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Incontinence: Silent No More

It is estimated that more than 1.5 million Canadians experience loss of bladder or bowel control,[1] with the majority being older adults living both in the community and in institutions.[2] Women are more often affected than men — as many as one in four adult women and one in ten adult men are affected by urinary incontinence during their lifetime.[3] Among seniors, more than one in five experience urinary incontinence.[4] It has been estimated that close to half of older residents of health care institutions experience urinary incontinence.[5] Incontinence itself is not a disease but is a symptom of some other problems with the body. It may be the result of weakening of the pelvic floor muscles, a disease such as muscular sclerosis, Alzheimer disease, Parkinson's, stroke and other neurological diseases, injuries, or the side effects of medications or surgery. Incontinence is not caused by being female or by aging.[6]

Even with a relatively high incidence, the condition is highly misunderstood. An Angus Reid random survey of 1,515 men and women, 18 years of age and over, conducted in September 1998, revealed that although 33 percent knew at least one person who suffered from a weak bladder, 45 percent were unable to define the word incontinence, and 7 percent defined it incorrectly as "problems with the stomach" or "inability to cope with life." As Malvina Klag, Executive Director of The Canadian Continence Foundation (which commissioned the survey) remarked: "It is distressing to think that half of the Canadian population has no idea what incontinence is."[7]

Despite the suffering, incontinence is likely under-reported in the wider population. A 1997 study reported by the

Ask yourself these questions

Do you leak urine when you laugh, cough, sneeze, lift something heavy or exercise?

Do you lose urine on the way to the bathroom or toilet?

Do you wet the bed at night?

Do you go to the bathroom frequently because you are afraid of wetting yourself?

Are you using pads or absorbent products to collect urine?

If you answered yes to any of the above, the information in this newsletter is important to you.

Canada

My Story

For a long time, my quality of life was affected by incontinence problems. But today, I know that thanks to the right exercises and medications, I will finally be able to control these problems.

With all the solutions available today for individuals experiencing incontinence, one should not hesitate to consult a specialist. One can only improve and become happier.

As "patients," we must help these wonderful medical and research teams, and we must make The Canadian Continence Foundation our fighting force. Even sharing our own stories and common points of view will help.

I will end by telling you that I am stronger because of this journey.

Mme Lise Renaud
(Excerpt from The Canadian Continence Foundation newsletter **The Informer**)

Canadian Medical Association Journal[8] estimated that about 45 percent of people experiencing symptoms never mention them to a doctor or a health care professional. Whether from embarrassment, limited information, fear of surgery or fear of confinement to an institution, many sufferers hide the condition, often curtailing their activities and seldom discussing the impact it has on their lives and relationships. In a 1997 survey of 800 Canadians experiencing incontinence, nearly 90 percent reported a negative impact on their overall feeling of well-being, over 80 percent reported feelings of embarrassment or frustration, and over 73 percent reported feeling discouraged. These feelings increased in respondents who had experienced five or more years of incontinence.[9]

The good news is that incontinence, once identified and its underlying causes understood, can almost always be cured, treated or managed. Many previous sufferers have reclaimed lost parts of their lives. Those whose lives are affected can benefit from consulting a knowledgeable and sympathetic health professional with a particular expertise and interest in incontinence such as a family doctor, physiotherapist, Nurse Continence Advisor, gynecologist, urologist or geriatrician. Surgery and continence management products are not the only solution — many conservative treatments, such as pelvic muscle exercises to improve bladder support, have been shown to make a difference.

The different types of incontinence

There are basically four kinds of adult urinary incontinence: stress, urge, overflow, and functional incontinence. They may occur alone, or in combination, especially in seniors. There is also transient (or acute)

incontinence which may be caused by a new medical problem, such as a urinary tract infection. Certain medications can also cause or contribute to an incontinence problem.

Stress incontinence

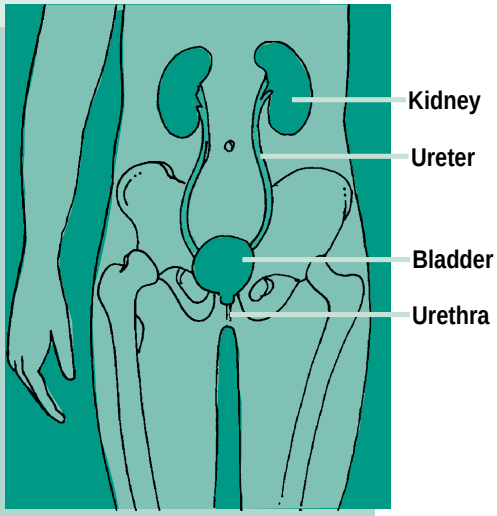
Stress incontinence is the involuntary leakage of small amounts of urine in response to increased pressure on the bladder, for instance when a person sneezes, coughs, laughs, or lifts heavy objects. Stress incontinence is seen mainly in women and is present in about 35 percent of incontinent seniors. Stress incontinence results from either weakened support of the pelvic muscles and/or sphincter weakness. The problem often begins in women where childbirth has caused a relaxation of the pelvic muscles. It also occurs, usually temporarily, in men who have undergone prostate surgery.

Urge incontinence

Urge incontinence is the leakage of significant amounts of urine when a person is unable to reach a toilet after getting the urge to urinate. Symptoms include urine loss on the way to the bathroom or "key in the lock" syndrome. Urge incontinence is the most common (60-70 percent) pattern in seniors. A condition called "unstable bladder" also occurs with urge incontinence and is associated with disorders of the

Glossary of medical terms

Bladder	A sac that temporarily retains urine and discharges from the urethra.
Catheter	A tubular device inserted into the urethra to withdraw urine.
Faecal incontinence	Loss of bowel control.
Kegel exercises	Repetitive contractions to increase the tone of the pelvic floor muscles.
Micturition	The desire to urinate.
Prostate gland	A partly muscular, partly glandular body, situated about the base of the male urethra, that secretes the fluid which is a major constituent of ejaculatory fluid.
Rectum	Straight part of the intestine before the anus.
SUI	Stress urinary incontinence.
UUI	Urge urinary incontinence.
Ureter	A duct that carries urine away from a kidney to the bladder.
Ureteritis	Inflammation of the ureter.
Urethra	The canal which carries urine from the bladder to outside the body and, in males, also carries ejaculatory fluid.
Urinary incontinence	Loss of bladder control.
Urinary system	The organs of the urinary tract — the kidneys, ureters, bladder and urethra.
Urologist	A physician specializing in the urinary and urogenital tract.
UTI	Urinary tract infection.



Source: **Merriam Webster Collegiate Dictionary,** 10th edition

urinary tract or neurologic system. Persons with urge incontinence may also strain to urinate and/or retain urine in their bladder.

Overflow incontinence

Overflow incontinence accounts for 10-15 percent of urinary incontinence. Overflow leakage of urine occurs when there is an obstruction in the bladder. The obstruction leads to overfill of the bladder and incontinence results when the bladder contracts. Usually, the person does not know why she/he leaks urine and frequent leakage is common. Often there is little sensation of bladder fullness and the stream of urine is weak.

Functional incontinence

Functional incontinence accounts for 25 percent of the incontinence seen in institutions and results when a person has difficulty moving from one place to another. Poor vision, hearing or speech may also interfere with reaching the toilet or notifying caregivers of the need to use the toilet.

This type of incontinence can also occur in the home. Often the person complains that she/he "cannot hold my urine until I can get to the bathroom." This is usually due to decreased mental function, impaired physical ability, and/or unwillingness to go to the toilet.

What to do about incontinence

There are various ways to address the incontinence problem so that it can be cured treated or managed.

Get a professional assessment

There are many qualified health care professionals who can do an assessment for you. The Canadian Continence Foundation (see **Resources**) maintains a database of continence clinics and specialists, including outreach/home care services, in communities across Canada.

Assessment and treatment depends on the type of incontinence you have, your age, medical history, and how you choose to proceed. Assessments should be performed by a knowledgeable general

What is a Nurse Continence Advisor?

The role of Nurse Continence Advisor (NCA) was established in England in 1974 to respond to the need for incontinence management in the community. An NCA is a nurse specialist who provides assessment and appropriate conservative treatment and/or management of incontinence. NCAs are also familiar with the cost and effectiveness of various products used to manage incontinence.

NCAs were introduced in Canada in 1995 when the Ontario Ministry of Health funded the training of 37 NCAs to work with the province's Home Care Programs. By early 1999 about 80 NCAs had been trained, including several in British Columbia and Manitoba. The six- to nine-month course is offered as a distance education program through McMaster University. The academic component is the equivalent of a full university course, about 150 educational hours of work, plus 150 hours of clinical work — 75 hours with a trained NCA and 75 hours working independently.

practitioner, a physiotherapist specializing in incontinence, a Nurse Continence Advisor (NCA) (see sidebar, p. 4) or a specialist such as a urologist. The assessment includes a medical history and physical examination, a mental assessment (if indicated), and an assessment of one's surroundings.

Some experts suggest keeping a bladder diary for a week, writing down the time you use the toilet each day, any accidents or leakage, the possible reason, and the amount (and type) of fluid intake. This will be important to bring with you when you see your health professional.

From your bladder diary, your health professional will be able to see the characteristics of your condition and the patterns of your incontinence behaviour, including onset, frequency, and severity. Symptoms can be classified as irritative or obstructive. Irritative symptoms include increased frequency and urgency and can usually be controlled by changing some behaviour patterns. Obstructive symptoms include hesitancy, dribbling, intermittent urination, lower abdominal pain, an intense desire to urinate and a feeling of not completely emptying the bladder.

Significant past medical history for women includes number of births, recurrent urinary tract infections, bladder repair surgery and current medications. For men, a history of prostate surgery is significant.

Modify your surroundings

Difficulty in reaching the toilet may often contribute to incontinence and can be addressed by changes to your surroundings such as providing higher toilet seats, bathroom grab bars and toilet seat arms. Clothing that is difficult to remove or undo, including pads worn for protection, can affect continence. For semi-mobile or immobile patients, bedside commodes, male and female urine collective devices or catheters may sometimes be appropriate (see "Publications," p. 17, for guides to incontinence products).

Have a physical examination

A physical examination generally includes a visual inspection to determine your general skin condition and color, and any structural abnormalities. As well, a pelvic, vaginal and/or rectal assessment will be made. A rectal exam is performed to determine the consistency of the faeces, sphincter tone and sensation. In men, the rectal examination includes an assessment of the size and consistency of the prostate.

The examination may also involve urinalysis to rule out bladder or urinary tract infection. This is usually done right in the medical office, by using a treated dipstick on your urine sample. Urinary tract infection, which is often a cause of

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Kegel exercises

Dr. Arnold Kegel, an American gynecologist, developed these exercises in the 1940s. They are designed to help the pelvic floor muscles become firmer, thicker and broader.

Locate the pelvic floor muscles

Step 1: Sit forward on your chair and place your feet and knees wide apart. Place your elbows on your knees and lean forward. Your pelvic floor should be touching the seat.

Step 2: Close your eyes and imagine stopping yourself from passing wind.

Step 3: Squeeze the muscles tightly around your back and front passages and lift your pelvic floor up and away from the chair. **Do NOT**:

- bear down as during a contraction
- use tummy, thigh or buttock muscles
- hold your breath

Exercises

- First squeeze the pelvic muscles for as long as is comfortable (10 seconds is the eventual aim).
- Rest for four seconds.
- Repeat squeezing, followed by a rest, for as many times as is comfortable (10 repeats is the eventual aim).
- Finish the exercise routine with five short squeezes.

Experts suggest practising the exercises at least six times a day — while watching television (using a repetitive ad to remind you), or whenever you hear the news on the radio. Make them a part of your life. Tighten the muscles when you walk, before you laugh, cough or sneeze, as you stand up, lift or push, and particularly on the way to the bathroom after you have controlled an urge to urinate.

transient incontinence, should be treated before other treatments are begun. Urine can also show the presence of glucose, an indicator of diabetes which may be an underlying cause of incontinence.

Treating incontinence

Conservative treatment options for incontinence include bladder retraining, strengthening the pelvic floor muscles, making dietary changes, vaginal weight training, biofeedback and electrical stimulation. These options can be discussed with your health care professional to assess the best source of help or referral.

Less conservative treatments include medication, as well as surgical treatments including bladder suspension, artificial sphincter, and collagen injections. Surgical methods for treating incontinence should be discussed with a specialist (urologist or urogynecologist).

Toning the pelvic floor muscles helps to support the bladder and decreases frequency as well as urgency of urination.

Bladder retraining

Bladder retraining can be very effective for people who suffer primarily from urge incontinence. Using the information from the bladder diary, the client and health care provider devise a schedule for urination. Initially this may be at hourly intervals, but the time between trips to the toilet is gradually increased. Over several weeks or months, the cycle approaches a normal interval of about four hours. At that point, the brain is in control of bladder emptying, not vice versa.

During bladder retraining, many health care professionals suggest that you drink between six and eight glasses of non-caffeinated, non-carbonated liquids every day, but cut back on liquids after 6 p.m. if you are waking more than once in the night to urinate. Do not go to the bathroom before you have the urge to urinate. Never rush to the bathroom but use deep breathing until the urge passes. Practise pelvic muscle contractions (Kegel exercises) to control the urge to urinate.

Timed elimination (usually every two hours) and prompted elimination (offering use of the toilet on a regular schedule) can be used to manage urinary incontinence among patients who have no conscious control over their bladders, who are debilitated or immobile, or who are unmotivated to increase the times between urination.

Strengthening the pelvic floor muscles

The pelvic floor supports all the organs inside the abdomen, especially when standing upright, and helps to hold the bladder in its correct place. Women with stress incontinence — those who regularly leak urine when coughing, sneezing or exercising — especially need to learn these exercises. Men will also benefit if they are experiencing incontinence after prostate surgery.

Toning the pelvic floor muscles helps to support the bladder and decreases frequency as well as urgency of urination. In fact, urinary continence may be difficult to maintain without strong pelvic floor

muscles. The best way to have good bladder and bowel control is to get these muscles working well and keep them that way.

It may take several months to achieve consistent pelvic floor muscle control, but people often experience improvement immediately after starting the exercises. According to Claudia Brown, a Montreal physiotherapist who uses Kegel exercises (as well as biofeedback and electrical stimulation) to treat urinary incontinence, only six clients in a hundred don't improve at all, and the majority experience more than 70 percent improvement. It is very important that these exercises are taught by a knowledgeable professional, such as a physiotherapist or a Nurse Continence Advisor. If the wrong muscles are exercised, there will be no benefit.

Dietary changes

Research suggests the importance of limiting alcohol, sugar (including artificial sweeteners), and foods and drinks containing caffeine, which cause the body to shed water. Caffeine is found in chocolate, coffee and tea, as well as many soft drinks (which also contain high amounts of sugar). Sugar, like alcohol, irritates the bladder.

Drink lots of liquids, particularly water, and eat foods high in fibre to alleviate constipation, which can contribute to incontinence, especially in seniors. Coarse wheat bran, found in some types of whole wheat bread, can be purchased at health food stores and added to breakfast cereal, cottage cheese, gravies, and even applesauce. It takes some time to work and, for the first while, may cause increased gas, but it is worth persisting. Talk to your doctor about the possibility of taking laxatives if the above steps do not bring relief.

Pure cranberry juice or cranberry juice capsules (available in health food stores) are effective in flushing Ecoli bacteria from the bladder, a primary cause of bladder infections. Yogurt containing active yogurt culture will benefit the urinary system of both men and women.

Drink lots of liquids, particularly water, and eat foods high in fibre to alleviate constipation, which can contribute to incontinence, especially in seniors.

Vaginal weight training

For women, a set of vaginal weights can be inserted in the vagina twice a day for about 10 minutes. The weight can then be increased gradually over time to strengthen the pelvic muscles.

Biofeedback

Biofeedback, using a probe or surface electrode in combination with a biofeedback machine, can be used to locate the pelvic muscles before starting exercises (see p. 6). When the correct muscles are contracted, the machine emits a signal. The strength and duration of the contraction can also be measured.

People who experience excessive bladder contractions may benefit from medications designed to reduce them. Excessive sphincter contractions can also be treated with medicine, as can an underactive bladder. Some prescription drugs have side effects which should be discussed with your doctor.

Electrical stimulation

For this treatment, a mild electrical current is applied to the muscle fibers in the pelvic floor using a vaginal or anal electrode. This produces an involuntary contraction of the pelvic floor muscles, helping to pinpoint their location. Electrical stimulation is often combined with biofeedback to help develop voluntary contraction of the muscles.

Medication

People who experience excessive bladder contractions may benefit from medications designed to reduce them. Excessive sphincter contractions can also be treated with medicine, as can an underactive bladder. Some prescription drugs have side effects which should be discussed with your doctor. For post-menopausal women, estrogen (administered by vaginal cream, patch or tablet) may strengthen the urethra and/or reduce inflammation. However, using estrogen in the management of urinary incontinence is not yet firmly established. ■

Endnotes

1. The Canadian Continence Foundation, **Is Urine Leakage, Keeping You from Sex, Laughing, Golf, Socializing?** (Canadian Continence Foundation, 1998, brochure).
2. Ian McDowell. **Analysis of Urinary and Faecal Incontinence in the Canadian Population Using Data from the Canadian Study of Health and Aging** (Ottawa: University of Ottawa, Department of Epidemiology and Community Medicine, Faculty of Medicine, March 1998).
3. J. Hamilton. "Incontinence a Hidden Medical Problem, Study Finds," **Canadian Medical Association Journal**, 157 (1997): 1501.
4. M. Klag. "Experiences, Perceptions and Needs Among a Large-Scale Canadian Population Experiencing Incontinence in the Community." (The Canadian Continence Foundation: 1999).
5. P. Tully and C. Mohl. "Older Residents of Health Care Institutions," **Health Reports**, Vol. 7, No. 3: 27-30 (Ottawa: Statistics Canada, 1995).
6. The Canadian Continence Foundation, op.cit.
7. The Canadian Continence Foundation, "New Survey Reveals Canadians' Most Embarrassing Pharmacy Purchase." (Press Release, 1999).
8. J. Hamilton, op.cit.
9. M. Klag, op.cit.

Managing Incontinence Effectively:

The Collaborative Continence Program

Jennifer Skelly, RN, PhD, helped found and is the Director of the Collaborative Continence Program at St. Joseph's Community Health Centre in Hamilton, Ontario.

Q ***Tell me about the Collaborative Continence Program.***

A The program is just finishing its fifth year. To my knowledge, it is unique in Canada in that it is independently nurse directed. We get 80 percent of our referrals from family physicians and 20 percent self-referrals, but when we started it was the exact opposite. I think that's because doctors have now seen what we've been able to achieve with conservative types of treatment. We try very hard to avoid the use of medication or surgery. We use pelvic muscle exercise training, and changing the amount (or type) of fluid people are drinking. If there is a large caffeine intake, we really encourage them to switch to decaffeinated beverages. Sometimes it's a question of urinating routinely, before the urge occurs, and often that will be successful.

Q ***Are there special circumstances related to seniors?***

A We particularly look at how well they are coping on their own, what their hand function is like (which would be a factor in their ability to undo clothing), and what mobility they have. We are also interested in how well the bowels are functioning because constipation contributes to at least 50 percent of the problem with many seniors. With Alzheimer disease or dementia, individuals sometimes lose the ability to understand the subliminal cue that tells them they need to go to the toilet. Sometimes this also happens after a stroke. Sometimes they forget where the toilet is. With Alzheimer disease, it becomes a case of the caregiver always providing that direction. For people who live on their own, a watch can be set to beep every two hours. That works very well in the early stages. But if memory is failing they may not remember what the beep is for.

A lot of people are mortified at the thought of talking to someone about their condition. ... Usually they leave very relieved to have found someone who understands and with whom they can talk.

Q ***Do you find clients apprehensive?***

A There's a certain amount of fear, especially if they've already had some kind of testing. A lot of people are mortified at the thought of talking to someone about their condition. Many are in tears when they first talk about it, because it has been such a big frustration. Usually they leave very relieved to have found someone who understands and with whom they can talk.

Q ***Do more women than men experience incontinence?***

A Yes. An interesting ratio, reported by the Australian Continence Foundation, is that one in four women and one in 10 men will have had a problem with incontinence in their lifetime. The more disability involved the

more likely there will be a problem. Then too, a lot of younger women have a problem with leakage when they laugh, cough or sneeze. They assume that's normal, whereas pelvic muscle exercises will improve or get rid of it. We are working hard to make people aware that it's a treatable problem and more doctors are referring clients with onset symptoms.

Q ***How do you assess your clients, particularly seniors?***

A With all clients we do an extensive history. We have them urinate to measure the amount of urine and check for urinary tract infection. Then we use an ultrasound to scan the bladder to make sure it is emptying properly. With women we examine the labia and put one finger into the vagina to check muscle tone. If there are larger problems that are beyond the scope of our practice, we refer them on to a urogynaecologist or a urologist.

Q ***What are some of the underlying problems that may cause incontinence?***

A Probably 20 percent of people with a problem also have an infection, and seniors often have no idea they have an infection because they don't have burning or discharge. Often the only symptom is the onset or an increase in incontinence. We use urine dipsticks to check for infection. The dipsticks also register glucose. If someone with diabetes is seeing me for urgency and night time frequency and they are showing high sugar during the day, getting them back on track with their diet often solves the nighttime problem.

Q ***Are there special problems men face?***

A We work with one urologist who refers clients to us before radical prostate surgery. This allows us the opportunity to teach Kegel exercises beforehand, to tell the client what it's going to be like when the catheter comes out, and prepare them for the fact that they may experience a little or a lot of incontinence at first. In fact, we saw a gentleman yesterday who first came in five weeks ago, had his surgery four weeks ago, and is now at least three months ahead of the people we don't see until three, six, or nine months after surgery.

Q ***Are Kegel exercises effective?***

A Yes, but if they have not been taught properly, they don't work. We no longer recommend stopping and starting voiding as a method of locating the appropriate pelvic muscles, because voiding isn't just about muscle control. Now we teach people to tighten their rectum. It's a simple exercise to do, but you'd be amazed at the number of people who think it's about tightening their buttocks, or tightening up their abdomen, or doing pelvic tilts. ■

The *Myth* and the Reality

Q ***Is incontinence (poor bladder control) normal in aging?***

A No. About five out of six older people never have any problem with bladder control.

Q ***Do bladder control problems become more common in aging?***

A Yes. Only about one in 20 younger adults are affected, but one in six people over 65 develop them. The number continues to rise with increasing age. In long-term care institutions the number of elderly people with bladder control problems is very high — about one in two.

Q ***If bladder control problems are not normal, why are they so common?***

A Proper bladder control requires a fine balance between the bladder and the brain (as well as good pelvic muscle tone). As we get older, this balance can be upset by diseases that affect the brain, such as strokes, Parkinson's and Alzheimer disease. Other factors may aggravate the situation, such as difficulty getting to the bathroom, forgetting where the bathroom is, not feeling a full bladder, incomplete emptying of the bladder, constipation and medications.

Q ***Can anything be done about severe incontinence problems that may develop during aging?***

A Something can almost always be done to improve the situation. Begin with a professional assessment to discover the causes and to discuss treatment, examining possible aggravating factors in order to change them and, where necessary, selecting continence aids or appliances.

Thanks to the Northern Alberta Continence Service.

A study of incontinence among seniors

A 1998 study by Dr. Ian McDowell, Department of Epidemiology and Community Medicine, University of Ottawa, analyzed urinary and faecal incontinence among Canadian seniors using data obtained from the 1991 Canadian Study of Health and Aging (CSHA). The survey clinically assessed 2,914 seniors nationwide, 1,659 of whom (682 men and 977 women) resided in the community and 1,255 (356 men and 899 women) in institutions. The analysis was commissioned by Health Canada's Division of Aging and Seniors to provide a clearer picture of incontinence among older Canadians and to estimate the prevalence of incontinence in seniors, by gender, age, residence, mental awareness, and mobility/immobility. The study results showed that urinary incontinence affects some 95,900 men and 250,500 women in Canada, while faecal incontinence affects approximately 22,000 men and 67,000 women. Among those in institutions, about 19,800 men and 48,700 women experience both urinary and faecal incontinence, whereas in the community, just under 1,000 men and 10,000 women experience both types of incontinence.

Slightly more than 5 percent of the men in the study and seven per cent of the women experienced daily urinary incontinence. After age 84, daily urinary incontinence noticeably increased (men 14.8 percent and women 23.5 percent), as it did for those suffering from severe dementia (men 64 percent and women 63.5 percent), and for those who were immobile (men 72.2 percent and women 75.4 percent). For seniors in institutions, daily urinary incontinence was nine to ten times higher (men 36.8 percent and women 36.9 percent) than among seniors residing in the community.

A smaller proportion of seniors (1.2 percent of men and 2.6 percent of women) experienced daily faecal incontinence. After age 84, daily faecal incontinence noticeably increased (men 6.1 percent and women 11.7 percent), as it did for those suffering from severe dementia (men 58.1 percent and women 56.8 percent). Among immobile men in the study, the incidence of daily faecal incontinence was about 52 percent, while almost 64 percent of women were incontinent on a daily basis. For all seniors in institutions, daily faecal incontinence was much higher for both sexes (men 23.6 percent and women 25.6 percent) than in the community (less than 1 percent). Approximately 93 percent of those reporting daily faecal incontinence also reported daily urinary incontinence.

The study results showed that urinary incontinence affects some 95,900 men and 250,500 women in Canada.

The study results indicate that incontinence affects more women than men (an effect partly due to the higher age of the women in the study). For both men and women, the prevalence of urinary and faecal incontinence increases with age, institutionalization, failing mental powers, and loss of mobility. Severe dementia and immobility are the factors most strongly associated with incontinence. ■

Source: Analysis of urinary and faecal incontinence in the Canadian population using data from the Canadian Study of Health and Aging, Ian McDowell, Department of Epidemiology and Community Medicine, Faculty of Medicine, University of Ottawa. Knowledge Development Unit, Division of Aging and Seniors, Health Canada, 1998.

Some Causes of Incontinence

Incontinence can result from a number of factors — some of these may be medical, while others may be related to certain types of medication.

Medical problems that may contribute to incontinence

CAUSE	REASON
Constipation	Faeces can block urine flow and/or cause urine to be retained. Persons with constipation complain of either urge or overflow incontinence, and may also experience faecal (bowel) incontinence.
Infection urethritis	Irritation from a bladder infection may cause or worsen urge incontinence. As well, a decrease in the estrogen hormone in women causes changes in the vagina and around the urethra contributing to urge and stress incontinence symptoms.
Large urine	Results from drinking large amounts of fluids, or from certain medical conditions that lead to increased output (e.g., high calcium levels, and high sugar levels). In persons with congestive heart failure, swelling in the legs can cause rapid and excessive bladder filling.
Urinary retention	Large amounts of urine remain in the bladder after urination.
Restricted mobility	Decreased function or limited mobility can contribute to incontinence (e.g., arthritis, poor eyesight, Parkinson's disease).

Medications that may contribute to incontinence

MEDICATION	EFFECTS
Diuretics (water pills)	Water shedding (as a result of taking diuretics) may precipitate incontinence — particularly in seniors and/or in those with impaired continence.
Sedatives	Long-acting agents such as flurazepam and diazepam, may build up in the bloodstream of an older person and cause confusion.
Alcohol	Alcohol can alter memory, impair mobility, and cause increased urine output.
Antihistamines, Antidepressants Phenothiazines, Disopyramides, Opiates, Antispasmodics, Parkinson drugs	Prescription as well as over-the-counter drugs commonly taken by persons with insomnia, itchy skin, and dizziness. Side effects include retaining urine, urinary frequency and overflow incontinence. Antipsychotics such as thioridaxine and haloperidol may cause sedation, stiffness, and immobility.
High blood pressure drugs, cold capsules, decongestants	May cause older men with enlarged prostates to retain urine and experience overflow incontinence, especially if a nasal decongestant is added.
Heart and blood pressure medications	Can reduce contractions in the bladder and occasionally cause urine to be retained leading to overflow incontinence.

Source: Access to Continence Care and Treatment (ACCT).

Workshop forges innovative partnerships

Participants, 45 in all, from the public, professional and commercial sectors cooperated in "bringing incontinence out of the closet," when they attended a March 1998 workshop of the same name, funded by Health Canada's Population Health Fund, and organized by The Canadian Continence Foundation. Participants identified five key strategies to address major incontinence issues:

- Facilitate appropriate assessment, treatment and follow-up: establish a national multidisciplinary and consumer committee to develop standardized care guidelines.
- Make incontinence a primary health issue in terms of resources and focus: establish links with other interest groups, organizations and associations dealing with incontinence.
- Enhance public knowledge about incontinence: develop advertising guidelines for and with industry to improve accuracy and effectiveness of advertising content.
- Develop a long-term care system that encourages and rewards continence: develop continence as a care requirement for licensing/accreditation of all facilities.
- Improve knowledge among doctors, nurses, physiotherapists, pharmacists, social workers, etc.: review all health professional education programs to identify incontinence content, and develop a few important messages to appear in professional publications.

The workshop made clear the need for a multidisciplinary approach to continence care that focused on the needs of those affected. Plans to develop these strategies are now in place. Find out more by visiting The Canadian Continence Foundation website at www.continence-fdn.ca. The proceedings of the workshop are available on the website or through the Foundation. ■

Reducing barriers in continence care

In 1998 — with funding from the Population Health Fund of Health Canada — VON Canada, McMaster University and the Collaborative Continence Program held round table sessions with community-based health care providers across Canada. Participants, including case managers, nurses, therapists and home support workers, identified the following barriers to treating incontinence:

- reluctance to disclose symptoms (embarrassment, fear of stigmatization or institutionalization)
- belief that incontinence is a normal part of aging
- lack of knowledge about treatment options and products
- inadequacy and cost of incontinence management products
- language barriers (how to talk about it)
- lack of transportation to services or distance to travel
- lack of knowledge on the part of health care providers about the condition and its treatment
- social stigmatization
- lack of priority and funding given to problem within the health care system
- perceived lack of support from family physicians when subject is broached
- inadequate resources, including lack of specialists

Pointing out that incontinence is one of the major reasons for providing home care services, participants underscored the need for fundamental changes in attitude and increased understanding about the issue.

Read more about reducing barriers at www.continence.von.ca. ■

Organizations

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Côte St. Luc, Québec H4W 3J6
Phone: (514) 488-8379
1-800-265-9575 (information and support)
Web: www.continence-fdn.ca
E-mail: help@continence-fdn.ca

The Canadian Continence Foundation

Founded in 1986, TCCF is a national non-profit organization addressing the needs of incontinence sufferers and professionals from all health disciplines. The Foundation encourages research, public and professional education, support, advocacy, and public awareness to advance incontinence treatment and encourage people to seek help. TCCF offers a variety of resources, including books, brochures, a newsletter, videotapes, and Kegel exercise instruction sheets.

Incontinence Awareness Month

Each November, The Canadian Continence Foundation coordinates **Incontinence Awareness Month**. This year, the major public awareness event will be a Travelling Continence Roadshow, which will go to 17 cities across Canada. A bi-yearly conference for health professionals: "Partners in Continence" will also take place in Toronto, November 4-5. Visit the Foundation's website for more information.

November

In 1998, with partial funding from the Population Health Fund of Health Canada, TCCF developed a computerized list of continence specialists and resources across Canada (call their toll-free line for more information), and published the first Canadian guide to incontinence products (see "Publications," p. 17). Also with funding from Health Canada, TCCF has just embarked on a three-year national project to develop the first continence care guidelines for Canada as well as recommended models of multi-disciplinary care. An in-home visiting program for isolated seniors is being developed in Ontario, as is a telephone support program in Quebec, with funding from Health Canada's Ontario and Quebec Regional Offices.

Canadian Prostate Cancer Network
Phone: (705) 652-0663
Web: www.cpn.org

Call for information or visit their web site to find useful resources, including a Directory of Local Support Groups across Canada and many links to related sites on the Internet.

The Victorian Order of Nurses (VON Canada)
National Office, 5 Blackburn Avenue
Ottawa, Ontario K1N 8A2
Phone: (613) 233-5694
Fax: (613) 230-4376
Web: www.von.ca

VON CANADA

VON Canada is a national health care organization that has been caring for Canadians in their homes and communities since 1897. The VON offers more than 50 different home nursing, health promotion, support and other services through its 70 local branches across Canada, 8,000 health care providers and 10,000 volunteers.

In 1998, VON Canada with funding from the Population Health Fund of Health Canada and, in conjunction with McMaster University School of Nursing and the

Collaborative Continence Program (Hamilton, Ontario), conducted a study identifying barriers experienced by Canadian seniors in accessing continence care services. As part of this project, a multidisciplinary handbook **Promoting Continence Care in Canada** was published (see "Publications" below).

The International Continence Society (ICS)
Web: www.continet.org

The International Continence Society has approximately 1,300 members from 52 different countries, including physicians, surgeons, nurses, physicists, bio-engineers and other scientists. Its primary focus is to study the physiology, diagnosis and treatment of incontinence. The Society meets each year.

Programs

[Note: The Canadian Continence Foundation provides information about continence services across Canada. Call the information and support Hotline at 1-800-265-9575.]

Collaborative Continence Program
St. Joseph's Community Health Centre
2757 King Street East
Hamilton, Ontario L8G 5E4
Phone: (905) 573-4823
Fax: (905) 560-1574
Contact: Jennifer Skelly, RN, PhD, Director

(To find out more about this program, see "Managing Incontinence Effectively: The Collaborative Continence Program" in this issue, p. 10.)

The Edmonton Prostate Centre
109-11910-111 Avenue
Edmonton, Alberta T5G 0E5
Phone: (780) 448-2789
1-800-299-2743
Fax: (780) 448-3641

Information for men with prostate problems is provided free of charge.

Northern Alberta Continence Service (NACS)
Misericordia Community Hospital and Health Centre
16940-87 Avenue
Edmonton, Alberta T5R 4H5
Phone: (780) 930-5670
1-800-567-5129 in Western Canada
Fax: (780) 930-5679
Web: http://ourworld.compuserve.com/homepages/nacs

Provides advice and support for adults suffering from incontinence and their caregivers. No doctor's referral is needed.

West Coast Continence Clinic
Box 400
Cumberland, British Columbia V0R 1S0
Phone: (250) 336-8708
Fax: (250) 339-5307
Web: www.direct.ca/continence

Provides assessment and treatment for men, women and children. Also publishes the **Canadian Continence Network** which contains updates on research, clinical practice, who's doing what where, upcoming events, training, workshops and conferences.

Publications

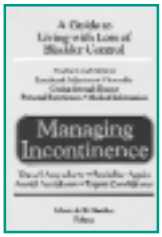
"Bladder control tips," **The Informer/L'Informateur**, April 1998, The Canadian Continence Foundation, Côte St. Luc, Quebec. See www.continence-fdn.ca for highlights of other issues.

Clinical Practice Guideline, Urinary Incontinence in Adults: Acute and Chronic Management, Agency for Health Care Policy and Research, U.S. Dept. of Health and Human Services, Rockville, MD, March 1996.

Consensus Statement: First International Conference for the Prevention of Incontinence, June 25-27, 1997, available from The Canadian Continence Foundation.

Incontinence: A Journey to Resident-Focused Care, by Anita Saltmarche, published in **Partners in Continence Conference Syllabus**, The Canadian Continence Foundation, 1997.

Incontinence in the Elderly: A Resource Manual, by Pat Foster and Ann Zambilowicz, West Coast Continence Clinic. Includes policy and procedural recommendations, as well as practical information for facilities wishing to implement a continence program.



Managing Incontinence: A Guide to Living with Loss of Bladder Control, edited by Cheryle B. Gartley, Jameson Books, Ottawa, IL, 1985. For sufferers, caregivers and professionals. Includes information about products and devices for managing incontinence.

Mission Possible: Your Canadian Undercover Guide to Incontinence Products, by Autumn Trumbull, The Canadian Continence Foundation, 1998. A comprehensive, illustrated guide to incontinence products, with contact information for suppliers.

Nursing for Incontinence, by C. Norton, Beaconsfield Publishers Ltd., Bucks, U.K., 1996.

Promoting Continence Care in Canada/Promotion des soins liés à la continence au Canada, edited by Paula Eyles, McMaster University Press, Hamilton, ON, 1998. A multi-disciplinary guide to types of incontinence, prevalence in Canada, assessments, treatments and incontinence products.

Staying Dry: A Practical Guide to Bladder Control, by Kathryn L. Burgio, K. Lynette Pearce and Angelo J. Lucco, The John Hopkins University Press, Baltimore, MD, 1990. A self-help guide which contains blank bladder diary forms for your initial self-assessment.

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E-mail: seniors@hc-sc.gc.ca
Internet: http://www.hc-sc.gc.ca/seniors-aines

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