



the
INFORMER
YOUR CANADIAN CONTINENCE RESOURCE

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Two audiences, one important message

Help begins with an open dialogue between patients and doctors

This is a very special issue of *The Informer*. Written with both the general/family physician and the patient in mind, its goal is to promote the development of a therapeutic alliance that we know produces better outcomes in incontinence.

The topic of incontinence can be an embarrassing one — for individuals who have the condition and, yes, physicians too. We hope that in providing *The Informer* to both audiences, we will encourage a dialogue about this highly treatable condition. Symptoms can improve, quality of life can return, but only if individuals feel comfortable enough to talk to their doctor about the problem in the first place. Often,

all it takes is a simple question — “Do you ever have any problems controlling your bladder or bowels?” — to begin a conversation that may significantly improve a person's life.

To help initiate and guide that conversation, our new edition of *The Source* includes a symptom checklist and bladder diary for people to complete and give to their physician. This updated Canadian guide to urinary incontinence also explains medical terms, tests and treatments — all with the goal of improving patient-doctor communication.

You can find a link to *The Source* and many other wonderful resources on our website: www.canadiancontinence.ca.



Jacqueline Cahill

And, as always, I welcome your comments and feedback. Send me an email at jcahill@canadiancontinence.ca.

All the best for a wonderful summer!
Jacqueline Cahill, Executive Director



Take control

Many options available to treat overactive bladder

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YOUR CANADIAN CONTINENCE RESOURCE

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NARUS
COMMUNICATIONS

by Elizabeth Garel

“I need to go! I need to go now!”

For someone with overactive bladder (OAB), the need to urinate can be sudden and overwhelming, even when the bladder isn't full. In addition to urgency, the other hallmark symptoms of OAB include frequency (the need to urinate more than eight times in a 24-hour period), nocturia (voiding one or more times during the night) and urge incontinence (urine leakage).

OAB occurs when a large muscle in the bladder known as the detrusor muscle contracts involuntarily, causing a feeling of fullness and urgency to urinate.

OAB affects an estimated one in five Canadians. Although it is more common in people over the age of 65, it is not a normal part of aging. The condition can have a significant impact on an individual's quality of life, causing embarrassment, withdrawal from social

and physical activities, disrupted sleep and sexual dysfunction.

Despite its prevalence and impact, OAB may be under diagnosed and under-treated. “Some people are embarrassed to discuss bladder problems with their doctor,” says Dr. Timothy Davies, assistant professor in the division of urology at McMaster University in Hamilton, Ontario. “Although there is a lot more awareness about OAB and incontinence these days, there is still stigma.”

Some individuals don't raise the issue with their physicians because they mistakenly believe there is no point. “They think OAB is part of getting older or something they just have to learn to live with. The fact is there are many effective treatments available,” says Dr. Davies.

➔ Lifestyle Changes

Lifestyle changes are the cornerstone of OAB treatment. These include:

Diet: Reduced consumption of caffeine (in both liquids and foods, such as chocolate) and alcohol can significantly improve symptoms of OAB. Dr. Davies says this is particularly true of people who have very high intake levels to start with. "I've seen remarkable improvements in patients who have cut out their eight cups of coffee or five beers a day. But if you are only drinking one cup of coffee a day to begin with, eliminating it won't make as much a difference."

Pelvic floor muscle exercises: Also known as kegels, these exercises strengthen the pelvic floor muscles that support the bladder.

Bladder retraining: By developing a timed voiding routine, an individual may be able to gradually increase the time between urinating and the amount of fluids that the bladder can hold.

➔ Medications

If lifestyle changes do not significantly improve OAB symptoms, the physician may recommend adding drug treatment. "It depends on the patient and their quality of life. I ask, 'Is this condition bothering you enough that you want to take medication?'" says Dr. Davies.

There are several factors to consider when choosing a medication to treat OAB. These include whether the patient has other health conditions or is taking other drugs that may interact with the OAB medication. Other considerations include:

Cost: Provincial insurance plans may cover a drug only if the patient has failed on another medication. "Some of these meds are expensive, so I always ask patients whether they have a drug plan or not," says Dr. Davies.

Side effects: Many OAB medications

are anticholinergics, which act by blocking the release of acetylcholine at the junction of nerves and bladder muscle fibres, hence diminishing bladder contractions. Unfortunately, these products don't act only at the bladder level but also on other organs where acetylcholine plays a role. As a result, they can produce anticholinergic side effects, which include dry mouth, constipation, blurred vision and some degree of cognitive impairment. Patients should report any adverse effects to their physician or pharmacist.

“A medication cannot be effective if the patient doesn't take it, so it is important to choose the right drug for each individual.”

Dosing: Studies show that the more pills a person has to take, the less likely they are to follow the medication regimen correctly. This reduces the likelihood that the drug will be effective.

Oral or topical: Many medical conditions are now treated with topical or transdermal medications (gels or patches), in which the medication is applied to and absorbed through the skin. In general, these formulations are convenient and offer a number of advantages over oral drug therapy, including improved pharmacokinetics (the way the body processes the drug), more convenient dosing schedules and a lower incidence of adverse events. While most medications for the treatment of OAB come in pill form, oxybutynin is now available in a topical (gel) and trans-

dermal (patch) formulation. The choice of oral versus topical medication depends on the individual's personal preference and risk of side effects.

Formulation: Immediate-release drugs are rapidly absorbed and eliminated, producing high concentrations of the drug in the blood for a short period of time. These tend to produce more side effects and require multiple daily dosing. Prolonged or extended release, on the other hand, are absorbed more steadily and produce a more stable blood concentration. The result is more sustained effect and fewer side effects. They are taken only once a day.

"A medication cannot be effective if the patient doesn't take it, so it is important to choose the right drug for each individual," says Dr. Davies.

The bottom line, he emphasizes, is that there is hope for people with OAB. A combination of lifestyle adjustments and well-chosen medication can significantly improve symptoms and quality of life. If symptoms do not resolve, family physicians should refer the patient to a specialist for follow up.

➔ Oral OAB medications

The following medications for the treatment of OAB are available in Canada as of May 2012. Cost coverage of these products varies according to provincial drug reimbursement programs and private insurance plans. The brand name in bold is followed by the generic drug name in parentheses.

Detrol; Detrol LA (tolterodine; tolterodine tartrate)

Usual dose: The usual starting dose of Detrol is a 2-mg tablet twice daily. The extended-release formulation (LA) is usually started at one 4-mg capsule once daily, but this may be decreased to one 2-mg capsule once daily.

Side effects: The most common adverse effect with both formulations is dry mouth. Regular Detrol can also cause headache. Other possible effects of

both formulations include stomach pain, dry and irritable eyes, heartburn, blurred vision, dizziness, irregular heart-beat, fainting and difficulty urinating.

Comments: In the extended-release formulation of Detrol, the film-coated beads dissolve over time, releasing the active ingredient over 24 hours. Better efficacy and improved tolerability have been documented when compared to regular Detrol. It is covered by many private and public drug plans.

Ditropan XL (oxybutynin chloride)

Usual dose: One 5-mg or 10-mg extended-release tablet daily. The dose may be increased to a daily maximum of 30 mg.

Side effects: Common side effects include dry mouth, constipation and blurred vision.

Comments: Ditropan XL 10 mg has been shown relatively similar to Detrol LA 4 mg regarding efficacy and side effects. It is on the drug reimbursement program in every province. Many plans will not cover other medications until a patient has tried and failed to respond to Ditropan XL.

Enablex (darifenacin)

Usual dose: One 7.5-mg or 15-mg extended-release tablet daily.

Side effects: The most common side effects are dry mouth and constipation. Other possible side effects include headache, abdominal pain, stomach discomfort after meals, nausea and dry eyes and nose.

Comments: Enablex has been shown to be relatively similar to Detrol LA in terms of efficacy and tolerability. Its high selectivity for bladder receptors may allow for a better tolerability, espe-

cially in older patients. It has no cardiac side effect but may have more effect on bowels. One of the newer medications on the Canadian market (introduced 2006), it was just recently added to the Ontario Drug Benefit Plan.

Trosec (trospium chloride)

Usual dose: One 20-mg tablet taken twice daily on an empty stomach at least one hour before meals.

Side effects: Most common side effects are dry mouth, constipation and abdominal pain. Less common events can include upset stomach, nausea, dizziness, flatulence, chest pain, dry eyes, blurred vision, increased heart rate, palpitations, urinary retention and heat prostration.

Comments: Introduced in Canada in 2006, Trosec has been available in



Europe for more than 25 years. Trospium doesn't cross the blood-brain barrier, so it may be a better choice for patients with cognitive issues. It is on the drug reimbursement program in some provinces.

Uromax (oxybutynin chloride)

Usual dose: One 10-mg or 15-mg tablet daily.

Side effects: The most common side effects are dry mouth, sore throat or dry skin. Other side effects include blurred vision, constipation, difficulty urinating, dizziness, drowsiness, headache, heartburn, nausea, sleeplessness, stomach pain and weakness.

Comments: This prolonged-release formulation was introduced in Canada in 2006. Cost and simplicity of use at higher dosage (15 mg) are its main advantages. It is on the drug reimbursement program in some provinces.

Vesicare (solifenacin succinate)

Usual dose: One 5-mg or 10-mg tablet daily.

Side effects: The most common side effects are dry mouth and constipation.

Other possible side effects include dry eyes, urinary retention, blurred vision, nausea, abdominal pain, indigestion and urinary tract infection.

Comments: At a starting dosage of 5 mg, Vesicare's efficacy and tolerability have been shown relatively similar to Detrol LA 4 mg. But when drugs are given at maximum dosage, Vesicare has shown a better efficacy. Its selectivity for bladder receptors may allow for a better tolerability, especially in older patients. Introduced in Canada in 2006, it is increasingly appearing on the drug reimbursement programs of some provinces.

➔ Topical/transdermal OAB medications

Gelnique (10% oxybutynin chloride gel)

Usual dose: Gelnique is a topical gel designed to be applied once daily to the abdomen, upper arms/shoulder or thigh. It comes in 1.14-gram packets.

Side effects: Common side effects include dry mouth, constipation, headaches, dizziness and a local skin reaction, such as itching and redness.

Comments: As a topical gel, Gelnique offers an effective alternative to oral OAB medications. It may also offer less skin irritation than the transdermal patch. It is quite new on the Canadian market, but most private plans cover at least some of its cost.

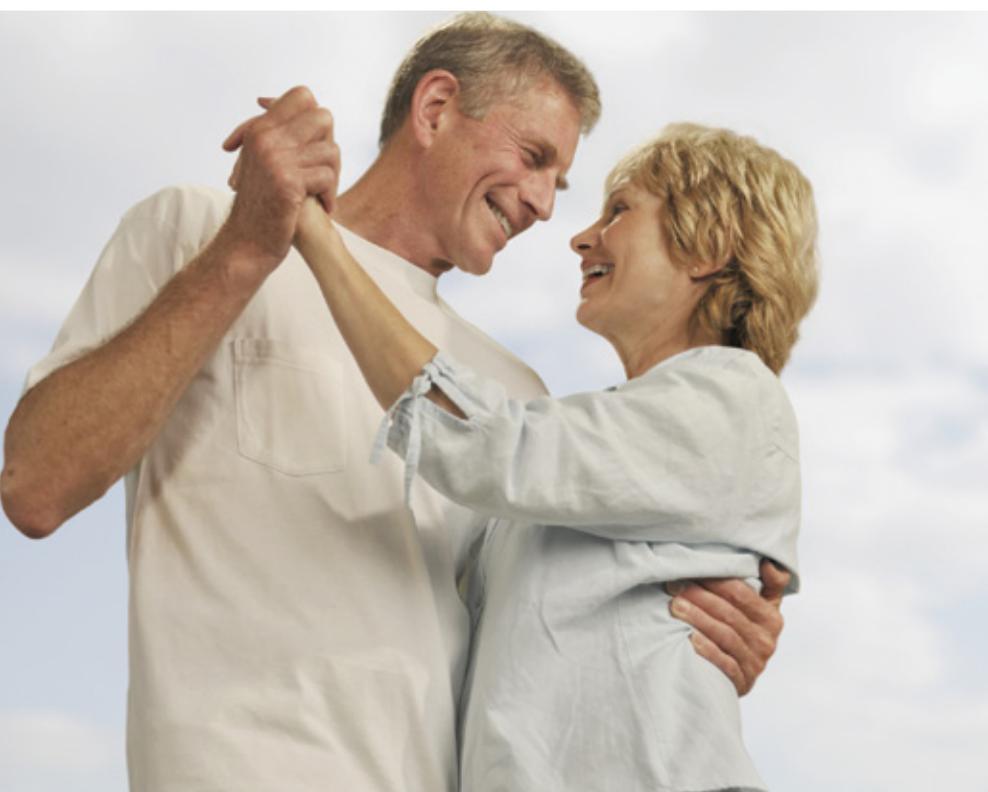
Oxytrol (oxybutynin transdermal system)

Usual dose: One 3.9-mg/day patch is applied to the skin twice weekly (every three to four days).

Side effects: The most common side effects are skin reactions where the patch is worn. These include itching and redness. Other side effects include dry mouth, constipation, abnormal vision and headache.

Comments: This transdermal system is designed to deliver oxybutynin continuously and consistently over several days. Its efficacy is equivalent to Detrol LA 4 mg but with less dry mouth. It is on the drug reimbursement program in some provinces. ■

— With files from the Canadian Continence Foundation. Elizabeth Garel is a Toronto-based freelance editor and writer who specializes in healthcare and medicine.



Some individuals don't raise the issue with their physicians because they mistakenly believe there is no point.

➔ PRESIDENT'S MESSAGE

Incontinence itself isn't a disease; it's a symptom of some other problem. If you are beginning to experience a loss of bladder or bowel control, you need to seek medical help and the first person to see is your family doctor.

A family doctor who is well versed about how to deal with incontinence should be able to determine whether you need to be referred to a specialist. Specialist referrals are sometimes necessary, but often a family doctor will be able to perform a routine assessment and prescribe effective treatment.

Incontinence is a relatively common problem that can develop in anyone at any age. However, it is especially likely to develop as people age, particularly amongst older women. For this reason, and because many people are embarrassed to bring the subject up, family

doctors should ideally be proactive and ask older people about whether they may be experiencing problems controlling their bladder or bowels.

Unfortunately, many family doctors are not as well informed about incontinence as they should be. Some family doctors always refer patients who complain about incontinence to a specialist. Referring patients whom the doctor should be able to treat is a hassle for the patient whose treatment is delayed and who may be subjected to unnecessary and uncomfortable tests. In addition, unnecessary referrals are an inefficient way to spend scarce healthcare dollars that could be more effectively spent in other ways.

For these reasons, educating family doctors about incontinence is important. TCCF, in cooperation with our industry



Dr. Thomas Alloway

partners, is looking for ways to promote continuing medical education about incontinence to family physicians. If we're successful, people who experience incontinence will be able to obtain better treatment faster and at lower medication cost.

Dr. Thomas Alloway, Ph.D.,
President, TCCF

Treating incontinence in family practice

Clear communication between patients and their physician — along with an informed and proactive attitude toward the condition — can go a long way to generating positive outcomes

by Brad Hussey

At least 7% of Canadian women and 3.5% of Canadian men experience moderate to severe incontinence daily — and the prevalence may be even higher. The condition is often associated with stigma, reduced quality of life and high costs for the individual, employers and healthcare system. Thankfully, many treatments are available to manage and sometimes cure the condition in both sexes. Patients are often hesitant to seek treatment and investigate their options due to feelings of embarrassment, but working in partnership with supportive, knowledgeable healthcare professionals can lead to very positive outcomes.

Dr. Mike Weir, urologist at the Peterborough Regional Health Centre in Peterborough, Ontario, and a board member for the Canadian Continence Foundation, sat down with *The Informer* to discuss current pathways for treating urinary incontinence.

How difficult is it to correctly diagnose the different etiologies (causes) of incontinence?

DR. WEIR: The greatest initial challenge to confirming a diagnosis is sorting out the true underlying cause of urinary incontinence (UI). The primary tool we have for diagnosing UI is the taking of a careful patient history. There are several etiologies of UI, each of which involves different causes of leakage and therefore varying treatments — so physicians have to be very clear about what kind of issues are leading to the incontinence. To complicate matters, some patients can have what we call mixed-picture incontinence, which involves more than one contributing factor. In these cases, we need to determine which underlying cause is most prominent, so we can focus our attention on treating it. Often, patient history alone will identify what we are dealing with.

What are you looking for in a patient's history?

DR. WEIR: We are trying to identify the

circumstances around when leakage occurred and any associated symptoms. With stress incontinence, for instance, leakages occur without warning due to pressure put on the bladder by exercise or even sneezing and laughing. We also tend to see stress incontinence more in women, particularly after childbirth, although it can also occur in men who have undergone a radical prostatectomy (surgery to remove a cancerous prostate). With urge incontinence, patients experience an overwhelming and unstoppable need to void their bladder. This form of UI can be caused by bladder cancer or infection, and can be associated with neurological disease, such as multiple sclerosis. In men, it can be caused by an enlarged prostate. In overflow incontinence — which involves constant leaking, even during sleep — constipation, an enlarged prostate and some medications that relax the bladder can be to blame.

These are all clues that can point us in one direction or another and help

us design a treatment regimen. It's important for patients and their physician to take the time and really focus on accurately teasing out recent medical history and the circumstances under which a leakage occurred. I sometimes see patients referred for stress incontinence, but when we drill down into a detailed history I find it was more about urgency, which often happens in people with mixed-picture incontinence. Of course, even patients can have trouble delineating the cause, and so physical examination and laboratory tests may be necessary.

Tell us about the physical exam.

DR. WEIR: Generally speaking, the physical exam is not as useful as a thorough history in making a diagnosis, except to rule out physiological features that may contribute to UI or other conditions that may be causing leakage. For instance, we should be looking for significant prolapse in females, which can be associated with stress incontinence. We should also rule out atrophic vaginitis, which can cause bladder contractions due to inflammation.

What common lab tests can help confirm a diagnosis?

DR. WEIR: In family practice, it is common and appropriate to perform a basic urinalysis and urine culture to rule out other bladder pathologies, such as infection or bladder stones. Ultrasounds are sometimes used to get a better picture of what's happening in and around the bladder. If there is blood in the urine, pelvic pain associated with UI or if a patient has not responded to standard therapy, they should be referred to a urologist or a urogynecologist. At that point, we would consider more precise urodynamic tests and cystoscopy (using a scope to view inside the bladder via the urethra) to elucidate the problem. In some cases, a focused neurological exam is necessary for patients with Parkinson's, MS or those at risk for spinal cord compression, all of which can affect bladder function.

Once a physician has made the diagnosis, how is UI treated?

DR. WEIR: Once we have a confirmed etiology, standard conservative measures

for controlling UI should be introduced. They include Kegel exercises, which have been shown to be beneficial in stress and urge incontinence, and bladder retraining for frequency and urge incontinence. Behaviour modification is particularly important for urge incontinence and even over-active bladder (OAB). These changes typically involve fluid restriction, avoidance of bladder irritants (such as caffeine), weight loss in some cases of stress and urgency and pre-voiding the bladder before engaging in activities that have triggered leakages.

Full clinical treatment guidelines for urinary incontinence, as well as educational and support materials for patients, are available on the Canadian Continence Foundation website: www.canadiancontinence.ca.

Which medications are used in treating UI? How do you choose which ones to use?

DR. WEIR: Anticholinergic medications, which block nerve signals that cause involuntary contractions of the bladder wall, are the most commonly prescribed drugs for UI, particularly for urge incontinence. They can be administered orally or topically, and are generally well tolerated. The newer agents seem to cause fewer cases of dry mouth and constipation. Importantly, these newer medications also have a reduced risk for exacerbating dementia, which has always been a concern with anticholinergics. They still have some risk, but in my opinion the benefits outweigh the dangers. We know that significant urinary leakage increases a patient's chances of being institutionalized, and waking up several times a night will do nothing to improve dementia. It behooves practitioners to consider treating patients who have significant UI symptoms even if they have some cognitive impairment. I advise families to monitor for any cognitive changes.

Tricyclic agents, such as amitriptyline, are sometimes used as second-line treat-

ment by specialists, primarily in cases with associated pelvic bladder pain or certain types of chronic pain. We can't forget to treat atrophic vaginitis with estrogen therapy when warranted, as well.

No matter what drugs are prescribed, it's important to note that the evidence clearly tells us patients will see an improved response when conservative approaches are included in a treatment regimen. For urgency leakage or OAB, behavioural modification is almost equally important as medication — whether a person needs both depends on the severity of their symptoms. Patients should never be treated with medications alone.

What surgical options are available?

DR. WEIR: Some surgical approaches can be utilized in patients who do not respond to the conservative interventions. Urethral slings are commonly used in stress incontinence. In my experience, they have a good success rate and are associated with high patient satisfaction. The procedure involves inserting a mesh sling under the urethra, so that when pressure is placed on the bladder (from a sneeze, for example), the urethra is pressed against the sling and is closed off, preventing leakage. The procedure is fairly simple, and is performed as a day surgery. The newer mid-urethra sling procedures for women can be done in as little as 30 minutes.

What is your message to patients and family physicians about UI?

DR. WEIR: I think there is a widespread perception out there that little can be done to manage UI. That's just not accurate. Many family physicians do a good job of helping their patients, but I would suggest that doctors and patients alike need to educate themselves about all the options available. We have many tools at our disposal, especially for stress incontinence. Urinary incontinence should not be considered a normal part of aging, which is another widespread myth. The key message is that it is never too late and it is always worthwhile to pursue treatment. I frequently hear from patients who tell us they wish they'd sought treatment earlier. ■

— Brad Hussey is a freelance writer based in Hamilton, ON specializing in healthcare and research translation.

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