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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: The forgotten problem of incontinence

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My local council has to find £18m (€22.3m; $24.7m) of savings by closing libraries, day centres, and public toilets.[1] Residents have organised to keep one toilet open: they know its value.[2] It's happening throughout the United Kingdom: even in my native Manchester, which the council says is "a great place to grow old,"[3] only one public toilet remains.[4]

We report isolation and loneliness as having the most impact on wellbeing as we age.[5] Fear of incontinence can be a major factor in trapping people in their own homes.[6] And incontinence is a major trigger for stress among carers, prompting moves to care homes.[7]

Urinary incontinence and lower urinary tract symptoms are a big deal but get low priority, partly because of our reluctance to discuss them. So I will. Storage symptoms include nocturia, increased daytime frequency, urgency, urge, and stress incontinence. Voiding symptoms include slow stream, straining, and dribbling. Post-micturition symptoms include sensation of incomplete bladder emptying and dribbling.[8]

> Clinical audits have shown epic gaps in assessing, diagnosing, and treating incontinence, even in care homes and hospitals

These symptoms don't have the drama or visibility of a disabling stroke, severe cardiorespiratory limitation, or terminal cancer, but that makes them no less worthy of clinical attention. About one in three people over 60 experiences nocturia, and one in five has urgency.[9] At least 15% of women over 60 report urinary incontinence at least monthly.[10] Because of considerable under-reporting, the prevalence may be much higher.[11]

Although much urinary incontinence can't be cured, symptoms can be reduced and their impact on lives attenuated through a mixture of pharmacology, surgery, lifestyle changes, self management aids, appliances, and personal care. The evidence is set out in statutory guidelines,[12] as are models for service delivery in NHS England commissioning toolkits.[13]

Yet clinical audits in England have shown epic gaps in assessing, diagnosing, and treating even severe and obvious incontinence.[14] This occurs even in care homes and hospitals. And incontinence lies near the bottom among quality of care indicators reported by people over 50 in primary care.[15] We may cause or worsen incontinence in hospitals by unnecessarily catheterising or padding previously continent people, by pushing them to stay in bed and use bedpans, or sometimes inadvertently through drugs such as diuretics.

We could do more to raise awareness and make it easier for patients and carers to report incontinence. And, when they do seek help, they need informed assessment, diagnosis, and support.

The commissioning of health services should meet population and individual needs. Local public health plans should support wellbeing and independence. The government's response to the Francis report emphasised essential standards of care for people in hospital.[16] These ambitions aren't always translated, as our failure to provide a decent offer for people living with urinary incontinence shows.

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