

Female urinary incontinence: another common chronic illness

THIS is a common problem for adult women with prevalence rates varying considerably, depending to a large extent on the population studied and the degrees of wetting used in assessing the incontinence. General practice prevalence rates are 16.4%,¹ 41%,² and 53%,³ and are confirmed by population based studies.^{4,5} A poll conducted by the British Association of Continence Care estimated that up to 10 million people, male and female, in the United Kingdom, suffer from urinary incontinence.⁶

The degree to which women report being affected by their incontinence also varies. More than half of the women in one study said that incontinence affected their work,⁷ and for many their social life is affected.³ In another study,⁵ 60% were concerned or worried about their incontinence and described feeling embarrassed, smelly or ashamed; it had affected their ability to go walking, shopping, use public transport, or travel long distances. In total in this British study, 73% felt that their lifestyle had been affected in some way, in contrast to a Scandinavian study which showed that only 15.6% experience much worry and 15.7% much restriction in relation to their incontinence,⁸ even when it is severe. Clearly, there is a range of tolerance among women, with some of the older studies showing an acceptance of their incontinence as a natural consequence of childbearing⁹ or ageing.¹⁰ This view may be changing with time. Since there are regional differences in the action taken by general practitioners,⁵ there may also be differences in women's tolerance thresholds between countries, and also within specific populations.

Urinary incontinence is an imprecise medical term¹¹ and not a diagnosis; 85% have stress urinary incontinence and 10% have detrusor instability, although both can coexist.¹² Patients need specialist input for diagnosis, as there is a wide variety of management strategies available to incontinent women depending on the diagnosis. Strategies include pelvic floor exercises, electrical stimulation, cones and drug treatments for stress incontinence, and bladder drill and drug treatment for detrusor instability.¹³ Pharmacological therapy may be an important component of treatment, but side-effects to alpha adrenergic and anticholinergic agents are common and long-term treatment is needed to maintain improvement. Oestrogen has been used successfully for urge incontinence, but with no improvement in stress incontinence.¹³ Surgery in stress incontinence has a definite role, and there are over 100 surgical operations for stress incontinence including bladder buttress, colposuspension and a bladder sling procedure.

Despite being a common problem which causes much social and physical morbidity, women are reluctant to consult their general practitioners; up to two-thirds of sufferers are unknown to their doctors.^{1,4,8} In one study, women waited four years before seeking help.⁷ In a study carried out in general practice, only 8% of people with incontinence who were invited to attend an incontinence clinic, actually attended.³ A small qualitative study throws light on some of the GP-related factors which might act as barriers to women seeking help.¹⁴ General practitioners in this study expressed unhappiness with their own management of urinary incontinence and of the treatment options open to them. Male general practitioners expressed reluctance to carry out gynaecological examinations and few expressed interest in teaching pelvic floor exercises or bladder drills. The study also

showed that many general practitioners actually avoid dealing with urinary incontinence because they find it to be such a difficult and chronic problem. Older patients may also be undertreated; in one study the treatment for older patients was mainly incontinence pads,¹⁵ while in another fewer older patients received an abdominal or vaginal examination.⁵ Patient-related barriers to attending include the belief that it is 'not important enough', an embarrassment, too personal a topic and not to be spoken about, only a minor inconvenience,⁵ or not considered abnormal.⁸ These expressed views are at odds with the reported degree of worry caused by the condition.

In this issue of the *Journal*, the long-term treatment of urinary incontinence in general practice is evaluated in two papers. The results of these studies are very welcome, and show that many women were improved or at least felt better about their condition, but at follow-up only 25% in one and 27% in another were dry. This is despite being managed by general practitioners who were dedicated, highly motivated, and understood the condition.

It is now necessary for doctors, nurses and patients to accept urinary incontinence as a chronic condition. Like adult asthma, hypertension, chronic obstructive disease, and inflammatory bowel disease, it needs to be managed with conservative expectations of cure. Like many chronic illnesses it is commonly undetected in the community, needing careful case-finding by the general practitioner. Its management is time-consuming, requires education of the patient, and commitment on their part. A strong case has been made for a team approach with a suggestion that interested practice nurses take the lead.^{1,16} Its recognition as a chronic illness would encourage the development of a shared care approach with both specialist and generalist input, which has become commonplace in other areas of general practice.

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Death notification and bereavement in general practice: optimizing the quality of care

One can survive everything nowadays, except death.

Oscar Wilde (1860-1900)

THE consequences of bereavement can be far reaching, but the topic still fails to occupy a significant place in the undergraduate or postgraduate/postregistration training of either doctors or nurses. How can the profile of this important issue be raised in general practice and primary care? Murray Parkes recently highlighted the multi-faceted nature of bereavement in adult life in the first of a series of articles dealing with the different types of loss that doctors will meet in their practice.¹ General practitioners and their teams have been traditionally involved in caring for the bereaved, although the exact nature of this care varies between individual practitioners and practices.

Two papers appearing in the *British Journal of General Practice*, one of which is published this month, highlight that good communication to the practice following the death of our patients in the hospital, hospice or at home is crucial.^{2,3} Families and carers may suffer because of poor communication by health professionals. Death notification should, ideally, cover deaths from all causes, and be incorporated into a practice-held death register. The paper by Stacey *et al*, together with earlier work that the authors refer to, indicate that death registers are valued by practices in Newcastle-upon-Tyne and Sunderland, and have benefits in relation to the quality of bereavement support offered. Despite, ironically, the obvious potential for such registers, their use is not widespread. Harris and Kendrick showed that only 56% of responding practices from South Thames kept death registers.

Sensitive dissemination of information within the practice team is another prerequisite for planning and delivering high quality bereavement care. Practical applications include the cancellation of further hospital appointments, noting the death in relatives' or other carers' records, planning bereavement visits, and screening for familial conditions. The few studies on this issue from general practice, however, have tended to be small, with limited generalizability, but some themes are emerging. The use of audit and protocol/guideline development, together with efficient methods of notifying the practice team, have been repeatedly advocated.⁴⁻⁹

Shared decision-making within the team and a knowledge of the factors that predict problems in bereavement enables these to be anticipated and prevented. The uniqueness of each individual's situation must be acknowledged and the manner of further care adapted accordingly. The balance of evidence suggests that risk factors for abnormal bereavement may be of value when used to plan care.^{10,11} Although there are known adverse health consequences of bereavement, many bereaved individuals adapt to their loss with minimal assistance from health professionals. However,

patients at risk after bereavement can develop complicated forms of grief that can culminate in physical or mental illness. We appreciate that grief is known to have a marked effect on morbidity and mortality. A clear understanding of these factors will enable us to target support to those most at risk; accurate assessment is a necessary part of management. Complications include the development of depression, anxiety, increased use of alcohol and prescribed drugs, and suicidal behaviour. Assessing the emotional needs of bereaved patients requires an empathetic attitude complemented by adept communications skills and familiarity with the issues surrounding the death.

As people live longer and acute illnesses become less common as a cause of death, progressive and chronic illnesses are becoming more prevalent. With a population of 10 000 patients, a group practice might expect almost 100 deaths (including 28 cancer deaths) per year where there is some need for palliative care, including bereavement support. Approximately equal numbers of men and women would die and the numbers would remain constant over time. Clinical audit is a means of improving quality of care for these patients and their families. A standardized questionnaire, used in studies since 1969, has been recently adapted for use as a postal questionnaire to assess the views of bereaved carers.¹²

Further original research, including both controlled evaluations of bereavement interventions and carers' opinions, is needed to identify the role for GPs and members of their primary care teams in providing optimum bereavement support. This would include research into the needs of patients and their carers from black and ethnic minority groups, who are known to be under-users of palliative care services. Indeed, the current services may be perceived as being insensitive and inappropriate to the needs of these groups. One of the major challenges for those in general practice and primary care, who seek to improve the care of patients, is to ensure that they consider palliative care and bereavement support an important part of their role. This includes having adequate knowledge, skills and organizational support to undertake it effectively.

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