, Lilly Partnership

HUMAN SUBJECTS: This study was approved by the Multiple ethics committees gave approval where this was required for this observational study and followed the Declaration of Helsinki Informed consent was obtained from the patients.