



U.S. Department of Veterans Affairs

Public Access Author manuscript

JAMA. Author manuscript; available in PMC 2015 May 27.

Published in final edited form as:

JAMA. 2010 June 2; 303(21): 2184–2185. doi:10.1001/jama.2010.747.

Talking About Incontinence:

The First Step Toward Prevention and Treatment

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Among adult patients, discussions about incontinence are usually avoided because they evoke feelings of embarrassment, fear, shame, and the loss of independence.¹ Incontinence has been associated with falls, functional decline, nursing home admissions, social isolation, and depressive symptoms,^{2,3} and patients often say, “Incontinence doesn’t kill you, but it takes your life away.”

More than a quarter of older women in the United States and other developed countries experience urinary incontinence, with 5% to 15% experiencing daily episodes,⁴ making incontinence one of the most common medical conditions in this population. Most women manage incontinence on their own, with the minority (30%–45%) seeking care.⁵ Patients are not always comfortable broaching the subject with their clinician, so it can be a challenge to inform them about the condition and their treatment options. The Internet can be an empowering tool for individuals with incontinence and other stigmatized conditions because they can search for information anonymously. Although finding accurate and trustworthy health information online can be challenging, a number of excellent Web-based resources for patients and families are available that describe the etiology, natural history, and treatment options for in-continance.²

In part because of its high prevalence, urinary incontinence accounts for approximately \$20 billion in annual costs in the United States.⁶ Ten percent of these costs is spent on “routine care,” which includes absorbent pads, skin protection, and laundry. An older woman with incontinence can spend upward of \$500 per year on routine care products, a cost that increases with more frequent incontinent episodes.⁶ Accordingly, effective treatment of incontinence may result in lower routine care costs. Although incontinence supplies are an insurance-covered benefit in several countries, such as Sweden, in the United States these costs are almost always paid for out of pocket, which places a large burden on elderly women, who are among the most economically disadvantaged in US society. Incontinence

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Financial Disclosures: None reported.

supplies are an allowed expense in medical flexible spending accounts (FSAs). However, this may be of little assistance given that employers provide FSAs and many older women are not employed.

While the data from 2 large prospective studies representative of the community-dwelling elderly US population are not conclusive, urinary incontinence appears to be a marker of frailty in community-dwelling elderly persons and may be an independent risk factor for nursing home or skilled nursing facility admission.³ It is estimated that approximately 5% to 10% of nursing home admissions are attributable to incontinence, with these additional admissions accounting for up to 25% of the estimated annual costs of incontinence.^{6,7} Therefore, treating incontinence might help prevent or delay nursing home admissions and reduce the costs of incontinence.

Many treatment options exist for women with incontinence, and the clinician should accommodate patient preferences for type of treatment and clarify the patient's goals of treatment. Reduced incontinence frequency, volume of urine lost, or number of protective pads used each day—rather than continence—may be an acceptable goal for patients. Clinicians should direct patients who use the Internet to Web-based resources on incontinence and treatment.² Behavioral treatments, such as Kegel exercises, biofeedback, and bladder control strategies, are the first line of treatment. Behavioral treatment strategies achieve similar efficacy as other nonsurgical treatments, have fewer risks and adverse effects compared with pharmacologic or surgical treatments, and are less expensive, making them well-suited for treating older women.

In the United States, behavioral treatments, including discussions about diet, exercise, bladder training, and Kegel exercises, are reimbursed through the evaluation and management payment. Separate reimbursement is possible for biofeedback, but insurance coverage is inconsistent. In the United States, Medicare and many commercial insurers cover pelvic floor biofeedback (CPT 90911); some insurers consider it investigational, despite the evidence, and deny coverage, while others handle coverage on a case-by-case basis. In countries with public health systems, such as Australia and England, biofeedback is available and queues for treatment are often the only “cost.” In Australia, for example, patients can attend a physiotherapist in a private practice and either pay cash or seek reimbursement through a private health insurance fund, if possible.

Women often struggle with initiating or maintaining these techniques. Several new technologies may enhance behavioral treatments such as bathroom finders, bladder diaries, and reminder applications that can be accessed through computers or smart phones. There are also social networking Web sites that are trying to make lifestyle changes, such as weight loss and diet, enjoyable and rewarding. Many of these applications are not specific to incontinence, but patients can adapt them as needed and consult their clinician if they have questions.

Several medications and surgical procedures are available for women who prefer or need alternatives to behavioral treatments. However, the relative advantages among these options are less clear. Phase 3 drug trials usually enroll select samples of study participants and

almost all are placebo-controlled, providing no data about how drugs compare with each other. Comparative effectiveness studies evaluating efficacy, adverse effects, and expense in broad samples, including older individuals and those with dementia, are needed.

At present, policy experts have not developed a strategic plan for managing incontinence, and incontinence is not listed as part of the proposed objectives for Healthy People 2020. This is a missed opportunity given the prevalence, effects on quality of life, and the potential for prevention of incontinence. A 2007 National Institutes of Health state-of-the-science statement concluded that urinary incontinence may be prevented by lifestyle changes (namely, diet and exercise), by effective management of comorbid conditions (eg, diabetes, impaired mobility, depression), and by using pelvic floor muscle training and biofeedback.⁸ Obesity, for example, is a strong risk factor for prevalent and incident incontinence, and a behavioral intervention including weight loss and physical activity reduced the frequency of urinary incontinence episodes among overweight and obese women compared with a control group.⁹

Treatment for incontinence can be effective and result in high patient satisfaction and improved quality of life. But it is only effective when sought, and too few women seek care. The National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services now track self-reported incontinence and care-seeking behavior among Medicare Advantage and commercial Medicare patients. These efforts will be critical for measuring progress in treating this condition as the US population ages. According to NCQA data, the percentage of women in commercial Medicare plans who discuss their incontinence with their physician increased from approximately 55% in 2003 to 58% in 2007.¹⁰ As is evident, there remains room for improvement. Clinicians should be proactive in asking about a patient's continence status and initiating a prevention or treatment plan. Although incontinence is not a normal part of aging, talking about it should be.

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