WORKSHOP A2 — CONTINENCE PROBLEMS IN THE OLD-OLD

Chair: Joseph Ouslander, Neil Resnick

WHAT IS NEEDED TO IMPROVE THE CARE OF OLD-OLD INCONTINENT PEOPLE? A VIEW FROM THE PRACTICING PHYSICIAN

Mathias Pfisterer, Heidelberg

Continence problems are very common in the old-old population (aged over 75). Most often achieving improvement of these problems is difficult especially in the frail elderly population. The aim of this talk is to describe the problems of incontinent old-old and to discuss what is needed to improve the care even in cases where continence can not be achieved.

PATHOPHYSIOLOGY OF LOWER URINARY TRACT DYSFUNCTION IN THE OLD-OLD

Neil Resnick, Pittsburgh

The presentation will review what is currently known about the impact of ageing on lower urinary tract function and the consequences that these changes have on the etiology, diagnosis, and management of voiding dysfunction and incontinence in older adults.

PATHOPHYSIOLOGY AND MANAGEMENT OF NOCTURIA IN THE OLD-OLD

Ted Johnson, Atlanta

Nocturia (defined as awakening from sleep at night to void) is common in older adults. Over 60% of men over 70 years of age experience two or more episodes nightly. Older adults rate nocturia as one of the most bothersome lower urinary tract symptoms and as one of the most significant causes of sleep disruption. Many caregivers named nocturia and the need to provide night-time assistance as a contributing factor in their decision to institutionalize at-home elderly. It is potentially morbid as well. Nocturia has been associated in older adults with accidental falls, sleep disruption, and future nursing home placement. Those with one or more episodes of nocturia per night have an increased risk (OR=1.8) of falling, and those with three or more nocturia episodes have an even higher risk of falling (OR=2.2).

Despite the impact of nocturia in older adults, the etiologies remain under-explored. While nocturia can result from factors causing sleep disruption, most experts believe that nocturia results mainly from inadequate urine storage (detrusor overactivity), night-time urine overproduction (nocturnal polyuria- NP), or a combination of these two. Nocturia is a well-recognized symptom of benign prostatic hyperplasia (BPH).

This talk will focus on what is understood about the pathophysiology of nocturia and what is understood about the efficacy and limitations of current treatment. New research findings will be highlighted.

THE ROLE OF URODYNAMICS IN ASSESSING AND MANAGING LOWER URINARY TRACT PROBLEMS IN THE OLD-OLD

Derek Griffiths, Pittsburgh

I have posed a series of questions and given some possible answers (or further questions) in note form. We will examine these more fully in the workshop.

1. What are the difficulties and disadvantages of urodynamics in this population?

- **a)** mobility problems
- **b)** communication problems
- **c)** morbidity
- **d)** reduced likelihood of initiating treatment based on urodynamic findings
- **e)** prominent role of non-LUT factors (e.g. in incontinence)

2. What are the common LUT problems in this population?

- **a)** incontinence with late-life onset or worsening
- **b)** poor bladder emptying
  - ***** *how evidenced?*
    - *feeling of incomplete emptying?*

- *hesitancy?*
- *palpation?*
- *ultrasound residual urine?*
- *overflow incontinence?*

3. What would we expect to find on urodynamics?

a) prostatic obstruction?
b) impaired detrusor contractility?
c) stress incontinence?
d) terminal detrusor overactivity?
e) detrusor overactivity incontinence?
f) reduced bladder sensation?
g) DHIC?

4. Is urodynamics necessary to make a diagnosis?

a) poor bladder emptying
* in males: impaired contractility and urethral (prostatic) obstruction are both likely, so urodynamics is needed to distinguish them;
* in females: impaired contractility is almost always the cause, so urodynamics is not usually needed to diagnose it.

b) incontinence
* incontinence of recent (late-life) onset is nearly always urge incontinence (= detrusor overactivity incontinence on urodynamics): so urodynamics is most likely simply to confirm it;
* if there is a suspicion that it is not detrusor overactivity incontinence, urodynamics may be needed to prove or rule this out;
* urodynamics may reveal reduced bladder sensation;
* DHIC: implies impaired contractility – see poor bladder emptying, above;
* in males, urodynamics may be needed to confirm or rule out co-existing urethral obstruction.

5. Does doing urodynamics affect treatment/outcome?

a) in incontinent males, some evidence that identifying and treating obstruction can improve outcome;
b) in incontinent females, may improve outcome (by guiding choice of treatment) if problem appears to be stress incontinence;
c) otherwise, management of non-LUT factors followed by trial of conservative/medical treatment according to symptoms (i.e. without invasive urodynamics) appears reasonable.

TRANSLATING RESEARCH INTO PRACTICE: MANAGEMENT OF INCONTINENCE IN LONG-TERM CARE FACILITIES

Joseph G. Ouslander, Division of Geriatric Medicine and Gerontology, Wesley Woods Center of Emory University, Emory Center for Health in Aging, Atlanta VA Rehabilitation Research & Development Center, Atlanta, GA, USA

Over the last 20 years, research has documented feasible and efficacious strategies to assess and manage urinary incontinence in long-term care facilities (LTCFs). This research has formed the basis of practice guidelines, including those developed by the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality (AHRQ)) and the American Medical Directors Association (AMDA). In addition, these strategies have been incorporated into the federally mandated Resident Assessment Instrument for LTCFs in the United States, which includes the Minimum Data Set (MDS) and Resident Assessment Protocol (RAP). Despite this progress, management of incontinence remains sub-optimal in the majority of LTCFs.

This presentation will briefly review data on efficacious interventions for urinary incontinence in LTCFs, describe barriers to translating this research into practice, and discuss strategies to overcome these barriers. A variety of factors play in role in the failure to translate of research into practice in LTCFs, including failure to disseminate the research and practice guidelines, inadequate education of physicians and LTCF staff, staffing shortages and turnover, lack of financial and regulatory incentives, inadequate targeting of the interventions

and related quality improvement programs, lack of consumer pressure, and the organizational culture of many LTCFs. While some of these factors may be difficult to overcome, others may not be. But until they are addressed, incontinent residents of LTCFs will not receive the most effective incontinence care that is feasible in this setting.