

GUIDELINES ON URINARY INCONTINENCE

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Introduction

The condition of urinary incontinence is far more prevalent in women than men with a significant progress in incidence with the increase of age.

Diagnosis

The first contact a patient has with healthcare providers should always focus on basic diagnostic tests, a physical examination and careful assessment of the patient's history, since this approach is always readily available.

If an accurate diagnosis of the disease requires further investigation (e.g. complex situations, such as neuropathic bladder), or if the initial treatment has failed, specialized diagnostics and sub-specific treatment options may become necessary.

For practical reasons, the guidelines presented here have been split up according to the target sub-populations (women, men, patients with neuropathic bladders and elderly patients and

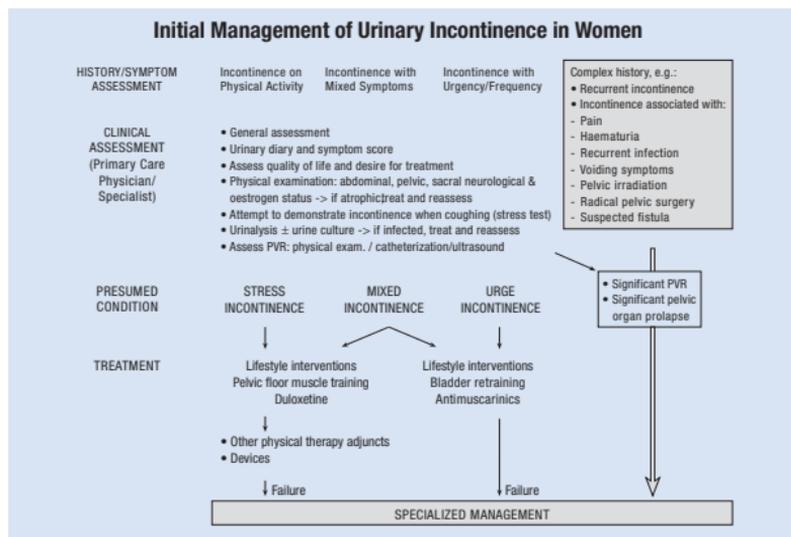
children). Each management algorithm is constructed chronologically and comprises the following features:

1. Assessment of the patient's history and symptoms
2. Clinical assessment of symptoms and disorders
3. Determination of condition and underlying pathophysiology
4. Therapeutic options, split into initial treatment and specialized therapy.

For comparability and research reasons, questionnaires on symptom scores and quality of life should be standardized. The validated ICIQ-SF questionnaire, developed by the International Consultation on Incontinence, represents a good compromise between scientific expectations and practicability and is therefore recommended for investigation of urinary incontinence.

Management of Urinary Incontinence in Women

Initial Management

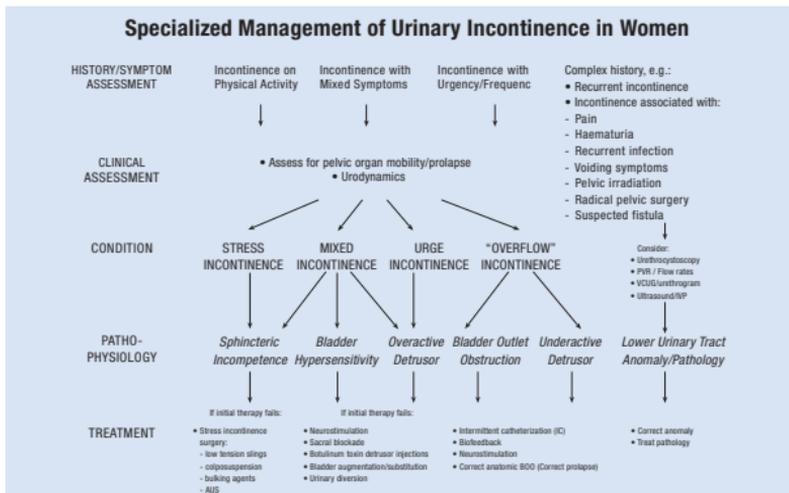


The introduction of the balanced serotonin and norepinephrine reuptake inhibitor duloxetine has enriched the conservative armamentarium of incontinence treatment in women. Its usefulness is especially promising if combined with pelvic floor exercises.

In patients with mixed incontinence, the predominant condition should be treated first.

Specialized management is necessary in women with complex history whose PVR exceeds 10% of the bladder capacity. Additionally, patients with significant pelvic organ prolapse and/or failed initial therapy should be referred to specialists promptly.

Specialized Management

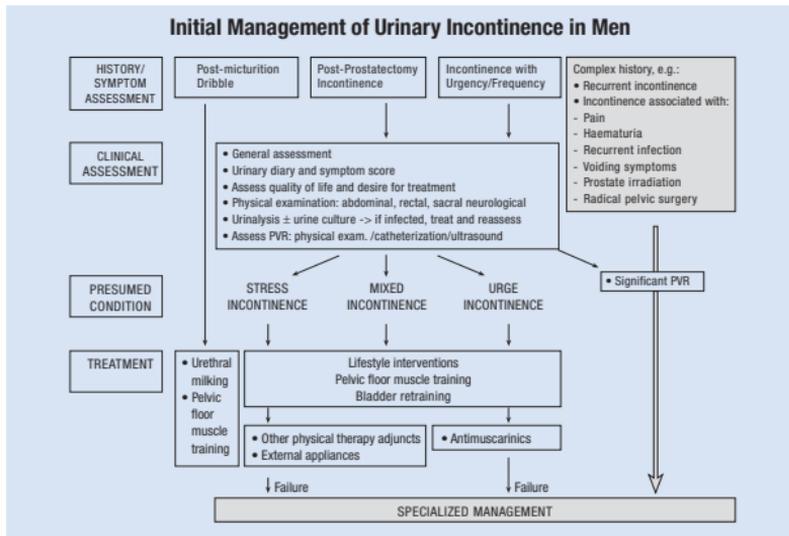


Only through cystometry can one differentiate between motor urge (overactive detrusor) and sensor urge (bladder hypersensitivity) in patients with symptoms suggestive of urge incontinence.

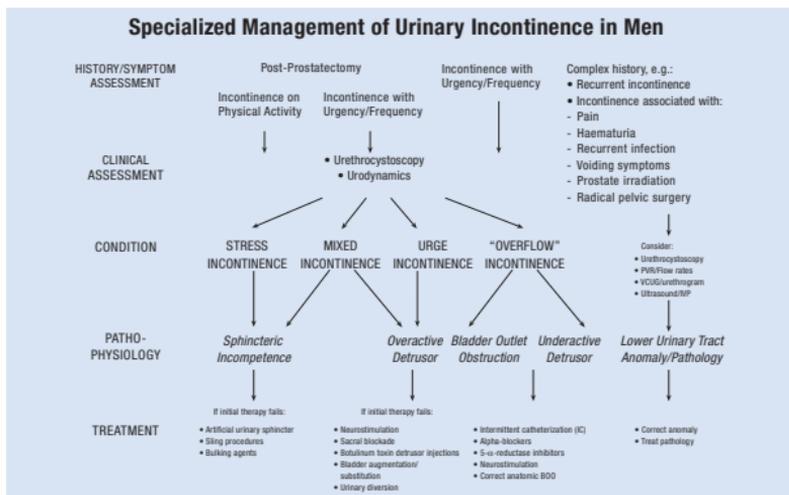
Recent studies have demonstrated promising results for botulinum toxin A detrusor injections in the treatment of urge incontinence. Since botulinum toxin is not approved for this indication, treatment should be restricted to specialized centres only.

Management of Urinary Incontinence in Men

Initial Management

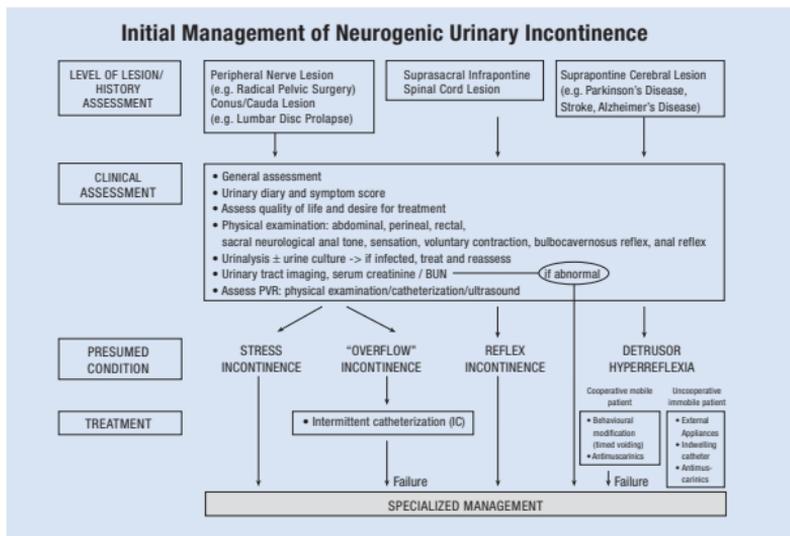


Specialized Management



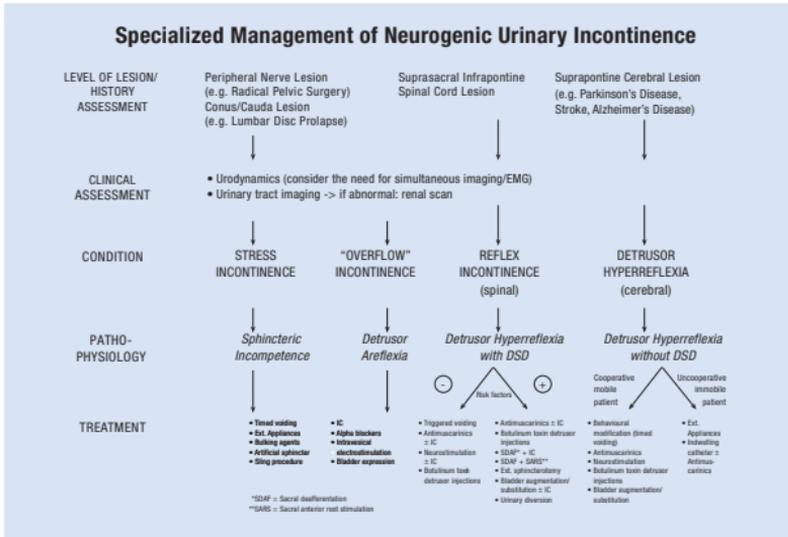
Management of Neurogenic Urinary Incontinence

Initial Management

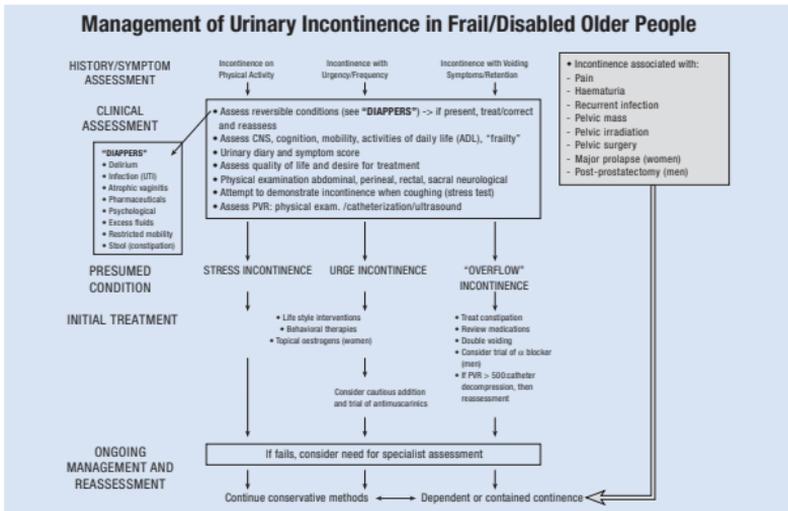


If the initial empirical treatment fails, special management is indicated for all cases of neurogenic incontinence.

Specialized Management



Management of Urinary Incontinence in Frail/Disabled Older People

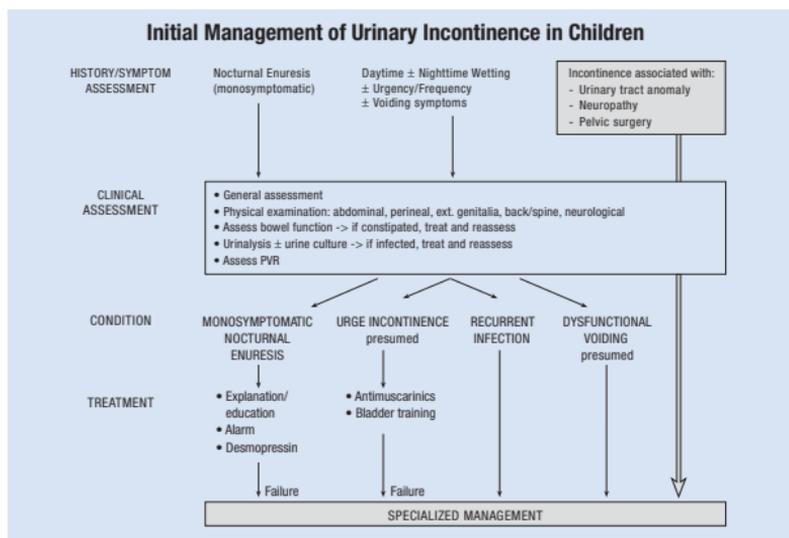


Due to their frequently impaired general health status, frail-disabled older people may be unfit for primary treatment regimens. In this case - or if initial treatment attempts fail – specialist reassessment and modified methods are indicated in order to achieve so-called ‘dependent’ or ‘contained’ continence.

Specialized management of urinary incontinence in frail-disabled people has to be individualized since it depends heavily on the patient’s condition.

Management of Urinary Incontinence in Children

Initial Management

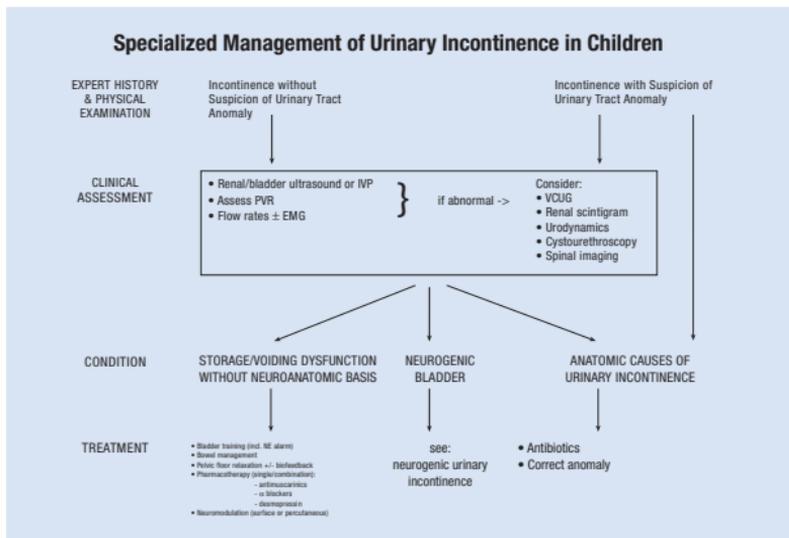


Post-void residual urine (PVR) is an important diagnostic parameter that should be evaluated in patients with a complex history.

If any form of initial therapy fails specialized management is required.

Any complex urinary incontinence which is considered to need specialized management requires further urodynamic evaluation and repeated PVR assessments, since the manifold treatment strategies strongly depend on the correct diagnosis, and usually have to be individualized.

Specialized Management



Conclusion

Since urological specialists are generally available throughout Europe, their intervention should not be restricted to the 'specialized' level of management. Although this may appear to challenge the division of the algorithms into 'initial' and 'specialized' management, early specialist involvement - even at the level of the patient's first presentation - is highly recommended. This avoids needless and expensive diagnostics, discouraging treatment failures and an unnecessarily prolonged course of the disease due to the lesser experience of 'generalists'.

This short booklet text is based on the ICI Recommendations (derived from the 3rd ICI Conference Monaco, 2004) and the more comprehensive EAU guidelines (ISBN 90-806179-3-8), available to all members of the European Association of Urology at their website - <http://www.uroweb.org>.