Urinary Incontinence

Nobody volunteers it and nobody asks · meanwhile it drives the falls you are already worried about

Residual before you prescribe
overflow masquerades as urge

⚠ THE ERROR THAT TURNS A NUISANCE INTO RETENTION

⚠ POST-VOID RESIDUAL BEFORE ANY DRUG FOR URGENCY

The single test that prevents the classic mistake. **OVERFLOW incontinence presents as urgency and frequency**, and an **antimuscarinic given for presumed overactive bladder will precipitate frank retention**. Bedside ultrasound is sufficient. **Also: do NOT treat asymptomatic bacteriuria** -it is common in older adults, treating it does not improve continence, and it drives resistance and *C. difficile*.

ASK, BECAUSE THEY WILL NOT

Massively under-reported -patients assume it is normal aging or were told nothing helps. **Not benign**: it drives **falls (rushing to the toilet at night), social withdrawal, depression, skin breakdown and nursing home placement**. One direct question in any older adult is among the higher-yield things in an ambulatory visit.

⚠ DIAPPERS: REVERSIBLE CAUSES

Delirium · **I**nfection (symptomatic only) · **A**trophic vaginitis · **P**harmaceuticals · **P**sychological · **E**xcess output (heart failure, hyperglycemia, hypercalcemia, diuretics) · **R**estricted mobility · **S**tool impaction. **Several are fixed in a single visit**, and much new-onset incontinence in older adults is drug- or constipation-related rather than urologic.

CLASSIFY BY HOW THE LEAK HAPPENS

Type	The story	Mechanism and clues
Stress	**Leaks with cough, sneeze, laugh, lift or exercise.** Small volumes, no warning	Raised intra-abdominal pressure overcomes a weak outlet -**pelvic floor weakness and urethral hypermobility**, or intrinsic sphincter deficiency. Commonest in women after childbirth; in men **after prostatectomy**
Urge overactive bladder	**Sudden compelling urgency, cannot reach the toilet.** Larger volumes, frequency, nocturia	**Detrusor overactivity.** Often idiopathic, but consider neurologic causes (stroke, Parkinson, MS, cord) and local irritation (infection, stone, tumor). **MIXED (both types) is very common in older women -treat the component that bothers her most first**
⚠ Overflow	**Dribbling, hesitancy, weak stream, incomplete emptying.** May feel like urgency	**Outlet obstruction** (BPH, stricture, prolapse) or **underactive detrusor** (diabetic/neurogenic bladder, cord disease, anticholinergics, opioids). **The one misdiagnosed as urge and made worse by treatment**
Functional	Bladder works; the patient cannot get there in time	**Mobility, cognition, environment, dexterity** -the frame across the room, the buttons, the bed rails. Often dominant in hospital and long-term care, and it responds to **a commode, not a drug**

TREATMENT: BEHAVIORAL FIRST, FOR BOTH MAIN TYPES

Intervention	Detail
Pelvic floor training stress, and helps urge too	**First-line for stress, effective in mixed and urge too. ⚠ SUPERVISED training far outperforms a leaflet** -most patients contract the wrong muscles when told to "do Kegels". Refer to pelvic floor physiotherapy. **Takes weeks to months**, so say so at the outset or it gets abandoned as useless
Bladder training urge	Scheduled voiding with lengthening intervals, plus **urge suppression: stop still, contract the pelvic floor, let the urge pass, THEN walk. ⚠ Rushing raises intra-abdominal pressure and makes the leak MORE likely** -counterintuitive, so it needs explaining
Fluids & diet	Cut **caffeine and alcohol** (irritants and diuretics). **⚠ Do NOT let patients severely restrict fluids** -concentrated urine is itself irritating, and dehydration causes constipation, falls and delirium. **Redistribute intake earlier in the day** instead. Also **treat constipation**, manage cough, **weight loss** for stress incontinence in obesity, and for functional incontinence **fix the environment** -accessible clothing, prompted voiding in cognitive impairment
⚠ Check drug TIMING	Diuretics, alpha-blockers, anticholinergics, opioids, CCBs, sedatives, ACE inhibitors (cough), SGLT2 inhibitors. **An evening diuretic converts a daytime problem into nocturia and night-time falls -moving it is free**

TWO THINGS THE WARDS GET WRONG

⚠ A CATHETER IS NOT A TREATMENT FOR INCONTINENCE

Catheterizing a patient because they are wet is **convenience, not care**. It buys **CAUTI, bacteriuria that then gets inappropriately treated, urethral trauma, immobility and delirium**, and catheter-associated infection is a **hospital-acquired condition**. Legitimate indications: **retention, accurate output measurement in critical illness, selected perioperative care, comfort at end of life or to let a sacral wound heal** -not incontinence. **If one goes in, set the removal date that day.** Use a **commode, scheduled toileting and a proper containment product** instead.

⚠ NOCTURIA IS ITS OWN PROBLEM

It is the component that **causes the falls**, and its causes are often outside the bladder: **heart failure and peripheral edema redistributing overnight, obstructive sleep apnea, poorly controlled diabetes, evening fluid or alcohol. Treating the bladder alone fails if the problem is fluid redistribution.** Practical: **elevate the legs in the afternoon, compression stockings, treat the apnea**, and **clear and light the night-time path to the toilet** -that last one prevents fractures more reliably than any drug here.

DRUGS: WHAT TO USE, AND WHAT DOES NOT EXIST

URGE INCONTINENCE

⚠ Antimuscarinics (oxybutynin, tolterodine, solifenacin) work but carry the **full anticholinergic burden**: dry mouth, constipation, blurred vision, **retention**, **confusion in older adults**. **Immediate-release oxybutynin is on the Beers criteria**, and the burden is **cumulative across the whole medication list**. **Beta-3 agonists (mirabegron, vibegron) relax the detrusor WITHOUT anticholinergic effects**, making them the sensible first choice in older or cognitively impaired patients -**monitor BP with mirabegron**. Third-line: **intradetrusor botulinum toxin** (counsel on **retention and possible self-catheterization**), PTNS, sacral neuromodulation. **⚠ On antimuscarinics and DEMENTIA the evidence is genuinely mixed** -large cohorts report higher incidence than with beta-3 agonists, a very large recent database analysis found none. **That is unsettled; the IMMEDIATE anticholinergic harm is not.**

⚠ STRESS: THERE IS NO US DRUG

No FDA-approved pharmacotherapy for stress incontinence in the United States -duloxetine is used elsewhere and off-label here, but the US application was withdrawn. **So if a patient with pure stress incontinence is on a "bladder drug", it is probably an antimuscarinic that will not help and may harm.** What does work: **pelvic floor training**, a **pessary** or continence device (reversible, good with coexisting prolapse), and **surgery, usually a midurethral sling**. **Topical vaginal estrogen** helps atrophy -note that **SYSTEMIC hormone therapy does not treat incontinence and may worsen it**. **⚠ REFER rather than treat** for hematuria without infection, obstruction, recurrent UTI, suspected fistula, or **new neurologic signs with back pain or saddle anesthesia -a cord syndrome until excluded**.

References: AUA/SUFU guidance on the surgical treatment of stress urinary incontinence and on non-neurogenic overactive bladder · AGS Beers Criteria (2023) on anticholinergics in older adults · published cohort and database analyses comparing dementia incidence with antimuscarinics versus beta-3 agonists · FDA labeling status of duloxetine in the United States.

Educational aid; verify against current guidance, local formulary and patient factors.

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