Continence
Current Awareness Bulletin
February 2020

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Title: Can Pelvic Floor Muscle Training Versus No Treatment or Inactive Control Treatments Reduce or Cure Urinary Incontinence in Women?: A Cochrane Review Summary With Commentary.

Citation: American Journal of Physical Medicine & Rehabilitation; Feb 2020; vol. 99 (no. 2); p. 178-179
Author(s): Di Benedetto, Paolo

Abstract: The aim of this commentary is to summarize and discuss from a rehabilitation point of view the published Cochrane Review “Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women”. It mentions that effects of urinary incontinence on quarter to a third of women in their lifetime; and involuntary loss of urine during increased intra-abdominal pressure and involuntary leakage associated with or immediately preceded by a sudden and strong need to void.

Title: Association of Physical Activity With Urinary Incontinence in Older Women: A Systematic Review.

Citation: Journal of Aging & Physical Activity; Dec 2019; vol. 27 (no. 6); p. 906-913
Author(s): Faleiro, Deis J. A.; Menezes, Enaiane C.; Capeletto, Eduardo; Fank, Felipe; Porto, Rafaela M.; Mazo, Giovana Z.

Objective: To analyze the scientific evidence on the association of physical activity with urinary incontinence in older women.

Design: Searches were performed in MEDLINE, PubMed, CINAHL, Web of Science, SCOPUS, and ScienceDirect. Observational studies were included. The following search terms were used: urinary incontinence, older adult, and physical activity. Methodological quality was assessed using the checklist proposed by Downs and Black.

Results: Ten articles were included. Sedentary lifestyle and <150 min/week of physical activity are at risk of developing urinary incontinence. Walking (at least 30 min) and physical activities (600-1,500 and 600METs/min per week) prevent urinary incontinence. Seven of the 10 studies indicated a good level of methodological quality.

Conclusions: Sedentary lifestyle is at risk of urinary incontinence, and walking, moderate and vigorous physical activities are associated with prevention of urinary incontinence.

Title: Management of incontinence-associated dermatitis patients using a skin protectant in acute care: a case series.

Citation: Journal of Wound Care; Jan 2020; vol. 29 (no. 1); p. 18-26
Author(s): Acton, Claire; Ivins, Nicola; Bainbridge, Paul; Browning, Paul

Objective: Incontinence-associated dermatitis (IAD) is a common type of irritant contact dermatitis. It is categorised by persistent erythema and can be associated with denudation and/or colonisation and infection. IAD is challenging to treat and affects 3.4–50% of patients. This case
series evaluates a novel, elastomeric, advanced skin protectant (3M Cavilon Advanced Skin Protectant) in a UK acute health-care setting, for the management of IAD in patients suffering from moisture-associated skin damage (MASD) in the sacral/genital area. Method: The patient’s skin was assessed by clinicians using the GLOBIAD classification tool at the point of recruitment and to monitor progress throughout the study period. The product was applied as a single layer in accordance with the instructions for use. Patients, when able, were asked to assess their own pain level using the Wong-Baker FACES pain scale. Photographs were taken as part of the ongoing assessment.

**Results:** The skin protectant was used on average every 2.28 days. Of the 18 IAD patients recruited, 79% (n=11) were classified as IAD-free, based on the GLOBIAD categorisation tool, by the end of the evaluation period. Skin deterioration during the evaluation period was seen in one patient (6%), and of the patients able to complete pain assessments, 55% (n=6) reported a reduction in pain.

**Conclusion:** These results suggest that the elastomeric skin protectant, applied every three days, plays a role in the improvement of IAD. The skin protectant adheres to wet and weeping partial-thickness wounds and may aid IAD management. Reducing application to every third day supports a change in practice which may offer benefits to patients and caregivers.

**Title:** Management of urinary incontinence in women.

**Citation:** Prescriber; Jan 2020; vol. 31 (no. 1); p. 32-33

**Author(s):** Chaplin, Steve

**Abstract:** NICE’s guideline on the management of urinary incontinence in women has now been expanded to include pelvic organ prolapse. This article provides an overview of the latest guidance.

**Title:** A meta-ethnography to understand the experience of living with urinary incontinence: 'Is it just part and parcel of life?'

**Citation:** BMC urology; Jan 2020; vol. 20 (no. 1); p. 1

**Author(s):** Toye, Francine; Barker, Karen L

**Objective:** Urinary incontinence (UI) is highly prevalent and affects the lives of many men and women. We aimed to conduct a qualitative evidence synthesis (QES) to explore the experience of living with UI and to develop a conceptual model that can help us to understand this experience, and the potential barriers to appropriate healthcare.

**Methods:** We used the methods of meta-ethnography developed by Noblit and Hare and recently refined for larger studies. Meta-ethnography involves identifying concepts from the studies and abstracting these concepts into a line of argument. We searched for studies that explored the experience of adults with UI. We used the GRADE-CERQual framework to assess confidence in review findings.

**Results:** We screened 2307 titles, 429 abstracts, 107 full texts and included 41 studies (36 unique samples) in the synthesis. We organised the concepts into 26 conceptual categories, which we further abstracted into 6 themes: (1) Am I ill or is this normal? (2) It effects who I am and how I feel;
(3) I feel stigmatised, ashamed and guilty; (4) talking can be difficult but it can help; (5) keeping incontinence under control; (6) have I got to the point that I need help? Our model conceptualises living with UI as navigating antagonists: Is UI normal or am I ill? Do I need help or am I managing? Do I keep UI to myself (and manage alone) or do I tell other people (and get the support that I need)? Do I use control strategies that focus on concealing (avoid risky situations, wear pads) versus, I use strategies that focus on improving the bodily function to improve continence. Our model highlights the experience of stigma, shame and guilt which exert a pull towards concealment.

**Conclusions:** The culture of secrecy and profound sense of shame is barrier to seeking help. An environment which reduces the shame and stigma of UI may help people to switch the focus to strategies that will improve continence, rather than conceal incontinence.

**Title:** Urinary and fecal incontinence in stroke survivors followed in general practice: a retrospective cohort study.

**Citation:** Annals of physical and rehabilitation medicine; Jan 2020

**Author(s):** Jacob, Louis; Kostev, Karel

**Objective:** Investigating the short- and long-term health outcomes after stroke is a public health priority. We aimed to analyze the incidence of urinary and fecal incontinence within 10 years of stroke in individuals followed in general practice in Germany.

**Methods:** Individuals who had received an initial stroke diagnosis at one of 1,262 general practices in Germany between January 2006 and December 2015 were included (index date). Individuals without stroke were matched (1:1) to those with stroke based on propensity scores by using a “greedy” algorithm and logistic regression with sex, age, index year, and 17 comorbidities diagnosed in the 12 months before the index date. The main outcome of the study was the incidence of urinary and fecal incontinence within 10 years of stroke.

**Results:** This study analyzed data for 16,181 individuals with stroke and 16,181 without stroke. Within 10 years of the index date, 22% and 11% of men with and without stroke received a diagnosis of urinary incontinence (log-rank p<0.001); the prevalence of urinary incontinence was 34% in female stroke survivors and 17% in females with no history of stroke (log-rank p< 0.001). The respective proportions of fecal incontinence were 5% and 2% for men (log-rank p<0.001) and 6% and 3% for women (log-rank p< 0.001). Overall, stroke was positively associated with both urinary incontinence (men: hazard ratio [HR] 2.34, 95% CI 2.10-2.61; women: HR 2.36, 95% CI 2.14-2.61) and fecal incontinence (men: HR 2.43, 95% CI 1.88-3.13; women: HR 2.60, 95% CI 1.98-3.41).

**Conclusion:** This study, using data from Germany, suggests that general practitioners should regularly screen for urinary and fecal incontinence in the decade following stroke.

**Title:** Incontinence and swimming: helping patients to enjoy a more active life.

**Citation:** British journal of nursing (Mark Allen Publishing); Jan 2020; vol. 29 (no. 2); p. 92-93

**Author(s):** Hillery, Sarah
Title: Does pre-operative urodynamics lead to better outcomes in management of urinary incontinence in women? A linked systematic review and meta-analysis.

Citation: European journal of obstetrics, gynecology, and reproductive biology; Jan 2020; vol. 244; p. 141-153
Author(s): Lor, Kar Yee; Soupashi, Maria; Abdel-Fattah, Mohamed; Mostafa, Alyaa

Abstract: The use of preoperative urodynamics as a standard investigation for urinary incontinence (UI) has long been a subject of debate, with a lack of robust evidence to demonstrate improved patients’ outcomes. We aim to compare the clinical and cost effectiveness of urodynamics versus office clinical evaluation only, prior to the treatment of UI. We conducted three linked systematic reviews and meta-analyses of randomised controlled trials (RCTs) comparing urodynamics assessment versus clinical evaluation only in women prior to 1) non-surgical treatment of UI, 2a) surgical treatment of stress urinary incontinence (SUI) and 2b) invasive treatment for overactive bladder (OAB). Women with severe pelvic organ prolapse, previous continence surgery and neuropathic bladder were excluded. Primary outcomes were patient-reported and objective success post-treatment. Secondary outcomes were adverse events, quality of life, sexual function and health economic measures. We searched MEDLINE, Embase and Cochrane Central Register of Controlled Trials databases for each category, which was last updated on January 2019. Study selection, risk of bias assessment and data extraction were performed independently by two reviewers. The random effects model was used to assess risk ratio and mean difference with 95% confidence interval. Statistical heterogeneity was assessed by I2 statistics and the quality of evidence by the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach. Four RCTs compared urodynamics versus clinical evaluation only prior to non-surgical management of UI. Treatment consisted of pelvic floor muscle training, with or without pharmacological therapy. Meta-analysis of 150 women showed no evidence of significant difference in the patient-reported and objective success rates between groups (P = 0.520, RR: 0.91, 95% CI 0.69-1.21, I2 = 0% and P = 0.470, RR:0.87, 95% CI 0.59-1.28, I2 = n/a, respectively). Seven RCTs were identified for surgical management of SUI. The majority of women underwent mid-urethral tape procedures (retropubic or transobturator approach). Meta-analysis of 1149 women showed no evidence of significant difference in patient-reported (P = 0.850, RR:1.01, 95% CI 0.88-1.16, I2 = 53%) and objective success between groups (P = 0.630, RR:1.02, 95% CI 0.95-1.08, I2 = 28%). There was no significant difference in incidence of voiding dysfunction, de novo urgency, and urinary tract infection between groups. No RCTs were identified for invasive management of OAB. In conclusion, limited evidence shows that routine urodynamics prior to non-surgical management of UI or surgical management of SUI is not associated with improved treatment outcomes, when compared to clinical evaluation only. Well-designed clinical trials are needed to evaluate the clinical and cost-effectiveness of routine urodynamics prior to surgical management of SUI and OAB.

Title: Psychological issues surrounding faecal incontinence: experiences of patients and nurses.

Citation: British journal of community nursing; Jan 2020; vol. 25 (no. 1); p. 34-38
Author(s): Butcher, Lesley
Abstract: Continence care breaches social norms about privacy, nakedness and bodily functions. Faecal incontinence (FI) is a condition that is associated with a significant emotional impact, which extends to not only the patient but also the nurse or care worker. Patients can experience feelings of guilt and shame and a sense of ‘incompetence’, which can be connected to childhood experiences. Similarly, nurses and caregivers can encounter feelings of disgust and revulsion, which are often denied, as part of the perceived professional expectation. Nurses can develop self-protective behaviours including emotional detachment and development of a task-orientated approach to physical care. This can, in turn, accentuate the negative feelings experienced by patients with FI. Nurses developing self-awareness through reflection on their own difficult feelings can help to improve communication, which will meet patients’ emotional needs and improve the therapeutic relationship. This article aims to encourage nurses and care workers to develop an empathetic understanding of the basic human emotional responses experienced by patients. It also aims to improve nurses’ awareness of their own feelings and help them recognise the effect of these emotions on their own behaviours and their patients. Lastly, the importance of providing emotional care to patients with FI is discussed.

Title: Management of functional constipation in children and adults.

Citation: Nature reviews. Gastroenterology & hepatology; Jan 2020; vol. 17 (no. 1); p. 21-39

Author(s): Vriesman, Mana H; Koppen, Ilan J N; Camilleri, Michael; Di Lorenzo, Carlo; Benninga, Marc A

Abstract: Functional constipation is common in children and adults worldwide. Functional constipation shows similarities in children and adults, but important differences also exist regarding epidemiology, symptomatology, pathophysiology, diagnostic workup and therapeutic management. In children, the approach focuses on the behavioural nature of the disorder and the initial therapeutic steps involve toilet training and laxatives. In adults, management focuses on excluding an underlying cause and differentiating between different subtypes of functional constipation - normal transit, slow transit or an evacuation disorder - which has important therapeutic consequences. Treatment of adult functional constipation involves lifestyle interventions, pelvic floor interventions (in the presence of a rectal evacuation disorder) and pharmacological therapy. When conventional treatments fail, children and adults are considered to have intractable functional constipation, a troublesome and distressing condition. Intractable constipation is managed with a stepwise approach and in rare cases requires surgical interventions such as antegrade continence enemas in children or colectomy procedures for adults. New drugs, including prokinetic and prosecretory agents, and surgical strategies, such as sacral nerve stimulation, have the potential to improve the management of children and adults with intractable functional constipation.
Sources Used

The following databases are searched on a regular basis in the development of this bulletin:

British Nursing Index, Cinahl, Medline, King’s Fund & Health Foundation

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