

## X. URINARY AND FAECAL INCONTINENCE IN FRAIL OLDER MEN AND WOMEN

- There is no reason to suspect why interventions which have proven efficacy in the community dwelling elderly should not also be effective in frail older people. Clinicians should, however, take due regard of the practicality, potential benefits and dangers of employing any single intervention in this population.
- Frail older people do require a different approach addressing the potential role of co-morbid disease, current medications (prescribed, over the counter and/or naturopathic), and functional and cognitive impairment in urinary and faecal incontinence.
- The extent of the investigation and management should take into account the degree of bother to the older person and/or caregiver, the goals for care, the degree that the older person is able to undertake any intervention and the overall prognosis and life expectancy.
- Effective management to meet the goals of care should be possible for most frail older people.

### 1. HISTORY AND SYMPTOM ASSESSMENT

- Active case finding for urinary and faecal incontinence should be done in all frail older people (GoR A).
- History should include comorbid conditions and medications that could cause or worsen incontinence.
- Physical examination should include a rectal examination for faecal loading or impaction (GoR C), functional assessment (mobility, transfers, manual dexterity, dressing and undressing ability, ability to toilet) (GoR A), a screening test for depression (GoR B), and cognitive assessment (to assist in planning and management, (GoR C)).
- The mnemonic DIPPERS (see urinary and faecal incontinence algorithms) covers some of these comorbid conditions. Note that urogenital atrophy does not, in itself, cause urinary incontinence and should not be treated for this purpose (GoR B).
- The patient and / or caregiver should be asked about the degree of bother of urinary incontinence and/or faecal incontinence (GoR B); goals for urinary and

faecal incontinence care (dryness, decrease in specific symptoms, quality of life, reduction of comorbidity, lesser care burden) (GoR B); and likely cooperation with management (GoR C).

- Evaluation for bowel “alarm” symptoms (rectal bleeding, positive blood screening from stool studies, obstructive symptoms, recent onset of constipation, weight loss, and a change in stool calibre) will need more extensive evaluation (GoR A)
- Urinalysis is recommended for all patients, primarily to screen for haematuria (GoR C).
- Treatment of otherwise asymptomatic bacteriuria/pyuria is not beneficial (GoR C), and it may cause harm by increasing the risk of antibiotic resistance and severe adverse effects. e.g., *Clostridium difficile* colitis (GoR C).
- Stool studies may not be needed in all patients with faecal incontinence. Patients with diarrhoea, especially those with more acute onset diarrhoea, may need to be tested for infectious causes of their diarrhoea. Other stool studies could involve testing for malabsorption syndromes.
- The utility of the Clinical Stress test in this population is uncertain (GoR D).
- Wet checks can assess urinary incontinence frequency in long-term care residents (GoR C).
- A post voiding residual volume (PVR) test is impractical in many care settings and there is no consensus for the definition of what constitutes a “high” PVR in any population. A PVR measurement is not recommended in the routine initial assessment of frail older people with urinary incontinence.
- However, there is compelling clinical experiential evidence for PVR testing in selected frail older people with: diabetes mellitus (especially long standing); prior urinary retention or high PVR; recurrent UTIs; medications that impair bladder emptying (e.g., opiates); severe constipation; persistent or worsening urgency urinary incontinence despite antimuscarinic/beta-3-agonist treatment; or prior urodynamics showing detrusor underactivity and/or bladder outlet obstruction (GoR C). Treatment of contributing comorbidity may reduce PVR. Trial with catheter may be considered for PVR > 200-500 ml if the PVR is felt to contribute to UI or urinary frequency (GoR C).

- Nocturia Assessment of frail elders with bothersome nocturia should identify potential underlying causes including nocturnal polyuria (by bladder diary/frequency-volume chart or wet checks; oedema on examination) (GoR C), primary sleep problems (e.g., sleep apnoea); and low voided volumes (e.g., from high PVR).
- Stool impaction/loading. If suspected on digital rectal examination, an abdominal x-ray may be necessary to further evaluate the degree and location of impaction/loading in frail older adults.

## 2. CLINICAL DIAGNOSIS

The most common types of Urinary Incontinence in frail older people are urgency, stress, and mixed urinary incontinence. Frail older people with urgency urinary incontinence also may have detrusor underactivity during voiding with a high PVR but without outlet obstruction. There is no evidence that antimuscarinics are less effective or cause retention in this situation (GoR D).

The most common types of faecal incontinence in frail older people are related to urgency and passive leakage. Passive leakage can refer to leakage, seepage and staining following bowel movements that are not associated with faecal urgency and may also occur with faecal impaction. Because constipation and impaction often contribute to faecal incontinence in older adults, these are considered separately in the algorithm.

## 3. INITIAL MANAGEMENT

- Initial treatment should be individualised and influenced by goals of care, treatment preferences and estimated remaining life expectancy, as well as the most likely clinical diagnosis (GoR C). In some frail older persons the only possible outcome may be containment; management with continence products, especially for people with minimal mobility (require assistance of > 2 people to transfer), advanced dementia (unable to state their name), and /or nocturnal urinary and faecal incontinence.
- Conservative and behavioural therapy for UI includes lifestyle changes (GoR C), bladder training for more fit alert persons (GoR B), and prompted voiding for frailer, more impaired older people (GoR A).
- For the select cognitively intact older person with UI or FI, pelvic floor muscle therapy can be considered, but there are few studies (GoR C). Antimuscarinics

may be added to conservative therapy of urgency UI (GoR A-C, depending on agent).

- For the select cognitively intact older with FI, biofeedback may be considered, but few studies exist among frail older adults.
- Alpha-blockers may be cautiously considered in frail men with suspected prostatic obstruction (GoR C). All drugs should be started at the lowest dose and titrated with regular review until either care goals are met or adverse effects are intolerable.
- DDAVP (vasopressin) has a high risk of severe hyponatraemia in frail older persons and should not be used outside specialist centres or without very careful monitoring and long term followup (GoR A).
- Improving stool consistency can be done with dietary fibre and supplementary fibre in older adults (GoR C). In older adults with diarrhoea, loperamide may be considered at low doses to improve stool consistency. However, close monitoring for constipation and impaction is needed.

## 4. ONGOING MANAGEMENT AND REASSESSMENT

Optimal urinary and faecal incontinence management is usually possible with the above approaches. If initial management fails to achieve the desired goals, the next steps are reassessment and treatment of contributing comorbidity and/or functional impairment.

## 5. SPECIALISED MANAGEMENT

If frail older people have either other significant factors (e.g., pain, haematuria, bowel “alarm” symptoms), UI or FI symptoms that cannot be classified as urgency, stress, or mixed or overflow or other complicated comorbidity which the primary clinician cannot address (e.g. dementia, functional impairment), then specialist referral should be considered. Referral may also be appropriate when there is been insufficient response to initial management. The type of specialist will depend on local resources and the reason for referral: surgical specialists (urologists, gynecologists, colorectal surgeons), gastroenterologists, geriatricians or physical therapist (functional and cognitive impairment); or continence nurse specialists (homebound patients). Referral decisions should consider goals of care, patient/caregiver desire for invasive therapy and estimated remaining life expectancy.

Age *per se* is not a contraindication to UI or FI surgery (GoR C), but before surgery is considered, all patients should have:

- Evaluation and treatment for any comorbidity, medications, and cognitive or functional impairments contributing to UI that could compromise surgical outcome (e.g., dementia that precludes patient ability to use artificial sphincter) (GoR C).
- Adequate trial of conservative therapy, including pharmacological therapies where relevant (GoR C).
- Discussion (including the caregiver) to ensure that the anticipated surgical outcome is consistent with goals of care in the context of the patient's remaining life expectancy (GoR C).
- Urodynamic testing or anorectal manometry, because clinical diagnosis may be inaccurate (GoR B).
- Preoperative assessment and perioperative care to establish risk of, and to minimise the risk of common geriatric post-operative complications such as delirium and infection (GoR A), dehydration and falls (GoR C).

# MANAGEMENT OF URINARY INCONTINENCE IN FRAIL OLDER MEN & WOMEN

## HISTORY/ SYMPTOM ASSESSMENT

## CLINICAL ASSESSMENT

- Delirium
  - Infection
  - Pharmaceuticals
  - Psychological
  - Excess urine output
  - Reduced mobility
  - Stool impaction (and their factors)
- (avoid overtreatment of asymptomatic bacteriuria (C))

## CLINICAL DIAGNOSIS

These diagnoses may overlap in various combinations, e.g., Mixed UI, DHIC (see text)

## INITIAL MANAGEMENT\*

(If Mixed UI, initially treat most bothersome symptoms)

## ONGOING REASSESSMENT AND MANAGEMENT

### Active case finding in all frail elderly people (A)

- Assess, treat and reassess potentially treatable conditions, including relevant comorbidities and ADLs (see text) (A-C)
- Assess QoL, desire for Rx, goals for Rx, patient & caregiver preferences (C)
- Targeted physical examination (cognition, mobility, neurological and digital rectal examination) (A-C)
- Urinalysis (C)
- Consider bladder diary or wet checks, especially if nocturia is present. PVR in specific patients (see text) (C)

### UI associated with:

- Pain
- Haematuria
- Recurrent symptomatic UTI
- Pelvic mass
- Pelvic irradiation
- Pelvic / LUT surgery
- Prolapse beyond introitus (women)
- Suspected fistula

### URGENCY UI\*

- Lifestyle interventions (B-C)
- Behavioural therapies (B)
- Consider trial of antimuscarinic drugs / beta 3 agonist (A-C)

### SIGNIFICANT PVR\*

- Treat constipation (C)
- Review medications
- Consider trial of alpha-blocker (men) (C)
- Catheter drainage if PVR 200-500 ml, then reassess (see text) (C)

### STRESS UI\*

- Lifestyle interventions (B-C)
- Behavioural therapies (B) (See text)

If insufficient improvement, reassess for and treat contributing comorbidity ± functional impairment

If continued insufficient improvement, or severe associated symptoms are present, consider specialist referral as appropriate per patient preferences and comorbidity (see text)

\* Consider CONTINENCE PRODUCTS for temporary support during treatment

# MANAGEMENT OF FAECAL INCONTINENCE IN FRAIL OLDER MEN & WOMEN

## HISTORY/ SYMPTOM ASSESSMENT

## CLINICAL ASSESSMENT

### Rx reversible causes:

- Delirium
- Infection
- Pharmaceuticals
- Psychological
- Excess stool output (diarrhoea)
- Reduced mobility
- Stool impaction (and their factors)

## CLINICAL DIAGNOSIS

\*\* These diagnoses may overlap in various combinations, e.g., Urgency-related, passive/seeepage, and impaction (see text)

## INITIAL MANAGEMENT\*

## ONGOING REASSESSMENT AND MANAGEMENT

### Active case finding in all frail elderly people (A)

- Assess, treat and reassess potentially treatable conditions, including relevant comorbidities and ADLs (see text) (A-C)
- Assess QoL, desire for Rx, goals for Rx, pt & caregiver preferences (C)
- Targeted physical examination (cognition, mobility, neurological and digital rectal examination) (A-C)
- Urinalysis (C)
- Consider bowel diary and clean checks (C)

### FI associated with:

- Pain
- Rectal bleeding
- Change in stool calibre
- Weight loss
- Chronic diarrhoea
- Faecal impaction
- Inflammatory bowel disease
- Pelvic irradiation
- Malabsorption syndromes
- Prolapse beyond introitus (women)
- Suspected fistula

### Urge FI\*\*

- Lifestyle interventions (B-C)
- Behavioural therapies (B)
- Biofeedback (C)
- Improve stool consistency (C)

### Constipation/ faecal Impaction\*

- Treat constipation (osmotic laxatives) If impacted, glycerine or Bisacodyl suppositories. Phosphate enemas if severe. (B-C)
- Review medications that may contribute to constipation (C)
- Consider biofeedback if dyssynergic defaecation is suspected (C)

### Passive FI\*

- Lifestyle interventions (B-C)
- Behavioural therapies (B)
- Biofeedback (C)
- Improve stool consistency (C)

If insufficient improvement, reassess for and treatment of contributing comorbidity ± functional impairment

If continued insufficient improvement, or severe associated symptoms are present, consider specialist referral as appropriate per patient preferences and comorbidity (see text)

\* Consider CONTINENCE PRODUCTS for temporary support during treatment