The assessment of continence problems in adults

Urinary incontinence is defined as a complaint, by a patient, of involuntary leakage of urine (Abrams et al, 2002). It is unpredictable and may be constant or occasional. Its effect on patients can be devastating.

**Prevalence** Urinary incontinence is a common condition. It is more predominant in women and its main causes are urethral sphincter incompetence and an overactive bladder (Thakar and Stanton, 2000).

Prevalence figures vary but the best available information (Department of Health, 2000) suggests that there is a prevalence in women of:

- Between one in 20 and one in 14 in those aged 15–44;
- Between one in 13 and one in seven in those aged 45–64;
- Between one in 10 and one in five in those aged 65 or over.

In men, the prevalence is:

- One in 33 in those aged 15–64;
- Between one in 14 and one in 10 in those aged 65 or over.

Prevalence for men and women living in institutions is:

- One in three in residential homes;
- Nearly two in three in nursing homes;
- A half to two-thirds in wards for older people, and older people with mental health problems.

**Integrated continence services and assessment** Good Practice in Continence Services (DoH, 2000) suggests that within integrated continence services, assessment should be available at four levels:

- **Level 4** assessment should be carried out in regional or national centres of excellence;
- **Level 3** should be undertaken by consultant medical and surgical specialists, and should include access to facilities such as urodynamic testing;
- **Level 2** should be provided by specialist continence services. In some areas, levels 2 and 3 are integrated;
- **Level 1** should be carried out in primary care.

This article describes the skills and knowledge necessary to carry out a level 1 assessment.

**Why is continence assessment necessary?**

Assessment is vital for patients with urinary symptoms to identify the underlying cause and contributory factors. Once a diagnosis is made, a treatment plan can be developed. If diagnosis is unclear or multifactorial, the patient may need referral for higher-level assessment.

Professionals who are ideally positioned to carry out the initial level 1 continence assessment include primary care professionals, and trained staff working in nursing, residential care homes and secondary care. Physical examination is an essential component of the assessment, but is sometimes omitted due to a lack of staff training. It may therefore be appropriate for one or two professionals within a primary health care team to develop their skills to carry out a physical examination and optimise the assessment and treatment process.

**Symptoms examined in a level 1 assessment**

In the report The Standardisation of Terminology of Lower Urinary Tract Function, Abrams at al (2002) divide lower urinary tract symptoms (LUTs) into three groups:

- **Storage symptoms** – experienced when urine is stored in the bladder. These include increased daytime frequency and nocturia (Box 1);
- **Voiding symptoms** – include a slow urinary stream, spraying, straining and an intermittent stream;
- **Post-micturition symptoms** – include feelings of incomplete emptying, and post-micturition dribble.

Level 1 assessment is suitable for patients with urine storage symptoms (Box 1). It could be suggested that those with voiding and post-micturition symptoms should be referred for level 2 or 3 assessment. Urinary symptoms are sometimes linked to storage and voiding problems, so referral for higher-level assessment must be made if there is doubt about the diagnosis.

**Key components of a level 1 assessment**

Good Practice in Continence Services (DoH, 2000) lists 10 key components of a level 1 assessment, considered here under four headings: history, physical examination, urine testing and contributory factors.
History This should include the following questions:
- What are the patient’s symptoms?
- How long have the symptoms been present?
- Does the patient experience urinary leakage? If so, how often does this occur and how much urine is lost? A severity index can be used and a useful tool is described by Hanley et al (2001).
- Are the symptoms better, the same or getting worse?
- What is the patient’s previous medical history? This should include childbirth and menopausal state in women, and previous surgery such as prostate surgery in men.
- What medication is the patient currently taking?
- What is the patient’s normal bowel habit?
- What is the type and volume of fluid intake? List these or use a bladder diary, which is described below.
- How do the symptoms impact on daily activities?
- What treatment alternatives does the patient wish to consider?

As part of the assessment process, the patient may be asked to complete a bladder diary. This is useful to record baseline information such as voiding times, volumes voided, type and volume of fluid intake, episodes of incontinence, and when incontinence pads are used.

Physical examination This should be carried out by a suitably trained health care professional and includes:
- Abdominal palpation – to detect the presence of a palpable mass, a loaded colon (indicating possible constipation), or palpable bladder (indicating possible urinary retention).
- Examination of the perineum in women – to assess the condition of the skin and vaginal tissues. It is important to note treatable conditions such as excoriation, and atrophic (postmenopausal) vaginitis caused by a deficiency of female sex hormones.
- Examination of the male genitalia – to assess the appearance of the prepuce (foreskin) and external urethral meatus.
- Vaginal examination – to identify pelvic organ prolapse and also to define pelvic floor muscle function. The tone of the pelvic floor muscles may be estimated at rest, and the strength of a voluntary contraction of the pelvic floor can be assessed. A validated graded system is often used, such as the PERFECT assessment technique to record pelvic floor tone (Laycock and Jerwood, 2001).
- Rectal examination should be performed if faecal impaction is suspected. It is also possible to assess anal tone at the same time. A digital rectal examination (DRE) can be carried out to assess the size and shape of the prostate gland in men. The DRE must only be carried out by a professional trained in this procedure.

Urine testing This should include:
- Routine urinalysis to exclude infection or previously undiagnosed diabetes;
- A midstream specimen should be obtained to exclude the possibility of infection or inflammation in all patients with incontinence (Shah and Leach, 2001);
- Urine cytology should be performed if symptoms of incontinence and haematuria (the presence of blood in urine) are present, or when red cells are seen on urine microscopy. This is to exclude cancers of the urinary tract, particularly in patients over 50 years of age who have irritative bladder symptoms (Shah and Leach, 2001).

Contributory factors The assessment must include factors that may affect the patient’s ability to be continent, such as:
- Manual dexterity;
- Accessibility of toilet facilities;
- Identification of conditions that may exacerbate incontinence, such as a chronic cough.

Treatment and product supply A diagnosis can be made after the assessment, unless the patient needs to be referred for a higher-level assessment. Good Practice in Continence Services states that initial treatment – for example, for stress urinary incontinence and urge urinary incontinence – can be performed in a primary care setting (DoH, 2000). Referrals can also be made for further assessment. Regular reassessment should take place to monitor the effectiveness of any treatment plans.

Products for the management of urinary symptoms – for example, absorbent pads – should not be issued routinely. The key principles of product supply are:
- Absorbent pads are only issued after an initial assessment of the patient;
- A full range of products is available;
- The supply of products should be governed by clinical need;
- The patient’s needs are reviewed on a regular basis (DoH, 2000).

Conclusion Within primary care, patients who present with urinary incontinence should be offered a timely and appropriate assessment of their symptoms and treatment. There must be access within the team to professionals trained in physical examination, including assessment of the pelvic floor.