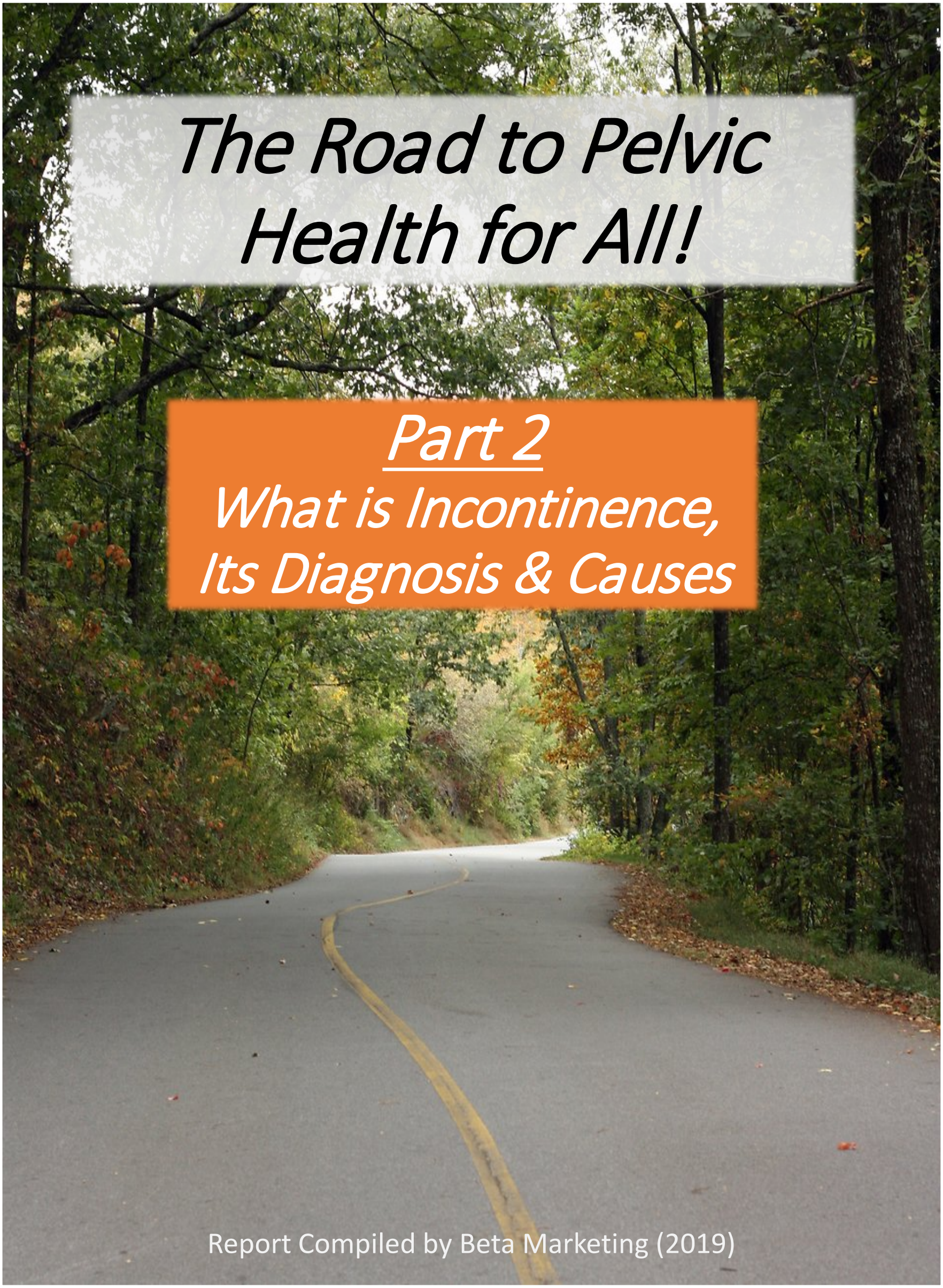

The Road to Pelvic Health for All!

Part 2

What is Incontinence, Its Diagnosis & Causes

Report Compiled by Beta Marketing (2019)

Part 2
What is Incontinence, It's Diagnosis & Causes

Content: Page

IMPORTANT NOTE

The information in this report is for educational purposes only.
It is not medical advice. Should you have any of these issues or problems please consult your Doctor.

Introduction

Many women and men live in silence with the shame of dealing with incontinence of some kind, however…

The most important thing to know is that you are not alone!

DID YOU KNOW…

- 9 million people in the United Kingdom (UK) experience some form of stress incontinence. It can affect women and men of all ages, although it is more common among women.

AND DID YOU KNOW…

- Urinary incontinence affects up to 13% of Australian men and up to 37% of Australian women (Australian Institute of Health and Welfare report, 2006).
- And in the United States of America (USA), more than 25 million people experience bladder leakage every day.

Many bladder problems are common in both men and women, whilst some are related to the anatomical differences between them.

Furthermore, there are numerous types of incontinence and within this section you will learn about the symptoms, causes and treatment.

The most important point to remember is that anyone with a bladder or bowel problem can be helped, and in some cases, can be completely cured.

What is Incontinence

According to the Merriam-Webster Dictionary, **Incontinence** is the inability of the body to control the evacuative functions of urination or defecation – either partial or complete loss of bladder (urinary incontinence) or bowel control (faecal incontinence).

How to Diagnose Incontinence

When diagnosing the type of bladder or bowel dysfunction you are suffering from, your GP will need to consider all aspects of the complex interactions and co-ordination's that need to happen for healthy urination and defecation to take place.

Your GP will look to identify the original cause(s) of the incontinence. They will treat the reversible causes first; for example, change a medication or treat diarrhoea.

However, if the causes are not reversible, your incontinence will be considered chronic and is more likely to be treated medically alongside conservative lifestyle changes to treat the incontinence and prevent recurrence.

To diagnose the type of incontinence, it's severity, your symptoms and the cause(s), there are a few tests your doctor may do with you.

The following are in no particular order:

Define incontinence - To ensure you are open and can share relevant information, your GP will define incontinence and the different symptoms that can be experienced

Discussion of other medical problems - Incontinence often occurs as a precursor or symptom of another condition. Your doctor will look at the timing of any other conditions you are suffering from, to determine if they have any relation. Potentially related conditions include; another pelvic disorder such as a pelvic organ prolapse, atrophic vaginitis (vaginal dryness), cardiovascular disease, irritable bowel syndrome, bowel cancer and diabetes.

Inform your GP of any medical conditions or activities you have started in recent months. This discussion can make use of any notes you have been making about the frequency and quantity of your urination and/or bowel movements - using a bladder or bowel diary as the basis. Your doctor may notice a pattern, which you did not.

Complete a bladder diary for no less than 3 days (for urinary incontinence) - Fill in a bladder diary (aka voiding diary) to track your fluid intake and output, which you can then share with your doctor.

Make a note of:

- What, and how much you drank
- How much urine you released when you went to the bathroom, was it a little or not
- Did your bladder feel completely empty after you finished
- If and when you leak, how much was it, did you change your underwear
- What were you doing and what urgency did you feel before urinating
- If and when you go to the bathroom at night.

NOTE: A BLADDER DIARY will be provided as a BONUS with PART 3 of this report.

Complete a bowel diary for no less than 7 days (for bowel incontinence) - Fill in a bowel diary to track your diet, medication and each bowel movement.

Make a note of:

- Did you have the sensation to go to the toilet;
- How urgent any sensation was
- Did you have any pains, if so rate how bad
- Using the Bristol Stool Chart (provided herewith), what was the stool type
- Did you have to strain to release the stool
- Did you have any accidents or leaks.

NOTE: A BOWEL DIARY will be provided as a BONUS with PART 5 of this report.

Assessment of pelvic floor muscle strength - Using an electronic biofeedback machine, you will be asked to squeeze against an anal probe or vaginal probe (women only) to measure the strength of your pelvic floor.

Physical examination - A physical examination can include:

- Measuring your blood pressure
- Seeing if there is any tenderness or any masses in your abdomen
- A prostate examination (for men)
- A vaginal examination (for women)
- A rectal examination looking for masses or a rectocele prolapse
- Checking your joint mobility
- A manual assessment of the strength of your anal and urethra sphincters
- Your GP will examine your perineum as you strain and squeeze, checking it for scarring and anal gaping

Colon screening - The entire colon can be screened for abnormalities, usually a test for those over 50 years old.

Measuring severity (for urinary incontinence) - The Sandvik's Severity index looks at the frequency and quantity of urine leakage to categorise urinary incontinence severity into four categories: mild, moderate, severe and very severe.

Imaging (for bowel incontinence) - You may have an endoanal ultrasonography or defecography for your doctor to see the anatomy and function of your rectum and anal sphincter muscles.

Quality of life survey - Completing one of these will give your doctor a good idea of your symptoms, and how you are affected daily. It can help them decide at which urgency each of your symptoms need to be treated.

Cough stress test (for urinary incontinence) - With a relatively full bladder, this test requires you to cough to determine the quantity (if any) of urine you leak into a pad or onto some paper which you stand over.

Post-void residual urine measurement (for urinary incontinence) - This test measures the quantity of urine left in your bladder after you visit the bathroom to attempt to fully empty it. It is preferably done with a hand held ultrasound unit. However, it can be done with a temporary catheter to release any remaining urine from your bladder to be measured.

Laboratory tests (urinary incontinence) - Your GP may take urine samples and send them to a laboratory for analysis. These will look to see whether you are retaining urine in your bladder due to an obstruction or muscle weakness (overflow incontinence), and exclude the possibility that you have a urinary tract infection (through urinalysis).

You may be referred to a Urologist or Urogynecologist for further diagnostic tests depending on the findings.

Causes of Reversible Incontinence

Reversible incontinence (aka Transient Incontinence) is incontinence that occurs suddenly and has been present for less than 6 weeks.

Your doctor will look to determine whether it was caused by:

An infection - Such as a urinary tract infection (UTI), irritating your bladder and/or urethra leading to urge or frequency incontinence, which can last after the UTI has cleared.

Atrophic vaginitis - Vaginal dryness, usually associated with menopause.

A psychological disorder - Especially depression and anxiety, which can make it hard to relax your muscles.

Hyperglycaemia, associated with diabetes - High blood sugar level, leading to excessive urine output.

Diarrhoea - Loose and wet stools more easily leak from even tight anal sphincters.

Diuretics - This includes any food, drink or medication, which increases the production of urine or stimulates the sensation to urinate. Including caffeine and spicy food.

Medications - Never stop taking a prescribed medication without first consulting your GP. Medications such as diuretics, opioids (e.g. morphine), blood pressure medicines, antidepressants, sedatives and hormone replacement therapy drugs can:

- Increase the amount of urine your kidneys produce
- Remove the sensation to urinate
- Interfere with the ability to store and pass urine correctly
- Cause constipation
- Impair the function of the muscles and nervous system

Please note, these are only a few of the factors which can cause temporary incontinence.

Causes of Gradually Developed Incontinence

Once your doctor has determined that your incontinence is not temporary, they will look to determine the gradual or irreversible cause(s):

Genetic predisposition - Certain ethnic groups are more likely to develop a form of urinary incontinence as they have a smaller amount of urethral muscle. Afro-Caribbean's are thought to have the lowest risk of developing urinary incontinence because they have a larger amount of urethral muscle.

Pregnancy and vaginal childbirth - Even uncomplicated pregnancy and childbirth (even caesareans) weaken your pelvic floor. It is very common for women to suffer from a degree of incontinence due to the damage that occurs to the pelvic floor from the weight of the baby and the hormones the body produces to relax and loosen the muscles in preparation for labour. The risk of developing a form of incontinence increases with a larger baby (over 4000 g), complicated vaginal delivery (where forceps or a vacuum where used) and multiple births. You can suffer from a sphincter or perineum tear, and your bladder and urethra can receive direct trauma.

Age - Your muscles become weaker with age. Your urethra and sphincter muscles will no longer contract as tightly, allowing leaks to occur. In women, the hormonal change associated with menopause can be a further factor affecting muscle strength.

Pelvic surgery - Any surgery that you undergo in the pelvis and lower abdomen, can cause nerve damage to the organs and tissue that are required for the normal storage and passing of urine and faeces. Your pelvic floor muscles can become temporarily bruised and sore, or suffer lasting damage. The surgery can even inadvertently alter the position of the organs.

Treatment for cancer - Alongside the risk of surgery, radiation treatment can lead to temporary or permanent incontinence as it effects the cells.

Obesity - If you carry around excess weight, which is the case if you have a BMI greater than 30, your pelvic organs and pelvic floor muscles will be under greater pressure consistently. These can lead to incontinence and make any existing incontinence worse.

Smoking and having a chronic cough - Suffering with a chronic cough can weaken your pelvic floor by often putting it under strain.

Chronic constipation - When you are constipated you will find yourself straining to empty your bowels. This weakens the pelvic floor and anal sphincter, and the full bowel can push against the bladder. This can cause urge urinary incontinence and the sensation to urinate often. Your body will also produce more liquid to soften stools, often resulting in soft orange/light brown diarrhoea which can easily leak.

High impact exercise - Taking part in high impact exercise can put pressure on and weaken your pelvic floor like running, jumping, high impact aerobics, heavy weightlifting, push-ups and squats.

Prostatis (in men) - Prostatis is the inflammation of the prostate gland, and can occur as a result of suffering from prostate cancer or benign prostatic hyperplasia (BPH). Prostatis causes your urethra to narrow and even close off, which reduces the flow of urine.

Disability and reduced mobility - Functional incontinence occurs where you experience the sensation to urinate, but cannot reach a bathroom. This may be due to a physical reason such as an issue with mobility or eyesight, or a psychological reason, such as an anxiety to go or depression.

Fibroids - Fibroids are non-cancerous tumours that grow in or on the wall of the womb, mostly in premenopausal women. They can range from the size of a walnut to larger than a grapefruit and they grow and shrink according to hormone levels. It is estimated that as many as 3 out of 4 women have uterine fibroids sometime during their lives and whilst some women do experience pelvic pain, heavy, painful and irregular periods with fibroids, many do not even realise they have them. However, if the fibroids press on the bladder or bowel, the potential for suffering with urinary incontinence and complete loss of bladder control increases.

Pelvic organ prolapse - Pelvic organ prolapses often occur gradually, and tend to cause urinary incontinence as they develop (60% of women with a prolapse also suffer from urinary incontinence). The prolapsing organ can cause dysfunctional voiding and irritate the bladder, urethra and/or bowel.

Please note, these are only a few of the factors, which can cause incontinence to gradually develop.

Once your GP has diagnosed what caused your incontinence, and what form of incontinence you are suffering from, they can begin to design a treatment plan.

----- END OF PART 2 -----

Important Notices

FIND 2x DOWNLOADABLE PDF BONUSES ON THE PART 2 REPORT PAGE

1. Pelvic floor (Kegel) seating guide.pdf
2. Quick start guide for both men and women.pdf

NEXT WEEK - KEEP AN EYE OUT FOR PART 3

Incontinence Treatment
& Potential Complications

With BONUS: Bladder Diary.pdf

Medical knowledge is always advancing and in light of this we acknowledge that this information herein is current as of the date of publication (July 2019) and that some information may no longer be valid in the future.

For updates and a first world understanding of what the current medical practices are, visit the National Institute for Health and Care Excellence (www.nice.org.uk) for advice into procedures you are offered .

If you have not yet subscribed for the full 8-part report titled, **The Road to Pelvic Health for All**, you can do so here: www.pelvichealthsubscribe.betamarketing.co.za

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