Patient motivation in managing stress urinary incontinence

Louise Richards* presented to the continence service at 10 weeks postnatal. This was her first delivery, and she had experienced a long and active second-stage labour of several hours, resulting in a forceps delivery.

I completed Mrs Richards’s initial assessment at her home. She was a first-time mother, unable to drive, with little family support. Her midwife was no longer visiting, and she felt unable to talk to her health visitor, whose main focus she felt was the baby and provided little support to her.

It would not have been appropriate to offer Mrs Richards a clinic appointment, as she could not easily attend. The right environment to provide treatment was crucial; she felt secure and supported.

I carried out an assessment using the trust continence assessment tool and care pathway guidelines. Mrs Richards had not experienced any symptoms of stress urinary incontinence (SUI) during pregnancy, but since delivery had been experiencing urinary leakage when she coughed, sneezed and on occasions when bending down. She was using sanitary products to help manage leakage. Urinalysis showed no sign of infection.

Mrs Richards’s fluid intake was about 2 litres in 24 hours. She was breastfeeding, and was aware of the importance of adequate fluid intake. I gave her a diary to record her fluid intake, bladder function and leakage.

Mrs Richards had also suffered from constipation leading up to the birth, and in the weeks after delivery. I used the Bristol Stool Scale (Heaton and Lewis, 1997) and a trust bowel diary to assess stool type, discussed dietary and fluid intake and gave her advice with supporting information on dietary fibre and bladder irritants. I also advised her on correct toilet position, and again supported this with an information leaflet.

**Assessment results**
Completed bladder and bowel diaries identified a fluid intake of mainly tea with occasional juice and water. Maximum voided volume was 300ml with a normal voiding pattern. Urinary leakage occurred up to three times daily. Bristol stool type 2 was identified.

Mrs Richards was aware she was drinking large quantities of tea. I explained the caffeine irritant effect, and encouraged her to reduce the size of her mug, and increase water intake. I also again discussed importance of fluid intake for bowel function; Mrs Richards said she was trying to increase her fibre intake.

The continence team’s specialist physiotherapist undertook a pelvic floor examination. Muscle strength was rated according to the Modified Oxford Scale (Laycock and Jerwood, 2001); contraction on the left side was moderate 3, with the right side 2. Women graded 0, 1 or 2 are offered one or more of the following treatments: electrical stimulation, biofeedback or cones. Those graded 3, 4 or 5 are offered pelvic floor exercises (PFE) (The Charted Society of Physiotherapy, 2003). Mrs Richards wanted to try a PFE regimen, and we agreed a care plan with goals for four-weekly reviews.

**Treatment**
Mrs Richards needed a PFE programme that was designed to fit around her busy life as a new mother. I also encouraged her to call me for support if she was struggling. Realistic goals enabled her to build on the number of contractions at her own pace.

I telephoned Mrs Richards two weeks after assessment to check her progress. At her first review visit Mrs Richards felt she had made some improvement. Her urinary leakage had reduced, and she was able to contract and hold for five seconds, five repetitions, three times a day. She had reduced her caffeine intake and increased both dietary fibre and water intake. Mrs Richards was positive in her approach and encouraged her to continue and build on the pelvic floor contractions.

Further four-weekly reviews continued for four months, and Mrs Richards’s symptoms improved. By maintaining her PFE regimen, urinary leakages stopped and her confidence started to return. She no longer suffered from constipation and was aware of her dietary and fluid requirements.

The key factors in the success of this case were Mrs Richards’s self-motivation, and the fact that the programme and support were offered in a place acceptable to her. By initiating home visits and recognising the potential problems, such as Mrs Richards being unable to attend clinic, I was able to gain her confidence and draw up realistic goals to help improve symptoms.

*The patient’s name has been changed. NT*