Incontinence: A Growing Age-Related Problem

Incontinence affects both ends of the age spectrum - we enter the World incontinent, and many of us leave the same way. For some, a significant proportion of adult life is affected.

The size of the problem

Studies from a number of countries suggest that 35% of women experience some urinary incontinence. In the UK alone, an estimated 6 million adults cannot control their bladders as well they would like[i]. A cross-sectional, postal survey of 14,600 community-dwelling adults, aged 40 years or more, was conducted by the Medical Research Council in Leicestershire, during 2000. Seventy per cent of questionnaires were returned, with 38.8% of women and 28.5% of men reporting clinically significant urinary symptoms. These included urinary incontinence of several times a month or more, experienced by 20.2% of women and 8.9% of men. This rose to 34% of adults if occasional stress incontinence was included[ii]. Previous research investigating non-responders in a postal survey of urinary symptoms, in adults aged 40 years or more, found no evidence of non-response bias, suggesting that these figures are likely to be accurate across the population as a whole[iii]. Younger adults are also affected. In New Zealand, for example, one study found more than a third of new mothers still experienced some degree of urinary incontinence three months after confinement[iv]. Perhaps more surprisingly, a recent survey of US women found that urinary incontinence affected 28% of women aged 30 – 39 years, of whom 8% assessed their problem as severe[v].

Despite its prevalence, urinary incontinence remains a taboo that engenders embarrassment and distaste. This needs to change for, as the population ages, incontinence will become an increasing health and social problem, contributing towards isolation, loneliness, depression, sexual problems, sleep disturbance and stigmatisation. Even mild urinary incontinence can have a profound effect on a person's quality of life[vi].

Several surveys have suggested that only one in four people who experience urinary incontinence seek medical help. This is often because they do not consider themselves 'incontinent' but just that they 'leak a little'. It is therefore helpful for healthcare professionals to use sensitive terms when raising the subject, such as 'bladder weakness', 'bladder problem' or 'leaky bladder'. This is more likely to encourage someone to admit they may need help.

BOX: The nature of the problem

Urinary incontinence can result from:

- Stress urinary incontinence
- Urge urinary incontinence/overactive bladder syndrome.
- Detrusor overactivity incontinence
- Mixed urinary incontinence

The majority of women with urinary incontinence are treated in primary care using conservative approaches. Guidelines and recommendations for the clinical management of female urinary incontinence in the UK include those of the Scottish Intercollegiate Guidelines Network (SIGN)[vii] and the Royal College of Obstetricians and Gynaecologists[viii].

Guidelines are also under preparation at the National Institute for Clinical Excellence (NICE)[ix]. Evidence has already been submitted by stakeholders, and consultation on the first draft of the guidelines is expected during May 2006, with consultation on the final draft in July and final publication expected during December 2006. The NICE guidelines will cover assessment and investigation, the appropriate use of conservative techniques (lifestyle modifications, behavioural interventions, physical therapies), pharmacotherapy, surgical management and incontinence products for containment.

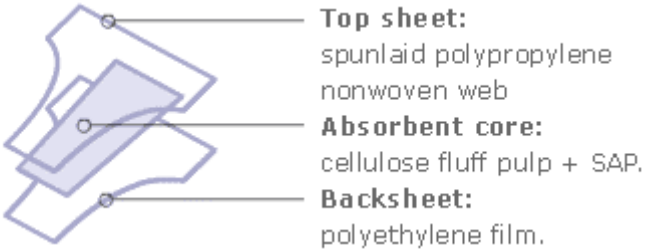
Incontinence products

Absorbent products specifically designed for adult incontinence were introduced into Europe in the late 1960s. They are invaluable in providing containment and reassurance for both men and women with urinary incontinence, helping patients lead a normal rather than a restricted life. Modern products are available in a surprisingly large range of shapes and sizes to fit different body shapes, and with different levels of absorbency to suit varying degrees of incontinence, disability and lifestyle. Products have become thinner, lighter, and more efficient over the years, making them discreet and suitable for use at home, in hospital and within institutions. They are appropriate for use within conservative, medical or surgical management plans, whether incontinence is regular or occasional, light or heavy.

Products have evolved to include:

- two–piece systems (pad and pant) for the whole spectrum of urinary and faecal incontinence
- insert pads – body-shaped pads which are fitted to the body in specially designed, knitted stretch briefs or used in normal panties/briefs (for light incontinence)
- Male pouches suitable for men with dribbling incontinence, which are kept in position with an adhesive strip or worn with close-fitting pants.

Adult urinary incontinence pads are made to a different specification than sanitary pads, and have a higher absorbency - typically ten times greater. The absorbent core is usually made from cellulose fluff pulp together with powdered superabsorbent polymers (SAP) that can quickly absorb many times their own weight of water. Linings are a non-woven web of polypropylene that maintains a dry feel, so the pad can still be worn comfortably, even after it has absorbed a leak - although they should be changed before becoming saturated. Some pads are available with a wetness strip to indicated when they need changing. Most also have a waterproof backsheet made of polyethylene film, but pads with no waterproof backing are also available for use as a booster.



Incontinence pads are designed to absorb urine rapidly, and distribute it throughout the absorbent core. This locks moisture away from the skin, minimising dermatitis and odour potential.

For light use, slim pads can be slipped unobtrusively inside ordinary underwear and kept in place with an in-built adhesive strip. Alternatively, they can be worn inside stretch pants or pants with a built-in pouch. If using pants with a waterproof backing or pouch, it is important to use a pad that does not have a waterproof backsheet. All-in-one nappy-style pads are also available for heavier urinary and/or faecal incontinence.

Pads can be mixed and matched according to a patient's needs. For example, smaller pad can be used during the day and changed frequently, with a more absorbent pad used overnight.

BOX: Product Requirements

The primary requirements for containment products are:
- Rapid absorption and retention of urine
- Isolation of wetness from the skin
- Reduction of odour
- Hygiene
- Comfort
- Simplicity
- Low noise factor - patients do not want rustling to give away their 'secret'.

These features are important so that users can manage their incontinence effectively and with dignity.

Reimbursement

A typical person with incontinence uses 4-5 absorbent products per day with an additional, heavier-performing product at night. This adds up to an average of six items per 24 hours or 2190 units per year. Throughout western Europe, based on data from 2001, an estimated 5.2 billion items are used annually, including body-worn inserts (for light, medium or severe incontinence), all-in-one products (briefs/pants for severe incontinence) and underpads for beds or chairs.

Patients with heavy incontinence account for around 90% of the market, with most obtaining their products via their national healthcare system. Figures suggest that

within Europe, this market is growing by 5-6% per year. The current emphasis is therefore, not surprisingly, on the need to reduce costs. There is little harmonisation with regard to reimbursement rates across the EU, however, and no universal agreement on whether or not people with incontinence can claim the cost of disposable absorbent products from health service providers, insurance companies or sick funds.

In the UK, absorbent containment products are available free of charge on the NHS via GPs or local continence services. The range available varies between healthcare providers, depending on local budgets, and patients may need to purchase products themselves - either because of local NHS rationing, because they use more products that their provider feels they need, or because they prefer a particular brand that is not supplied free-of-charge. Self-purchase is not difficult, as adult absorbent pads are widely available from high street pharmacies, supermarkets and by mail order. It can prove expensive, however, as patients are unable to negotiate the bulk discounts available to healthcare providers. Regulators also need to formulate more equitable policies regarding VAT. Although individuals can purchase a certain number of incontinence products without paying VAT, and without filling in an exemption form, VAT has not actually been abolished on these products in the UK. [Q: IS THIS STILL THE CASE?] Can adult incontinence products really be classed as luxuries rather than healthcare essentials?

Although it is important to contain costs, it is also important to remember that cheaper products may have a lower performance. As a result, although unit costs are reduced, more products may be consumed, which can cost more overall.

Acceptance

Our ageing population will necessitate different attitudes towards age-related health problems such as urinary incontinence. More and more retail outlets are now selling adult absorbent hygiene products, and it is as easy for a patient to slip a pack of incontinence pads into their shopping trolley as it is to buy sanitary products and disposable baby nappies. Nevertheless, it is important to ensure free provision of these products where they are clinically indicated. It is important that future guidelines include statements about who will fund these essential products, which undoubtedly contribute to patient mobility, independence, dignity and quality of life - as well as easing the burden on care givers in families and institutions.

Resources

Further information is available from:
The Continence Foundation
307 Hatton Square
16 Baldwin Gardens
London, EC1N 7RG
Helpline: 0845 345 0165 (Monday to Friday, 9:30 am to 1:00 pm)

www.continence-foundation.org.uk

[i] http://www.continence-foundation.org.uk/symptoms-and-treatments/index.php
[ii] Perry S et al. 2000. An epidemiological study to establish the prevalence of urinary symptoms and felt need in the community: the Leicestershire MRC Incontinence Study. Leicestershire MRC Incontinence Study Team. J Public Health Med. 22(3):427-34.
[iii] Dallosso HM et al. 2003. An investigation into nonresponse bias in a postal survey on urinary symptoms. BJU Int. 91(7):631-6.
[iv] Wilson PD et al. 1996 Obstetric practice and the prevalence of urinary incontinence three months after delivery. Br J Obstet Gynaecol. 103(2):154-61.
[v] Melville JL et al. 2005. Urinary Incontinence in US Women: A Population-Based Study. Arch Intern Med. 165(5):537-42.
[vi] Brittain K, Perry S, Williams K. 2001 Triggers that prompt people with urinary symptoms to seek help. Br J Nurs. 10(2):74-80
[vii] http://www.sign.ac.uk/guidelines/published/
[viii] http://www.rcog.org.uk/mainpages.asp?PageID=754
[ix] http://www.nice.org.uk/page.aspx?o=63363