

The Companion Guide to 'First Steps in the Management of Urinary Incontinence in Community- Dwelling Older People' Clinical practice guideline, Third Edition, 2010

This short guide is based on and
TO BE USED IN CONJUNCTION WITH
'First Steps in the Management of
Urinary Incontinence in Community -
Dwelling Older People: A clinical
practice guideline for primary level
clinicians (registered nurses and
allied health professionals)'
Third Edition 2010



A resource developed by the Home and Community Care (HACC)/Medical Aids Subsidy Scheme (MASS) Continence Project

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ISBN: 9781921447839

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For detailed information, including references and grading of evidence for the information included in this booklet, please consult the “First Steps in the Assessment and Management of Urinary Incontinence in Community-Dwelling Older People: A clinical practice guideline for primary level clinicians (registered nurses and allied health professionals)”, Third Edition, 2010, published by the HACC/MASS Continence Project, also referred to as the CPG.

This book is not a stand alone document. It is a quick reference guide to prompt clinicians through the continence assessment and management process.

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THE BATHE TECHNIQUE

BATHE Technique	Sample Questions and Statements
B ackground	<p>Tell me what's happening?</p> <p>How are things with your bladder and bowel function?</p> <p>Do you have any problems with your waterworks?</p> <p>What's going on with your bladder?</p>
A ffect	<p>How do you feel about that?</p> <p>How do you feel about what is going on?</p> <p>How is that affecting you?</p>
T rouble	<p>What troubles you the most about this?</p> <p>What worries you most about this situation?</p> <p>Of all these problems, which one is the most troublesome for you?</p>
H andle	<p>How are you handling the situation?</p> <p>How are you managing this?</p>
E mpathy	<p>I can understand how that would make you feel.</p> <p>That must be difficult for you.</p>

The BATHE technique is a brief psychotherapeutic method that enables a clinician to find out what part of the problem concerns the individual, what he/she was hoping the clinician would do and why he/she is coming for help at this time.

RED FLAGS

Significant and causative factors related to urinary incontinence
Pain on voiding, urogenital pain, or pain in the lower pelvic area
Recent unexplained weight loss
Recent sudden change in bowel habit
Pelvic mass
Rectal bleeding
Persistent diarrhoea
Haematuria
Recurrent symptomatic urinary tract infection
History of pelvic surgery or irradiation
Major pelvic organ prolapse

**IF IDENTIFIED OR SUSPECTED,
PROMPTLY REFER TO MEDICAL PRACTITIONER**

DIAPPERS

Potentially reversible/treatable causes of urinary incontinence
Delirium
Infection of urinary tract (UTI)
Atrophic urethritis/vaginitis
Pharmaceuticals
Psychological
Excessive urine output, endocrine disorders (e.g. diabetes)
Reduced mobility
Stool impaction

**IF IDENTIFIED OR SUSPECTED,
REFER TO MEDICAL PRACTITIONER**

TOILETED

Potentially reversible/treatable causes of urinary incontinence

Thin and dry vaginal and urethral epithelium

Obstruction (of bowels)

Infection (urinary tract)

Limited mobility

Emotional or psychological factors

Therapeutic medications

Endocrine disorders

Delirium

**IF IDENTIFIED OR SUSPECTED,
REFER TO MEDICAL PRACTITIONER**

FACTORS THAT CONTRIBUTE TO URINARY INCONTINENCE

- Alcohol
- Arthritis
- Back pain
- Bowel problems
- Caffeine
- Cardiac conditions
- Childhood history
- Constipation/
stool impaction
- Dehydration
- Dementia
- Diabetes Mellitus
- Ethnicity
- Frailty
- Gynaecological factors
 - o Pelvic organ prolapse
 - o Gynaecological surgery
- Medications
 - See table on page 29
- Mobility problems
- Neurological conditions
- Obesity
- Oestrogen deficiency
- Pregnancy and childbirth
- Prostate problems
- Psychiatric/mental illness
- Renal conditions
- Respiratory disease
- Sleep-disordered breathing
- Smoking
- Stroke/cerebrovascular accident (CVA)

Evidence based recommendation from the CPG:

Supervised weight reduction should be considered a first-line, non-surgical intervention for urinary incontinence. A 5% - 10% loss of base line weight in morbidly obese women has been shown to decrease incontinence.

Level of Evidence: 2++ Grade of Recommendation: B

Refer to the CPG for explanation of level of evidence and grade of recommendation.

RISK FACTORS ASSOCIATED WITH URINARY INCONTINENCE

- Admission to residential care
- Anxiety
- Carer strain
- Depression
- Falls
- Inappropriate presentation to acute care
- Reduced fluid intake
- Skin breakdown
- Sleep disruption
- Social isolation

Evidence based recommendation from the CPG:

Screen women with moderate to severe urinary incontinence for co-morbid major depression and refer for treatment if depression is present.

Level of Evidence: 4 Grade of Recommendation: D

Refer to the CPG for explanation of level of evidence and grade of recommendation.

LOWER URINARY TRACT SYMPTOMS (LUTS)

Storage Symptoms

- Increased daytime frequency
- Nocturia
- Urgency
- Urinary incontinence
- Stress urinary incontinence
- Urge urinary incontinence
- Mixed incontinence
- Nocturnal enuresis
- Continuous urinary leakage
- Other types of urinary incontinence (e.g. coital)

Voiding Symptoms

- Slow stream
- Intermittent stream
- Hesitancy
- Straining to void
- Terminal dribble

Post Micturition Symptoms

- Feeling of incomplete emptying
- Post micturition dribble

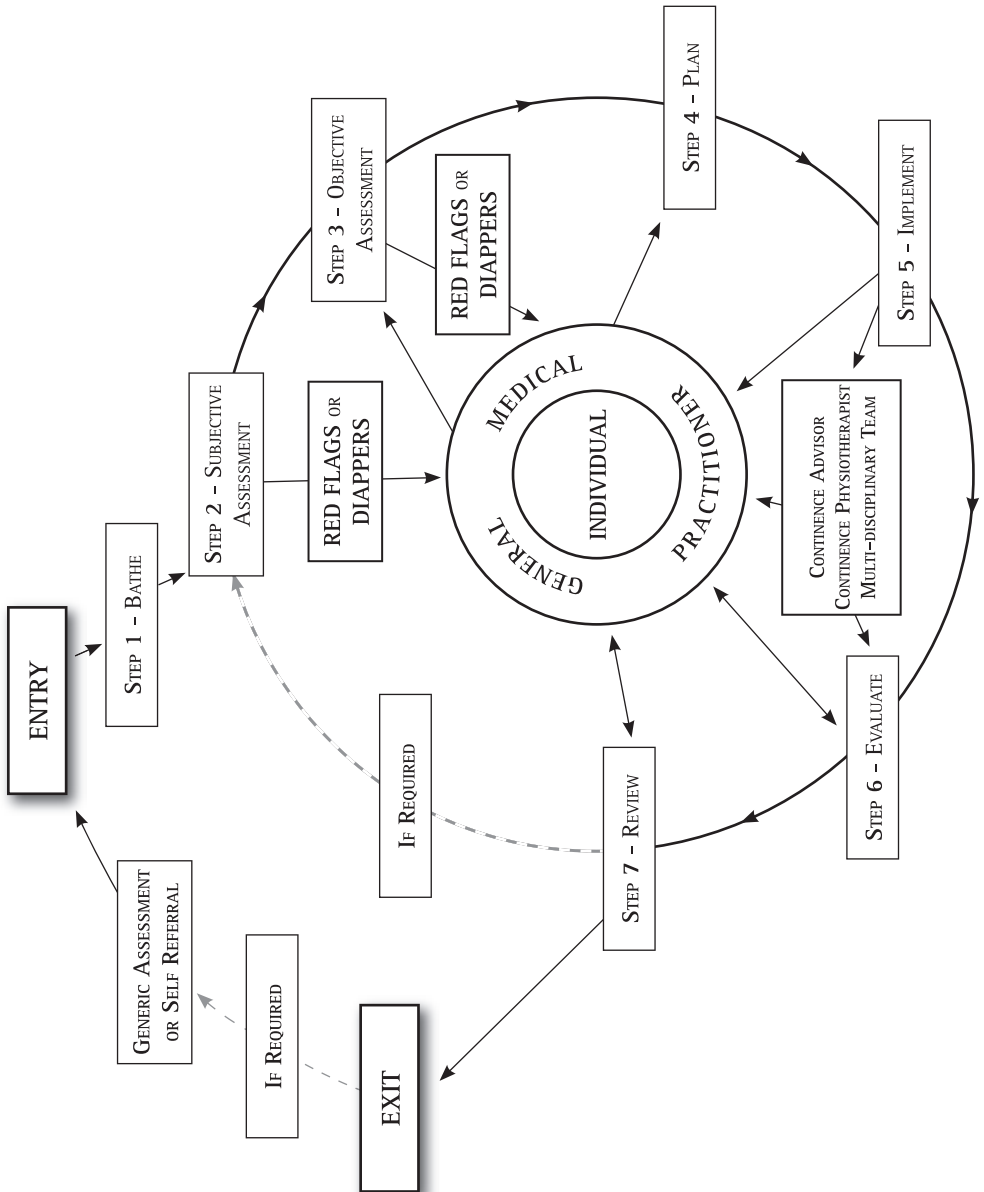
BLADDER SENSATION

Bladder sensation can be described as being:

- Normal
- Increased
- Reduced
- Absent
- Non-specific

Altered sensation requires referral to medical practitioner for further assessment and management.

CLINICAL ALGORITHM FOR THE CARE OF COMMUNITY-DWELLING OLDER PEOPLE WITH URINARY INCONTINENCE



FIRST STEPS IN THE ASSESSMENT AND MANAGEMENT OF URINARY INCONTINENCE

AN EPISODE OF CARE

The SOAPIER mnemonic aids in remembering the elements of an episode of care
S ubjective and O bjective A ssessment
P lan
I mplement
E valuate
R eview

STEP ONE: ESTABLISH AN APPROPRIATE ENVIRONMENT

- **Consider the client's attitude to talking about incontinence:**
 - o Embarrassment
 - o Shame
 - o Evoking painful memories.

Shame and embarrassment, combined with attitudes to disclosure about personal matters, prevent people from seeking advice.

- **Consider needs of Aboriginal and Torres Strait Islander (ATSI) people:**
 - o Gender of health worker is critical to successful management of incontinence
 - o ATSI health workers and professionals should be used whenever possible
 - o Engage with ATSI elders/family when appropriate
 - o Use culturally appropriate information, assessment and management.

Use specific resources addressing incontinence for Indigenous people where possible. Source these resources through the National Continence Helpline on 1800 33 00 66, the Continence Foundation of Australia (www.continence.org.au), the Australian Government Department of Health and Ageing (www.bladderbowel.gov.au), and the HACC/MASS Continence Project.

www.health.qld.gov.au/mass/docs/resources/continence/haccmasscontresources.doc

- Consider people from culturally and linguistically diverse (CALD) backgrounds:
 - o Use a trained interpreter whenever possible to ensure that accurate information is being given and received
 - o Use culturally appropriate information, assessment and management
 - o Individual should be able to speak with health professional of same gender
 - o Learn about and respect cultural differences
 - o Avoid stereotyping
 - o Take time to build rapport with the individual
 - o Be open and willing to learn from the individual about his/her beliefs and values.

STEP TWO: SUBJECTIVE ASSESSMENT AND HISTORY

Clients identified as having urinary incontinence should undergo a subjective assessment covering the following areas:

- Onset of urinary incontinence
- Presenting symptoms
- Mobility status and safety
- Surgical history
- Medical history
- Nutritional history
- Medications
- The impact of urinary incontinence on everyday life
- Current management strategies
- Motivation and cooperation
- Carer issues and needs.

Services may have their own incontinence assessment tool that covers these areas, or clinicians can contact the HACC/MASS Continence Project at contpro@health.qld.gov.au for a generic assessment tool.

Evidence based recommendation from the CPG:

Individuals who have been identified as having urinary incontinence should undergo subjective assessment covering the following areas: onset of urinary incontinence, presenting symptoms, mobility status, surgical history, medical history, medications, the impact of urinary incontinence on everyday life, motivation and cooperation.

Level of Evidence: 4 Grade of Recommendation: D

Refer to the CPG for explanation of level of evidence and grade of recommendation.

STEP THREE: OBJECTIVE ASSESSMENT

Clients identified as having urinary incontinence should undergo an objective assessment in the following areas:

Psychological/behavioural/cognitive status

- Seek urgent medical attention if person presents with symptoms of delirium
- Cognitive or behavioural changes affect the usefulness of some assessments and interventions.

Physical examination

- Skin examination for perineal and general skin health and integrity
- Refer to medical practitioner, continence nurse or pelvic floor/women's physiotherapist for vaginal and/or rectal examination examinations.

Bladder diary

- A 24 hour bladder diary should be completed and assessed for fluid intake and output, polyuria and nocturnal polyuria.

Bowel diary

- Complete a 5-7 day bowel diary and assess for pattern and types of bowel movements.

Urinalysis

- Should be performed on all clients presenting with urinary incontinence
- If required, refer to medical practitioner or nurse for this assessment.

Evidence based recommendation from the CPG:

Individuals who have been identified as having urinary incontinence should undergo an objective assessment in the following areas: psychological/behavioural/cognitive status, physical examination, bladder diary and urinalysis.

Level of Evidence: 4 Grade of Recommendation: D

Perform urinalysis on all individuals presenting with urinary incontinence.

Level of Evidence: 4 Grade of Recommendation: D

Refer to the CPG for explanation of level of evidence and grade of recommendation.

STEP FOUR: CONSERVATIVE MANAGEMENT

Initial management strategies:

- Ensure adequate fluid intake
- Ensure adequate fibre intake from a wide variety of foods
- Promote physical activity and exercise such as walking and swimming for at least 30 minutes each day
- Encourage healthy weight for height
- Use the correct toilet position for emptying the bladder and bowel
- Encourage good toileting habits
- Encourage to quit smoking
- Refer to medical practitioner as required.



Quit Smoking



Swimming



Walking

CONSTIPATION MANAGEMENT PLAN

Registered nurses, allied health professionals or health care workers should not attempt to treat acute constipation before medical screening for underlying pathology has been completed.

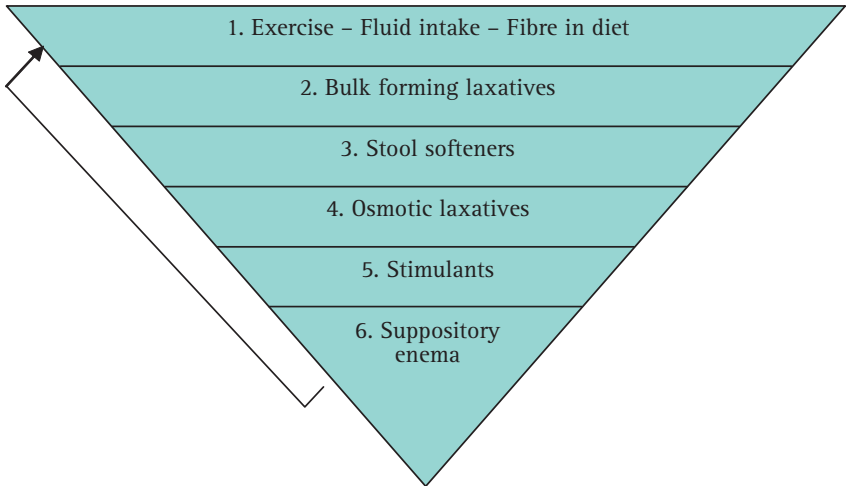
The individual's bowel pattern and dietary intake should be recorded for at least one week using a bowel diary and the Bristol Stool Form Scale to identify stool type.

Assess bowel function in individuals with urinary incontinence:

- What is the main problem with your bowels?
- What is your bowel motion like?
- Do you have difficulty opening your bowels?
- Do you need to strain? If so, for how long?
- Do you ever need to self assist the passage of stool?
- How often do you feel as though you haven't emptied your bowel completely?
- How often do you feel as though you have a blockage during bowel emptying?
- How many times do your bowels open per week?
- Do you ever not get to the toilet in time and have a bowel accident?
- Do you have any leakage from your back passage of which you are unaware? Is this liquid or solid?
- Can you control wind? Are you able to tell the difference between wind and the need to empty your bowels?
- Do you have pain and/or blood associated with opening your bowels?

STEPPING OUT OF CONSTIPATION

Follow the 'Stepping out of Constipation' algorithm for the management of constipation. Refer an individual with recent, sudden onset of constipation or symptoms and signs such as blood in stools, pain associated with defecation etc. promptly to the general medical practitioner.



- Management of simple constipation starts at STEP 1, exercise, fluid intake and fibre in the diet. If constipation does not resolve in 3-4 days, compliance to recommendations should be checked. If compliance has been good, progress to STEP 2, non-prescription bulk-forming agent, if required.
- Management of long-standing constipation starts at STEP 1, exercise, fluid intake and fibre in the diet, and works through to STEP 3, stool softeners, if required.
- Management of severe constipation involves STEP 3, stool softeners, and STEP 4, osmotic laxatives, followed by STEP 1 and possibly STEP 2.

MANAGEMENT OF STOOL IMPACTION

Evidence based recommendation from the CPG:

Once impaction is identified, the loaded rectum and bowel must be cleared (disimpacted) prior to any other intervention. Rectal preparations such as enemas, suppositories and water lavage are used to clear faecal impaction; however, the use of stimulant laxatives is contra-indicated.

Refer to medical practitioner.

Level of Evidence: 4 Grade of Recommendation: D

Refer to the CPG for explanation of level of evidence and grade of recommendation.

After disimpaction:

- May need oral bowel medication which is prescribed and monitored by medical practitioner
- Review bowel habit and pattern using bowel diary
- Implement constipation management plan using the prevention strategies in STEP 1. Strategies in STEP 2 may also be required on an ongoing basis.

GOOD HABITS FOR BOWEL EMPTYING

- Clients should be encouraged to go to the toilet to empty their bowels when the urge is first experienced
- Allow sufficient time for successful bowel movement
- Olfactory, visual and auditory privacy should be ensured; otherwise, the person may suppress the urge to defecate
- The most common times of the day to get the urge to defecate are first thing in the morning or following a meal

THE BEST POSITION FOR EMPTYING THE BOWEL



- Adjust clothing so legs are comfortably apart with feet supported
- Lean forward and rest on thighs or knees
- Sit with lower back straight, not slumped
- Use of a foot stool may be appropriate, but consider safety issues and lower back position

THE BRISTOL STOOL FORM SCALE

THE BRISTOL STOOL FORM SCALE

Type 1



Separate hard lumps,
like nuts (hard to pass)

Type 2



Sausage-shaped
but lumpy

Type 3



Like a sausage but with
cracks on its surface

Type 4



Like a sausage or snake,
smooth and soft

Type 5



Soft blobs with clear-cut
edges (passed easily)

Type 6



Fluffy pieces with ragged
edges, a mushy stool

Type 7



Watery, no solid pieces
ENTIRELY LIQUID



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FIBRE SOURCES

Food	Fibre (g)
Wholemeal/multigrain bread, 2 slices/60g	4.0 (3.0-6.0)
Fruit, average, 1 piece	3.0
Dried fruit (3 figs, prunes, or dates)	4.0
Vegetables, average, 1/2 cup	2.0 (0.5-4.0)
Baked beans, lentils, 1/2 cup	4.0 (3.0-5.0)
High fibre cereal, 1 bowl	5.0 (5.0-10.0)
Medium fibre breakfast cereal (eg. wheat cereal biscuits), 2	4.0
Psyllium husks, 2 tablespoons, 10 g	8.0
Wheat bran, 2 tablespoons, 15 g	6.5
Nuts, nut butters, seeds, 1 tablespoon	2.0
Rice, white, 1 cup	2.0
Rice, brown, 1 cup	4.0
Pasta, cooked, 1 cup	3.0
Wholemeal pasta, cooked, 1 cup	9.0

FIBRE INTAKE

Encourage 25-30 g of dietary fibre per 24 hours.

Steps to increase fibre intake should be gradual, occurring over days or weeks, depending on individual tolerance.

More fluids are required when fibre intake is increased. An extra 250 mL per day is required for every 3-5 g increase in fibre above 25 g.

Provide individual with a food fibre guide.

Poor fibre intake can be affected by:

- Poor swallowing
- Poorly fitting dentures
- Mouth problems
- Food choices
- Food availability.



FLUID INTAKE

For healthy bowel and bladder function, recommend fluid intake of 24-30 mL of fluid per kg of body weight (including fluids found in foods), unless otherwise advised. This equates to approximately 1500-2000 mL in a 24 hour period, and is sufficient to produce a urine output of 500-1500 mL in 24 hours.

Fluid Content of Various Foods	
170 mL clear soup	170 mL
170 mL thicker soups (6 oz = 170 mL)	150 mL
30 mL gravy/sauce, e.g. white sauce	25 mL
1 ice cream slice 100 mL = 46 g	30 mL
Jelly, average serve	1/2 cup
Jelly served with custard (1/4 cup jelly)	50 mL
Custard, average serve	100 mL
Custard served with cake etc., 1/4 cup custard	50 mL
Jelly & custard together	100 mL
100 g tub yoghurt	80 mL
1 serve cooked porridge	160 mL
1/2 cup watermelon/other melons (100 g)	80 mL
1 medium apple/pear/orange	120 mL
1 medium tomato (160 g)	90 mL
Pawpaw (1/2 cup) = 75 g	66 mL
20 grapes (60 g)	50 mL
5 prunes (70 g)	50 mL
1 kiwi fruit (80 g)	65 mL
Vegetable and beef lasagne	90 mL

Excessive fluid intake may cause cardiac problems, hyponatremia and major diuresis.

Fluid intake should be increased in hot weather or with strenuous exercise.

CAFFEINE

People with overactive bladders, and those with frequent faecal incontinence are advised to limit their caffeine intake to no more than 100 mg per day.

Caffeinated drinks should not be the sole source of fluid.

Beverage/Food	Serving Size	Caffeine Content (mg)
Coffee, generic brewed	240 mL	133 (range: 102-200)
Tea, brewed	240 mL	53 (range: 40-120)
Green tea	200 mL	18
Cola drink	375 mL (1 can)	35 -38
Lemonade	375 mL (1 can)	0
Energy drink	250 mL	80
Hot chocolate	240 mL	9 (range: 3-13)
Chocolate bar	45 g	31
Over the counter medications used for mental fatigue (maximum strength)	1 tablet	100

Alcohol can affect the pituitary gland, suppressing the production of anti-diuretic hormone, and reducing reabsorption through the kidneys, causing dehydration.

Many carbonated drinks contain significant caffeine, sugar and preservatives, and may increase the risk of overactive bladder.

THE BLADDER DIARY

Reasons to use a bladder diary:

- To determine the 24 hour fluid input and output and voiding patterns
- To help development of a management plan
- To help measure the effectiveness of a management program.

How to use a bladder diary

Encourage completion of a 48-72 hour (2-3 day) diary.

If even one void in the 24 hour period is omitted, the diary can be misinterpreted. If it is impractical to measure all volumes for greater than 24 hours, encourage completion for 24 hours only, and record the number of voids and leakage episodes for several days after that.

Bladder diary analysis may indicate:

- Daytime frequency
- Nocturia
- Total, timing and type of 24 hour fluid intake
- Maximum and minimum voided volumes and intervals
- Total 24 hour output (diurnal 24 hour polyuria). Urine output should be 1500-2500 mL
- Nocturnal polyuria
- Leakage episodes
- Potential dehydration/excessive hydration.

Details on how to analyse the bladder diary are in the CPG.

NOCTURIA

Determine the cause of waking - is it the urge to void or other reasons?

Evidence based recommendations from the CPG:

If nocturia is still present once underlying conditions have been addressed by the medical practitioner, consider the following:

- Timing of diuretic in consultation with medical practitioner
- Reduction in caffeine and alcohol intake
- Reduction in fluid consumption close to bedtime
- Modifying night-time influences on sleep
- Taking day-time rests with feet elevated, especially in the afternoon/evening, if lower limb peripheral oedema is present
- Using elasticised (compression) stockings with medical practitioner's approval if lower limb peripheral oedema is present.

Level of Evidence: 4 Grade of Recommendation: D

Refer to the CPG for explanation of level of evidence and grade of recommendation.

GOOD HABITS FOR BLADDER EMPTYING

Evidence based recommendations from the CPG:

Females should be informed that it is best to sit on the toilet and avoid the hovering position, which causes a reduction in urine flow rates and an increase in post-void residual volume.

Level of Evidence: 3 Grade of Recommendation: D

Females should sit on the toilet in a safe, leaning-forward position to void, to achieve best flow rates and decreased residual volume.

Level of Evidence: 3 Grade of Recommendation: D

Males should be advised to void in either the standing or the sitting position according to preference.

Level of Evidence: 2+ Grade of Recommendation: C

Refer to the CPG for explanation of level of evidence and grade of recommendation.

Ensure females are aware of importance of wiping from the front to the back, to minimise the risk of urinary tract infection.

THE BEST POSITION FOR EMPTYING THE BLADDER



Encourage 30 minutes of moderately intense activity (e.g. walking) most days of the week to decrease the frequency of daytime urinary incontinence episodes. This can be broken up into a number of shorter periods of walking.

PELVIC FLOOR MUSCLE EXERCISE (PFME)

N.B. Check for RED FLAGS and DIAPPERS/TOILETED first

People with cognitive or behavioural impairment, and those with a neurological condition, are unsuitable for verbal Pelvic Floor Muscle Exercise (PFME) training. Verbal instruction by itself does not always produce a correct contraction, and may be counter productive.

Refer to a continence physiotherapist or trained continence nurse advisor for suitability for and teaching of pelvic floor exercises.

CORRECT SITTING POSITION WHEN DOING PFME

- Sit unsupported, away from the back of the chair
- Legs comfortably apart with feet firmly on the ground
- Lower back straight, not slumped
- Shoulders relaxed
- Feel the perineal area in contact with seat
- Maintain normal breathing.

Reinforce use of the ‘Knack’ (contraction of the pelvic floor muscles) to those who leak urine during specific activities.

If in doubt, check with a continence physiotherapist.

CONTINENCE PRODUCTS AND TOILETING AIDS

Consider the client’s physical, sensory and cognitive abilities when selecting an appropriate continence product. The book “Continence products and toileting aids: Personal characteristics and specific considerations when selecting continence products and toileting aids” (2010) by the HACC/MASS Continence Project, assists clinicians in this.

EXAMPLES OF MEDICATIONS THAT MAY CAUSE OR AGGRAVATE URINARY INCONTINENCE

α -adrenergic blockers → involuntary leakage on effort or exertion, or on sneezing or coughing
α -adrenergic agonists → hesitancy, straining to void, urinary retention → leakage from a constantly over distended bladder
ACE-inhibitors → cough induced sphincter weakness → stress incontinence
Alcohol → frequency, urgency, nocturia, confusion, sedation, immobility
Anticholinergics → hesitancy, straining to void, urinary retention → leakage from a constantly over distended bladder NB. Consider the potential adverse cognitive effect of drugs with anticholinergic actions in the older person. Avoid using anticholinergics in people with dementia as such drugs impair cognition.
β -adrenergic antagonists → hesitancy, straining to void, urinary retention → leakage from a constantly over distended bladder
β -adrenergic agonists → involuntary leakage on effort or exertion, or on sneezing or coughing
Cholinergics → detrusor activity, urgency → urge incontinence
Calcium channel blockers → hesitancy, straining to void, urinary retention → leakage from a constantly over distended bladder
Centrally acting antihypertensives → leakage
Diuretics → polyuria, frequency, urgency → involuntary leakage accompanied by or immediately preceded by urgency; confusion, delirium
Lithium → polyuria, frequency, urgency → involuntary leakage accompanied by or immediately preceded by urgency
Muscle Relaxants → polyuria, frequency, urgency
Narcotics → urinary retention; ↓ voluntary control to void
Non steroidal anti-inflammatory drugs → ↓ detrusor contractions; urinary retention
Psychotropics → hesitancy, straining to void, urinary retention → leakage from a constantly over distended bladder; confusion, delirium

EXAMPLES OF MEDICATIONS THAT MAY CAUSE CONSTIPATION

Anticholinergics
Anticonvulsants
Antidiarrheals
Antihistamines
Antihypertensives (some)
Anti-inflammatories
Antiparkinsonian drugs
Antipsychotics
Antispasmodics
Calcium channel blockers (some)
Calcium supplements
Cholestyramine
Diuretics
Iron supplements
Laxative abuse
Opioids
Polystyrene resins
Sympathomimetics
Tricyclic antidepressants

COMMONLY USED LAXATIVES

Bulk-forming laxatives – oral preparations (need to be taken with adequate fluid or else may contribute to constipation)
Osmotic laxatives – oral and rectal preparations
Stool-softeners – oral preparations
Stimulant laxatives – oral and rectal preparations
Stimulant combined with bulk-forming laxatives – oral preparations (need to be taken with adequate fluid or else may contribute to constipation)
Lubricant laxatives – oral and rectal preparations

Refer to CPG for information on class of laxatives and time to effect.

