THE MANAGEMENT GUIDELINES FOR URINARY CONTINENCE PROMOTION IN ADULTS WITHIN PRIMARY CARE

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Lincolnshire Community Health Services
The Treatment And Management Guidelines
For Urinary Continence And Promotion
In Adults Within Primary Care

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Background and Definitions of Urinary Incontinence

International Scientific Committee (2009) divides the complaint of lower urinary tract symptoms into storage and voiding symptoms. Urinary incontinence is a complaint of any voluntary leakage of urine (Abrams 2009). Urinary incontinence may be further defined according to symptoms:

♦ Urgency urinary incontinence is the complaint of involuntary leakage accompanied or immediately preceded by urgency.

♦ Stress urinary incontinence is the involuntary leakage on effort, exertion or on coughing and sneezing.

♦ Mixed Urinary incontinence is the complaint of involuntary leakage associated with urgency and also with effort, exertion, sneezing and coughing.

♦ Nocturnal enuresis is any involuntary loss of urine occurring during sleep.

♦ Post micturition dribble and continuous leakage denotes other symptomatic forms of incontinence.

♦ Overactive bladder is characterised by the storage symptoms of urgency with or without urgency incontinence.

Urodynamic diagnoses: include:

♦ Overactive Detrusor Function characterised by involuntary detrusor contractions during the filling phase, which may be spontaneous or provoked. The overactive detrusor is subdivided into:

  - Idiopathic Detrusor Over-activity, defined as bladder over activity when there is no clear cause.

  - Neurogenic Detrusor Over-activity is defined as over activity due to a relevant neurological condition.

♦ Urodynamic stress incontinence is noted during filling cystometry, and is defined as the involuntary leakage of urine during increased abdominal pressure, in the absence of a detrusor contraction

Incontinence can be a distressing and embarrassing symptom and certain groups of patients are frequently more susceptible to the physiological, psychological and pharmacological factors which may predispose an individual to develop incontinence. Although incontinence is a common condition, it is one that may be cured in around 70% of cases (RCP 1995) and significantly improved in the majority of others. However, continence problems continue to be underreported and under treated in many cases and the challenges remain to increase awareness and promotion of continence and to advance the understanding of continence problems and effective communication (Getliffe, 2009). The aim of this guidance is to standardise care and to provide an agreed framework for referral from primary and secondary care, in line with the concept of integration required by national guidance (DH, 2000; DH 2001, NICE 2013).

Prevalence Rates
The prevalence rates for urinary incontinence have been identified as:

- Urinary incontinence (UI) affects 1 in 3 women aged 18+ (35,000:100,000 women), but less than 20% are actively treated.

- Lower urinary tract symptoms (LUTS) affect 2.7% of men aged 18+ and 35% of men aged 60+.

- UI and/or faecal incontinence affect 50-80% of care home residents.

For a standard population of 250,000, assuming that around 40% are women aged 15 years or older (100,000), the average number of women requiring referral into a bladder and bowel dysfunction service would be 800 per year (0.80% of the female population).

For an average practice with a list size of 10,000, assuming that around 40% are women aged 15 years or older (4000), the average number of women requiring referral into a bladder and bowel dysfunction service would be 32 per year (0.80% of the female population).

It is envisaged that in the next 30 years the number of people over the age of 65 years shall rise considerably in the UK. The projected impact of incontinence in people over the 65 years from 2008-2033 is estimated to increase by 7% -10%. In females this figure is estimated to be a rise of between 10% - 20%. (DH; 2011; Operational Guidance to the NHS: Extending Patient Choice).
Continence Care Pathways

Introduction

The guidance has been divided into sections to take into account the complexity and causes of lower urinary tract symptoms between the varying types of Lower Urinary Tract symptoms (LUTs) due to gender, age and other comorbid conditions. The various management algorithms can be found in the Appendices.

It is important to note that no algorithm can be applied to every patient and that each patient’s management must be individualised. Each treatment pathway continence care may be delivered by any health/ social care practitioner in any setting. The initial evaluation should be undertaken, by a clinician, in every patient presenting with symptoms/signs suggestive of these conditions.

Good Practice in Continence Services (DH, 2000) suggests that all patients presenting with incontinence should be offered an initial continence assessment performed by a suitably trained healthcare professional.

Patients presenting with the following triggers should be offered an assessment:
- Do you have to go to the toilet frequently at night; i.e. more than twice?
- Do you have to go to the toilet frequently during the day? I.e. more than 6-7 times per day?
- Do you have to rush to the toilet?
- Do you leak urine at any time?
- How often do you have your bowels open (Use Bristol stool chart to ascertain stool consistency)?
- Do you have accidents with your bowel at any time?
- Do you have to take laxatives?

(National Audit of Continence Care 2010)

History and General Assessment

Management of a symptom such as incontinence requires caregivers to assess the sufferer in a holistic manner. Many factors may influence a particular individual’s symptoms; some may cause incontinence, and may influence the choice and the success of treatment.

To assist with a nursing diagnosis the following components of the medical histories are particularly emphasized:
- The severity, duration, and bother of any urinary, bowel or prolapse symptoms;
- Identifying symptoms in the related organ systems;
- Effect of any symptoms on sexual function and quality of life questionnaire;
- Presence and severity of symptoms suggesting neurological disease;
- Past medical History for example previous conservative, medical and surgical treatment, in particular, those that affects the genitourinary tract and lower bowel;
- Patient medication: it is always important to review every patient’s medication and to assess as to whether current treatment may be contributing to the patient’s condition. For
example alpha–adrenergic antagonists may decrease sphincter tone causing stress incontinence in women (Dwyer and Teele 1999); hypnotics may cause drowsiness and confusion, immobility and eventually incontinence (Button et al 1999 and Nazarko 2002); diuretic therapy may cause urgency and medications influencing bladder dysfunction including antimuscarinics, anti-Parkinsonians drugs, antidepressants and antispasmodics may cause urinary retention (Button et al 1999);

- Obstetric and Menstrual History; the number and type of deliveries and their outcome would normally be documented. The menstrual history and menopausal status should be determined, and enquiry made into symptoms of utero-vaginal prolapse. The woman’s sexual function and her expectations from this point of view should also be considered;

- Physical impairment: individuals who have compromised mobility, dexterity, or visual acuity may need to be managed differently;

- Social history to assess the impact of bladder/ bowel dysfunction;

- Environmental issues to include social, cultural and physical environment;

- Lifestyle including exercise, smoking and the amount and type of foods and fluid intake;

- Cognitive function: For example, cognitive function testing for individuals for whom the clinician has concerns regarding memory deficits and/or inattention/confusion, and depression screening for individuals for whom the clinician has concerns about abnormal affect.

Physical Examination

The more complicated the history and the more extensive and/or invasive the proposed therapy, the more complete the examination needs to be. However, to reach a diagnosis it is important to perform some objective tests and these are usually done in partnership with the patient’s registered Medical Practitioner. The following components of the assessment are required:

Nursing Assessment

- General Status: Mental status; Obesity (BMI); Physical dexterity and mobility issues, mandatory holistic assessment.

- Urinalysis: Exclude red flags such as nonvisible haematuria and symptomatic urinary tract infection.

- The use of a simple frequency volume chart or bladder diary is highly recommended to document the frequency of voiding, the volumes of urine voided, incontinence episodes and the use of incontinence pads. Determination of fluid ingested may determine a high intake of irritants such as caffeine/alcohol.

- Standard biochemical tests for renal function are recommended in patients with urinary incontinence and a probability of renal impairment.

- Post void residual Volume (PVR) in patients with suspected voiding dysfunction, PVR should be part of the initial assessment if the result is likely to influence management, for example, in neurological patients. If chronic retention of urine is not detected, serious
and painful complications may occur, including recurrent infection and /or hydronephrosis, which may lead to renal failure (Chiodo 2002).

Acute urinary retention may be defined as complete and painful inability to empty bladder less than 800mls (Brewster 2001)

Acute on chronic urinary retention is usually defined as the complete and painful inability to empty the bladder and is usually a volume of more than 800mls (Brewster et al 2001). Differentiation is also made between high pressure and low pressure acute-on-chronic retention.

High pressure acute-on-chronic retention is characterised by hydronephrosis and elevated serum creatinine of more than 150umol/L. Therefore it is important that U/Es and Creatinine levels are checked and discussed with GP re: next steps in management plan.

Low pressure chronic retention is characterised by no evidence of hydronephrosis as identified by ultrasound scan of kidneys, ureters and bladder (Wareing 2003).

Chronic retention is when patients can void but leave a post void residual of more than 500ml of urine.

Following relief of urinary obstruction, period of significant polyuria may occur. This is a normal physiologic response and known as post obstructive diuresis. This response is due to the volume expansion and solute accumulation occurring during the obstruction. With the return of homeostasis, the period of diuresis ends (Campbell-Walsh 2007).

The majority of patients do not demonstrate a clinically significant post obstructive diuresis following relief of urinary tract obstruction. However, a pathologic post obstructive diuresis may occur. This is characterised by inappropriate renal handling of water or solutes or both, and urine outputs of 200ml/hour or greater may occur. Those susceptible to this phenomenon may have signs of fluid overload, oedema, congestive cardiac failure or hypertension (Campbell-Walsh 2007). This is considered an acute medical condition requiring medical management and hospitalisation (Sullivan 2010).

Patients in acute retention should be referred to Accident and Emergency department for treatment.

Patients presenting with chronic urinary retention require a urology referral to diagnose the correct categorisation of urinary retention; this will determine onward management and subsequent treatment (Wareing 2003; refer to Appendicies 8 and 9).

- Pad testing is an optional test for the routine evaluation of fluid balance / treatment evaluation over a 24 hour period.
- Digital rectal examination to exclude faecal impaction, assess for rectal sensation, stool consistency and, external anal sphincter muscle tone.
- Examination of the perineum and external genitalia. Observation and or palpation of a pelvic floor contraction enables the healthcare professional to assess whether or not the patient is able to perform a correct pelvic floor contraction.

GP Assessment
Vaginal & Bimanual pelvic examination to assess for pelvic mass, vaginal atrophy and prolapse.

- Abdominal/flank examination for masses, bladder distension, relevant surgical scars.
- Digital rectal examination to assess prostate size.
- Neurological examination.

**Treatment and Planning Issues**

It is important to ascertain the patient’s desire for treatment and the extent of treatment that is acceptable. Patients with lower urinary tract symptoms should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.

The following should be ascertained:

- Patient goals and expectations of treatment.
- Patient support systems (including carers).
- Quality of life questionnaires for example ICIQ questionnaire, Cleveland tool, International Prostate Symptom score; may be required to support treatment outcomes.
- If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines. ‘Reference guide to consent for examination or treatment’ (DH, 2001 & 2005).

**Care Pathways**

The first International Consultation on Incontinence (ICI) in 1998 developed recommendations for assessment and treatment of incontinence based on the review of evidence and the consensus of international experts. As an outflow of this process, recommendations for the management of incontinence were developed and presented in a specific format/flow sheets called algorithms. These algorithms had recommendations for initial management and specialised management of urinary incontinence.

However for the purpose of this guidance the emphasis is mainly for conservative primary care treatments and thus the initial management algorithms are used. The specialist guidelines have been listed as part of the appendices to signpost patients along the integrated care pathway.
**Initial Management of Urinary Incontinence in Women**

Urinary incontinence (UI) is a common symptom that can affect women of all ages, with a wide range of severity and nature.

**Assessment and Investigation**

At the initial clinical assessment, the woman’s UI should be categorised as stress UI, mixed UI or urge UI/ Overactive Bladder Syndrome (OAB). Initial treatment should be started on this basis. In mixed UI treatment should be directed towards the predominant symptom.

**Conservative Management**

- A trial of supervised pelvic floor muscle training of at least 3 months should be offered as a first line treatment to women with stress or mixed UI. Pelvic floor muscle training programmes should comprise at least 8 contractions performed 3 times per day. Continue an exercise programme if pelvic floor muscle training is beneficial.

- Bladder retraining for at least 6 weeks should be offered as the first line treatment to women with urge or mixed UI.

- Recommend a trial of caffeine reduction to women with OAB. Consider advising modification of high or low fluid intake in women with UI or OAB.

- Pelvic floor muscle training should be offered to women in their first pregnancy as a preventative strategy for UI.

- Prompted voiding or scheduled voiding may be useful if the woman has cognitive difficulties.

- Constipation and defecation problems should be identified and treated to alleviate bladder over activity, incomplete bladder emptying and weakening of the pelvic floor muscles.

- Advise women with UI or OAB who have a BMI greater than 30 to lose weight.

- Immediate release, non-proprietary Oxybutynin should be offered to women with OAB or mixed UI as a first line treatment is bladder retraining is ineffective. If immediate release oxybutynin is not well tolerated then other formulations in accordance with LCHS formulary should be considered. Women should be counselled about the adverse effects of antimuscarinic treatment.

- The use of desmopressin may be considered specifically to reduce nocturia in women with UI or OAB who find it a troublesome symptom. Use particular caution in women with cystic fibrosis and avoid in those over 65 years with cardiovascular disease or hypertension.

- Do not use duloxetine as a first-line treatment for women with predominant stress UI. Although it may be offered as second-line therapy if women prefer pharmacological to surgical treatment or are not suitable for surgical treatment. If duloxetine is prescribed, women should be counselled about its adverse effects.
• Offer intra-vaginal oestrogens for the treatment of OAB symptoms in postmenopausal women with vaginal atrophy.

• Refer women who are found to have a palpable bladder on bimanual or abdominal examination after voiding to a specialist.

The full details of initial management of urinary incontinence in women may be found within www.nice.org.uk/guidance/CG171/FullGuidance.
Initial Management of Urinary Incontinence in Men

Lower urinary tract symptoms (LUTS) in men comprise storage, voiding and post-micturition symptoms affecting the lower urinary tract. There are many possible causes of LUTS such as abnormalities or abnormal function of the prostate, urethra, bladder or sphincters. In men, the most common cause is benign prostate enlargement (BPE), which obstructs the bladder outlet. BPE happens when the number of cells in the prostate increases, a condition called benign prostatic hyperplasia. Other conditions that can cause LUTS include detrusor muscle weakness or bladder over activity, prostate inflammation (prostatitis), urinary tract infection, prostate cancer and neurological disease.

LUTS are a major burden for the ageing male population. Age is an important risk factor for LUTS and the prevalence of LUTS increases as men get older. Bothersome LUTS can occur in up to 30% of men older than 65 years.

Assessment and Investigation

- At initial assessment the LUTs in men should be categorised into voiding, storage or post-micturition symptoms to help define the source of the problem.
  - Voiding symptoms include weak or intermittent urinary stream, straining, hesitancy, terminal dribbling and incomplete emptying.
  - Storage symptoms include urgency, frequency, urgency incontinence and nocturia.
- In order to make a provisional diagnosis, men with lower urinary tract symptoms (LUTS) should be offered a full physical examination, including a digital rectal examination, as part of their initial assessment. This should be done in partnership with the GP.

Storage LUTS

- It is important to make sure that men with LUTS have access to care that can help with: their emotional and physical conditions and relevant physical, emotional, psychological, sexual and social issues.
- A trial of supervised bladder training, pelvic floor exercises, advice on fluid intake, lifestyle advice should be given to men with symptoms suggestive of overactive bladder (OAB).
- Scheduled or prompted toileting may be offered to men who are unable to independently use the toilet due to cognitive difficulties.
- NICE (DH, 2010) suggests an alpha blocker such as Alfuzosin, Doxazosin, Tamsulosin or Terazosin to men with moderate to severe LUTS as first line treatment. A medication review should be undertaken every 4-6 weeks and then 6-12 months. This may be followed by a combination with an anticholinergic in men with storage symptoms such as OAB syndrome.
- Men with overactive bladder symptoms may be offered anticholinergic medication and should be reviewed every 4-6 weeks until symptoms are stable and then every 6-12 months. Post void residual urinary volumes should be less than 100ml.
Supervised pelvic floor muscle training should be given to men with stress urinary incontinence caused by prostatectomy and these should be continued for 3 months before referral to a Specialist Nurse.

Consider permanent use of containment products for men with storage LUTS (particularly urinary incontinence) only after assessment and exclusion of other methods of management.

Voiding LUTS

Voiding LUTS cannot be used to make a definitive diagnosis. At the initial assessment it is therefore, important to follow the most appropriate pathway if incomplete bladder emptying is suspected. This may be onward referral to Urology. Please refer to the LCHS male abnormality pathway.

Men with voiding symptoms may be offered surgery only if voiding symptoms are severe or if drug treatment and conservative management have been unsuccessful or are not appropriate.

Drug treatment includes the use of alpha blockers, 5-reductase inhibitors or a combination of both medications (NICE Clinical Guideline 97, 2010).

Treating acute urinary retention: Men with symptoms of acute retention of urine should be referred to secondary care for immediate catheterisation and to access urological referral. If a man is catheterised in hospital then an alpha blocker should be considered for managing acute urinary retention before removal of the catheter.

Treating chronic urinary retention: Refer to the Abnormality Algorithm in Males, Appendix 9: Patients should be referred to secondary care for further investigations.

Carry out a serum creatinine test and imaging of the upper urinary tract in men with chronic urinary retention (residual volume greater than 1 litre or presence of a palpable/percussable bladder.

Post Micturition Dribble

Men with lower urinary tract symptoms (LUTS) who have post-micturition dribble should be given information about how to exert a strong contraction after voiding or to manually compress the bulbar urethra directly after micturition (Thuroff et al 2011).

For further information download www.nice.org.uk/guidance/CG97/FullGuidance.
Initial Management of Neuropathic Urinary Incontinence

Continence problems are common in people with neurological disability. The type of bladder disorder which occurs due to the neurological damage depends on which area of the nervous system—brain and sphincter—is affected (Getliffe 2009). Neural control of the lower urinary tract is complex, but the main functions are limited to storage and voiding, with reciprocal association of the higher centres and spinal pathways. The key pathophysiological consequences of neural lesions are outlined in tables 1 and 2 taken from the NICE guidance (2012).

**Table 1 Lower Urinary Tract Dysfunction That Can Be Seen With Damage at Different Levels Within The Nervous System**

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<th>Bladder function</th>
<th>Sphincter function</th>
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<td>Suprasacral spinal cord conditions</td>
<td>Overactive (neurogenic detrusor over-activity)</td>
<td>Uncoordinated with bladder function in some cases (detrusor sphincter dyssynergia).</td>
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<tr>
<td>Sacral spinal cord or peripheral nerve conditions</td>
<td>Underactive. Impaired bladder compliance in some cases</td>
<td>Underactive</td>
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Note: The table provides an overview of typical patterns of neurogenic lower urinary tract dysfunction. Individual patients will exhibit a pattern of dysfunction which is dependent on the site and severity of the neurological damage. The effect of neurological damage on urinary tract sensation is variable; sensation may be absent (e.g. in complete spinal cord injury), impaired or preserved.

It is also possible to distinguish between conditions that produce a fixed or stable insult to the nervous system (for example stroke, spinal cord injury and cauda equina compression) and those that produce progressive damage through processes that might be inflammatory or degenerative. Examples of progressive conditions include the dementias, Parkinson's disease, multiple sclerosis and peripheral neuropathy (see Table 2).
Table 2 Examples Of Neurological Conditions Which Affect The Spinal Cord

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<th>Congenital and prenatal lesions</th>
<th>Acquired stable conditions</th>
<th>Acquired progressive or degenerative conditions</th>
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<tr>
<td>Brain conditions</td>
<td>Cerebral palsy</td>
<td>Stroke</td>
<td>Multiple sclerosis</td>
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<td>Head injury</td>
<td>Parkinson’s disease</td>
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<tr>
<td>Supra sacral spinal cord</td>
<td>S Spinal dysraphism (e.g. myelomeningocele)</td>
<td>Spinal cord injury</td>
<td>Dementias</td>
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<td></td>
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<td>Multiple sclerosis</td>
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<td>Sacral spinal cord or peripheral nerves</td>
<td>Spinal dysraphism (e.g. myelomeningocele)</td>
<td>Cauda equina syndrome</td>
<td>Cervical spondylosis with myelopathy</td>
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<td>Sacral agenesis</td>
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<td>Peripheral neuropathy</td>
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<td>Ano-rectal anomalies</td>
<td>Peripheral nerve injury</td>
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Given that such a wide range of neurological conditions can impact on the function of the LUT, it is not surprising that the subsequent urinary dysfunction is variable. Some patients with neurogenic lower urinary tract dysfunction (NLUTD) experience symptoms which relate to impaired urine storage, such as increased frequency of micturition (by day and/or night), urinary urgency and urinary incontinence. Bladder emptying will be a problem for other individuals; voiding symptoms include hesitancy, a slow urinary stream, the need to strain and urinary retention. Storage and voiding problems may also arise simultaneously.

Assessment and Investigation

The precise type of bladder disorder which occurs due to neurological damage depends on which area of the central nervous system is affected. Hence assessment needs to answer two questions:

- Is there a failure of bladder storage (Neurogenic bladder over activity)?
- Is there a failure of the bladder to empty?
1. When assessing lower urinary tract dysfunction in a person with neurological disease, take a clinical history, including information about:

- Urinary tract symptoms.
- Neurological symptoms and diagnosis (if known).
- Clinical course of the neurological disease.
- Bowel symptoms.
- Sexual function.
- Comorbidities.
- Use of prescription and other medication and therapies.

A detailed history is important and the healthcare professional must be aware that people with neurological conditions may have non-neurological cause for their bladder and bowel symptoms. This is often performed under the direction of a multidisciplinary team.

2. Measurement of the post void urinary residual. Repeated measurements of post void residual volumes of over 100mls may be clinically significant and interventions to improve bladder emptying are usually required (Haslam 2009).

3. Urinalysis to exclude red flags and screen for urinary tract infection. If the dipstick test result and person’s symptoms suggest an infection, arrange a urine bacterial culture and antibiotic sensitivity test before starting antibiotic treatment. Treatment need not be delayed but may be adapted when results are available. Urinary tract infections may exacerbate incontinence, cause symptoms of malaise and may progress to involve the upper urinary tract with possible loss of renal function. In the population with neurological diseases such as multiple sclerosis, Parkinson’s disease and dementia, the rise in temperature with urinary tract infections can cause deterioration in neurological function and even a relapse of multiple sclerosis. There are therefore numerous reasons why people with neurogenic lower urinary tract dysfunction should avoid urinary tract infections.

4. Refer people for urgent investigation if they have any of the following 'red flag' signs and symptoms:

- Haematuria
- Recurrent urinary tract infections (for example, three or more infections in the last 6 months) Recurrent urinary tract infections in people with neurogenic bladder dysfunction are a cause of considerable morbidity. The causes for the high prevalence of urinary tract infections in such people include loss of physiological bladder function and high intra-vesical pressures.
- Loin pain
- Recurrent catheter blockages (for example, catheters blocking within 6 weeks of being changed) -hydronephrosis or kidney stones on imaging – biochemical evidence of renal deterioration.

5. Use of bladder diary to identify the frequency of passing urine and episodes of incontinence. Charting is invaluable to identify the frequency of passing urine or incontinent episodes. If the patient is unable to record a chart due to cognitive impairment or upper limb disability, then carers may need to be involved to assist with charting. Carers may be able to check pads hourly in the day for up to 3 days to record this information.

6. Observations: Disabilities due to neurological cause often has a severe effect on toileting.
which may be a critical factor in losing or gaining continence (Getlliffe, 2009). The extent and nature of disabilities are also likely to affect the implementation or success of management strategies.

7. Referral to Urology services for urodynamic and flexible cystoscopy may be required. This is especially important for patients with neuropathic bladder dysfunction who present with new onset incontinence or change to continence pattern or to voiding pattern suggesting poor bladder compliance. Video-urodynamic investigations should be done to people who are known to have high risk of renal complications (such as those with spina bifida, spinal cord injury and those with anorectal abnormalities). NICE (2012) does not recommend routine urodynamic studies to be given routinely to people with low risk of renal complications e.g. those presenting with MS.

**Management Options**

The general principles for management are as follows:

- **Protection of the upper urinary tracts and preservation of renal function** This is especially the case for patients presenting with static neurological diseases such as cerebral palsy, spinal injury and spina bifida;

- **To improve symptom control**, this is especially so for those patients presenting with more progressive disease and experiencing neurogenic bladder over-activity such as multiple sclerosis and Parkinson's disease;

- **Tailor management in respect to medical/ functional status in conjunction with patient expectations**

- **Management should be individualised to meet the patient’s needs to include environmental assessment with aid of physiotherapist and or occupational therapist**
Treatment Strategies for Neurogenic Detrusor Over activity (failure of bladder storage)

1. Consider a behavioural management programme (for example, timed voiding, bladder retraining or habit retraining) for people with neurogenic lower urinary tract dysfunction and in conjunction with education about lower urinary tract function for the person and/or their family members and carers.

2. When choosing a behavioural management programme, take into account that prompted voiding and habit retraining are particularly suitable for people with cognitive impairment.

3. Oral medication: Consider Antimuscarinic drug treatment in people with: conditions affecting the brain (for example, cerebral palsy, head injury or stroke) and symptoms of an overactive bladder and in people with urodynamic investigations showing impaired bladder storage. Monitor residual urine volume in people who are not using intermittent or indwelling catheterisation after starting antimuscarinic treatment. (NICE 2012). When prescribing antimuscarinics take into account that: antimuscarinics known to cross the blood-brain barrier (for example, oxybutynin) have the potential to cause central nervous system-related side effects (such as confusion) antimuscarinic treatment can reduce bladder emptying, which may increase the risk of urinary tract infections.

4. Other treatments include Botulinum A toxin, sacral nerve stimulation, surgical options such as augmentation cystoplasty – see Specialist algorithm for treatment options.

5. Pelvic floor muscle training should be offered to patients with lower urinary tract dysfunction due to MS, CVA or other neurological conditions where there is the potential of voluntary contract of the pelvic floor is preserved.

6. Offer people with neurogenic urinary tract dysfunction, their family members and carer’s specific access to a range of products that meet their needs to include sheaths, urinals or pads.

Treatment Strategies for Voiding Dysfunction

The range of bladder management strategies available to manage lower urinary tract dysfunction in neurological disease includes permanent urethral catheterisation and suprapubic catheterisation, intermittent self-catheterisation, penile sheath collection systems and pads.

1. Bladder management strategies are a long-term treatment with implications for maintaining health and quality of life.

2. Intermittent catheterisation: Clean intermittent catheterisation has been the preferred method of drainage for people with neurogenic voiding problems. Intermittent catheterisation has the potential to significantly improve continence and reduce the likelihood of upper tract problems. Some patients may be unable to catheterise themselves, but with consent of the patient, the procedure may be carried out by a caregiver (Getliffe 2009).

3. Long-term catheterisation: It is important that long-term catheterisation is not perceived as failure. With the common catheter-associated problems and the potential for urethral
trauma, supra pubic catheters are becoming more widely used and offer substantial advantages over urethral catheters. Catheters may be used with or without catheter valves (Haslam, 2009).

4. People who are judged to be at high risk of renal complications (for example, consider surveillance ultrasound scanning at annual or 2 yearly intervals) should be offered lifelong surveillance of the kidneys. Those at high risk include people with spinal cord injury or spina bifida and those with adverse features on urodynamic investigations such as impaired bladder compliance, detrusor-sphincter dyssynergia or vesico-ureteric reflux.

5. In order to make informed choices about the most appropriate method of bladder management, patients and/or their family members and carers require information about the risks and benefits of the available options. There is currently little evidence about which methods are most likely to produce long-term complications (renal impairment, urinary stones and infections, hydronephrosis, bladder malignancy).

6. Patients with complex multi-disciplinary needs may require follow-up within a specialist team (e.g. in a neuro-rehabilitation unit or urology department).

For further information download www.nice.org.uk/guidance/CG148/FullGuidance
Initial Management of Urinary Incontinence in Frail Older Persons

Healthy older people should be offered the treatment options similar to younger persons. Frail older persons require a different approach and so the assessment must address the impact of comorbidity, current medications, functional/cognitive impairment in the causation of urinary incontinence (2009; 4th International Consultation on Incontinence).

Intervention in the frail older person should consider the degree of bother to them or the caregivers, their goals of care, the level of cooperation and the overall prognosis and life expectancy.

Although there does not appear to be a clear definition on what factors would constitute frailty. Becoming frail may be a clinical syndrome compounded by comorbid medical illnesses, neurological and psychiatric conditions, functional impairment and environmental issues. Inability to compensate for these factors can lead to urinary and faecal incontinence referral.

Moreover, a key consideration is whether or not incontinence may be cured in this group. Fonda et al (2005) suggest that while it may depend on the types of treatment and the aim of that treatment; cure is doubtful for particularly frail patients. They emphasise that quality of life is a fundamental issue and that incontinence which cannot be cured may still be open to improvement.

Common conditions affecting the lower urinary tract and the bowel in the frail elder are detrusor hyperactivity with impaired contractility (DHIC), nocturia, urinary tract infections and constipation. DHIC may present with an elevated post void residual in the absence of outlet obstruction, patient will also have symptoms of frequency, urgency and nocturia.

The most common types of urinary incontinence are urge urinary incontinence, stress urinary incontinence and mixed urinary incontinence (ICI 2009).

Assessment and Investigations

1. History should identify co-morbid conditions and medications likely to cause or worsen urinary incontinence. The mnemonic DIAPPERS (Delirium, Infection, Atrophic Vaginitis, Pharmaceuticals, Psychological conditions, excess urine output, reduced mobility, stool impaction) includes some comorbid conditions and factors to be considered. However, two alterations from the original mnemonic should be noted; Atrophic vaginitis does not cause urinary incontinence and the current consensus criteria for the diagnosis of urinary tract infections are both poorly sensitive and non-specific (ICI,2009).

2. If a urinary tract infection is suspected, the clinical condition of the patient should be fully assessed to include the search for other diagnosis and new symptoms localised to the urinary tract. Loeb et al 2001, recommend a set of criteria for antibiotic treatment for urinary tract infection. They recommend that treatment with antimicrobials only for those patients who present with acute dysuria alone or fever (> 37.9° C) and at least one of the following:

   ♦ New or worsening urgency.
   ♦ Frequency.
Suprapubic pain.
- Macroscopic haematuria.
- Costovertebral angle tenderness.
- Urinary incontinence.

3. A bladder diary (frequency and volume chart) may be useful in the evaluation of patients with nocturia. For frail older people with nocturia, assessment should focus on identifying the potential underlying causes including nocturnal polyuria, a primary sleep problem including sleep apnoea and conditions resulting in low voided volumes for example overactive bladder or elevated post void residuals.

4. Measuring post void residual volume may be useful in frail older people with diabetes; those with prior episodes of urinary retention; or those with a history of high PVR; recurrent urinary tract infections; medications that impair bladder emptying, chronic constipation, persistent or worsening urinary incontinence despite treatment with anticholinergics (ICI, 2009).

5. Functional assessment is required to assess mobility, transfers, manual dexterity and ability to successfully toilet.

6. Screening test for depression and cognitive assessment to assist in planning management may also be required.

**Urinary Incontinence and Dementia**

A number of cognitive skills are required for successful independent toileting. These are:

- Being able to recognise the need to use the toilet;
- Being motivated to use the toilet;
- Ability to identify the appropriate place;
- Ability to locate the appropriate place;
- Having the physical ability to get to the toilet;
- Holding on until an appropriate place is reached
- Being able to sustain goal-orientated behaviour;
- Being able to adjust clothing and use the toilet (Robinson 2000).

Gathering information from the person may be difficult, although this should not be a barrier to a thorough assessment. Carers or the family members may be involved to gain information in these circumstances.

The persons’ incontinence could simply be due to difficulty getting to the toilet and with some help and supervision, the problem may be resolved. Observing the persons’ behaviour e.g. restlessness, agitation, pulling clothing, may be a good indicator of when they need the toilet (Eustice 2009).
Treatment/ Management Options

Developing a care plan for a frail patient requires an attitude and approach that recognises the particular characteristics and uniqueness of this group. By implementing treatment or management strategies which focus on achievable targets should help the avoidance of dealing with the additional complexity of incontinence in the frail person.

1. Initial management should be individualised and influenced by goals of care and treatment preferences. In some patients it may be recognised that contained urinary incontinence may be the only possible outcome for urinary incontinence that persists after the treatment of contributing comorbidity and other factors. Treatment is a matter for discussion and joint decision making between the patient and his health care professional. Inter-professional working is fundamental in achieving better outcomes in managing the complexity and multifactorial nature of frail elder care.

2. Conservative and behavioural therapies for urinary incontinence include lifestyle changes and bladder retraining for fit alert patients.

3. Strategies to promote continence may include habit retraining, timed voiding and prompted toileting may be an option for frail cognitively impaired people. Habit training involves the implementation of a toilet schedule based on an individual's bladder diary thus avoiding wet episodes. Timed toileting is based on fixed intervals to establish voiding pattern, for example every 2-3 hours (Eustice, 2009).

4. Asymptomatic bacteriuria is also common and the treatment of asymptomatic bacteriuria / pyuria may cause harm by increasing the risk of adverse effects such as clostridium difficile, colitis and antibiotic resistance (ICS 2009). Treatment of symptomatic bacteriuria is appropriate whereas asymptomatic bacteriuria is not.

Treatment of coexisting conditions and (constipation) and stopping anticholinergic drugs may reduce PVR. Intermittent catheterisation may also be considered to reduce urinary symptoms.
Community Integrated Continence Standards

LCHS Trust Continence service promotes an integrated approach to community continence services to capture the varying needs of the population (DH, 2000). The Community Continence Service objectives are:

- Provision of improved access to services closer to home;
- Provision of a nurse led two tiered community based model, with appropriate assessment and investigation, thereby reducing inappropriate/unnecessary referral to secondary care;
- Reduction of waiting times for to access the service by the utilisation of an integrated approach;
- Delivery of treatments enabling patients to reach their individual treatments goals sooner such as improved quality of life;
- Delivery of clinically effective treatments, reducing the demand on secondary care services and the need for more costly interventions;
- Provision of continence care which have a strong emphasis on patient education and self-management, thereby promoting active, healthy lifestyles and reducing recurrence of bladder/bowel dysfunction;
- Reduction of unnecessary treatment and inappropriate reliance on products for the containment of urinary/faecal incontinence.
- Provision of the best possible outcomes for women, men and their carers through identification and intervention, resulting in alleviation of symptoms and/or cure;
- Reduction in the risk of catheter associated urinary tract infections, by providing access for routine catheter changes;
- Continual service improvement and innovation;
- Provision of robust training programme to fulfil integrated continence service objectives;
- Provision of Link champion scheme;
- Participation with local audit and research programmes;
- Liaison with specialist services such as spinal injury units and secondary, tertiary care centres;
- Resource for the wider community teams;
- Patient engagement;
- Interdependence with other services for example access to multidisciplinary meetings with local urological, urogynaecological and gastrointestinal services.
Referral Process for Accessing Level 1 and Level 2 Continence Care

There are 2 ways to refer into the service; Health care professional referral and patient self-referral (direct access).

The service is accessible for Adults, 18 years and over registered with a Lincolnshire GP practice. Continence care will be delivered from centres as close to home as possible. Level 1 and Level 2 care pathways will be held at clinics as much as possible, but domiciliary care is provided for house bound patients. The integrated community continence service within LCHS NHS Trust offers two levels of continence care dependent upon the patient needs; thus patients benefiting from basic lifestyle changes to promote continence or those with intractable incontinence requiring management strategies will be triaged towards Level 1 Care Pathway. Patients requiring treatment care pathways requiring a complexity of continence treatments will be offered Specialist Nurse, Level 2 pathways.

If a nursing home referral is reviewed at triage and it is deemed appropriate and clinically indicated to be seen within the service it would be directed to Level 2 care pathway

Exclusion Criteria for Females

- Haematuria (frank, microscopic or Dipstick)
- Suspected gynaecological malignancy
- Palpable bladder
- Abdominal or pelvic mass
- Recurrent UTI – more than 4 in 12 months of unknown cause
- Neuropathic bladder (of unknown cause)
- Recent Gynae/urological surgery
- Suspected fistula
- Previous Pelvic irradiation
- Incontinence associated with pain

Exclusion Criteria for Males

- Men under 50 years particularly with irritative lower UTI symptoms who must be referred to secondary care.
- Haematuria (frank microscopic or dipstick).
- Elevated age- adjusted PSA (prostate specific antigen).
◆ UTI/ Prostatitis.

◆ Raised creatinine.

◆ Palpable bladder or abdominal/pelvic mass.

◆ Neuropathic bladder of unknown cause.

◆ Previous urological surgery excluding circumcision and benign scrotal lumps.

◆ Rapid onset of symptoms (less than 4 months).

◆ Digital Rectal Examination (DRE) suspicious of prostate malignancy (NB: Patients attending found to have a first degree relative who has had prostate cancer must be counselled appropriately regarding the advisability of reporting for annual PSA testing / Digital Rectal Examination (DRE)).

**Bowel Exclusions**

◆ Unexplained change in bowel habit.

◆ Black tarry stool and not taking ferrous sulphate.

◆ Undiagnosed or unexplained bleeding from the rectum.

◆ Signs of obstruction.
Lincolnshire Community Health Services Community Response Schedule

The Lincolnshire Community Health Services Community Response Schedule is a framework of documents providing treatments offered in respect to response times and skill mix for each urological or bowel task. There is also a local clinical decision making tool called the Continence Assessment Tool (CAST) to facilitate triage process onwards the most appropriate health care professional. Thus the system may be summarised as follows:

Level 1 Care

- Holistic needs assessment to include mandatory testing to include Waterlow score, MUST and Moving and Handling assessments;
- Referral to GP for appropriate examination for example pelvic examination in women, digital rectal examination in men and neurological examination;
- Assessment to include continence history;
- Interpretation of bladder record chart;
- Urinalysis;
- Portable bladder scan Investigation;
- Exclusion of constipation to include digital rectal examination;
- Examination of perinea and genitalia;
- Initiation of treatments and development of management plan;
- Health promotion and lifestyle advice, information of leaflets and self-care booklets;
- Triage patient using CAST tool or refer to other services as appropriate;
- Prescription for containment products/medication;
- Patients deemed untreatable will be assessed and provided with mechanism for daily pads (disposable/reusable containment products);
- Decision regarding follow up;
- Communication to GP after first consultation;
Level 2 Care

As above plus:

- Pelvic floor muscle examinations and rehabilitation;
- Portable uroflowmetry as appropriate;
- Assistance with complex continence care plans/joint visits
- Clinical Nurse Specialist (Continence) Referral forms are available. Completion of the appropriate referral forms will facilitate triage to the most appropriate assessment and treatment pathway.

Thus appointment decision for either Level 1 or 2 will be based on the triage assessment, undertaken by a senior/specialist clinician in continence care of clinical indicators / CAST tool and complexity of presenting symptoms. The CAST tool is provided in the Appendices.
Service Pathway – Diagrammatic

Referral to service

Paper Triage by Clinician

Clinically appropriate Consultant Specialist within secondary care

Q of L and symptom profile Questionnaire sent out (support to complete must be available)

Level 1 Appointment With or without investigation

Level 2 Appointment with or without investigation

Management plan/personalised care planning

Follow up plan to meet individual need

Specialist Nurse

Clinically appropriate Consultant Specialist within secondary care via GP

Discharge

Follow up plan to meet individual need

Specialist Nurse

Discharge
Assessment Process

On receipt of a referral and if appropriate, patients will be sent a bladder and bowel questionnaire either a 3 day frequency and volume chart and or a 14 day bowel diary. Alternatively a carer’s assessment tool is available as required for patients unable to complete the symptom profile. Both assessment tools are available on the SystmOne clinical letter templates. Patients attending the CNS clinics will be sent an invitation to attend appointments and will be able to choose the most appropriate clinic venue. All patients will be asked to bring the completed bladder and bowel questionnaires to their initial assessment. This supports shared decision making and facilitates diagnostic capability at the first appointment. Following assessment, patients will be managed on the most appropriate clinical pathway. Treatments allied to most appropriate continence pathway may include:

- Intermittent self-catheterisation for patients in whom persistent urinary retention or lower urinary tract symptoms exist
- Bladder drill/ bladder retraining
- Drug treatment if bladder training is ineffective
- Lifestyle interventions.
- Pelvic floor muscle training
- Catheterised patient pathways for catheter reinsertion and ongoing care
- Rectal irrigation (complex bowel management for spinal injury, multiple sclerosis)
- Medication review and feedback to the GP if prescribed treatment is the cause of bladder and or bowel dysfunction;
- Level 1 Continence pad review – 6 monthly – 12 monthly. Patients will remain on the inactive caseload following completed successful review and reappointment 6 monthly onto caseload.

Discharge from the Service/ Long Term Monitoring

Patients should be discharged from the service when the desired clinical outcomes have been reached and/or it is deemed that a patient could derive no further benefit from continuing the course of treatment. Patients requiring long term management should be kept on the caseload but their record are recorded on as “inactive” until the next review date. Upon discharge patients are to be provided with a mutually agreed, appropriate management and treatment plan specific to their needs.
**Did Not Attend (DNA)**

If a patient fails to attend a Level 2 appointment (DNAs) the patient will be contacted by a further invitation to attend an appointment. If the patient fails to react to the invitation after 4 weeks or if the patient DNAs a further appointment, then they will be discharged from the service. A letter will be sent to the referrer informing them of the situation. Patients who do not attend (DNA) their appointment on more than two occasions will be discharged from the service and their GP informed.
References


Department of Health (2011) Operational Guidance to NHS Extending Patient Choice


Department of Health (2001c) Good Practice in consent implementation guide: consent to examination or treatment. London: Department of Health


NICE (2012) Urinary Incontinence in Neurological disease: Management of Lower Urinary


National Audit of Continence Care (2010) Royal College of Physicians :https://www.rcplondon.ac.uk/resources/national-audit-continence-care


Appendices

Appendix 1 – Initial Management of Urinary Incontinence in Women

Initial Management of Urinary Incontinence in Women

- History
- Clinical Assessment
- Presumed Diagnosis
- Management

Appendix 1

HISTORY

- Subject to local guidance (see black box warning)

CLINICAL ASSESSMENT

- If other abnormality found, e.g., significant post void residual, significant pelvic organ prolapse, pelvic mass

PRESUMED DIAGNOSIS

- OAB-w/ or w/o urgency, incontinence
- OAB-w/ urgency, incontinence
- Mixed incontinence
- Stress incontinence, presumed due to sphincter incompetence

MANAGEMENT

- Life style interventions, pelvic floor muscle training for SUI or OAB
- Bladder retraining for OAB
- Dilatation (SUI), anticholinergic (OAB or urgency incontinence)
- Vaginal devices, such as electrical stimulation inserts
- Failure

SPECIALIZED MANAGEMENT

researcher.

Appendices

Appendix 1 – Initial Management of Urinary Incontinence in Women

Initial Management of Urinary Incontinence in Women

- History
- Clinical Assessment
- Presumed Diagnosis
- Management

Appendix 1

HISTORY

- Subject to local guidance (see black box warning)

CLINICAL ASSESSMENT

- If other abnormality found, e.g., significant post void residual, significant pelvic organ prolapse, pelvic mass

PRESUMED DIAGNOSIS

- OAB-w/ or w/o urgency, incontinence
- OAB-w/ urgency, incontinence
- Mixed incontinence
- Stress incontinence, presumed due to sphincter incompetence

MANAGEMENT

- Life style interventions, pelvic floor muscle training for SUI or OAB
- Bladder retraining for OAB
- Dilatation (SUI), anticholinergic (OAB or urgency incontinence)
- Vaginal devices, such as electrical stimulation inserts
- Failure

SPECIALIZED MANAGEMENT

researcher.
Appendix 2 – Specialised Management of Urinary Incontinence in Women

**HISTORY/SYMPTOM ASSESSMENT**
- Incontinence on physical activity
- Incontinence with mixed symptoms
- Incontinence with urgency / frequency

**CLINICAL ASSESSMENT**
- Assess for pelvic organ mobility / prolapse
- Consider imaging of the UT/ pelvic floor
- Urodynamics (see notes)

**DIAGNOSIS**
- URODYNAMIC STRESS INCONTINENCE (USI)
  - Treat, most bothersome symptom first
- MIXED INCONTINENCE (USI/DOI)
- DETRUSOR OVERACTIVITY INCONTINENCE (DOI)
- INCONTINENCE associated with poor bladder emptying

**TREATMENT**
- If initial therapy fails:
  - Stress incontinence surgery
  - Bulking agents
  - Tapes and slings
  - Colposuspension

- If initial therapy fails:
  - Botulinum toxin
  - Neuromodulation
  - Bladder augmentation

- Correct anatomic bladder outlet obstruction (e.g. genito-urinary prolapse)
- Intermittent catheterization

- Correct anomaly
- Treat pathology

**Consider:**
- Urethrocystoscopy
- Further imaging
- Urodynamics

"Complicated" incontinence:
- Recurrent incontinence
- Incontinence associated with:
  - Pain
  - Hematuria
  - Recurrent infection
  - Voiding symptoms
  - Pelvic irradiation
  - Radical pelvic surgery
  - Suspected fistula
Appendix 3 – Initial Management of Urinary Incontinence in Men

1. General assessment (see relevant chapter).
2. Urinary Symptom Assessment and Symptom Score (ICSD-3).
4. Pelvic floor muscle function.
5. Assess post-void residual urine.

**Stress Incontinence**
- Presumed due to sphincter incompetence.

**Mixed Incontinence**
- Presumed due to detrusor overactivity.

**Urgency/Incontinence**
- Associated with post-void residual, significant delayed post-void residual.

**Urgency**
- Frequency/urgency with or without urgency.

**Incontinence with micturition symptoms**
- Post-micturition dribble.

**Specialized Management**
-生活方式的改变
- Pelvic floor muscle training + biofeedback
- Scheduled voiding
- Antimuscarinics (if urgency incontinence and urethral outlet obstruction)

Failure to respond to initial treatment options may require further investigation and management.

**HISTORY**

**CLINICAL ASSESSMENT**

**PRESUMED DIAGNOSIS**

**MANAGEMENT**
Appendix 4 – Specialised Management of Urinary Incontinence in Men

Specialized Management of Urinary Incontinence in Men

HISTORY/SYMPOTM ASSESSMENT

CLINICAL ASSESSMENT

DIAGNOSIS

TREATMENT

If initial therapy fails:
- Artificial sphincter
- Male sling (see chapter)
- Anti-muscarinics
- Neuromodulation
- Correction with intermittent catheterisation
- Correct anatomic obstruction
- Anti-muscarinics
- Antimuscarinics

If initial therapy fails:
- α-blockers, 5ARI
- Correction with intermittent catheterisation
- Cure bladder outlet obstruction
- Anti-muscarinics
- Antimuscarinics

Mixed Incontinence due to detrusor overactivity (during filling)
- Treat major component first

Urgency Incontinence due to detrusor overactivity (during filling)
- Treat with coexisting bladder outlet obstruction

Stress Incontinence due to sphincteric incompetence
- Treat with coexisting bladder outlet obstruction

Consider urodynamics if indicated

Post-prostatectomy incontinence

Incontinence with urgency/frequency

"Complicated" Incontinence:
- Recurrent incontinence
- Incontinence associated with:
  - Prostate or pelvic irradiation
  - Radical pelvic surgery

Consider further imaging:
- Urthrocytoscopy
- Urodynamic study
Appendix 5 – Initial Management of Neuropathic Urinary Incontinence

**Initial Management of Neurogenic Urinary Incontinence**

**HISTORY, level of lesion**
- Suprapontine cerebral lesion (e.g. Parkinson’s disease, stroke, multiple sclerosis)
- Suprasacral infrapontine spinal cord lesion (e.g. trauma, multiple sclerosis)
- Peripheral nerve lesion (e.g. radical pelvic surgery, Conus/cauda equina lesion, e.g. lumbar disc prolapse)

**CLINICAL ASSESSMENT**
- Further history
- General assessment including home assessment
- Urinary diary and symptom score
- Assessment of functional level, quality of life and desire for treatment
- Physical examination: assessment of sensation in lumbosacral dermatomes, anal tone and voluntary contraction of anal sphincter, bulbocavernosus and anal reflexes, gait
- Urine analysis + culture (if infected: treat as necessary)
- Urinary tract imaging, serum creatinine: if abnormal: specialised management
- Post void residual (PVR) by abdominal examination or optional by ultrasound

This assessment will give basic information, but does not permit a precise neurourolological diagnosis.

**PRESUMED DIAGNOSIS**
- Stress urinary incontinence due to sphincter incompetence
- Urinary incontinence due to detrusor overactivity
  - With Poor bladder emptying (Significant PVR)
  - With Negligible PVR
    - Depending on cooperation and mobility:
      - Behavioural modification, Antimuscarinics, External appliances, Indwelling catheter

**MANAGEMENT**
- Behavioural modification
- External appliances
- Intermittent catheterisation with or without Antimuscarinics

Failure

Specialised management preferable for more "tailored" treatment
Appendix 6 – Specialised Management of Neuropathic Urinary Incontinence
Appendix 7 – Initial Management of Urinary Incontinence in Frail Older People
Appendix 8 – Abnormality Algorithm in Females

**FEMALE ABNORMALITY ALGORITHM**

1. Painless visible haematuria at any age
2. Age >40yrs - recurrent or persistent UTI with haematuria
3. Age >50yrs with unexplained microscopic haematuria
4. Abdominal or Pelvic Mass

- Urgent Referral as per NICE Referral Guidelines for suspected cancer

1. Age < 40yrs - recurrent or persistent UTI with haematuria
2. Age 40-50yrs with non visible haematuria (no UTI), with or without proteinuria
3. Age < 40yrs – asymptomatic non visible haematuria (2 of 3 dipstick positive) without proteinuria, UTI or raised serum creatinine

- Referral to urologist as per NHS 18 week referral to treatment pathway

1. Age < 40 yrs: non visible haematuria with significant proteinuria or eGFR <30mL or declining by >10mL/m in previous 5 yrs or isolated hypertension
2. Visible haematuria coinciding with an upper respiratory infection

- Refer to Nephrologist - CKD as per Guidelines

**Recurrence UTI**

- Refer Urology

**Neurogenic Bladder – Spinal injury, Spina bifida, disc prolapse, MS**

- MDT approach, identify Red Flags/abnormalities
  - Access appropriate algorithms

**Suspected overflow incontinence – Palatable Bladder/Abnormal PVR**

- PVR 200-500 mls with deteriorating U & Es/PVR > 500 ml
  - Urgent admission

- PVR 200-500 mls with normal U & Es
  - CNS Level 2 secondary care. Management options may be ISC, double voiding, urethral dilation, QSBS
Appendix 9 – Abnormality Algorithm in Males

MALE ABNORMALITY ALGORITHM

1. Painless visible haematuria at any age
2. Age >40yrs - recurrent or persistent UTI with haematuria
3. Age >50yrs with unexplained microscopic haematuria
4. Abdominal or Pelvic Mass
5. Suspected Prostate cancer (age specific raised PSA and/or abnormal DRE)

Urgent Referral as per NICE Referral Guidelines for suspected cancer

1. Age < 40yrs - recurrent or persistent UTI with haematuria
2. Age 40-60yrs with non visible haematuria symptomatic (no UTI)
3. Age < 40yrs – with asymptomatic non visible haematuria (2 of 3 dipstick positive) without proteinuria, UTI or raised serum creatinine

Referral to urologist as per NHS 18 week referral to treatment pathway

1. Age < 40 yrs: non visible haematuria with significant proteinuria or eGFR <30ml or declining by >10ml/mt in previous 5 yrs or isolated hypertension
2. Visible haematuria coinciding with an upper respiratory infection

Refer to Nephrologist – CKD as per Guidelines

1. UTI
2. Abnormal PVR

Refer routinely to Urology

PVR 50-200 ml

Refer routinely to Urology to exclude Bladder outflow obstruction

PVR 200-500 ml & abnormal U & E or PVR >500ml

Urgent admission to secondary care

PVR 200-500 ml & normal u & E

Liaise with GP/CNS consider ISC

Urgent Choose & Book referral to Urologist

Neurological – spinal injury, tumour, disc prolapsed, MS, Spina Bifida

MDT approach, Red flags and abnormalities identified and acted upon, appropriate algorithm to be accessed
Appendix 10 – Patient Urinary and Bowel Symptom Questionnaire

Patient Name: ____________________________
Patient NHS: ____________________________
DoB: ____________________________

Lincolnshire Community Health Services NHS Trust

Patient Urinary & Bowel Symptom Questionnaire

I understand that you have been referred for an assessment about your bladder and or bowel problems. It would assist the assessment process if all relevant sections of the urinary and bowel questionnaire are completed, prior to the consultation with your healthcare professional. The questionnaire will provide useful information about your symptoms and assist with the formulation of your treatment plan. All information will be treated confidentially and the completed information will form part of your health record. If you require any assistance do not hesitate to contact the assessing healthcare professional. Many thanks for your assistance.

What do you feel is your main problem?

How long have you had this problem for?

Under 6 months [ ] 6 months to 1 year [ ] 1 to 5 years [ ] Over 5 years [ ]

Many people leak urine some of the time. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

Q1 How often do you leak urine? (tick one box)

<table>
<thead>
<tr>
<th>Never</th>
<th>About once a day</th>
<th>All the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>About once a week or less often</td>
<td>Several times a day</td>
<td>All the time</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Two or three times a week</td>
<td>All the time</td>
<td>4</td>
</tr>
</tbody>
</table>

Q2 We would like to know how much urine you think leaks.

How much urine do you usually leak (whether you wear protection or not)? (tick one box)

<table>
<thead>
<tr>
<th>None</th>
<th>A moderate amount</th>
<th>A large amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A small amount</td>
<td>A moderate amount</td>
<td>A large amount</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Q3 Overall, how much does leaking urine interfere with your everyday life?

Please ring a number between 0 (not at all) and 10 (a great deal)

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>A great deal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q4 When does urine leak? (please tick all that apply to you)

<table>
<thead>
<tr>
<th>Never – urine does not leak</th>
<th>Leaks when you are physically active/exercising</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaks before you can get to the toilet</td>
<td>Leaks when you have finished urinating and are dressed</td>
</tr>
<tr>
<td>Leaks when you cough or sneeze</td>
<td>Leaks for no obvious reason</td>
</tr>
<tr>
<td>Leaks when you are astoopy</td>
<td>Leaks all the time</td>
</tr>
</tbody>
</table>
Patient Name: ____________________________
Patient NHS: ____________________________
DOB: ____________________________

Patient Urinary & Bowel Symptom Questionnaire

Please answer the following questions about your fluid intake and diet.

<table>
<thead>
<tr>
<th>List the kind of drinks you have each week</th>
<th>How many of these do you drink each day?</th>
<th>How much do you drink ie: cup/mug/pint etc?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I restrict the amount I drink  Yes [ ] No [ ]  Why?
I am on a special diet  Yes [ ] No [ ]  Why?

What foods do you eat in a normal day? (vegetables, fruit, meat, fish, bread etc)

Please list all the medication/drugs you are taking, including all vitamins, laxatives, creams, injections, herbal remedies/inhalers.

<table>
<thead>
<tr>
<th>Name of drug and dose</th>
<th>Reason you are taking it</th>
<th>How often you take it</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any allergies? Yes [ ] No [ ]  If you ticked yes please state what you are allergic to.
### Patient Urinary & Bowel Symptom Questionnaire

Tick the box you feel is most like you and how often it happens i.e. usually, sometimes, never.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I pass urine more than 7 times in an average day.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>When I need to pass urine it is urgent.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have to go to the toilet if I hear/put my hands in water.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I get the urge to pass urine during sexual intercourse.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urge incontinence</td>
<td>Urine leaks from me when I urgently need to go to the toilet.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urine leaks from me during sexual intercourse.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urine leaks from my bladder during the day.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dysuria</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>It hurts when I pass urine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I suffer from cystitis/urine infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I notice blood in my urine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nocturia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I get up for the toilet more than once a night.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nocturnal Enuresis</td>
<td>I wet the bed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hesitancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>When I try to pass urine I have difficulty starting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have to strain to pass urine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stream</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>My urinary stream/flow is poor.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dribbling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>My bladder dribbles after passing urine.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incomplete void</td>
<td>When I have passed urine I have to go back and pass urine again almost straight away.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual expression</td>
<td>I have to press over my bladder to empty it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incomplete Void</td>
<td>I cannot tell when my bladder is full</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I feel I do not empty my bladder completely.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urine leaks from me when I cough, laugh, sneeze or move.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urine leaks from me when I play sports, jump or run.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I always sit on the toilet to pass urine.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient Urinary & Bowel Symptom Questionnaire

Please indicate what your bowel movements are like (tick boxes below)

<table>
<thead>
<tr>
<th>BRISTOL STOOL CHART</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Separate hard lumps, like nuts, hard to pass</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2</td>
<td>Sausage shaped but lumpy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges, passes easily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces entirely liquid</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Colour of stool (tick as appropriate)  
Pale  [ ]  Black  [ ]  Brown  [ ]

How often do you empty your bowels? ........................................................................

How long do you have to sit on the toilet in order to have a bowel movement? ..........

What time of day do you usually have a bowel movement? ........................................

Please list anything you take to help you empty your bowels: ....................................

.................................................................

.................................................................

.................................................................

.................................................................

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.................................................................

.................................................................
Patient Name: ____________________
Patient NHS: ____________________
DoB: ____________________

Lincolnshire Community Health Services NHS

Patient Urinary & Bowel Symptom Questionnaire

Tick the box you feel is most like you and how often it happens is: usually, sometimes, never.

<table>
<thead>
<tr>
<th></th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have to strain to open my bowels.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is painful to empty my bowels.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t completely empty my bowels.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After I have had a bowel movement, I have to return soon after to empty my bowels again.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I pass mucus with my bowel movements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I pass blood with my bowel movements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have to apply pressure around my back passage in order to open my bowels.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have to insert a finger into my back passage (or my vagina) in order to have my bowels open.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have itching, irritation or soreness around my back passage.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have haemorrhoids (piles).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a dragging sensation around my vagina or back passage.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I find small smears of bowel motion in my underwear.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I cannot stop myself from passing wind (flatus).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I need to move my bowels, I have to rush to get there.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel motion leaks from me when I urgently need the toilet.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t know when I need to move my bowels.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel motion leaks from me without me realising.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel motion leaks from me after a bowel movement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I find it difficult to clean myself after I have had a bowel movement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I cannot tell the difference between wind and bowel motion.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wear a pad because of my bowel problem.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Patient Urinary & Bowel Symptom Questionnaire

I live in: (please tick)
House ☐ Flat ☐ Bungalow ☐ Warden assisted ☐
Number of raised toilet seats ☐ Toilet upstairs ☐ Toilet downstairs ☐

I live with: (please tick)
Husband/wife/partner ☐ Live alone ☐ I live with: ..........................................................

How would you describe your personality?
Quite laid back ☐ Anxious ☐ A worrier ☐ Depressed ☐

My occupation is: ..........................................................

I have problems with my walking and/or using my hands:
I have difficulty getting to the toilet ☐
I have difficulty getting on/off the toilet ☐
I use a commode/bottle/bedpan in my bedroom ☐
I use a commode/bottle/bedpan in my home ☐
I use a stick/sticks ☐
I use a wheelchair ☐
I use a zimmer frame/mobilator ☐
I use a stair lift ☐

I have problems with my eyesight:
Yes ☐ No ☐
I am blind ☐
I wear glasses/contact lenses for: Reading ☐ Distance ☐ All time ☐
I have cataracts on: Right eye ☐ Left eye ☐ Both ☐

I have problems with my hearing:
Yes ☐ No ☐
I wear a hearing aid ☐
I am hard of hearing in my: Right ear ☐ Left ear ☐ Both ☐
I am deaf ☐
Equality and Diversity Monitoring

Lincolnshire Community health Services collect and monitor equality and diversity information to ensure that we are treating all people fairly and to help us identify any barriers that may need to be addressed. This information will be kept completely confidential. You do not have to answer these questions if you do not wish to.

Please tick the box if you do not wish to answer □

<table>
<thead>
<tr>
<th>What is your gender?</th>
<th>□ Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Female</td>
</tr>
<tr>
<td></td>
<td>□ Gender unspecified</td>
</tr>
</tbody>
</table>

The recording of Sexual Orientation for under 16’s is not a requirement.

<table>
<thead>
<tr>
<th>Which of the following options best describes you</th>
<th>□ Heterosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Male homosexual</td>
</tr>
<tr>
<td></td>
<td>□ Female homosexual</td>
</tr>
<tr>
<td></td>
<td>□ Bisexual</td>
</tr>
<tr>
<td></td>
<td>□ Sexual orientation not given – patient refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your religion or belief?</th>
<th>□ Christian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Hindu</td>
</tr>
<tr>
<td></td>
<td>□ Muslim</td>
</tr>
<tr>
<td></td>
<td>□ Buddhist</td>
</tr>
<tr>
<td></td>
<td>□ Jewish</td>
</tr>
<tr>
<td></td>
<td>□ Sikh</td>
</tr>
<tr>
<td></td>
<td>□ Not religious</td>
</tr>
<tr>
<td></td>
<td>□ Religion not given – patient refused</td>
</tr>
<tr>
<td></td>
<td>□ Religion - Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your Marital status?</th>
<th>□ Married/Civil Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Separated</td>
</tr>
<tr>
<td></td>
<td>□ Divorced</td>
</tr>
<tr>
<td></td>
<td>□ Single</td>
</tr>
<tr>
<td></td>
<td>□ Widowed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you consider yourself disabled or have a health condition?</th>
<th>□ Disabled (Ongoing Episode)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Not disabled (Ongoing Episode)</td>
</tr>
<tr>
<td></td>
<td>□ Disability status not given – patient refused (Ongoing Episode)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>□ Visual disability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Hearing loss</td>
</tr>
<tr>
<td></td>
<td>□ Physical disability</td>
</tr>
<tr>
<td></td>
<td>□ Communication disability</td>
</tr>
<tr>
<td></td>
<td>□ Learning difficulties</td>
</tr>
<tr>
<td></td>
<td>□ Mental health disorder</td>
</tr>
<tr>
<td></td>
<td>□ Autistic spectrum disorder</td>
</tr>
<tr>
<td></td>
<td>□ Other relevant information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which Ethnic Group best describes you?</th>
<th>□ White British – ethnic category 2001 census</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ White Irish – ethnic category 2001 census</td>
</tr>
<tr>
<td></td>
<td>□ Gypsy/Romany – ethnic category 2001 census</td>
</tr>
<tr>
<td></td>
<td>□ Other White background – ethnic category 2001 census</td>
</tr>
<tr>
<td>Any other White Background for example Eastern European: Polish</td>
<td></td>
</tr>
</tbody>
</table>
### Equality and Diversity Monitoring

<table>
<thead>
<tr>
<th>Asian or Asian British (Ongoing Episode)</th>
<th>Black or Black British (Ongoing Episode)</th>
<th>Chinese or other ethnic group (Ongoing Episode)</th>
<th>What is your preferred language? (Ongoing Episode)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tick one</td>
<td>Tick one</td>
<td>Tick one</td>
<td>Please specify</td>
</tr>
<tr>
<td>Any other Asian Background (please state)</td>
<td>Any other Black Background (please state)</td>
<td>Any other Ethnic Group (please state)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Indian or British Indian - ethnic category 2001 census
- Pakistani or British Pakistani – ethnic category 2001 census
- Bangladeshi or British Bangladeshi-ethn cat 2001 census
- Other Asian background – ethnic category 2001 census
- Caribbean – ethnic category 2001 census
- African – ethnic category 2001 census
- Other Black background – ethnic category 2001 census
- Chinese – ethnic category 2001 census
- Other – ethnic category 2001 census

**If you require an interpreter, please let us know when you contact the department to make your appointment.**

Thank you for your help and support in completing this document. This information will be used to improve services for patients. All information you have provided is completed confidential.

- Patient’s Signature .......................................................... Date
- (PRINT NAME) ........................................................................
- Nurse Specialist Signature ........................................ Date
- (PRINT NAME) ........................................................................

Ref. LCHS2014  

Review date: July 2016
The Continence Assessment Scoring Tool (CAST) is an “aid” to clinical decision making – it does not replace it!

It facilitates the **OBJECTIVE MEASUREMENT OF CLINICAL NEED** and is a useful adjunct to **SUBJECTIVE CLINICAL OPINION**

**BASIC PRINCIPLES:**
There are 13 CATEGORIES:
- Type of Residence - (one score)
- Type of incontinence - (may be combined score)
- Wet/Soiled Episodes – Frequency (use average) - (one score)
- Wet/Soiled Episodes – Severity (use average) - (one score)
- Frequency of Micturition (with normal fluid intake) - (one score)
- Medical History – Adult/ Child - (may be combined score)
- Surgical History - (may be combined score)
- Obstetric History - (may be combined score)
- Carer / Help availability - (one score)
- Ability to perform activities of daily living - (one score)
- Impaired Mobility - (one score)
- Medications - (may be combined score)
- Pads usually used (clinically needed rather than patient preference) per day (24hrs) - (one score)

A Score – is given for each category; single or total score depending on the category (see above)
The **total score** indicates a course of action – eg: Treatment; (Treatment + products; Treatment unlikely to help = management of incontinence)
The Scoring:
- **Below 35** indicates “LOW” clinical need = May be amenable to Treatment

  “Offering pads prematurely can lead to a psychological dependence upon them and a reluctance to attempt curative treatment (DoH 2000 GPCS 3.12 p13)

- **36-45** indicates “MEDIUM” clinical need = May be amenable to treatment but may need a short-term supply of products for the management of incontinence, with regular review (at least 6-monthly)

- **46 or above** indicates “High” clinical need = May be amenable to treatment but is more likely to require the long-term use of products for the management of incontinence, with regular review (at least annually)
<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SCORE</th>
<th>INDIVIDUAL SCORE</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Residence:</strong> (Single score)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential/Nursing Care home</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private house – adequate facilities</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private house – inadequate facilities</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type of Incontinence:</strong> (Score all that apply)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overflow</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal and/or occasional faecal incontinence</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urge</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enuresis</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurogenic/ Voiding dysfunction</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Benign Prostatic Hyperplasia / Neurological / Urological / Other voiding dysfunction)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faecal (regular)</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wet Episodes – Frequency (in 24 hrs):</strong> (Single score)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4+</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Wet Episodes – Severity: ** (Single score)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (damp pad/pants or “+”)</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 (wets pad/pants or “++”)</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 (Soaking/ wets outer clothing or “+++”)</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faecal</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frequency of Micturition (with normal fluid intake):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Single score)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 5</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 – 7 times</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continence managed by catheterisation (Intermittent or indwelling)</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to establish pattern of micturition due to complex or severe needs</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medical History (Adult only):** (Score all that apply)
- Other: 2
- Respiratory: 2
- Diabetes: 2
- Mental health disorder: 2
- Prolapse: 3
- Lower intestinal disorder: 3
- Cardiac failure: 4
- Urological disease (or high urological risk): 4
- Dementia: 5
- Palliative care: 8
- Learning disability: 8
- Neurological disorder: 8

(*Multiple Sclerosis / Spinal injury or spinal disease affecting continence / Parkinons disease / Stroke / If Other – please state*)

**Medical History (Child or Young Adult):** (Score all that apply)
- Physical Disability (significant): 7
- Learning Disability (significant): 8
- On ‘Child in Need’ / ‘At Risk’ Register or ‘Statemented’: 8

**Surgical History:** (Score all that apply)
- Bowel repair: 3
- Unsuccessful pelvic floor or prolapse repair: 3
- Unsuccessful transurethral prostatectomy: 3
- Abdominal / vaginal hysterectomy: 4
- Bladder surgery: 5
- Ca Bladder / prostate: 5
- Ca Bowel: 5
- Spinal surgery which has affected continence: 5

**Obstetric History:** (Score all that apply)
- Number of babies:
  - 1 – 2: 1
  - 3: 2
  - 4 or over: 4
- Forceps delivery: 4
- Breech delivery: 4
- Large baby (over 9lb / 4kg): 4

**Carer / Help Availability:** (Single score)
- 24 hour availability: 1
- Daily throughout: 3
- Partial: 4
- None = requires help with toileting but has none: 7

**Ability to Perform Activities of Daily Living:** (Single score)
- Fully mobile: 1
- Able to toilet: 3
- Partial ability: 4
- Unable to self-care: 6
<table>
<thead>
<tr>
<th>Impaired Mobility: (Single score)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild (eg: walks with a stick)</td>
<td>2</td>
</tr>
<tr>
<td>Moderate (eg: walks with help)</td>
<td>4</td>
</tr>
<tr>
<td>Severed (eg: needs wheelchair all the time)</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications: (Score all that apply)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Laxatives</td>
<td>1</td>
</tr>
<tr>
<td>Oestrogens</td>
<td>1</td>
</tr>
<tr>
<td>Analgesia</td>
<td>2</td>
</tr>
<tr>
<td>Anti-muscarinics / anti-cholinergics</td>
<td>2</td>
</tr>
<tr>
<td>Anti-hypertensives</td>
<td>2</td>
</tr>
<tr>
<td>Anti-epileptics</td>
<td>2</td>
</tr>
<tr>
<td>Muscle relaxants (eg: Baclofen)</td>
<td>2</td>
</tr>
<tr>
<td>Hypnotics / sedatives</td>
<td>3</td>
</tr>
<tr>
<td>Anti-depressants</td>
<td>3</td>
</tr>
<tr>
<td>Diuretic</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pads – ‘clinically’ required per day: (Single score)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 pad or reusable</td>
<td>1</td>
</tr>
<tr>
<td>2 pads</td>
<td>2</td>
</tr>
<tr>
<td>3 pads</td>
<td>3</td>
</tr>
<tr>
<td>4 pads or over</td>
<td>4</td>
</tr>
</tbody>
</table>
## Monitoring Template

This template should be used to demonstrate compliance with NHSLA requirements for the procedural document where applicable and/or how compliance with the document will be monitored.

<table>
<thead>
<tr>
<th>Minimum requirement to be monitored</th>
<th>Process for monitoring e.g. audit</th>
<th>Responsible individuals/group/committee</th>
<th>Frequency of monitoring/audit</th>
<th>Responsible individuals/group/committee (multidisciplinary) for review of results</th>
<th>Responsible individuals/group/committee for development of action plan</th>
<th>Responsible individuals/group/committee for monitoring of action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Review</td>
<td>Review</td>
<td>CNS</td>
<td>Bi-annually</td>
<td>CNS GPsl MDT</td>
<td>CNS GPsl</td>
<td>QSC CGC</td>
</tr>
</tbody>
</table>
### Section 1 – to be completed for all policies

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Briefly give an outline of the key objectives of the policy; what it’s intended outcome is and who the intended beneficiaries are expected to be.</td>
<td>Provision of local guidance and treatment pathways for Healthcare Professionals to use when treating and managing patients presenting with lower urinary tract symptoms or urinary incontinence.</td>
</tr>
<tr>
<td>B.</td>
<td>Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? <strong>Please give details</strong></td>
<td>No – disability, sexual orientation, gender, race, religious and age neutral</td>
</tr>
<tr>
<td>C.</td>
<td>Is there is any evidence that the policy/service relates to an area with known inequalities? <strong>Please give details</strong></td>
<td>No – cross population.</td>
</tr>
<tr>
<td>D.</td>
<td>Will/Does the implementation of the policy/service result in different impacts for protected characteristics?</td>
<td>For medical reasons the policy guidance is necessarily specific to gender but is applied equally regardless of this. It complies with recognised national guidance and standardises accordingly.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Marriage/Civil Partnership</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Maternity/Pregnancy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Carers</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

If you have answered ‘Yes’ to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2

The above named policy has been considered and does not require a full equality analysis

**Equality Analysis Carried out by:** Suzanna Kinder  
**Date:** 23rd July 2014