Speaker Powerpoint Slides
Please note that where authorised by the speaker all PowerPoint slides presented at the workshop will be made available after the meeting via the ICS website www.ics.org/2017/programme Please do not film or photograph the slides during the workshop as this is distracting for the speakers.

Aims of Workshop
This workshop will focus on the assessment and conservative management of incontinence in specific patient populations including frail, community-dwelling elders, individuals who have had a stroke, and persons with OAB. ICI-6 recommendations relative to these patient populations will be addressed. Incontinence-specific health literacy needs of informal caregivers of individuals with incontinence will be discussed.

Learning Objectives
1. Discuss the assessment and evidence-based management of urinary incontinence in frail, community-dwelling older adults and individuals who have had a stroke.
2. Discuss nursing implications relative to pharmacological therapy in the management of patients with OAB.
3. Discuss recent research findings relative to continence health literacy.
4. Discuss the use of pelvic floor muscle exercise and electric stimulation in the management of post-prostatectomy incontinence.

Learning Outcomes
After this course, participants will be able to:
1. Apply the knowledge gained in care of individuals with incontinence.
2. Address the incontinence-related health literacy needs of informal caregivers of individuals with incontinence.
3. Inform or educate colleagues about the most recent evidence-based approaches to managing incontinence in the patient groups discussed.

Target Audience
Nurses and members of other health care disciplines who collaborate with nurses in research and practice

Advanced/Basic
Basic

Suggested Reading


Managing Bladder Dysfunction Following a Stroke

Presenter: Jo Booth, Nursing, UK:
Urinary incontinence is common following a stroke with prevalence rates of 32% to 79% on admission to the hospital. While the prevalence decreases following hospital discharge, many patients continue to experience UI. UI is known to have a considerable negative impact on stroke survivors. This presentation will outline types of bladder dysfunction commonly experienced at different points in the trajectory following stroke and the impact on individuals and their families. Nursing management of stroke-related bladder dysfunction will be discussed, with particular focus on the hyperacute/acute and rehabilitation phases and supporting stroke survivors to self-manage ongoing bladder dysfunction.

Pharmacological Management of OAB: Nursing Implications

Presenter: Alison Bardsley, Nursing, UK:
In a review by Irwin et al (2011), an estimated 10.7% of the 2008 worldwide population (4.3 billion) were affected by Overactive Bladder (OAB), with this expected to increase to 20.1% (546 million) by 2018. Nurses are often the first contact for patients with OAB and therefore play a pivotal role in assessment, diagnosis and treatment pathways. Behavioural therapies to improve symptoms are recommended as first-line therapy for all patients with OAB. However, studies indicate that complete resolution of OAB symptoms with behavioural therapy alone is minimal.

Guidelines recommend second-line therapy with oral antimuscarinic agents for patients whose symptoms are not adequately managed with behavioural modification alone. A combined approach that includes behavioural therapy and pharmacologic intervention is considered the most efficacious option in terms of patient satisfaction, perceived improvement, and reduction in bladder symptoms. Second line pharmacological options from other therapeutic classes—mirabegron, a beta-3 adrenoceptor (beta-3 AR) agonist and botulinum toxin A, a neurotoxin—are also approved for the treatment of patients with OAB and nurses need to consider when these may be appropriate for patients who are not responding to oral antimuscarinic therapy. Many nurses will provide advice on, or prescribe medication to manage OAB and provide a role in supporting and educating patients. Since there are a number of pharmacological options now available, it is important that nurses understand the pharmacological action of the different medications and how they can be utilised for individual patients to gain optimum effectiveness.

This session will provide an overview of the role of pharmacology in the management of OAB, taking into account the current international guidelines for prescribing in OAB. The nurse’s role in medications management for this group of patients will be discussed.

Health Literacy about Incontinence

Donna Bliss, Nursing, US:
Health literacy is the ability of an individual to obtain and understand information about their health condition or problem and the services they may need in order to communicate with others and make appropriate decisions about care that they desire. General health literacy is low in the population in the US and other countries with certain groups (e.g., elderly, low income, and minority racial and ethnic groups) affected more than others. There are negative consequences to low health literacy for the individual and health care system. The under-reporting of incontinence is well-known and may be influenced by low health literacy.

This session will examine recent research about incontinence health literacy. Although health literacy has traditionally been focused on individual patients, there is growing recognition that health literacy among informal caregivers is vital. Family and friend caregivers of individuals with cognitive deficits who have or may develop incontinence are the exemplar group for this discussion. Incontinence health literacy needs that emerged were in three areas: knowledge, skills in managing, and attitudes. In addition, barriers to communication and information seeking specific to different types of caregivers are revealed.

**Management of Incontinence in Frail Community-Dwelling Elders**

Sandra Engberg, Nursing, US:

This presentation will examine recent evidence on the assessment and management of UI in frail, community-dwelling older adults. Frailty, age-associated declines in physiologic reserve and function across multiple body systems, and urinary incontinence (UI) are two geriatric syndromes that often co-exist in the geriatric population. Evidence suggests that the presence of either frailty or UI increases the likelihood of the other syndrome with the risk of both syndromes increasing as age increases. Among frail older adults, the etiology of UI is generally multifactorial. These factors include age-related changes in lower urinary tract function as well as a wide variety of factors outside the lower urinary tract such as the effects of medications, comorbid medical and psychiatric illnesses, functional impairments and environmental factors. Given the multifactorial nature of UI in frail elders, assessment must be comprehensive with the goal of identifying all potential contributing factors. Managing UI in the frail elder population should start with the assessment, treatment and re-evaluation of potentially treatable conditions. Lifestyle and behavioral interventions are recommended as the initial treatment for unresolved UI followed by consideration of a trial of pharmacotherapy in appropriately selected patients. The goals of treatment need to consider patients’ level of frailty, comorbid conditions, and patient/caregiver goals and expectations. While UI can almost always be improved, complete continence may not be a realistic goal for some frail older individuals.

**Management of Post-Prostatectomy UI**

Presenter: Stefano Terzoni, Nursing, Italy

Urinary incontinence is a common problem following prostate surgery. This presentation will focus on the management of urinary in this population. Current evidence about practical aspects of pelvic floor exercises is unclear in the literature. This includes the idea body position, use of gravity, and how to increase the required muscular effort during the rehabilitation program. These issues will be discussed during this presentation as well as when and how to combine well-known treatments such as functional electrical stimulation and biofeedback with pelvic floor muscle exercises. Practical issues such as which type of stimulation to use, in which phase of the rehabilitation program it should be used and for how many sessions should be included will be discussed. The role of biofeedback and how it should be included as part of the exercise program will also be discussed.
Continence Care Nursing

W29

Learning objectives

1. Discuss the assessment and evidence-based management of urinary incontinence in frail, community-dwelling older adults and individuals who have had a stroke.
2. Discuss nursing implications relative to pharmacological therapy in the management of patients with OAB.
3. Discuss recent research findings relative to continence health literacy.
4. Discuss the use of pelvic floor muscle exercise and electric stimulation in the management of post-prostatectomy incontinence.

Topics and Speakers

• Management of Bladder Dysfunction Following a Stroke: Jo Booth
• Pharmacological Management of OAB: Nursing Implications: Alison Bardsley
• Health Literacy about Incontinence: Donna Bliss
• Management of Incontinence in Frail Community-Dwelling Older Adults: Sandie Engberg
• Management of Post-Prostatectomy Incontinence: Stefano Terzoni

**NEW FOR 2017**
Please complete the in-app evaluation in the workshop before leaving.

Step 1, open app and select programme by day

Step 2, locate workshop

Step 3, scroll to find evaluation button

Step 4, complete survey

A shortened version of the handout has been provided on entrance to the hall

A full handout for all workshops is available via the ICS website.

Please silence all mobile phones

Please refrain from taking video and pictures of the speakers and their slides. PDF versions of the slides (where approved) will be made available after the meeting via the ICS website.
Managing bladder dysfunction following a stroke
Gestione delle disfunzioni urinarie post-ictus

Joanne Booth, PhD RN
Professor of Rehabilitation Nursing
School of Health & Life Sciences

Content
- Summary of stroke and effects on person
  - Punti chiave dell’ictus e suoi effetti
- Types of lower urinary tract dysfunction (LUTD)
  - Tipologie di disfunzioni bel basso tratto urinario
- ICI 2017 management options for LUTD following stroke
  - Gestione dei LUTD post-ictus secondo ICI 2017

Stroke in UK (1)
- More than 150,000 strokes each year
- 85% ischaemic, 15% haemorrhagic
- 1.2 million stroke survivors
- Stroke is the fourth leading cause of death in UK, second most common across Europe

Effects of stroke
- Sensory-motor sensitivi/motori 80%
- Communication comunicazione 33%
- Cognition capacità cognitive 24-39%
- Vision capacità visive up to 65%
- Swallowing deglutizione 40%
- Emotional/psychological Sfera emotiva 20-29%
- Pain Dolore 20%
- Social Sfera sociale

Stroke in UK (2)
- Stroke causes 7% deaths in men, 10% deaths in women in UK; across Europe 10% deaths in men, 15% deaths in women
- Stroke is leading cause of disability in UK - two thirds of stroke survivors leave hospital with a disability

Funding for speaker to attend:
- Self-funded
- Institution (non-industry) funded
- Sponsored by:

None

Joanne Booth
Affiliations to disclose†:

Stoke Association 2013
Impact of stroke on the bladder (1)

- Little good quality research investigating LUTD after stroke
- Very limited understanding of pathophysiology, natural history, types of bladder and bowel dysfunction

Impact of stroke on the bladder (2)

- Minimal evidence of effective intervention: focus is on containment more than supporting recovery and treatment
- Consensus on current evidence – International Consultation on Incontinence (ICI) 2017

Urinary incontinence after stroke

- Affects 40-60% of people following a stroke: in UK 60,000 – 90,000 people each year
- Colpisce 40-60% dei pazienti post-ictus: 60-90.000 persone in UK ogni anno
- 44% report UI at 3 months, 38% at 12 months
- 44% riferisce incontinenza a 3 mesi, 38% a 12 mesi
- Physical, psychological and social impact
- Impatto fisico, psicologico, sociale
- Associated with complications
- L’incontinenza è associata a complicanze

LUTD post stroke

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LUTD</td>
<td>53%</td>
<td>84%</td>
<td>64%</td>
</tr>
<tr>
<td>Nocturia</td>
<td>36%</td>
<td>79%</td>
<td>49%</td>
</tr>
<tr>
<td>Urgency UI</td>
<td>29%</td>
<td>32%</td>
<td>33%</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>Difficulty voiding</td>
<td></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Retention</td>
<td>6%</td>
<td></td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Types of lower urinary tract dysfunction after stroke – ICI, 2017

- Neurogenic UI (OAB wet)
- Functional UI– cognitive, communicative, motor impairments and environmental challenges
- Mixed
- Incidence of LUTD in stroke patients ranges from 14-53% principally due to OAB and is higher when the frontal cortex is involved (LOE 3)

ICI 2017 summary of stroke specific evidence

- OAB (wet or dry) most common LUTD after stroke
- OAB asciutta o bagnata è il più comune LUTD post ictus
- Infarction – increased detrusor overactivity likely
- Nell’ischemia è probabile aumento iperattività detrusoriale
- Haemorrhage – detrusor underactivity more likely
- Nell’emorragia è probabile una ipoattività detrusoriale
ICI 2017 summary of stroke specific evidence (2)

- Localisation
  - frontal lobe associated with OAB
  - brainstem infarcts/haemorrhage may be associated with more voiding difficulties
  - No evidence for laterality

Impact of urinary incontinence after stroke (1)

- More significant for stroke survivors than for those without stroke.
- More severe stroke increases risk of UI
- Increased mortality and disability
- Increased institutionalisation, in first year

Impact of urinary incontinence after stroke (2)

- Decreased discharge home
- Depression – 4 times more likely following stroke
- Poorer quality of Life
- Reduced participation, impoverished social life and relationships

Impact of urinary incontinence after stroke (3)

Associated complications:

- Urinary tract infection
- Dehydration
- Skin breakdown
- Sleep disturbance
- Pain/physical discomfort

Impact of urinary incontinence after stroke (2)

Conseguenze dell’incontinenza post ictus
Dimissione tardiva, depressione, scarsa qualità di vita, impatto sociale

Human costs of UI and FI

- Isolation
- Dependence
- Embarrassment
- Discomfort
- Fear
- Frustration

Effects on stroke survivor and carers

Costi umani: isolamento, dipendenza, imbarazzo, disagio, paura, frustrazione. Impatto su pazienti e caregiver.

Nurses rehabilitation priorities

High
- Mobility
- Swallowing
- Speech
- Psychological support
- Bladder and bowel rehabilitation

Low

Priorità per l’infermiere: mobilità, deglutizione, comunicazione verbale, supporto psicologico, riabilitazione urinaria e intestinale.
Rehabilitation and care mismatch

- Management of bladder and bowel dysfunction are priorities for patients and their carers
- Not seen as a priority by health care professionals:
  - Poor assessment and case finding
  - Poor treatment and care planning
  - Poor implementation of treatment and care plans
  - Poor bladder and bowel rehabilitation in evidence

Bladder management post stroke (1)

- ICI, 2017 - Management will depend on the type of LUTD – neurogenic or functional or combination [LOE 3]

- Treatment regimens should be individualised.

Bladder management post stroke (2)

- Hyperacute interventions
- Lifestyle changes
- Behavioural therapies
- Pharmacological
- Environmental management
- Electrical stimulation

Hyperacute phase

- Urinary retention common – 37% (Cowey 2011)
- Support spontaneous recovery
  - Early mobilisation
  - Regular attempts to use toilet
  - Monitor fluid balance
- Intermittent catheterisation
- Full continence assessment

Lifestyle changes

Neurogenic and functional LUTD

- Fluid management – Type, amount, timing
- Bowels – avoid constipation
- Exercise
- Medication

Stile di vita: gestione liquidi, evitare costipazione, esercizio fisico, farmaci

Behavioural therapies

Functional LUTD

- Education & self-monitoring
- Voiding programmes eg prompted voiding, timed voiding with physical assistance
- Bladder training
- Pelvic floor muscle training
Pharmacological

• Bladder focused (neurogenic)
  – Anticholinergics / antimuscarinics – those that do not cross blood-brain barrier easily
  – Beta 3 adrenergic agonist (Mirabegron)

• Disease focused (functional)
  – Anticoagulants for atrial fibrillation
  – Diuretics for hypertension

Environment

Functional and neurogenic LUTD

• Access to toilet
• Provision of assistance
• Equipment and toileting aids
• Comfort and cleanliness of toilet/toilet aid

Management of Incontinence

• Containment - for social continence, not recovery of bladder function and continence promotion
  ➢ Absorbent products
  ➢ Penile sheaths
  ➢ Indwelling urethral catheters
  ➢ Supra-pubic catheters

Conclusion (1)

• Limited understanding of LUTD following stroke
• ICI 2017 recommends dividing UI in stroke into two types – neurogenic UI (OAB wet) and functional UI (immobility and loss of initiative/cognition)
• Neurogenic needs anticholinergic drugs that do not penetrate blood brain barrier
• Functional UI needs behavioural therapy

Electrical stimulation

Neurogenic LUTD — OAB and incomplete emptying

• Electro-acupuncture

• Transcutaneous tibial nerve stimulation
  – Monteiro 2014
  – Booth 2016

What is current situation for majority of stroke survivors?

• ICI 2017 recommends dividing UI in stroke into two types – neurogenic UI (OAB wet) and functional UI (immobility and loss of initiative/cognition)
• Neurogenic needs anticholinergic drugs that do not penetrate blood brain barrier
• Functional UI needs behavioural therapy

Environment

Ambiente: accesso ai servizi igienici, assistenza, ausili, comfort e pulizia
Conclusions (2)

• Functional UI needs behavioural therapy

• More stroke specific research needed

• Evidence on effective treatments essential

L'incontinenza funzionale richiede terapia comportamentale. Serve più ricerca con evidenze solide sui trattamenti efficaci.

Thank you

Brighter futures begin with GCU

Jo.booth@gcu.ac.uk
Pharmacological Management of OAB: Nursing Implications

Alison Bardsley
RGN, DipDN, MSc, PgCert HE
Senior Lecturer
Course Director for Non-medical prescribing
Coventry University

Affiliations to disclose:

None to Declare

Funding for speaker to attend:

Coventry University - Employer:

Self-funded

Institution (non-industry) funded

Sponsored by:

Oral Medication options

- Antimuscarinic/Anticholinergic drugs first choice
- BETA3 Adrenoceptor Agonists
- Botulinum Toxin A

Neurotransmitters

- Acetylcholine main neurotransmitter in bladder
- Drugs are competitive antagonists within smooth muscle
- Inhibiting micturition
- Some are M3 selective
- Others are non-selective

Overactive bladder

- A problem with bladder storage function that causes a sudden urge to urinate.
- The urge may be difficult to suppress, and overactive bladder can lead to the involuntary loss of urine (incontinence).

Mode of action

- Acetylcholine main neurotransmitter in bladder
- Drugs are competitive antagonists within smooth muscle
- Inhibiting micturition
- Some are M3 selective
- Others are non-selective
Role of Neurotransmitters in the Bladder

- Main neurotransmitter in storage phase - norepinephrine
- Activates adrenergic receptors in bladder muscle and internal sphincter ($\beta_3$ and $\alpha_1$) – relax the bladder and close the internal sphincter

Role of Neurotransmitters in the Bladder

- Main neurotransmitter in voiding phase - acetylcholine
- Muscarinic receptor function mediated by acetylcholine – controls contraction of detrusor muscle and relaxation of internal sphincter muscle
- Purinergic receptors (P2X₃) are mediated by adenosine triphosphate (ATP) and sense bladder fullness for voiding

Muscarinic receptors

- Muscarinic receptors – subtypes M₂ and M₃ predominant
- $M_3$ important for normal bladder contractions
- $M_3$ may play more prominent role in certain disease states
- Binding of acetylcholine to $M_3$ on detrusor activates signalling → bladder contraction and voiding

Side effects

BETA₃ Adrenoceptor Agonists

- Mirabegron (Betmiga- MR) - potent and selective beta 3-adrenoceptor agonist → relaxation of bladder smooth muscle
- Side effects: GI disorders, ↑ Blood pressure
- Mirabegron should be offered if ‘antimuscarinics’ do not work, if they are not suitable, or their side effects are unacceptable
- Combination therapy an option for anticholinergic-resistant neurogenic bladder

Alternatives??

- Atropine – not used due to side effects
- Flavoxate - scarce clinical evidence of effectiveness
- Propantheline – non-selective – effects not well documented
- Imipramine – antidepressant with anticholinergic side effects – not recommended due to side effects (especially cardiac)
- Intravesical Vanilloids - Capsaicin and Resiniferatoxin
- Baclofen
How do you choose?

- Take into account pre-existing conditions and co-concomitant medications especially the use of other anticholinergic medications
- Risk of adverse effects and common side effects
- Treatment should be individualised

- Also consider
  - The likelihood of success
  - Frequency and route of administration
  - Some adverse effects may indicate treatment is starting to have an effect
  - May not see full benefit for 4 weeks

Nursing considerations

- Importance of patient information
- Review after 4 weeks – consider increasing dose or alternatives if ineffective or side effects not tolerated
- Patient concordance
- How long to continue treatment
- Relapse rates
- Consider combination therapies

Botulinum Toxin A

Summary

- Individualised treatment/management plan is essential
- Patient assessment needs to be holistic
- The provision of Patient information is important to concordance
- Patients must be reviewed after 4 weeks when starting oral medication

References

Incontinence Health Literacy

Donna Z. Bliss, PhD, RN, FAAN, FGSA
Professor, University of Minnesota School of Nursing
Minneapolis, MN

Health Literacy

US (NIH and IOM):
- Access and navigate health information and healthcare system and seek care
- Ability to communicate with a healthcare provider
- Understand info and make choices
- Manage chronic health conditions
- Engage in symptom self-management

Europe (WHO):
- Health care + disease prevention + health promotion

Low Health Literacy

Surveys in US, Europe, Italy, Australia
- 12%-50% of adults (varies by country)
  - In Europe, better in Netherlands, worse in Bulgaria, Spain, & Austria
  - Older people (70% of those >75yrs; 29%-75% in Europe)
  - Non-White racial groups, minority immigrants
  - English not first language
  - Incomes ≤ poverty level, low SES (all)
  - Education < High school (all)
  - Chronic diseases

Low Health Literacy Effects

- Report worse health status
- Increase rates of non-communicable diseases
  - cancer, diabetes, heart, and respiratory disease
- Stigma
- Less communication with providers
- More hospitalizations
- Increased healthcare costs
- Cost of limited health literacy to US economy = $106 - $236 billion USD annually (2010)

Low Incontinence Literacy

- Women with pelvic floor (PF) disorders (UI and/or POP) → poor understanding of their PF diagnosis and treatment plan
  - POP < UI
  - 36 women, 42-94 years, 61% White, >90% high school
  - Interview & checklist about diagnosis and treatment plan at clinic, taped
  - Took Test of Functional Health Literacy in Adults
Low Incontinence Literacy

- Adults with fecal incontinence lack terms to describe their problem to clinicians (Patel et al., JWOCN, 2010)
- Use terms for other GI problems—confound dx
  (e.g., diarrhea, colitis. IBS)
- UI terms confusing (OAB vs UI?)
  (Chelvanayagam & Norton, Nurse Times, 2000; Patel et al. JWOCN, 2010)
- < 25% church group reported their UI, FI or DI to a clinician
  n=145, M & F, aged 21-80+
  1/3 desired more info about incontinence and its treatment (Haasan, C. JWOCN Abstract, 2016)

Caregiver Health Literacy Needs

- Caregiving is self-affirming yet stressful
  (AIHW 2011; Lieberman, 1995; Almberg et al., J Adv Nurs. 1997; Mittelman, et al., 2006)
- Caregivers of cancer patients
  - Difficulty learning clinical information
  - Unable to interpret details
  - Receive too little or too much information
  - Dissatisfied with the communication & abrupt manner of clinicians
  (Bevan et al., Patient Education Counseling 2008)
- UI and FI occur in Alzheimer’s disease (AD) -- Family caregivers feel unprepared to manage – in different conditions
  (McCallum et al., Australian J Aging, 2005)

Assessing Incontinence Literacy Needs of Carers of Individuals with AD

- 15 million carers in US; 1 million in Australia
- >1 million Italians are living with dementia. By 2020, 584,000 new cases of dementia are estimated for the country (http://www.alz.org/it/dementia-alzheimers-italy.asp)
- Our study -- Informal caregivers who assist or will assist family member or friend with incontinence
  - 7 community care sites

Informal Caregiver Sample

- n = 48
- Sex: 75% female
- Age = 64 (14) yrs (mean (sd))
- Race/Ethnicity
  - 52% White, not Hispanic
  - 48% minority
  - 10 % Black
  - 6% > 1 race
  - 31% Hispanic
- Types of Caregivers
  - 43% spouses
  - 31% children (daughters)
  - 14% other relative
  - 10% friends
- Education
  - 71% ≥ high school

Care Recipient Characteristics

- Sex: 62% female
- Age: 80 (9) yrs (mean (sd))
- Current Incontinence
  - 58% incontinent
    - 33% UI only
    - 25% UI+FI

Incontinence Literacy needs

Knowledge

- Why does incontinence occur in AD? during sleep?
- Common “adult” terms for incontinence and skin damage
- Management options other than pads
  - Medications, diet, fluids, surgery, behavioral
- Guide to absorbent and skin care products
- Skin damage descriptions
- Questions to ask a nursing home
Incontinence Literacy Skills

• “How to” -- Manage undressing/dressing, modesty issues, skin care
• Going out into public – avoid “accidents”
• Reduce physical burden, encourage cooperation of care recipient

(Bliss et al., JWOCN, 2013)

Incontinence Literacy Attitudes

• Health vs. behavior problem
• Discuss without embarrassment
  • Clinician initiate questions
• Be prepared
• Clinician advice is trusted/value
• Mixed opinions: talk to MD in presence of care recipient or not
• Share experiences and problem-solving with other caregivers
• Take care of self

(Bliss et al., JWOCN, 2013)

Raise Incontinence Literacy Promote Continence


Free National Continence Helpline (1800 33 00 66) Speak with a nurse continence advisor

School program

Studies of Interventions

• Tät mobile app for self-management of stress UI improved ICIQ-UI and LUTs scores of 62 Swedish women vs 62 with delayed Rx (Asklund et al., NAU 2016)
• A continence education brochure prompted individuals to take self-care actions (O’Connell, JWOCN 2000)
• Self-management/literacy UI intervention improved ICIQ-UI scores, knowledge, attitudes
  o 17 community Korean women
  o Intervention = UI knowledge, attitudes, myths, lifestyle factors, behavioral Rxs, communication in five 90 min group sessions

(De Gagne J Int Nurs Sci, 2015)

Studies of Interventions

• Educational and supportive materials about fecal incontinence for AD patients and caregivers

(Bliss et al., JWOCN, 2013)
  • available via bliss@umn.edu or ICS Nursing Committee webpage
• Training caregivers of homebound elderly with AD in prompt voiding reduced UI episodes of care recipients 22% (Engberg, JWOCN 2002)
• Caregivers of frail elderly trained to perform a toileting intervention reduced frequency and volume of UI and perineal dermatitis in 19% of care recipients (Cullen, Univ Nurs 2003)
Summary

- Incontinence literacy is low
- Patients and carers need/desire more info
- Nurse continence specialists have an important role in raising incontinence literacy
- Provide care resources, increase communication, and educate on management
- Mobile resources – new tools
  - Hard copy and face to face consultation may benefit others/elderly

References

- Rohnke, SJ, Blais, DZ, Jackson, JM. Healthcare providers’ perspectives for promoting communication with family caregivers and patients with dementia about incontinence and skin damage. *JWOCN*. 2013;38(4):52-57.
Management of UI in Frail Community Dwelling Older Adults
La gestione dell’incontinenza urinaria negli anziani fragili a domicilio
Sandra Engberg, PhD, RN, CRNP, FAAN

Affiliations to disclose†:
None

Funding for speaker to attend:
☐ Self-funded
☒ Institution (non-industry) funded
☐ Sponsored by:

Frailty – Fragilità
• A decline in physiologic reserve and function across multiple organ systems
  • Una riduzione delle riserve fisiologiche e delle funzioni nei sistemi organici
• Increased vulnerability to stressors results in increased risks for disability, nursing home admission, hospitalization and mortality
  • L’aumento di vulnerabilità a ‘stressors’ aumenta il rischio di disabilità, ammissione nella casa di riposo, ospedalizzazione e mortalità

Frailty – Fragilità
• As the population worldwide ages, the proportion of frail individuals is increasing
  • Estimated prevalence of 30% in those ≥85 years
• La popolazione mondiale invecchia e la proporzione degli individui fragili aumenta:
  • Prevalenza stimata al 30% nelle persone ≥85 anni

UI and Frailty – Incontinenza urinaria e fragilità
• Geriatric syndromes that often co-exist
  • The presence of each increases the risk of the other
  • In one study, UI was associated with a 6.5 greater risk of frailty (controlling age and sex)
• Sono sindromi geriatriche che spesso coesistono
  • La presenza di una aumenta il rischio dell’altro
  • In uno studio, l’incontinenza urinaria è stata associata ad un aumento del 6.5 del rischio per fragilità (controllato per età e sesso)
Assessment - Assessment

• Goal: identify potentially contributing factors
• Obiettivo: identificare possibili fattori contribuenti
• Screen for frailty
• Screening della fragilità
• Comprehensive assessment to identify co-morbid conditions, functional impairments and medication that increase the risk for UI
• Assessment multidimensionale per identificare possibili condizioni di comorbidità, un deterioramento funzionale e farmaci che aumentano il rischio di incontinenza urinaria

Management - Gestione

• Treatment goals need to: consider level of frailty, co-morbid conditions and impairments and patient/caregiver preferences and outcome expectations
• Gli obiettivi di trattamento devono: considerare il livello di fragilità, le condizioni di comorbidità e deterioramento, le preferenze del paziente/dei caregiver e le aspettative sugli outcome
• Complete continence may not be a realistic goal for those who are very frail
• La continenza completa potrebbe essere un obiettivo non realistico per i pazienti in uno stato di fragilità avanzato

Management - Gestione

• Absorbent pads
• May have a role when complete continence is not an achievable goal
• Often overused
• Research suggests they are the most frequent UI management approach in frail elders across all settings
• Can increase the risk for incontinence, UTIs and skin irritation
• Should not be a substitute for active treatment of UI
• Assorbenti
• Possono essere utili in caso la continenza completa non è un obiettivo raggiungibile
• Spesso eccessivamente utilizzati
• La ricerca indica che presentano l’approccio più frequente nella gestione dell’incontinenza urinaria per anziani fragili nei vari settori
• Possono aumentare il rischio di incontinenza, infezioni delle vie urinarie e irritazione della cute
• Non devono sostituire il trattamento attivo dell’incontinenza urinaria
Management - Gestione

- Environmental interventions
  - Lack of access to toilets and timely toileting assistance are well known risk factors for UI
  - For frail elders unable to toilet independently, the availability of timely toileting assistance is critical to the success of all other interventions for UI

- Interventi ambientali
  - Mancanza di accesso al bagno e assistenza precoce per andare in bagno sono fattori di rischio per l’incontinenza urinaria
  - Per anziani fragili che non sono autonomi a recarsi in bagno, l’assistenza precoce è un fattore cruciale per il successo degli altri interventi sull’incontinenza urinaria

Management - Gestione

- Behavioral interventions
  - Lack of side effects make behavioral interventions ideal first-line treatment options
  - Cognitive and functional status guides the best approach

- Interventi comportamentali
  - l’opzione primaria è ideale per il trattamento per l’assenza di effetti indesiderati
  - Lo stato cognitivo e funzionale guida l’approccio migliore

Management - Gestione

- Voiding programs
  - When cognitive and/or physical impairments that limit ability to actively participate in self-care
    - Require active caregiver participation
  - Prompted voiding: combines regular prompts to void with positive feedback for appropriate toileting

- Programmi di voiding/svuotamento
  - Se la partecipazione attiva e il ‘self-care’ sono limitati a causa del deterioramento cognitivo e/o funzionale
    - Richiede la partecipazione attiva da parte del caregiver
  - Prompted voiding-Svuotamento guidato: combinazione tra tentativi regolari con un rinforzo positivo quando lo svuotamento è stato appropriato

Management - Gestione

- Prompted Voiding
  - 3-day trial is recommended to identify those most likely to benefit
    - At least a 20% reduction in wet checks, appropriate toileting rate of at least 66% and requires assistance of no more than one caregiver to toilet

- Prompted Voiding - svuotamento guidato
  - 3 giorni di sperimentazione sono raccomandati per identificare gli anziani che possano trarne beneficio
    - Una riduzione di almeno il 20% di perdita delle urine, un tasso di toileting appropriato di almeno il 66% e per andare in bagno non necessita più di un caregiver

Management - Gestione

- Habit training (matching toileting schedule to voiding pattern) and scheduled toileting (regular toileting without prompts)
  - Insufficient evidence to determine effectiveness

- Il Habit training (adattare il piano di toileting al ritmo e al modello minzionale) e la toileting programmata (toileting regolare senza guida da parte del caregiver)
  - Evidenza sull’efficacia non sufficiente

Management - Gestione

- Those able to actively participate in treatment may be candidates for pelvic floor muscle training (PFMT) and/or bladder training (BT)
  - Limited research examining effects of these intervention

- Anziani che possono partecipare attivamente ai trattamenti sono candidati per la ginnastica pelvica (‘pelvic floor muscle training’) e/o addestramento vescicale (‘bladder training’)
Management - Gestione

• Systematic review with 3 studies examining the effect of a multicomponent behavioral intervention (with PFMT and BT): significant reductions in UI at the end of the interventions

  Revisione sistematica di 3 studi esaminando gli effetti di un intervento multicomponente comportamentale (con ginnastica pelvica e addestramento vescicale): riduzione significativo dell’incontinenza urinaria alle fine dell’intervento

• Study comparing PFMT in frail (homebound) and non-frail older adults: significant reductions in UI in both groups (frail: 64.5%; non-frail: 70.4%); no significant group differences

  Uno studio ha comparato la ginnastica pelvica tra anziani fragili (a domicilio) e anziani non-fragili: riduzione significativa dell’incontinenza urinaria in tutti e due i gruppi (fragili: 64.5%; non-fragili: 70.4%); nessun differenza tra i gruppi

  La maggior parte degli anziani fragili ha bisogno di un supporto continuo per sostenere il miglioramento della continenza urinaria

Management - Gestione

• Pharmacologic treatment
  • Increased risk for adverse effects in frail elders
  • Only consider after potentially remedial comorbid conditions/factors are addressed and there is an appropriate trial of behavioral therapy and lifestyle interventions

  Trattamento farmacologico
  • Rischio elevato per effetti indesiderati negli anziani fragili
  • Da considerare solo dopo possibili condizioni/fattori di comorbidità sono stati indirizzati e dopo una fase di prova sufficiente di interventi comportamentali e interventi sullo stile di vita

Management - Gestione

• Pharmacologic treatment
  • Generally, should not be used if unable/unwilling to toilet

  Trattamento farmacologico
  • In generale, non da considerare se l’anziano non è in grado/cooperante ad andare in bagno

Conclusions - Conclusioni

• The prevalence of both frailty and UI increase with age and the two conditions often co-exist

  La prevalenza della fragilità e dell’incontinenza urinaria aumenta con l’età e spesso queste due condizioni coesistono

• The etiology of UI is generally multifactorial with contributing factors extending beyond the lower urinary tract

  L’etiologia dell’incontinenza urinaria è multifattoriale con fattori contribuenti il basso tratto urinario

Conclusions - Conclusioni

• Assessment and treatment must take the many potential contributing factors into consideration

  L’assessment e il trattamento devono prendere in considerazione i vari possibili fattori contribuenti

• Goals of treatment need to consider the individual’s level of frailty, co-morbid conditions, and patient/caregiver preferences and expectations

  Gli obiettivi del trattamento devono considerare il livello di fragilità e le condizioni di comorbidità dell’individuo e le preferenze e aspettative del paziente e il suo caregiver
Conclusions - Conclusioni

• Treatment should start with the assessment, treatment and re-evaluation of potentially treatable conditions
• Il trattamento inizia con l’assessment, il trattamento e la ri-evalutazione delle possibili condizioni trattabili
• If UI is unresolved, treatment should focus on lifestyle and behavioral interventions
• Se l’incontinenza urinaria non viene risolta, il trattamento deve focalizzarsi sullo stile di vita e sugli interventi comportamentali

References - Bibliografia


Conclusions - Conclusioni

• If UI continues, a trial of pharmacotherapy can be considered in appropriately selected patients
• Se l’incontinenza urinaria persiste, si può prendere in considerazione un trattamento farmacologico nei pazienti appropriatamente selezionati
• UI can almost always be improved in frail elders but complete continence may not be a realistic goal depending on the level of frailty
• L’incontinenza urinaria può quasi sempre essere migliorata negli anziani fragili, però dipende dal livello di fragilità. La continenza completa non è un obiettivo realistico

References - Bibliografia

Management of post-prostatectomy incontinence

Stefano Terzoni, PhD, RN
San Paolo teaching hospital, Milan
Chair EAUN – European Association of Urology Nurses

Affiliations to disclose:
None to Declare

Funding for speaker to attend:

- Self-funded
- Institution (non-industry) funded

Sponsored by:

- Stefano Terzoni
- Coventry University – Employer

Source: http://www.uro-innsbruck.at

How can we help these patients?

1 - Assessment

Post-prostatectomy urinary incontinence

- Prevalence 2%-60%: surgical technique, follow-up times, definition of incontinence chosen by the authors (Anderson A et al. Cochrane Data Syn Rev 2015: 1)


- No difference in UI incidence after robotic vs open prostatectomy (Haglind et al, Eur Urol 68(2):216-21(2015))

- Intraoperative damage of the rhabdomyosphincter (Peterson & Chen, Neurol Urodyn 31;60-63(2012))

How can we help these patients?

1 - Assessment

- Life-style interventions
- Pelvic floor muscle training (biofeedback
- Electrical nerve stimulation (bladder and urethra
- Anticholinergics (OAB & urgency incontinence) and anticholinergics (overactive bladder outlet obstruction)
- Surgery
The ICIQ modular questionnaire

Assessment
- Patient history (surgery, comorbidities, risk factors, LUTS, quality of life)
- Voiding diary
  24 hours pad test

Lower Urinary Tract Symptoms

Filling:
- Increased frequency
- Nocturia
- Urgency
- Incontinence

Voiding:
- Poor stream
- Hesitancy
- Strain
- Terminal dribbling

Post-micturition:
- Post-micturition dribbling
- Incomplete voiding

Bladder activity:

<table>
<thead>
<tr>
<th>Score</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Micturition for social reasons, without stimulus</td>
</tr>
<tr>
<td>1</td>
<td>Stimulus without urgency</td>
</tr>
<tr>
<td>2</td>
<td>Urgency solved before reaching the toilet</td>
</tr>
<tr>
<td>3</td>
<td>Urgency until micturition, without leakage</td>
</tr>
<tr>
<td>4</td>
<td>Urgency with leakage before reaching the toilet</td>
</tr>
</tbody>
</table>

Voiding diary
- 4 days of assessment
- Fluid intake and urine voiding
- Urine volume
- Leakage

Conservative treatments
- Neither pharmacological, nor surgical
- Behavioral interventions
- Pelvic Floor Muscle Training (PFMT)
- Biofeedback (BFB)
- Functional electrical stimulation (FES)
- Extracorporeal magnetic innervation (ExMI)
- Tibial nerve stimulation (PTNS)

Part 2 – Conservative management
What is really appropriate?
Recommendations from the literature

Pelvic floor muscle training

How to perform PFMTs?

Pelvic floor and continence

Ideal patients...

Real patients...

Developing a rehabilitation programme for male urinary incontinence: detailed schemes and results on 122 patients

© 2003 Primal Pictures Ltd.
What should we tell patients to contract?

Healthy men: muscle displacement in the mid-urethra: “shorten the penis” better than “tighten around the anus” (p=0.007) but not better than “stop the flow” (p=0.187)


“Am I doing it right?”

- Importance of feedback during the exercises: self-palpation of the fibrous nucleus
- But: what if pelvic muscles are too weak to allow sensing contraction clearly?
- Biofeedback or functional electrical stimulation?

Rehabilitation of PREhabilitation?

Preoperative pelvic floor training improves post-prostatectomy continence after 3 months from surgery, but not after 6 months


Preoperative biofeedback

Can FES be useful for teaching PFMEs?

- Post-prostatectomy patients who could not learn PFMT were offered FES (leakage reduction<50 g/day after 6 PFMT consultations/6 weeks, in presence of initial leakage >100 g/day). FES: 15 min, 250 to 400 microsecs, 30 to 100 Hz, max 60 mA
- Leakage reduction

Take home messages: our patients...

- **Need motivation**: fostered by "enthusiast clinicians", reinforcement messages and explanations on why they should do the exercises every day in that way.
- **Need no taboos**: they’ve been through enough!
- **Need support** when results do not come immediately.
- **Need their caregivers**: they’re part of patients’ life!
- **Experience complex situations** if compared to most literature papers: need for evidence-based practice, medical humanities, and commitment.

*Thank you*

s.terzoni@uroweb.org