

## Management of urinary incontinence in patients with multiple sclerosis

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**SUMMARY.** We investigated the management of urinary incontinence in 50 patients with multiple sclerosis (MS) in two London boroughs. Only seven appeared to be satisfied with the management of their bladder problems. A total of 51 suggestions was made for improving management in 33 of the patients. Most of these suggestions involved services which were available though not being used. The management of urinary incontinence in patients with MS should be tailored to the requirements of the individual. Alternative forms of management may often not be reaching patients who might benefit from them.

### Introduction

**M**ULTIPLE sclerosis is a leading cause of disability in early and middle adult life. One of its most distressing features is impairment of bladder control. Miller and colleagues (1965) described a series of 297 patients with MS, 46 per cent of whom reported urinary incontinence.

### Aim

We aimed to investigate the management of incontinence in patients with MS aged 15 to 64 and living at home in the London boroughs of Brent and Harrow, so that we could describe current practice, compare this with facilities theoretically available and suggest improvements where appropriate. This study was part of a larger study we were carrying out of the prevalence of incontinence (Thomas *et al.*, 1980).

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### Methods

In order to identify patients with MS aged between 15 and 64 living at home in the two boroughs in 1977, we contacted the health and social service agencies likely to be in touch with MS patients as well as the local branches of the MS Society. These agencies were asked to get the patients' permission before any names were given to us. After a letter to the general practitioner to obtain his agreement, the patients were approached by one of the interviewers by letter or by phone to ask if they would agree to be interviewed. Urinary incontinence was defined as the involuntary excretion or leakage of urine in inappropriate places or at inappropriate times, occurring twice or more a month. Patients with indwelling urethral catheters were included.

Fifty-four patients were identified, 22 by the community nurses, 20 by the MS Society, eight through the local incontinence pad service, one by a health visitor and three through hospital clinics. Twenty-one were notified from more than one source. Fifty of the 54 patients were interviewed by a survey team nurse using a structured questionnaire; of the other four patients, two had moved before the time of interview, one had died and one we were unable to trace. The interviewing nurses were experienced in talking to incontinent patients and were aware of the range of managements available. They asked for information on the severity and duration of incontinence and details of current and previous management. Patients were asked about the adequacy of the supplies they were receiving for incontinence and about laundry arrangements. They were also asked: "What aspect of your daily life do you find most difficult to cope with?" and "What aspect of your bladder trouble do you find most difficult to cope with?" The nurse recorded in her summary of the interview possible ways in which the patients' management might be improved, but it was not possible in this study to implement all of them and to evaluate their effectiveness.

**Table 1.** Source of help with incontinence.

Spouse and district nurse	11
Spouse alone	8
Parents	3
Sister	1
Neighbour and district nurse	1
District nurse	11
Coping alone	15
Total	50

**Table 2.** Collection methods.

	Male	Female	Total
Catheter	6	10	16
Appliance	2	—	2
Pads and pants	—	16	16
Sanitary towels	—	4	4
None	3	9	12
Total	11	39	50

**Table 3.** Alternative management suggestions (33 patients).

Pads and pants	—new or altered supply	16
Extra services	—e.g., home adaptations, district nurse, laundry	12
Urine collection	—catheters, urinals, appliances, commodes	11
Medical	—e.g., further investigations	12
Total		51

## Results

There were 39 women and 11 men. Nine patients were under 35 years old. Nearly half were chair- or bed-bound and, of the eight who used no aids, only four had no impairment of locomotion. Fifteen were unable to use their hands for the management of their incontinence and a further 10 were impaired in this respect by tremor or unsteadiness. Table 1 shows the sources of help being given with aspects of incontinence.

Table 2 shows the management methods being used. These fell into five main groups. Sixteen patients had indwelling urethral catheters and two men had appliances. Of the 16 patients using pads and pants, only two sorts of pants were used—Sandra plastic (8) and Kanga (8). Four of the women used only sanitary towels. The group who were using no method of collecting urine were in the main reliant on help with transfer to commode or toilet. Only three of the patients were on any medication—emepronium bromide ('Cetiprin') in each case. Less than a quarter had had specialist investigation of their urinary symptoms.

Seven patients appeared to be satisfied with the management of their bladder problems. They were

using five different methods: Kanga pants and pads (one), indwelling urethral catheter (two), Sandra pants and interliners for going out and commode indoors (one), fixed appliance (one) and sanitary towels (two). Replies about the worst problem in managing incontinence by the 43 patients who were not satisfied with their management were as follows: eight of the 16 patients with a catheter reported some leakage and all eight gave this as their worst problem; both patients with an appliance reported leakage, though one (see above) was nonetheless satisfied with this method; fifteen patients felt that getting to or transfer onto the lavatory or commode was the worst problem; 10 cited embarrassment as their main problem in daily life; and a further 23 reported serious embarrassment and/or restriction of activities, but not as their main problem.

The survey nurses were able to make alternative management suggestions for 33 patients (Table 3). Included are recommendations for three of the seven patients who declared themselves satisfied with the management they were receiving. A total of 51 suggestions was made: 16 patients may have benefited from a new or altered supply of pads and pants; a new method of urine collection was suggested for 11 patients; three patients may have been suitable for a self-catheterization programme; and at least three may have benefited from the Continator, which is no longer available. Twelve of the 33 patients who had not had recent investigations would have been prepared to go for assessment.

## Discussion

The 54 patients represent a prevalence of MS patients with incontinence of approximately 22/100,000. If about half of all MS patients are incontinent (Miller *et al.*, 1965), this figure is compatible with an expected UK prevalence of MS of 30-60/100,000 (Acheson, 1972) and suggests that our ascertainment of incontinent MS patients was complete or nearly so. The ratio of women to men with MS is about 1.4:1. The ratio of 3.5:1 in our survey might be due to a greater prevalence of incontinence in women with MS than in men; this has been reported in other studies (Bradley *et al.*, 1973; Andersen and Bradley, 1976). MS gives rise to a wide spectrum of disabilities. When considering the best method of managing incontinence for a patient with MS, both mobility and manual dexterity are of great importance—only four of the 50 patients interviewed had full mobility and use of their hands. Most of the patients who were coping alone at the time of interview were doing so from choice as they wished to retain their independence.

The majority of the changes in management suggested did not involve major or very costly alternatives. Many of the suggestions were for services or equipment already available. The 17 patients for whom no suggestions were made included four who were satisfied with their management and also eight patients

# The

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# Diagnostic Quiz

The answers to the March quiz are as follows:

1. What are the likely causes of this ulcer?  
**Trauma, varicose ulcers, heat (the one shown was, in fact, caused by a hot water bottle burn).**
2. What are the likely infecting organisms?  
**Non-clostridial anaerobes such as Bacteroides.**
3. How would you treat this patient?  
**Systemic antibiotics and metronidazole.**

The winner of a £100 British Airways travel voucher is Dr A. R. Khan of Dudley, West Midlands.

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with leaky catheters; improved catheter management may have been possible for this latter group. Early investigation of incontinent patients with MS is being increasingly advocated. It was apparent in this survey that retention is still probably the commonest reason for referring a patient with MS for urinary tract investigation. Very few patients had been referred for investigation of urinary symptoms at an early stage.

We draw two main conclusions. First, there is no generally applicable solution for urinary incontinence in MS, and management must be tailored to the individual's needs. Second, alternative courses of management are almost certainly not being made available to all those with MS who might benefit from them. Possible reasons for this include inflexible organization of services, poorly disseminated information about equipment and management methods, the fact that health care workers meet the problem of MS relatively infrequently and a tendency to assume that little can be done for these patients.

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### Statistics on drunkenness

In 1979 117,813 people were found guilty of offences of drunkenness; fewer than one in 10 of these people were women, 5,708 were under 18 years old. The number of people imprisoned for failing to pay a fine after being convicted of drunkenness increased by 15 per cent to 3,074.

Source: Home Office Statistical Bulletin, Issue 15/80 (November 1980). London: HMSO.