

ELDERLY INCONTINENCE MANAGEMENT IN HOSPITAL SETTINGS

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DATE: 27 NOVEMBER 2024

Please find following a summary of a literature search and relevant results. All articles can be provided in full - email library@monashhealth.org for a list of the articles you require.

QUESTION

What is the best practice for continence management for older adults in the hospital setting?

RESULTS

ONLINE RESOURCES (GREY LITERATURE)

CLINICIAN DECISION SUPPORT TOOLS

UpToDate. (2024). **Female urinary incontinence: Treatment.** [Web link.](#)

- Initial treatment includes modifying contributory factors, lifestyle modification, pelvic floor muscle exercises, bladder training, and trialing vaginal estrogen therapy for peri- or postmenopausal women with either stress or urgency incontinence.
- If initial treatments are not sufficient, continence pessaries, pharmacotherapy, and surgical intervention may be appropriate.

UpToDate. (2024). **Urinary incontinence in males.** [Web link.](#)

- Adjunctive measures include protective pads and undergarments, catheters, and penile clamps.
- Nonpharmacologic therapies for urge urinary incontinence (UUI), SUI, and mixed incontinence include pelvic floor muscle exercises, lifestyle modification and bladder training.
- Pharmacological management and surgical interventions may appropriate for those that don't respond to initial treatment.

BMJ Best Practice. (2023). **Faecal incontinence in adults.** [Web link.](#)

- Primary care treatment is diet, bowel habit intervention, coping strategies. Specialist referral may be required.

Therapeutic Guidelines. (2022). **Management of faecal incontinence in adults.** [Web link.](#)

- If dietary modification and psyllium are not effective, an antidiarrheal drug or a neuromodulatory drug (eg a tricyclic antidepressant) can be trialed.
- or patients with faecal incontinence who have loose stools in whom dietary modification and psyllium are not effective, use loperamide.
- Patients with faecal impaction associated with constipation should be treated with a laxative—see Faecal impaction in adults for more information.

- If symptoms persist despite the above therapies, refer to a gastroenterologist for anorectal manometry and endoanal ultrasound (to investigate the pelvic floor and sphincter function and structure), and consideration of second-line therapies such as biofeedback, rectal irrigation, anal plugs and surgical intervention.

GUIDELINES

Royal Australian College of General Practitioners. (2024). **RACGP Aged Care Clinical Guide: Urinary incontinence.** [Web link.](#)

- Lifestyle and behavioural measures, medications, bladder drainage, surgery, and specialist referral are recommended treatment options.

NICE (UK). (2015). **Urinary incontinence in women.** [Web link.](#)

- Women with urinary incontinence are only offered containment products as a temporary coping strategy, or as long-term management if treatment is unsuccessful.
- Women with stress or mixed urinary incontinence are offered a supervised pelvic floor muscle training programme of at least 3 months' duration as first-line treatment.
- Women with symptoms of urgency or mixed urinary incontinence are offered bladder training for a minimum of 6 weeks as first-line treatment.
- Women with urinary incontinence have indwelling urethral catheters for long-term treatment only if they have an assessment and discussion of the practicalities and potential urological complications.
- Women with overactive bladder or stress urinary incontinence symptoms have a local multidisciplinary team review before surgery or other invasive treatment.

PEER-REVIEWED LITERATURE – MOST RECENT FIRST

Articles are grouped by theme:

- Product Intervention
- Therapies
- Conservative treatment
- Neurological conditions

Each article summary contains excerpts from the abstract and an online link.

PRODUCT INTERVENTION

Bugge, C., et al. (2020). **Pessaries (mechanical devices) for managing pelvic organ prolapse in women.** *The Cochrane Database of Systematic Reviews*, 11(11), CD004010. [Click for full-text.](#)

The authors are uncertain if pessaries improve pelvic organ prolapse symptoms for women compared with no treatment or PFMT but pessaries in addition to PFMT probably improve women's pelvic organ prolapse symptoms and prolapse-specific quality of life. However, there may be an increased risk of adverse events with pessaries compared to PFMT.

Francis, K., et al. (2017). **Disposable versus reusable absorbent underpads for prevention of hospital-acquired incontinence-associated dermatitis and pressure injuries.** *Journal of wound, ostomy, and continence nursing*, 44(4), 374–379. [Click for full-text.](#)

Findings suggest that use of disposable incontinence pads reduces HAPI but not IAD occurrences. The effect of disposable, absorbent incontinence pads should be considered when initiating a hospital-wide skin and PI prevention and treatment plan.

Deutekom, M., & Dobben, A. C. (2015). **Plugs for containing faecal incontinence**. *The Cochrane database of systematic reviews*, 2015(7), CD005086. [Click for full-text](#).

The available data were limited and incomplete, and not all pre-specified outcomes could be evaluated. Consequently, only tentative conclusions are possible. The available data suggest that anal plugs can be difficult to tolerate. However, if they are tolerated they can be helpful in preventing incontinence. Plugs could then be useful in a selected group of people either as a substitute for other forms of management or as an adjuvant treatment option. Plugs come in different designs and sizes; the review showed that the selection of the type of plug can impact on its performance.

THERAPIES

Funada, S., et al. (2023). **Bladder training for treating overactive bladder in adults**. *The Cochrane database of systematic reviews*, 10(10), CD013571. [Click for full-text](#).

This review focused on the effect of bladder training to treat OAB. However, most of the evidence was low or very-low certainty. Based on the low- or very low-certainty evidence, bladder training may cure or improve OAB compared to no treatment. Bladder training may be more effective to cure or improve OAB than anticholinergics, and there may be fewer adverse events. There may be no difference in efficacy or safety between bladder training and PFMT.

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Hargreaves, E., et al. (2022). **Acupuncture for treating overactive bladder in adults**. *The Cochrane database of systematic reviews*, 9(9), CD013519. [Click for full-text](#).

The evidence is very uncertain about the effect acupuncture has on cure or improvement of overactive bladder symptoms compared to no treatment. It is uncertain if there is any difference between acupuncture and sham acupuncture in cure or improvement of overactive bladder symptoms. This review provides low-certainty evidence that acupuncture may result in a slight increase in cure or improvement of overactive bladder symptoms when compared with medication and may reduce the incidence of minor adverse events.

Wieland, L. S., et al. (2019). **Yoga for treating urinary incontinence in women**. *The Cochrane database of systematic reviews*, 2(2), CD012668. [Click for full-text](#).

The author's identified few trials on yoga for incontinence, and the existing trials were small and at high risk of bias. In addition, they did not find any studies of economic outcomes related to yoga for urinary incontinence. Due to the lack of evidence to answer the review question, they are uncertain whether yoga is useful for women with urinary incontinence.

Stewart, F., et al. (2016). **Electrical stimulation with non-implanted electrodes for overactive bladder in adults**. *The Cochrane database of systematic reviews*, 12(12), CD010098. [Click for full-text](#).

Electrical stimulation shows promise in treating OAB, compared to no active treatment, placebo/sham treatment, PFMT and drug treatment. It is possible that adding ES to other treatments

such as PFMT may be beneficial. However, the low quality of the evidence base overall means that we cannot have full confidence in these conclusions.

Thaha, M. A., et al. (2015). **Sacral nerve stimulation for faecal incontinence and constipation in adults.** *The Cochrane database of systematic reviews*, 2015(8), CD004464. [Click for full-text.](#)

The limited evidence from the included trials suggests that SNS can improve continence in a proportion of patients with faecal incontinence. However, SNS did not improve symptoms in patients with constipation. In addition, adverse events occurred in some patients where these were reported.

CONSERVATIVE TREATMENTS

Johnson, E. E., et al. (2023). **Conservative interventions for managing urinary incontinence after prostate surgery.** *The Cochrane database of systematic reviews*, 4(4), CD014799. [Click for full-text.](#)

Conservative treatments such as pelvic floor muscle training (PFMT), electrical stimulation and lifestyle changes were investigated. Despite a total of 25 trials, the value of conservative interventions for urinary incontinence following prostate surgery alone, or in combination, remains uncertain. Existing trials are typically small with methodological flaws.

Todhunter-Brown, A., et al. (2022). **Conservative interventions for treating urinary incontinence in women: an Overview of Cochrane systematic reviews.** *The Cochrane database of systematic reviews*, 9(9), CD012337. [Click for full-text.](#)

There is high certainty that PFMT is more beneficial than control for all types of UI for outcomes of cure or improvement and quality of life. We are moderately certain that, if PFMT is more intense, more frequent, with individual supervision, with/without combined with behavioural interventions with/without an adherence strategy, effectiveness is improved. We are highly certain that, for cure or improvement, cones are more beneficial than control (but not PFMT) for women with SUI, electrical stimulation is beneficial for women with UUI, and weight loss results in more cure and improvement than control for women with AUI. Most evidence within the included Cochrane Reviews is of low certainty.

Su, M. Y., et al. (2015). **A prospective, randomized, controlled study of a suspension positioning system used with elderly bedridden patients with neurogenic fecal incontinence.** *Ostomy/wound management*, 61(1), 30–39.

Rates of perianal fecal contamination, skin breakdown, incontinence associated dermatitis, pressure ulcer development, and lower urinary tract infection (LUTI) were significantly lower in the SPS than in the control group ($P < 0.05$). Length of hospitalization and costs of care were also lower in the SPS group ($P < 0.05$). Patient quality-of-life (QoL) and FI QoL scores were similar at baseline but significantly higher (better) at the 6-month follow-up interview in the SPS than in the control group ($P < 0.05$). In this study, the rate of FI-associated morbidities was lower and 6-month patient QoL scores were higher in the SPS than in the control group. No adverse events were observed, and all patients completed the study. Further clinical studies are needed to examine the long-term effects of SPS use among neurologically impaired FI patients.

NEUROLOGICAL CONDITIONS

Todd, C. L., et al. (2024). **Conservative, physical and surgical interventions for managing faecal incontinence and constipation in adults with central neurological diseases.** *The Cochrane database of systematic reviews*, 10(10), CD002115. [Click for full-text.](#)

There remains little research on this common and, for patients, very significant issue of bowel management. The available evidence is almost uniformly of low methodological quality.

Thomas, L. H., et al. (2019). **Interventions for treating urinary incontinence after stroke in adults.** *The Cochrane database of systematic reviews*, 2(2), CD004462. [Click for full-text.](#)

Low-quality evidence suggests behavioural interventions may reduce the mean number of incontinent episodes in 24 hours. Further, low-quality evidence from two trials suggests that behavioural interventions may make little or no difference to quality of life. Specialised professional input interventions: One trial of moderate-quality suggested structured assessment and management by continence nurse practitioners probably made little or no difference to the number of people continent three months after treatment. Low-quality evidence from five trials suggested that complementary therapy may increase the number of participants continent after treatment. Physical therapy: Two trials reporting three comparisons suggest that physical therapy using transcutaneous electrical nerve stimulation (TENS) may reduce the mean number of incontinent episodes in 24 hours. There is insufficient evidence to guide continence care of adults in the rehabilitative phase after stroke.

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APPENDIX

SEARCH METHODOLOGY

A systematic search was conducted for literature. The results were screened by librarians using [Covidence](#).

SEARCH LIMITS

- English-language
- Published within the last 10 years
- Randomised controlled trials and systematic reviews

DATABASES SEARCHED

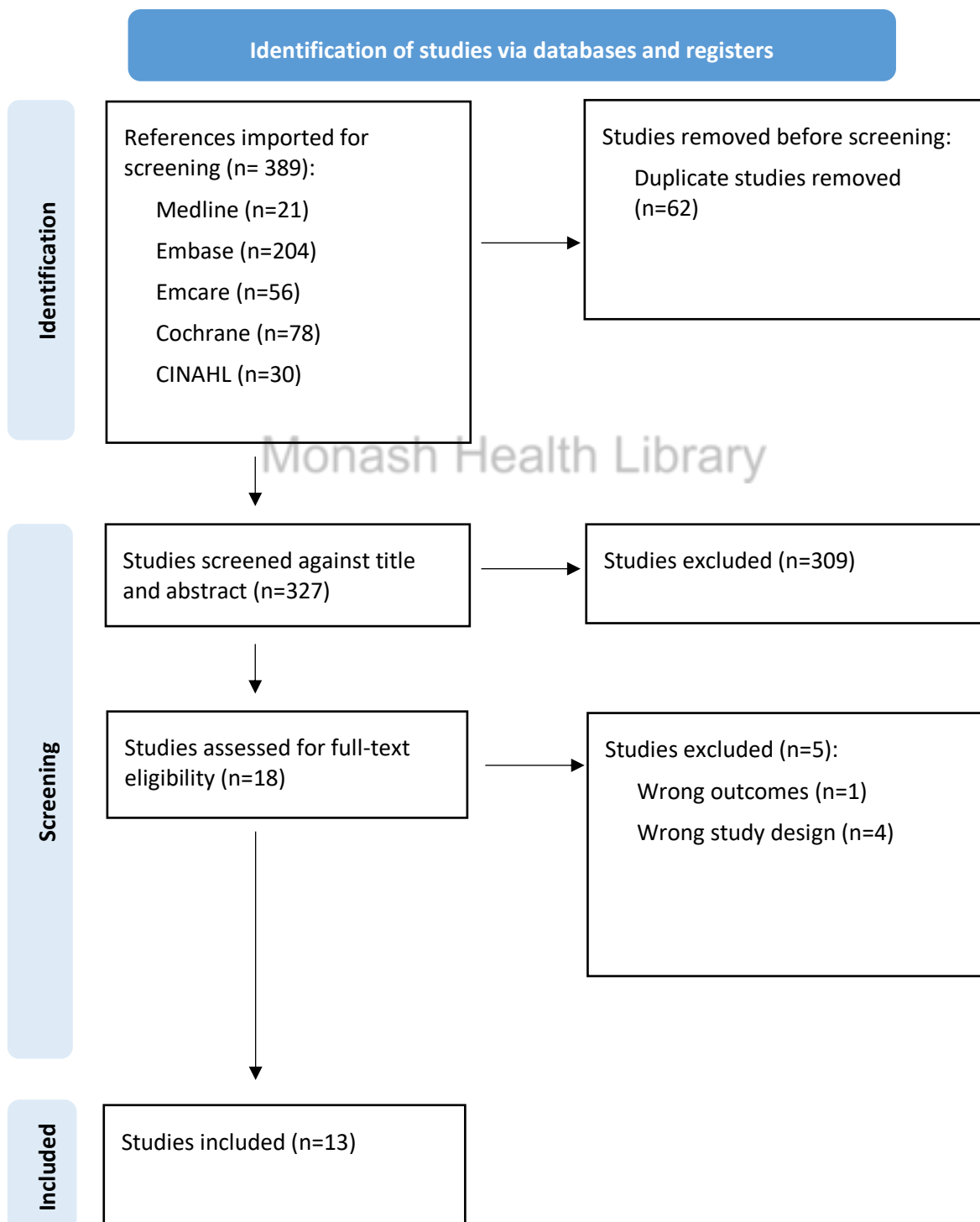
- Medline – index of peer reviewed articles across health sciences and medicine.
- Embase – index of biomed and pharmacological peer reviewed journal articles.
- Emcare – index of nursing, allied health, critical-care medicine and more.
- Cochrane Library – collection of databases containing high-quality independent evidence.
- CINAHL – scholarly journals, theses, and grey literature for nursing & AH.
- UpToDate & BMJ Best Practice – synthesised evidence for patient care.
- Grey literature – Google, Google Scholar, Trip database, Biomed Central Proceedings.

MEDLINE SEARCH STRATEGY

- 1 ((incontinen* or continen*) adj3 (aid* or manage* or product* or assist* or intervention* or maintain* or care or support* or assist* or treat* or pad or pads or equipment* or control* or therap*)).tw,kf. 11983
- 2 Fecal Incontinence/pc, th [Prevention & Control, Therapy] 3039
- 3 Urinary Incontinence/pc, th [Prevention & Control, Therapy] 6104
- 4 Incontinence Pads/ 548
- 5 1 or 2 or 3 or 4 18114
- 6 (aged or elder* or geriatric* or retired or retiree* or old* or pensioner* or elder* or old age or senior citizen* or later life or sexagenarian* or septuagenarian* or octogenarian* or nonagenarian* or centenarian* or gerontolog*).tw,kf. 2761186
- 7 ((older or senior) adj (adult* or patient* or people* or person* or m?n or wom?n)).tw,kf. 259622
- 8 exp Aged/ or "Aged, 80 and over"/ 3604503
- 9 6 or 7 or 8 5551014
- 10 (hospital setting or hospital environment or in?hospital or presentation* or hospitali?ed or hospitali?tion).tw,kf. 700164
- 11 Hospitalization/ or Inpatients/ 171444
- 12 10 or 11 825630
- 13 (systematic adj (review or literature or scoping or narrative or qualitative or evidence or quantitative or meta or critical or mixed studies or mapping or cochrane or integrative)).tw. 350815
- 14 (metaanaly* or meta analy* or meta-analy*).mp. 362102
- 15 Controlled clinical trial.pt. 95644
- 16 Randomized.ab. 670263
- 17 Placebo.ab. 254009
- 18 Drug therapy.fs. 2757226

19 Randomly.ab. 447451
 20 Trial.ab. 726259
 21 Groups.ab. 2769631
 22 meta-analysis/ or "systematic review"/ or exp randomized controlled trial/ 998397
 23 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 6468083
 24 5 and 9 and 12 and 23 53
 25 limit 24 to (english language and last 10 years) 21

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