Managing adults with urinary incontinence
Clinical practice guidelines

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"Promoting a Collaborative Consumer-Focused Approach to Continence Care in Canada" was sponsored by the Canadian Continence Foundation. This initiative responded to consumers' need for information on treatment options for incontinence and health care professionals' need for information on managing urinary incontinence. It was funded by Health Canada's Population Health Fund. Producing the guidelines involved review of international models of continence care, review of existing international clinical practice guidelines and management flow charts, an updated literature review, and a consensus conference followed by regional discussions during which consumers and health care professionals ("reactor panels") could react to the material produced.

The Canadian Continence Foundation then convened a multidisciplinary committee of consumers and health care professionals knowledgeable about managing incontinence. The committee had representatives from family medicine, nursing, physiotherapy, gynecology, urology, urogynecology, geriatric medicine, and Health Canada's Division of Seniors and Aging, along with an independent evaluator.

The committee accepted the second edition (1996) of the United States Agency for Health Care Policy and Research's (AHCPR) "Clinical Practice Guideline for Urinary Incontinence in Adults" as a starting point. Committee teams did systematic literature searches from January 1995 to January 2000 using key search terms and reviewed relevant papers using established levels of evidence.

The committee then looked at the AHCPR guideline and recommendations again and endorsed or modified them according to the new evidence from their literature review. A series of flowcharts, produced for the First International Consultation on Incontinence in 1998, were adapted in light of the findings of the literature review to reflect management of incontinence in men, women, and frail elderly people.

Participants were selected, based primarily on nominations, from national associations of health professionals and consumer groups and from various geographic regions across Canada for a consensus conference, which was held in May 2000. Draft guidelines were circulated to participants before the conference; during the conference, the draft guidelines were presented and discussed in small groups and further revised. Consensus was defined as more than 80% of participants voting in favour of a revision.

The resulting consensus guidelines and flowcharts were presented to reactor panels at seven community meetings. A consistent recommendation from the reactor panels was to consolidate the flowcharts for men, women, and frail elderly people into one chart. **Figure 1** presents the resulting integrated "Initial Management of Urinary Incontinence" chart. Specialist health professionals attending the Canadian Continence Foundation's Biennial Conference in October 2001 also indicated their preference for an integrated flowchart for specialized management of urinary incontinence.

The guidelines and initial management flowchart emphasize assessment of consumers' goals, consideration of quality-of-life issues, and use of appropriate outcome measures, such as voiding diaries. A continence history, focused physical examination, and consideration of non-urologic contributing factors, particularly in elderly people, can establish type of incontinence and guide interventions. Lifestyle strategies, such as fluid intake volume and timing; caffeine reduction; and conservative behavioural interventions, such as bladder retraining, pelvic muscle exercise and urgency suppression techniques, are first-line interventions for most people with incontinence.

Patient education is critical; taking time to instruct patients makes positive outcomes more likely. Family physicians might elect to do the initial assessments and instruction themselves. Alternatively, they might identify the problem of incontinence and refer their patients to health professionals (such as nurses or physiotherapists) or to interdisciplinary continence clinics, who can provide the expertise and time to ensure effective instruction, reinforcement, and follow up. Referral to specialists for second-line management is required for those with complex histories, those who do not respond to initial lifestyle and behavioural interventions, and those in whom urodynamic assessment or cystoscopic assessment is necessary to evaluate other options, such as periurethral bulking agents or surgery.

The positive message from the consensus conference to people with incontinence and to health professionals involved in their care is that urinary incontinence can be resolved, better managed, or better contained in 100% of people affected. The full text of the process, guidelines, and flowchart can be seen on the Canadian Continence Foundation website at **www.continence-fdn.ca**. A complimentary laminated copy of the initial management flow chart may be obtained by contacting the Canadian Continence Foundation at **help@continence-fdn.ca**.

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Figure 1. Initial management of urinary incontinence in men, women, and frail elderly people