

Incontinence

Causes, management and provision of services

SUMMARY OF A REPORT OF A WORKING PARTY OF THE ROYAL COLLEGE OF PHYSICIANS

The effects of incontinence on life-style and self regard of those afflicted by it may be calamitous, and incontinence may also place a great burden on carers of those with this problem. Recently there have been various initiatives to encourage incontinent patients to seek medical advice for a condition that is often curable and always manageable. However there is an additional difficulty; patients presenting with urinary or faecal incontinence often find clinicians are inadequately informed as to how to diagnose its causes or how best to manage it.

This report is the work of a multi-specialty working party which was convened by the Royal College of Physicians in response to a Department of Health initiative *An agenda for action on continence services*. The report reviews the prevalence and what is known of the causes of both urinary and faecal incontinence and discusses ways of investigation and management of the condition. The current provision of services are reviewed together with the components that are neces-

sary for a good continence service. There is also a review of products to cope with intractable incontinence. The report calls for better medical education and for more research into the causes and prevention of incontinence.

The prevalence of incontinence is much greater than is generally understood and affects people of all ages (see Tables 1 and 2). Childhood incontinence forms a significant part of the paediatric work load, and among the old incontinence is one of the major problems of management. The cost of incontinence accounts for about 2% of the total health service budget.

The causes of incontinence are numerous but the main factors are dependent on the age or sex of the patient. For example, nocturnal enuresis is the commonest type of incontinence affecting children. The two most common reasons for urinary incontinence in women are genuine stress incontinence following childbirth and detrusor instability; the cause of the latter in otherwise healthy women is unknown. Urinary incontinence in men most commonly occurs in the elderly due to enlargement of the prostate gland. In elderly people who are mentally sound and living at home the causes of urinary incontinence are little different from those at other ages except for their

Table 1. Percentage of the population who have urinary incontinence. Based on an average of data taken from various studies

	Age (years)	% incontinent
Women living at home	15-44	5-7
	45-64	8-15
	65 and over	10-20
Men living at home	15-64	3
	65 and over	7-10
Both sexes together living in institutions		
Residential homes		25
Nursing homes		40
Hospital (elderly and elderly mentally infirm)		50-70

Table 2. Percentage of the population who have faecal incontinence. Based on averaged data taken from various studies

At home	Age (years)	% incontinent
	15-64	0.4
	65+	3-5
	85+	15
Living in institutions		
Residential homes		10
Nursing homes		30
NHS (elderly and elderly mentally infirm)		60

relative prevalence. Detrusor instability probably due to age changes in both the central nervous system and in the lower urinary tract is the main cause. Genuine stress incontinence is less common, but in 10% of incontinent old people detrusor instability and stress incontinence are combined.

Where there is no urodynamic abnormality, as is often the case among institutionalised old people, causes such as immobility and compounding factors such as sub-optimal nursing may play a part. Appropriate intervention may often be effective, even in patients with minor dementia.

Urinary incontinence is a very common additional problem for patients with chronic neurological diseases.

Faecal incontinence is even more neglected than urinary incontinence and yet is more devastating. Much of it results from childbirth trauma and requires surgical intervention. Colorectal diseases (eg irritable colon, carcinoma and the effect of radiotherapy) can cause faecal incontinence, and in elderly people it is a source of long-term care where its management is generally sub-optimal.

Whilst it is acknowledged that in primary care incontinence may sometimes be managed initially by symptomatic treatment, the primacy of a medical diagnosis is stressed and should be generally achievable. Patients may present to general practitioners, continence nurse advisors or social workers and the need for a properly structured and well recognised continence service is clear. Secondary referral may be to any of the appropriate specialist services, most of which were represented on the working party (see below), but will probably serve the patient best if—for urinary incontinence—referral is to a uro-dynamic assessment clinic. Most districts now have such a service, usually headed by a urologist or gynaecologists, sometimes a geriatrician and occasionally a neurologist.

Evidence suggest that, although improving, education about incontinence is patchy in medical schools and depends very much on the influence of a few particularly interested clinicians. It plays little part in post-graduate training for specialists and even less for general practitioners. It is often regarded as a nursing, rather than a medical problem. Yet the diagnostic possibilities and scope for successful medical or surgical treatment are enormous.

The report was launched at the same time as a complementary report of the Continence Foundation—*Commissioning comprehensive continence services: guidance for purchasers*. The College report provides essential information for all doctors who may be confronted by the problems of incontinence; the companion report of the Continence Foundation is a step-by-step guide to provision of a structured service. Together the reports will provide valuable guidance to clinicians and to purchasers and providers of continence services.

RECOMMENDATIONS

Management

- 1 Whenever possible a medical diagnosis should be made in every incontinent patient and this should precede symptomatic treatment.
- 2 Purchasers of health care should contract for a comprehensive continence service across the boundaries of disciplines and hospital/community Trusts to meet the needs of the local population.
- 3 The continence service should include, directly or by referral:
 - facilities for full investigation, including urodynamics
 - access for investigation of faecal incontinence
 - co-ordination of continence advisors
 - a full range of aids and appliances
 - programmes of professional and public education
 - active local publicity for the service.
- 4 The continence service should ideally be consultant-led.
- 5 When commissioning a continence service efforts should be made to assess its cost effectiveness.
- 6 Tertiary referral centres for more specialised management should be nationally available.

Products for the management of incontinence

- 7 Continence products should be provided only following individual assessment by an appropriately trained health care professional.
- 8 Selection of a product should be made on an individual basis and periodically reviewed. A range must be available to suit different needs.
- 9 Patients and carers should be given written information to augment verbal teaching on how to use an appliance and obtain further supplies.
- 10 Patients and carers should be involved in the choice of product and there should be regular review of patient satisfaction.
- 11 There should be a clearly defined procedure for the inclusion of new and innovative products on the drug tariff.

Education

- 12 All doctors, nurses and other health professionals should be taught about urinary and faecal incontinence while students.
 - Action is required by the General Medical Council, curriculum committees of medical schools, all national Boards of Nursing & Midwifery and other professional regulatory bodies.

- 13 The subject of incontinence should be specifically included in the post-basic curricula wherever appropriate.
 - Action is required by postgraduate advisors in general practice, the joint committees of higher medical and surgical training and the appropriate bodies relating to nursing and other health professions.
- 14 An advanced course for continence advisors should be created to equip them with clinical, management, teaching and research skills needed to plan and implement a comprehensive continence service.

Public awareness

- 15 There is need for the public to be made aware of the high prevalence of incontinence and the fact that it can be well evaluated and often successfully treated. Improved public awareness can be achieved via the lay press, by advertising in doctors' surgeries and by public awareness campaigns. Groups interested in the well-being of children, women and elderly people should be particularly targeted.

Research

- 16 The research needs listed in the Medical Research Council's report Research opportunities in urinary and faecal incontinence (1993) [2] are endorsed, with particular reference to:
 - further evaluation of physiotherapy techniques
 - improved medication
 - preventive measures for incontinence, particularly related to childbirth management.
 - assessment of cost effectiveness of continence services.

Membership of the Working Party on Incontinence

Sir Leslie A Turnberg MD FRCP, President of the Royal College of Physicians; **JC Brocklehurst** CBE MD FRCP, Professor Emeritus, University of Manchester; Associate Director, Research Unit, Royal College of Physicians (Chairman of the working party); **Clare J Fowler** FRCP, Consultant Uro-neurologist, National Hospital for Neurology and Neurosurgery, London (Honorary Secretary of the working party); **Margaret Borzyskowski** FRCP, Consultant Neuro-developmental Paediatrician, Guy's & St Thomas' Hospital Trust, London; **Linda Cardozo** MD FRCOG, Professor of Urogynaecology, King's College Hospital, London; **Miriam Chellingsworth** MRCP(UK), Consultant Physician, Staffordshire General Infirmary, Stafford; **GS Clayden** MD FRCP, Hon Consultant Paediatrician, St Thomas's Hospital, London; **NJR George** MD FRCS, Consultant Surgeon, Department of Urology, University Hospital of South Manchester; **Janet Heyes** FRCP, General Practitioner, Liverpool (nominated by the Royal College of General Practitioners); **Jacqueline Jolleys** MD MRCP, Hon Lecturer, Department of General Practice, University of Nottingham (nominated by the Royal College of General Practitioners); **MA Kamm** MD FRCP FRACP, Consultant Physician and Gastroenterologist, St Mark's Hospital, London; **Christine Norton** MA RGN, Director, The Continence Foundation; **W Thorne** MFPHM, Observer from the Department of Health; **DR London** DM FRCP, Registrar of the Royal College of Physicians.

In attendance:

Elaine Stephenson BA, Working Party Secretary
Barbara Coles MA, Working Party Secretary

NEW TITLE

INCONTINENCE

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