Upper Peninsula Health Plan

UPHP Clinical Guideline for Assessment and Management of Urinary Incontinence (UI) in Adults

Eligible Population	Key Components	Recommendation	Frequency
Adults 18 years or older	**Assessment and Diagnosis**	The basic assessment has three purposes 1) to determine cause of the incontinence, 2) to detect related urinary tract and nervous system pathology and 3) to evaluate patient comprehensively. Assessment includes: • Physical exam (including genital system exam) • Mental status exam • Complete urinary history: ➢ Duration and characteristics of UI (consider having patient do a voiding diary) ➢ Frequency, timing and amount of continent and incontinent voids ➢ Precipitants and associated symptoms of incontinence ➢ Fluid intake pattern ➢ Alterations in bowel habits and sexual function ➢ Previous treatment and its effect on UI ➢ Use of pads, briefs, or other devices • Review of comorbidities • Review medications; common categories associated with UI: ➢ Major tranquilizers ➢ Antidepressants ➢ Anticholinergics ➢ Sedatives ➢ Anti-Parkinson's-disease drugs ➢ Antihistaminics ➢ Antiarrhythmics ➢ Diuretics ➢ Antihypertensives ➢ Narcotics ➢ H_2 antagonists ➢ Anticonvulsants ➢ α-Adrenergics ➢ Others (alcohol, caffeine, or nicotine) • Review of environment • Review of quality of life issues • Review of availability of resources Tests for assessment of UI: • Cough-test for suspected UI • Urinalysis with culture • Postvoid residual (PVR) urine measurement	Comprehensive exam at initial visit, and as needed for new UI symptoms or changes in UI symptoms. Urinary symptom history at least annually or more frequently as needed for patients at risk for UI or with history of UI; every two years for all others.

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Individuals with a potentially reversible cause for UI	**Management:** **Discuss treatment options with patient, family, or caregiver**	Individuals identified as having a potentially reversible **(DIAPPERS)** cause for UI: **D** Delirium (commonly related to medication or acute illness) **I** Infection (especially from urinary tract) **A** Atrophic urethritis/vaginitis (frequent source of UTI, including incontinence) **P** Psychiatric disorders (primarily depression) **P** Pharmaceuticals **E** Excess Urine Output (excess fluid intake, metabolic disorders, medications or medical conditions) **R** Restricted mobility **S** Stool impaction Conservative treatments for suspected or identified UI with a reversible cause, use one or a combination of the following: • **Bladder Retraining:** Scheduled voiding urgency-control strategies, self-monitoring of voiding behavior, a trial period of no less than 6 weeks • **Pelvic Floor Muscle training (PFMT):** Also known as Kegel exercise; consider Physical Therapy referral for individuals who have trouble doing Kegel exercises; should be continued for at least 12 weeks • **Lifestyle modifications:** Weight loss, limit fluid and urinary irritants (caffeine, alcohol, or nicotine), eliminate environment factors that interfere with toileting • **Pharmacologic intervention:** Optimal treatment should be individualized, considering the patient's co-morbidities, concomitant medications and the pharmacological profiles of the different drugs. Pharmacotherapy for UI is best used as an adjuvant to conservative and/or surgical therapy. ➢ **Hormones:** Topical estrogen - for atropic urethritis and/or vaginitis in women; Desmopressin - for nocturia (care should be taken because of the risk of hypnatremia, especially in the elderly) ➢ **Antimuscarinic drugs** ➢ **Antidepressants** ➢ **Alpha-adrenoreceptor antagonists:** For men with BPH (Benign Prostatic Hypertrophy) ➢ **Phosphodiesterase 5 inhibitors:** For male LUTS (Lower Urinary Tract Symptoms) / OAB (Overactive Bladder)	Assess response to treatment within 12 weeks

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Failure of conservative treatment or for those with complex urinary incontinence	**Specialist referral**	Those who have failed conservative treatment or have complex urinary incontinence should be referred to a specialist for management. The complex UI group comprises patients with incontinence associated with: • Pain • Hematuria • Recurrent infection • Previous failed incontinence surgery • Total incontinence • Voiding dysfunction PVR > 200 (e.g. due to bladder obstruction), poor bladder emptying may be suspected from symptoms, physical exam, or if imaging has been performed by ultrasound or X-ray after voiding • Previous pelvic radiotherapy and/or radical pelvic surgery • Suspected pelvic organ abnormality (e.g. fistula, prolapsed organ, or mass)	Referral should be considered if initial treatment is unsuccessful after a reasonable period of time (e.g. 8- 12 weeks)
	Education and risk factor modification	**Educate patient/family /caregiver regarding:** • **Lifestyle changes:** Lose weight if overweight; avoid constipation as repeated straining can damage the pelvic floor; drink less fluids or stop fluid intake prior to bedtime if nocturia or enuresis is a problem; limit intake of caffeine; stop smoking; seek treatment for frequent coughing; eliminate physical barriers that interfere with toileting • **Bladder Training:** Gradually increase time intervals between urinating by controlling the urge to empty (every 3-4 hrs during the day, and every 4-8 hrs at night); should be tried for minimum of 6 weeks • **Pelvic Floor Muscle Training (PFMT)/Kegel Exercises:** Squeeze the muscles that you use to stop the flow of urine, hold up to 10 seconds, then release. Repeat 10-20 times at least 3 times a day. It may take up to 4-6 weeks to notice an improvement in symptoms, and should be continued for at least 12 weeks. • **Medications:** Medication schedule, actions, potential side effects, and any potential interactions with other medications	
This guideline is based on several sources, including: Guidelines on Urinary Incontinence, European Association of Urology, 2010; Quality Indicators for the Screening and Care of Urinary Incontinence in Vulnerable Elders, Journal American Geriatric Society, October 2007-Vol. 55, No. S2 S443-449; Basic Assessment of Urinary Incontinence, Southern Medical Journal, Vol. 95, No. 2, pp 178-182, February 2002			

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