

expects the impossible from his office staff; his secretary persecutes the typing pool; those at the bottom of the totem pole, having no one to sit on, find endless ways of frustrating the wishes of their immediate and more remote superiors. Stress is universal—none can escape it. So if Mr Smith has a stroke on his way to work it was not an inevitable consequence of vascular disease evolving over most of his lifetime, but of the unpleasant conditions in his office, a 10-hour day, the annual stocktake, the new manager, or some other factor causing his blood vessels to collapse under the strain.

How would the stress of daily life compare with that of unusual conditions? Former prisoners of war, the survivors of concentration camps, and Kampuchean refugees understand what real stress is. Against this scale how does one calculate the tribulations of the bored, frustrated, disgruntled employee, whether he be labourer or chief executive?

It seems likely that the medical profession will come under pressure to recognise stress as a contributing factor in illness in many cases where workers' compensation or retirement on health grounds is at issue. This question should be approached like any other in medicine. Where is the proof that stress "causes, aggravates, or accelerates" the development of such conditions as hypertension, atheroma, or cancer? Moreover, if stress as a contribution to any illness is to be recognised it must be seen in relation to the ability of the person to tolerate it. The labourer promoted to acting foreman may be under much greater stress, for him, than is the accountant promoted to manager or the departmental head to under secretary. Before stress becomes the key to the treasury, we should look for evidence of its effects and a means to measure it. And if we are to accept a role for stress, with or without the evidence, we should make sure that its benefits, as well as its ill effects, are available to all comers.

Hospital Topics

Changing attitudes in the management of urinary incontinence—the need for specialist nursing

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Abstract

Much interest has been shown recently in the plight of the incontinent patient and how incontinence should be managed. Incontinence has a complex aetiology and may be part of many medical and social problems. Because there is a delay between completing investigations and making a diagnosis we have established a system of nursing care. Initially this was meant to provide the person protective garments and appliances, but it now covers management in both the community and the hospital. The preliminary results show that patient assessment is effective and that specialist nurses and a co-ordinated scheme to educate both doctors and nurses are needed.

Introduction

Urinary incontinence is common and yet its management has been largely ignored. Thomas¹ showed a wide disparity between those who were recognised to be incontinent and those who reported in a postal survey that they were. About 2.5% of women over 65 were recognised as incontinent, but the survey showed a prevalence of 11.6%. Almost three-quarters of those who complained of moderate or severe leakage were receiving no help.

Even those people who do reach the health service often

receive poor treatment. They are seen by many different doctors who may find diagnosis difficult and management unsuccessful. The patients and their relatives do not receive immediate help in what for them is an urgent and distressing condition.

Recognising this failure to manage incontinence in Bristol, we started a nursing clinic where patients were given early help with their immediate problems and where diagnosing the specific mechanism of bladder dysfunction was of secondary importance. The clinic was organised (together with ward assessment and community care) as part of a large Medical Research Council study into all aspects of urinary incontinence. The service has prospered and seems to be satisfying an important but often unrecognised need.

Setting up the clinic

The clinic is held once a week and was started by a nursing sister appointed to research into the aids available for managing incontinence. She is helped by two trained nurses from the urology outpatient department, and there are no doctors. Men and women with incontinence are referred from hospital consultants, family doctors, and community nurses, and occasionally patients or their relatives come seeking advice on their own.

Certain patients benefit from a short stay in hospital, and for these we have three beds in the urology ward. The second ward sister was appointed with a specific interest in managing incontinence, and part of her job is to liaise with community nurses and visit her patients before and after their stay in the ward.

Patient assessment

The main task of these clinics is the individual assessment of the patient in a relaxed and unhurried atmosphere. It is not a diagnostic clinic, and investigation is usually limited to urine analysis alone. The

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responsibility for medical care remains with the referring doctor. We record medical, social, and psychological details as well as the type and degree of incontinence, housing conditions, accessibility of lavatories, and the attitude and support of the relatives. With this information the nurse can tailor the management to the needs of the individual.

Important factors include encouraging regular bowel habits, giving advice on diet, fluid intake, and exercise, bladder training, and treating atrophic skin changes in the vagina. Drug treatment often requires reorganising, particularly treatment with diuretics and hypnotics among the elderly, and this is done with the help of the family doctor. Some patients need the help of protective garments, and advice on selecting aids, how to use them, how to dispose of them, and where to get further supplies. We have found that a positive attitude is necessary throughout so that the patient will regain continence. Sometimes a sense of security is induced by protective garments and the motivation to "get up and go" is lost. Pelvic floor exercises have been found to play an important part in restoring bladder control in both men and women: there seems no age limit to the ability to restore function to this group of muscles.

Those with neurological bladder impairment form an important group. We see patients with spina bifida, multiple sclerosis, and paraplegia and women with large volumes of residual urine for whatever reason. Where appropriate we have established a regimen of self-catheterisation for these women.

We have found that among those who benefit from a short stay in hospital are young adults with enuresis. Temporary alteration of their environment often breaks their pattern of bed-wetting, and with a retraining programme designed to increase bladder capacity we have had good results. The elderly person with multiple social and medical problems requires a short admission so that he or she is assessed correctly and a regimen of management outlined. We admit also those men and women with extreme frequency, urgency, and nocturia and have found that they respond well to an inpatient regimen of the type described by Frewen.²

The nursing clinic and the five-day-ward assessment are followed up with home visits by the nurses. They liaise with the primary health care team to ensure continuity of management.

Results

Of the first 200 patients seen in the clinic 127 were women. Eighteen of these were found to be dry after full assessment: they needed to be convinced that they were dry and have their confidence restored. Of the remaining 109, 26 were cured and have remained dry for at least six months. Five have been helped by appliances, pads, and pants and pelvic floor exercises. Eight have needed long-term catheterisation, and two of these have had a suprapubic catheter inserted (table).

Results of managing women and men with incontinence

	Outcome	No
Women		
No referred	127
Not incontinent	18
Cured	26
Methods—PFE, bladder training, improving facilities (provision of commode or urinal). Teach anticipation of need to void where mobility/dexterity is reduced		
Appliances		
Self-catheterisation	5
Suprapubic catheterisation	2
Urethral catheterisation	6
Patients improved—needing less protection	22
Patients supplied with equipment, p/pants, showing little improvement	48
Men		
No referred	73
Bladder training (cured)	5
With appliances	11
With urethral catheters	4
With suprapubic catheters	2
Patients improved by facilities/urinals	4
Not incontinent	3
P/pants—most showed little improvement	44

Of the 73 men, three were found to be dry, five were cured and are still continent after a minimum of six months, four have been helped by using pads and pants, and 11 patients are satisfactorily wearing appliances. Four have long-term indwelling urethral catheters, and two have suprapubic catheters. All have remained in the community.

Discussion

The achievements of the nursing clinic speak for themselves. The co-ordinated three-pronged approach of outpatient clinics, inpatient assessment, and domiciliary follow-up has greatly improved patient care. The team work of the nurses has generated much interest among their colleagues and has altered the attitude of resentment towards this condition that existed before. We have found that a well-informed nurse will realise the extent of her responsibilities and the need for communication with the referring source and the patient's own doctor.

Various simple points have emerged. The time spent on individual assessment is most important. It is as necessary to convince the patient that she is dry as it is to teach her to cope with her incontinence. Indiscriminate use of diuretics and hypnotics can cause incontinence if given without explanation. Hormone replacement in the postmenopausal woman often relieves symptoms of urgency and frequency. Informed advice is necessary in selecting the appropriate appliance or combination of pants and pads since no item on the market is appropriate to all individuals.³

The clinic has provided the material for critical trials of methods of management, including the re-education of the pelvic floor with development of a vaginal exerciser. Various combinations of pants and pads have been assessed, and a trial of long-term catheters has been completed. Male appliances need to be improved, and there is still no suitable female appliance on the market. Contact with the manufacturers has led to improvements in collecting bags, attachments, emptying devices, and catheter balloons and new designs for pants and pads.

The positive approach towards promoting continence and managing incontinence has been the largest contribution made by our unit in the changing of attitudes of all concerned in this common and humiliating problem. The early practical help given by nurses has meant men and women can remain independent but supervised in their own homes. The service has been appreciated by district nurses and family doctors, and we receive an average of 20 telephone inquiries daily. There are about 40 nurses throughout the United Kingdom who have this particular expertise. We feel that other areas would benefit from our experience and that these clinics could be held in health centres as well as in district hospitals if there were more appointments created for these specialist nurses.

References

¹ Thomas TM, Plymat KR, Blannin J, Meade TW. Prevalence of urinary incontinence. *Br Med J* 1980;281:1243-5.
² Frewen WK. Urgency incontinence. Review of 100 cases. *Journal of Obstetrics and Gynaecology of the British Commonwealth* 1972;79:77-9.
³ Shepherd AM, Blannin JP. A clinical trial of pants and pads used for urinary incontinence. *Nursing Times* 1980;76:1015-6.

In a random mating population the proportions of genotypes AA, Aa, and aa where A is dominant and a is recessive is p², 2pq, and q² respectively where p is the incidence of the "A" gene and q is the incidence of the "a" gene, p + q being 1. What is the proportion of aa when q is very small and first cousins mate?

The proportion of "aa" individuals in the offspring of first cousins is roughly q/16. The probability that such children will be homozygous for one of the four genes present at a particular gene locus in the two common grandparents (that is the "inbreeding coefficient") is 1/16. The probability that this gene is "a" is q, and so the joint probability is q/16. There is a small additional probability that the child will be "aa" independently of the parental consanguinity, but this is negligible when q is very small.—C O CARTER, professor of clinical genetics, London.

Cavalli-Sforza LL, Bodmen WF. *The genetics of human populations*. Ch 7. San Francisco: Freeman and Company, 1971.