Urinary Incontinence (Men)

Disclaimer

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Background

About urinary incontinence in men

➢ Urinary incontinence is a common problem occurring in 17% of men aged > 50 years and 1 in 4 men aged > 70 years.¹
➢ Causes to consider include overactive bladder (OAB), chronic urinary retention with overflow, treatments for prostate cancer including surgery and radiation therapy, and neurological conditions e.g., stroke and multiple sclerosis.
➢ OAB and chronic retention with overflow may result from longstanding, untreated obstruction. It is therefore important to refer men with significant LUTS and incontinence after prostatic surgery or radiation therapy.
➢ New urinary incontinence in men is usually due to prostate or urethral disease but sometimes may reflect serious pathological conditions, such as new neurological conditions.

Red flags

• Unexplained acute onset urinary incontinence
• Symptoms suggestive of neurological emergency
• Urinary retention

Assessment

1. Take a history
   • Onset, frequency, severity, and type e.g., stress versus urge versus overflow
   • Any associated haematuria – follow the Haematuria pathway
   • Dysuria suggesting UTI
   • Medical history indicating possible causes e.g., diabetes, spinal cord compression, disc prolapse, multiple sclerosis
   • Lower urinary tract symptoms (LUTS) and International Prostate Symptom Score (I-PSS) – any LUTS or a moderate to severe I-PSS score preceding incontinence may suggest urinary retention with overflow
   • Feeling of incomplete emptying
   • Enuresis
   • Medications

Lower urinary tract symptoms (LUTS)

➢ Obstructive (voiding):
  ○ Poor flow
  ○ Hesitancy
  ○ Terminal dribbling
➢ Irritative (storage):
  ○ Frequency
  ○ Nocturia
  ○ Urgency
  ○ Incontinence or pain if voiding is deferred
2. Perform an examination:
   - Check:
     o abdomen for bladder size.
     o external genitalia for skin excoriation.
     o foreskin for retractability.
   - Perform:
     o digital rectal examination for prostate size and rectal pathology.
     o neurological examination if indicated.

3. Arrange investigations:
   - Urinalysis and MSU if suspected UTI
   - Creatinine
   - Consider blood sugar level (BSL) and prostate-specific antigen (PSA)
   - Renal ultrasound and residual

Management

Management relies on identifying the type of incontinence present e.g., stress, urge, mixed, or continuous.

1. If symptoms are suggestive of an underlying neurological emergency or if in urinary retention, refer to nearest Emergency Department.

2. Arrange urinary tract ultrasound with post void residual and arrange urgent urology referral if:
   - significant or persistent urinary incontinence.
   - recurrent UTIs.
   - haematuria is present.
   - suspected benign prostatic hyperplasia or prostate cancer.
   - post-void residuals of > 300 mL despite medical management.

3. For all patients, lifestyle modifications can be incorporated.
   - Modify high or low fluid intake

   Fluid intake

   ➢ Provide a frequency volume chart.
   ➢ Aim for a daily output of 1.5 to 2 L per day, adjusting fluid intake and caffeine consumption as required.

   - If BMI is > 30, reduce weight. Dietitian assessment may be appropriate.

   BMI for adults

   Body mass index = kg/m² (weight divided by height squared)
   Use your clinical software or the Heart Foundation’s online BMI calculator.
   - < 18.5 = underweight
   - Between 18.5 and 24.9 = healthy or normal weight
   - Between 25 and 29.9 = overweight
   - ≥ 30 = obese

   For patients aged < 20 years, calculate BMI using the Child and Teen BMI Calculator.
• If post-prostate treatment incontinence is present, trial pelvic floor exercises. If this fails, urological referral is warranted.
• Consider smoking cessation.

2. If urge incontinence (overactive bladder):
   • minimise caffeine intake as much as possible.
   • advise bladder retraining for 6 weeks.
   • consider medications. Residual volumes should be checked 2 weeks after starting therapy.

### Medications

- **First-line is oxybutynin or similar drugs.**
- **Oxybutynin**
  - The only antimuscarinic on the PBS.
  - Side-effects include blurred vision, dry mouth, constipation, and cognitive impairment.
  - Contraindicated in closed-angle glaucoma.
  - Start with 2.5 mg twice daily, increasing to 5 mg, maximum 4 times daily.
  - Avoid in frail elderly patients.
- **Solifenacin** may be an alternative for patients who are intolerant of oxybutynin, or if oxybutynin is ineffective.
  - Solifenacin
    - Private script
    - 5 mg once daily, increasing to 10 mg if no response
    - Generally better tolerated than oxybutynin
- **Tolterodine**
  - Private script
  - 1 to 2 mg taken twice daily
  - Contraindicated in closed-angle glaucoma and significant liver impairment
  - Interacts with other anticholinergics
- **Darifenacin**
  - Private script
  - 7.5 or 15 mg once daily
  - Contraindicated in severe liver impairment and patients prone to urinary retention
  - Side-effects include dry mouth and constipation
- **Mirabegron**
  - Beta adrenergic agonist
  - Relaxes detrusor muscle and increases bladder capacity
  - Not available on the PBS
5. If chronic retention with symptoms of prostatic obstruction and large residual > 400 mL:
   - commence medical management with **alpha-1-blockers** or with dual agent **dutasteride and tamsulosin** while awaiting assessment.

**Alpha-1 blockers**

Alpha-1 blockers work by relaxing smooth muscle. If one agent is ineffective or causes troublesome side-effects, it is useful to switch to an alternative agent.

Common side-effects include dizziness, fatigue, and postural hypotension

Four agents are available:

- **Prazosin**
  - Requires dose titration over the first 2 weeks, starting at 0.5 mg twice a day, aiming for 2 mg twice a day
  - Postural hypotension more likely if on antihypertensive therapy and may need dose adjustments
  - Listed on the PBS

- **Tamsulosin**
  - 400 micrograms once a day
  - No dose titration required
  - Postural hypotension uncommon but can be a cause of falls
  - Repatriation Schedule of Pharmaceutical Benefits (RPBS) or authority script

- **Silodosin**
  - 8 mg once a day
  - No dose titration required
  - Postural hypotension uncommon but can be cause of falls
  - Private script

- **Alfuzosin**
  - 10 mg once a day
  - No dose titration required
  - Postural hypotension uncommon but can be cause of falls
  - Repatriation Schedule of Pharmaceutical Benefits (RPBS) or private script

**Dutasteride and tamsulosin**

- 500 micrograms/400 micrograms once daily dosing
- No titration required
- Authority script
- Has been shown to reduce PSA levels
- May cause sexual side-effects

- arrange urology review as per the **Benign Prostatic Hyperplasia** pathway.

6. If continuous urinary incontinence is present, arrange urology assessment.

7. Consider arranging an **adult continence referral** for incontinence management and products. In elderly patients with incontinence, offer urology assessments in addition to continence products.
Referral

- If symptoms suggestive of an underlying neurological emergency or if in urinary retention, refer to the nearest Emergency Department.
- Arrange urgent urology referral if:
  - significant or persistent urinary incontinence.
  - recurrent UTIs.
  - haematuria is present.
  - suspected benign prostatic hyperplasia or prostate cancer.
  - post-void residuals of > 300 mL despite medical management.
- If a postsurgical new neurological condition is suspected as the underlying cause, arrange urgent or routine neurology referral.
- Consider arranging an adult continence referral for education and advice on incontinence management and products.

Information

For health professionals

Further information

Urology Specialists, P.C. – International Prostate Symptom Score (I-PSS)

For patients

Continence Foundation of Australia:

- Men
- Pelvic Floor Muscles in Men

Sources

References


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