

Madigan Army Medical Center

Referral Guidelines

Urge Urinary Incontinence (Female)

Definition/Diagnosis:

- Involuntary loss of urine associated with a sense of urgency

Initial Diagnosis:

- Inquire about fluid volume amounts and liquid type
- Obtain a 3 day bladder diary to include fluid type & intake (in oz), voiding frequency per 24 hours and notation of activity/sensation associated with leakage (urge, no sensation, walking, etc)
- Inquire about use of pads (type and # used/day)
- History of anti-incontinence procedure (sling, Burch, etc)
- Urinalysis and urine culture
- Assessment of pelvic floor muscle strength

Initial Management

- Reduce fluid intake to <64 oz, if possible. Let thirst be the guide. Most people do not need 64 oz per day, unless there are medical reasons that requires increased fluid intake
- Limit fluids 3 hours prior to bedtime and elevate legs (especially if lower extremity edema is present)
- Place consult to vascular clinic for compression hose if significant lower extremity edema is present and patient reports bothersome nocturia
- Avoid bladder irritants such as caffeine, alcohol, artificial sweeteners, citrus fruits/juices, tomatoes, some dairy products (yogurts, aged cheeses, sour cream), and other acidic foods (vinegar, onions). Taper caffeine slowly to prevent withdrawal headaches
- Weight loss – reduces pressure on bladder
- Timed voiding - Voiding on a schedule, such as every 2.5 hours to avoid leakage; it is helpful to have a bladder diary available for review
- Urge suppression strategies – “Freeze and Squeeze” – educate your patient
 - Do not run to the bathroom when there is an urge to urinate
 - Instead, stop and stay still
 - Squeeze the pelvic floor muscles, repeatedly if needed until the urge subsides
 - Relax and/or distract yourself
 - Once the urge subsides, walk to the bathroom at a normal pace
 - Don't ignore the urge to void

- Bladder training – once you have mastered the Urge suppression strategies, you can start increasing the time between voids by 15 minutes each week, with a goal of 3 or more hours
- Strengthen the pelvic floor with Kegel exercises, which help delay voiding. Consider a network referral to “M RCC” for pelvic floor physical therapy
- When lifestyle and behavioral therapies are not sufficient, try anticholinergic medications, such as Detrol 2mg LA. Increase to 4mg, as needed.
- Contraindications for anticholinergic medication: suspicion for urinary retention (prior anti-incontinence procedure or significant pelvic organ prolapse), gastroparesis, narrow-angle glaucoma (99% of glaucoma is open-angle), and myasthenia gravis. Common side effects: dry mouth, dry eyes, constipation.

Ongoing Management and Objectives:

- Reduction in urinary incontinence episodes and/or reduction in bothersome episodes

Indications for Subspecialty Referral:

- If pain accompanies urinary incontinence and is not associated with urinary tract infection
- If patient has a history of anti-incontinence surgery or currently has pelvic organ prolapse
- If response to behavioral and medical management are not sufficient and/or side effects prevent continuation of medical management
- Patient request

References:

<http://www.voicesforpfd.org/p/cm/ld/fid=61> (American Urogynecology Society Website)

Last Review for this Guideline: **November 2012**

Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division
Clinical Practice and Referral Guidelines Administrator