

# **Returning Dignity to the Aging Bladder and Bowels**

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# INCONTINENCE HOT LINE



**Whose expectation is this? The patient? Ours? Society?**

# Since the requirements for continence are...

- Awareness of urge to void or defecate
- Knowing how and where to respond
- Getting to the appropriate place to empty the bladder or bowels
- Holding on until that place is reached
- Getting clothing down or undone
- Being able to use the elimination place
- Completely emptying once there

# AND...

- Assuming that every person, culture has the same beliefs and values about what is bladder and bowel “appropriate”
- AND...

# Toilets are the same...

- And operate in the same way and internationally known to all

# Can we change misunderstandings about aging and incontinence?

BETTY



**Untreated and unmanaged  
incontinence increases mortality and  
morbidity in older adults!**

A few major consequences of UI and FI:

Loss of independence and dignity

Increased clinical depression and anxiety disorders

Falls! Fractures! Injuries!

UTI and MROs and C-Diff = delirium

Negative affects on both formal and informal care providers

**A Geriatric Giant!!!**

# A few “elimination” stories

- The fertilizer bucket
- The corner plant
- Over the side rails
- The Shredder
- Occupation
- Yours...???

# **So what is normal and what does aging actually do?**

Nani  
From: The Jane Goodall Institute

# Etiology of Urinary and Fecal Incontinence

**Urinary Incontinence**  
And Fecal  
Incontinence

**Health, Aging & Lifestyle  
Factors**

**Lower urinary tract problems  
(Urge, Stress, Overflow)**

**Functional Causes  
(Mobility / Cognition)**

# Age Related Changes

- Previously thought that bladder capacity decreased but now no change in bladder capacity
- Increased residual urine with latency in urge response - bladder wall becomes more rigid and weaker
- Involuntary / spontaneous bladder contractions; increased detrusor instability

# Age Related Changes

- Prostate enlargement - produces obstruction leading to irritation symptoms (e.g. hesitancy, overflow)
- Decreased estrogen – produces atrophic changes in urogenital area leading to irritation symptoms (e.g. vaginitis, dryness)

# Age Related Changes

- Decreased ability to postpone voiding due to detrusor instability
- Nocturia (night time voiding) due to decline in ADH. Must factor in CHF effects as well as sleep pattern alterations in deep sleep stage.

# Health, Aging & Lifestyle Causes

- Transient causes =  
DISAPPEAR
- Persistent causes = improve  
management

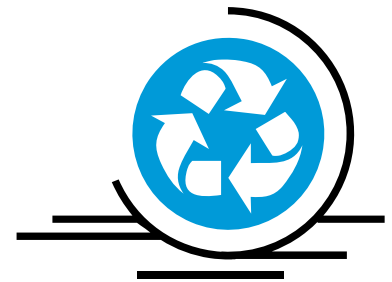
# Transient Causes

## First step in assessing & managing Urinary Incontinence

- Look for and treat, reverse or reduce impact of transient causes
- If you deal with the transient causes, the incontinence will hopefully **DISAPPEAR**

# Transient Causes of Urinary Incontinence

- **D** – Delirium (Drugs and/or Bugs, disinhibition)
- **I** – Infection & Intake
- **S** – Stool impaction/constipation
- **A** – Atrophic vaginitis/urethritis
- **P** – Pharmaceuticals
- **P** – Psychological ( depression, psychosis)
- **E** – Excess urine (endocrine)
- **A** – Abnormal lab values
- **R** – Restricted mobility



# Delirium

## Disappear

- Impacts central cortical inhibition over micturition centre (conscious control)
- Impairs cognition reducing ability to interpret environment
  - bathroom? urinal?, clothing? bedpan? commode? lighting? obstacles?

Action: Find & treat cause of delirium

# Infection

d|sappear

- Frequency & urgency resulting from UTI may overwhelm ability to get to toilet quickly enough, especially if acutely ill.
- Atypical presentation – change in gait and balance, delirium

## Action:

- If new onset urinary incontinence:  
Leuks/nitrite positive; send urine for C & S  
and treat UTI if symptomatic

# Intake

disappear

- Caffeine intake (coffee, tea, colas) are irritants and diuretics, contribute to urge
- High intake leads to dehydration, concentrated urine
- Alcohol: polyuria, frequency, urgency, sedation, delirium, immobility

## Action:

- Reduce caffeine intake - slowly
- Drink minimum 1500 – 1800 ml of water (caution if fluid restricted)

# Stool Impaction

diSappear

- Impaction leads to obstruction of urethra
- Impairs detrusor contractility
- Leads to retention and retention with overflow
- or irritates the detrusor - leads to urgency

## Action:

- Bowel program: fluids, fibre, exercise; increase bowel motility
- Disimpaction if necessary, then assure regular bowel regime

# Posture for Defecation

- What's normal?
- Optimal conditions and posture



# Optimal Conditions for Defecation/Voiding

- Stool that is easy to pass
- Urge to defecate/desire to void
- Ability/help to heed the “call the stool” or void (mobility/access)
- Pelvic floor support/ability to release sphincters
- Appropriate place
- Privacy
- Time
- **Good posture**

# Optimal Posture for Defecation

- On toilet (commode) ASAP
- Knees higher than the hips (commode footrests +/- pillows, footstool)
- Back straight
- Leaning forwards at hips
- Don't forget hip precautions for THR patients
- Supported upper body on forearms
- Toes turned in
- Additional pelvic floor support? (splinting)

# Atrophic Vaginitis & Urethritis

disAppear

- Dryness & irritation resulting from low levels of estrogen post menopause. Can contribute especially to stress incontinence

Action:

- Use perineal wash product instead of soap
- Estrogen cream (prescription) – a little dab will do you!
- Soothing creams: Calmoseptine, Trimosan

# Pharmaceuticals

disaPpear

Drugs may affect ability to store by contributing to:

Urethral relaxation ( Stress UI):

alpha adrenergic blockers (prazosin), skeletal muscle relaxants (robaxacet)

Sedation:

antidepressants, antipsychotics, sedatives, narcotics, alcohol

Frequency, urgency:

diuretics, caffeine

# Pharmaceuticals

Drugs that affect ability to empty and may cause retention:

- anticholinergics: (bladder relaxation, constipation)
- antidepressants: (anticholinergic, sedation)
- antipsychotics (relax smooth muscle)
- narcotics: (fecal impaction, sedation)
- alpha adrenergic agonists (pseudoephedrine): increase urethral resistance
- calcium channel blockers (when combined with other anticholinergics- reduce smooth muscle contraction)

# Pharmaceuticals

- An older woman with diminished urethral closure pressure because of reduced estrogen plus a weak pelvic floor due to multiple births stays continent until she is put on Hytrin for her HTN. Hytrin relaxes smooth muscles in the bladder neck and urethra so further reduces urethral closure pressure. At this point she starts to leak urine when she laughs, coughs or sneezes.

# Pharmaceuticals

- An older man with prostate enlargement has hesitancy, a weak stream and post void dribbling but goes into full retention when he takes a multi component cold capsule which contains alpha agonists and anticholinergics.
- Action:
  - drug review and medication reconciliation

# Psychological Factors

disapPear

- Depression:
  - Reduces/delays attention to physical cues
  - Apathy, hopelessness, helplessness
- Action:
  - Refer to mental health as depression is reversible with both counselling and anti-depressants (be sure to stay alert for s/e)

# Excess Urine

disappEar

- Result of excess intake (more than 6 - 8 cups per day) - IV fluids!? Dry mouth from drugs?
- CHF, lying down at night results in emptying of fluid from extremities, contributing to nocturia
- endocrine imbalance (uncontrolled diabetes)
- Action:
  - Treat underlying cause

# Abnormal Labs

disappeAr

- Hyperglycemia
- Thyroid imbalance
- Hypercalcemia
- Positive urine culture or urinalysis
- Action:
  - Treat underlying imbalance or cause

# Restricted Mobility

## disappeaR

- Can't get to bathroom at all (call bell not answered, restraints)
- Can't get to bathroom on time (call bell not answered, restraints, pain)
- Can't manipulate clothing quickly enough (eg. Has on containment product)
- Reduced mobility, leading to constipation
- Action:
  - Mobilize! Look to OT and PT for help

# Watch our for Post-Op Retention!

- Drugs and bugs especially when foley involved
- Look for possible neuro or cardio event (intra-operative stroke or MI)
- When in doubt do a post-void residual (preferably with bladder scanner)
- Positioning for toileting
- **MOBILIZE!**

# Lower Urinary Tract

If Urinary Incontinence persists,  
increase depth of assessment\*

# **Persistent UI**

Older adult's GOAL!!!

Assure appropriate investigations and  
treatments

Management improvements

# Stress Incontinence: Treatment

1. Pelvic muscle exercises with or without biofeedback / electrical stimulation
2. Bowel hygiene and management
3. Topical estrogen therapy
4. Routine voiding regimes and fluid management
5. Weight Loss (cautiously as elderly need enough nutritional reserves)
6. Pessaries if prolapse

# **Kegels and bladder support**

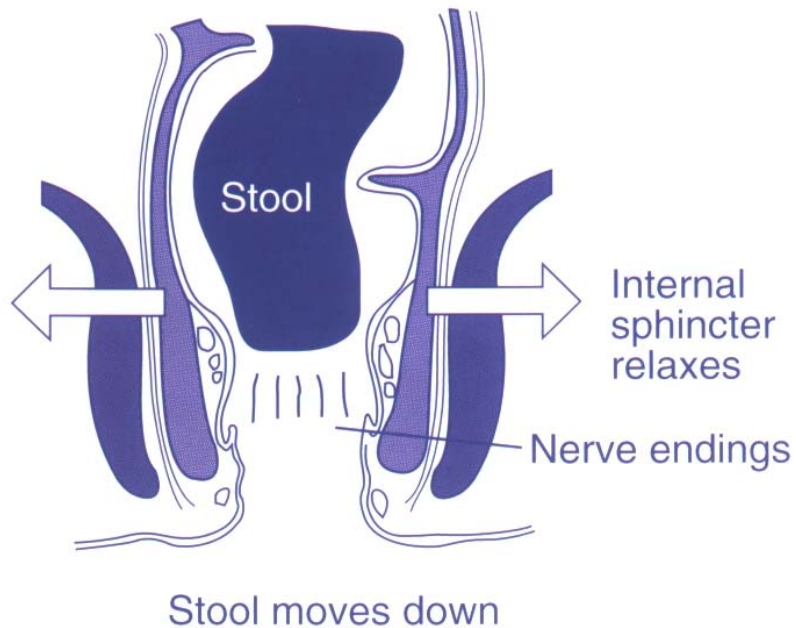
A fit pelvic floor helps support the bladder and bladder neck which then helps to prevent leaks.

# Constipation/Impaction

- Pushing, "bearing down" – pelvic floor strain
- Impaction – bypassing (urine and stool)
- Smearing/staining - ? rectocele as it can increase incidence of UTI
- Gastrocolic reflex – USE IT!
- Caution: The vicious cycle of treating one problem to create another (UTI, antibiotic, C-Diff)

# Control of Defecation

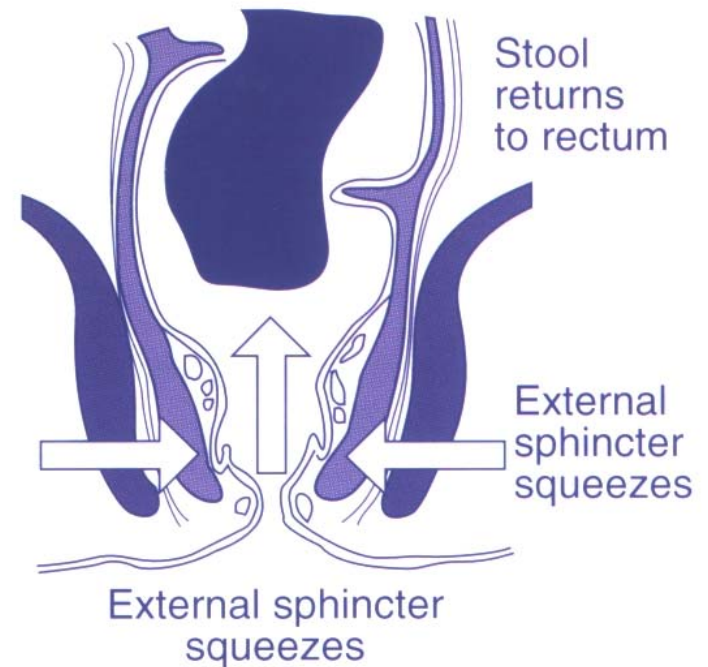
FIGURE 4



Sampling occurs – is it solid, liquid or gas? If on the toilet defecation occurs.

From "Bowel Control. Information and Practical Advice." Norton and Kamm

FIGURE 5



If not on the toilet the external sphincter contracts causing retrograde peristalsis and the feces is pushed back up through the anal canal and rectum to the colon.

# Be Proactive in Your Care

- Prevent the consequences as they are predictable!
  - Regular toileting – before leaving the patient ask: “Do you need to use the toilet?”
  - CORRECT and meticulous peri care
  - Correct use of appropriate containment product
  - Others?

# Being Proactive!

- If on opioids or any medications that are constipating get them on a bowel regime **BEFORE** the constipation or impaction
- Get it formed, get it down, get it out.
- Fluid, Fibre and Mobilize
- Regular toileting and positioning on toilet
- **IMPECCABLE** peri care!

# Urge Incontinence (OAB)

- “An involuntary loss of urine preceded by a strong urge to void a few seconds/minutes prior to loss of urine.”
- Occurs both day & night
- Presents as urgency, frequency (8+x’s/24 hrs), nocturia (2+ during night) & reduced ability to postpone voiding.
- “Abrupt sensation that voiding is imminent”.
- Presents as intermittent moderate to large amount of urine leakage
- MAJOR safety issue in elderly

# Urge Incontinence

- Bladder diary essential
- Treat and manage reversible factors
- Manage timing and amount of fluid
- Manage Functional Problems (Mobility)
  - Commode, urinal
  - Clothing that is easy to remove
- Behavioral treatment
  - Bladder (Re)training
  - Urge Suppression
- Medication (e.g. diuretic timing)

# Combining Behavior Treatment and Medication

Percent reductions in UI episodes after 8 weeks

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<b>Behavioral therapy alone</b> <b>(N = 8)</b> <b>57.5%</b>	<b>When drug therapy added</b> <b>(N = 8)</b> <b>88.5%</b>	<b><i>P</i>-value</b>  <b>0.034</b>
<b>Drug therapy alone</b> <b>(N = 21)</b> <b>72.7%</b>	<b>When behavioral therapy added</b> <b>(N = 27)</b> <b>84.3%</b>	<b>0.001</b>

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# Retention with Overflow Incontinence

- Periodic or continuous dribbling of urine resulting from urethral obstruction or weak bladder wall.
- Continuously incontinent of small amounts of urine both day & night
- Presents as difficulty starting the stream, weak or intermittent stream, post void dribbling, elevated PVR & a feeling of not emptying the bladder.
- There may be no sensation of bladder fullness associated with large residuals. Common in the elderly. However no good evidence nor consensus as to limit

# Overflow Incontinence

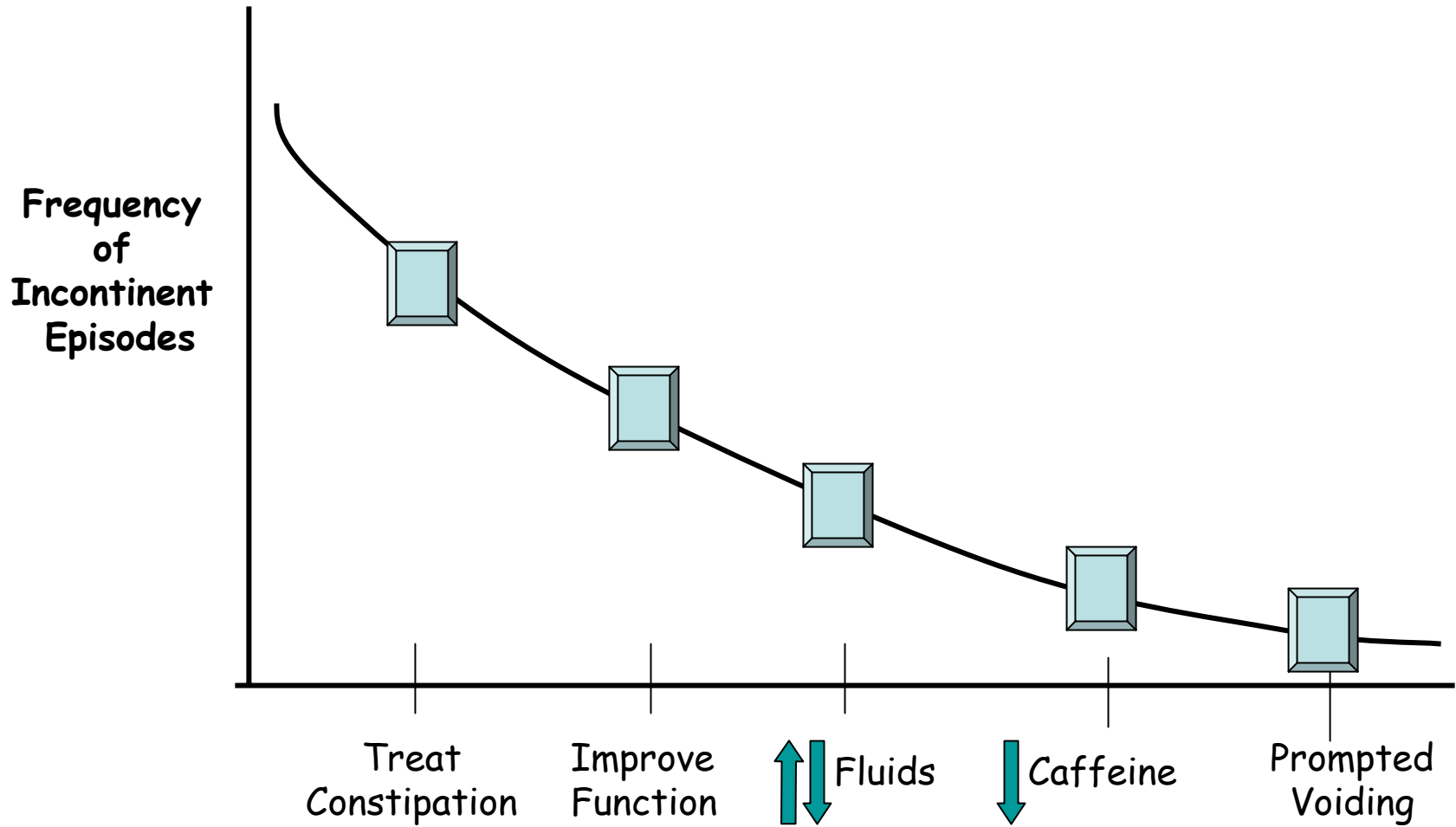
- Timed Voiding / Double Voiding
- Treat Constipation / Impaction
- Medications
- Abdominal Straining / Crede Maneuver
- Clean Intermittent Catheterization
- Pelvic Organ Prolapse - pessary/surgery
- BPH - Surgery

# Functional: Cognition/Mobility

- Occurs in combination with other factors that precipitate problems with incontinence.
- Functional and mobility problems (COPD with continuous O<sub>2</sub>; OA; Parkinson's; MS; Compression #; SCI)
- Cognitive problems (e.g. dementia, ABI, stroke)

# GOAL: Decrease Excess Disability Caused by Incontinence

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# Interventions

- Need to modify intervention plan to accommodate and compensate for impaired memory, comprehension, function and mobility.
- Raised toilet seats; contrast coloured toilet seats; grab bars; accessible clothing; commodes; urinals; timed and prompted voiding (RNAO guidelines); non-skid flooring; non-skid socks; fluid intake management
- Impeccable peri care!!!

PLEASE NO Automatically  
reaching for “HOOVER DAM”  
products when...

We know that proactive care  
works!

# Re-Gaining Control!

- Look at your older adults risk factors
- BE PROACTIVE!
- ASK and DO NOT assume...
- Be the solution to returning dignity!

Thank you for caring!!!

QUESTIONS?

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