Urinary incontinence
Keeping family physicians involved in care

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Urinary incontinence (UI) is a great example of the inverse care law, which states the more common the subject, the less time is spent on it in medical school. Some of the articles in this issue of *Canadian Family Physician* (pages 86 and 96) highlight the fact that many family physicians have little experience or knowledge of how to approach UI in the office. Despite the high prevalence cited, particularly in the elderly, UI remains a problem that neither patients nor family physicians are comfortable addressing.

The sequelae of UI are well-known and include urinary tract infections, skin breakdown and ulceration, social isolation, and depression. Despite this, as noted in the paper by Swanson and colleagues (page 86), patients are sometimes unwilling to identify the problem, even to their family physicians. For this reason, physicians need to include UI on their list of "health promotion" issues to address with older patients. Unfortunately, uncertainty about how to investigate and manage UI means that physicians do not look for this problem. If a patient mentioned the problem, only one third of family physicians responding to the survey said they would feel comfortable assessing or treating it, and half would refer patients to a specialist. In some circumstances, family physicians do not deal with the problem at all. Fewer than half of patients report continence problems and, as noted in this issue, fewer than half of family physicians reported that they asked patients about it. Patients report UI to their physicians after an average of 5 to 10 years of dealing with it.

Challenging and rewarding

What most family physicians do not realize is that initial management of UI is challenging and rewarding and is not as complicated or specialized as they might think. By using history, physical examination, some very basic laboratory investigations, and a postvoid residual urine test, they can develop an effective management strategy.[1] Gynecologists and urologists use surgery as a last-line treatment. Many of the earlier interventions, including behavioural and environmental strategies and medications can be managed by family physicians. Incontinence can be assessed within the time constraints of a busy office practice. Frequently, even if the symptoms are only ameliorated and not cured, patients are grateful to have some consideration of a problem that might have been going on for many years. Support and patient education might substantially decrease the effects of UI.

Survey reveals interesting findings

Several interesting points were raised in the survey by Swanson et al. Family physicians identified urodynamics as an important investigation, despite the fact that this test often requires referral to a specialist clinic and is relatively difficult to access in most places. An office test, bedside cystometrics, can be done by family physicians themselves to augment their histories and physical examinations.[2] Cystometrics can provide estimates of postvoid residual volume, total bladder capacity, and is effective in identifying detrusor overactivity.

Another interesting finding was that respondents to the survey most commonly identified urologists as the primary resource for UI management. Gynecologists were identified second most frequently. Nurse continence advisors were infrequently mentioned as a resource, despite evidence that nonpharmacologic management is more important than drug therapy. Access to nurse continence advisors should be viewed as a huge asset by family physicians and specialists alike, where they are available.

The role of physiotherapists registered nurses, and other health care professionals does not appear to be well recognized by family physicians.

Geriatricians are not commonly viewed as a resource, but because medical comorbidities and functional limitations play an important role in UI with older patients, geriatric medicine could play a greater role. As noted in the article by Swanson et al, a study of the effectiveness of family physicians in treating UI in conjunction with a multidisciplinary team could support the important role family physicians can play in UI management.

Attitudes must change

The first step to improving the management of geriatric UI, however, is changing family physicians' attitudes and knowledge. Most respondents viewed UI as a serious problem, yet fewer than half asked their patients whether they had it. Strategies to improve our management of this problem need to begin during residency training. Including geriatric rotations and core lectures on managing UI in residency programs might improve both knowledge and confidence. I left my residency with little idea of how to respond to inquiries about continence and, therefore, actively avoided the issue! Papers such as the ones in this issue of *Canadian Family Physician* increase the profile of this common problem, and I hope they will stimulate family physicians to review their approach. Clinical practice guidelines recently published by the Canadian Continence Foundation are available on their website (**www.continence-fdn.ca**). They provide an organized approach for family physicians, both for assessment and referral.

As the focus in UI management shifts from health care professionals to consumers, and as the "baby boomers" start becoming incontinent, we will likely be forced to become more active in this field or be bypassed completely. Developing knowledge, skills, and a more proactive attitude now will be necessary to prevent this from happening.

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