
Executive Summary

Health Council of the Netherlands: Urinary incontinence. The Hague: Health Council of the Netherlands, 2001; publication no. 2001/12.

Within the framework of an investigation being carried out into the appropriateness of current medical procedures (the '126-List'), a committee of the Health Council of the Netherlands assesses in this advisory report the current diagnosis and treatment of urinary incontinence – the involuntary loss of urine – in adults.

The committee distinguishes two groups of patients: those with simple health care requirements, suffering no serious comorbidity and no severe constraints upon ordinary daily activity; and geriatric patients requiring complex health care, generally suffering multiple comorbidity and severe constraints upon ordinary daily activities and mobility.

Urinary incontinence is a common problem; an estimated five percent of the adult population has to contend with it, including more than half of retirement home residents and about 90 percent of nursing home residents. The condition is considerably more prevalent in women than in men. This is principally because of the relatively weaker construction of the closure mechanism in the female bladder, whose effectiveness can be even further impaired as a consequence of vaginal deliveries. However, many other factors can also play a role in the development of incontinence. Particularly amongst the elderly, these factors include the impairment of other functions such as mobility or cognition. The environment may also present hindrances which make it harder to reach or use a toilet in time. This is sometimes called functional incontinence.

Current preventive health care consists principally of post-partal pelvic floor muscle and bladder training exercises. It has been shown that this significantly reduces

the likelihood of incontinence. Research is still being carried out into the effectiveness of pelvic floor muscle exercises performed during, rather than after, pregnancy. No data are available on preventive measures for geriatric patients. There are, however, indications that amongst the incontinent elderly incontinence may diminish or even disappear if comorbidity is reduced, i.e., if non-urological disorders are limited. This relates to matters that can lead to or worsen incontinence, such as limitations of movement or mobility, of determined behaviour, of communication or of cognition. These are areas in which preventive measures should also be taken.

In the Netherlands, primary diagnosis and treatment is performed by the patient's general practitioner. There exists an NHG (Nederlands Huisartsen Genootschap, or Dutch College of General Practitioners) standard for such diagnosis and treatment, and the committee stresses the importance of following it. For many patients with stress incontinence, one of the two important types, pelvic floor exercises will lead to the considerable amelioration of symptoms, particularly for patients with simple health care requirements. For patients with urge incontinence, the second important type, bladder training is the most appropriate treatment. Instruction in these exercises is generally given by the general practitioner, but can also be given by a physiotherapist.

The treatment of urinary incontinence in patients with complex health care requirements does not differ essentially from that of other patients, but should also comprise research into and treatment of the causes of comorbidity. In many instances functional incontinence can be ameliorated by relatively simple and straightforward means.

In practice, medical care for patients with complex health care requirements generally means the provision of incontinence pads to absorb the lost urine. The committee believes, however, that the replacement of active treatment with this more passive form is appropriate only for those patients who expressly desire it, or for terminal patients. The use of permanent catheters should be avoided wherever possible unless the patient, after having been informed of the risk, elects for this option. Permanent catheters carry an increased risk not only of urinary infection, but also of damage to and strictures of the urinary ducts.

On the basis of the (incomplete) information available, the committee has drawn up an inventory of the costs associated with urinary incontinence. In the year 2000 at least NLG 600 million was spent on the diagnosis and treatment of this condition. In all likelihood this figure is a substantial underestimate. The principal costs are generated by health care expenses in retirement and nursing homes, and by the provision of incontinence pads.

The committee does not expect that the reduced use of incontinence pads would lead to any great savings, since it would probably be accompanied by an increase in

care requirements, such as assistance in toileting. In that case, the actual benefit would lie in the improved quality of life of those affected.

The committee concludes its advisory report with a number of recommendations.

Firstly, it urges stimulation of the adoption of existing guidelines for general practitioners and physiotherapists, the creation of transmural guidelines, and the creation of a single set of guidelines for gynaecologists and urologists.

Staffing shortages in home care organisations, retirement homes and nursing homes have encouraged the widespread use of incontinence pads. Concomitantly, there is a comparative lack of proper diagnostic attention and effective incontinence treatment. In this patient category, too, the quality of many sufferers' lives could be considerably improved by the provision of proper treatment.

Besides advocating the employment of more care staff in general, the committee recommends that a number of experimental positions be set up as Incontinence Nurse as a specialisation within clinical nursing. Incontinence Nurses would take over the urinary incontinence-related tasks within general practices (for instance, diagnostic inventories and the supervision of therapeutic attendance). The committee also recommends that all forms of exercise therapy be incorporated into standard physiotherapeutic training, in order to make this form of therapy more widely available.

Much is still unknown about preventive measures and the most effective treatments. In the committee's view, scientific research should be carried out into the importance of the various factors contributing towards incontinence in elderly people with complex health care requirements; the effectiveness of the training provided by a general practitioner as opposed to the training provided by intensive physiotherapy; short-term and long-term evaluations of the effectiveness of bladder training; and the effectiveness (including recurrence rates) of surgical procedures.

The commission also makes a number of practical recommendations directed towards the alleviation of functional incontinence. It urges for the adoption of hygienic, safe, easily accessible and ground-floor public toilets, both on the street and in public buildings, stations and shops, particularly for women. It ought also to be possible for patients living at home to obtain more accommodating furniture (a higher bed, higher chairs) and an adapted, ground-floor toilet. Clothing which is easy to open and close should also be more widely available.