Guest Editorial

Urinary Incontinence: Bridging the Gender Gap

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Urinary incontinence has long been acknowledged as a distressing disease with potentially devastating social consequences for the afflicted older adult. William Shakespeare, in The Merchant of Venice, provides what may be one of the earliest clinical treatises on urinary incontinence in men:

"Some men there are, love not a gaping pig; Some, that are mad if they behold a cat; And others, when the bagpipe sings ’t’ the nose, Cannot contain their urine."

Unlike other activities of daily living, such as ambulation and eating, bladder control is often not perceived as a function critical to physiological survival. However, urinary incontinence is a major marker of social function and acceptability in all cultures, regardless of anthropological origins. Consequently, patients and caregivers may be more inclined to consider urine incontinence more of a social embarrassment than a physical disease. Likewise, some health professionals diminish the significance of urinary incontinence in comparison with other activities of daily living, by incorrectly describing it as a nonhierarchical index of functional status. Over the past decade, urinary incontinence, along with other diseases, such as erectile dysfunction and andropause, that border on genital function and sexuality, has received increasing public attention (1,2).

However, this campaign of health awareness is frequently hijacked by product commercials that focus on curative pharmacological therapy or the use of aids and appliances to achieve a state of social continence. Unfortunately, among health professionals, the situation may be even more dire. Urinary incontinence, one of the great sleeping giants of geriatrics, continues to remain just that—a formidable obstacle in our path that may cause us to stumble as we age. This is supported by the volume of research highlighting the morbid consequences of urinary incontinence, and the relative paucity of complementary research offering effective intervention strategies.

Urinary incontinence affects 15%–35% of community-dwelling older adults and 50% of nursing home residents (3,4). The inclusion of persons with "dependent continence"—continence preserved only as a result of assistance from staff or caregivers—increases the prevalence of incontinence in the nursing home by at least an additional 10% (5). Annually, more than $3 billion are spent on the management of incontinence in long-term care facilities.

However, the cost of incontinence extends way beyond economic considerations, as the psychological impact of incontinence is often far reaching and socially devastating. Urinary incontinence frequently exerts enormous psychosocial strain on the caregiver, family members, and social network, which in several cases far exceeds the distress experienced by the patient (6).

At first glance, the findings of Nuotio and colleagues, in this issue of the Journal, may appear to be yet another addition to the extensive literature on incontinence morbidity (7). However, their study is one of the few that shows a refreshing departure from the monotonous reiteration of the medical complications of incontinence. Nuotio and colleagues establish an independent link between urinary incontinence in men and institutionalization. The association was maintained even after correction for age, comorbidity, and living arrangements. This clear-cut and convincing gender bias mandates close scrutiny of psychosocial and cultural factors if we are to succeed in unraveling the linkage between incontinence and institutionalization.

Traditionally, basic tenets of geriatric medicine are firmly grounded in logic and well-worn, but nevertheless proven, clichés that highlight the benefits of a common-sense approach. It is therefore surprising that, in spite of the distinct anatomical differences in external genitalia between men and women, the effect of gender on urinary incontinence in older adults remains relatively ignored. This tendency is rendered even more peculiar by the fact that gender is a primary and fundamental consideration in evaluating urinary incontinence during childhood, the other extreme of life. Maggi and colleagues, in an earlier issue of the Journal, identified an association between chronic obstructive pulmonary disease, Parkinson’s disease, hip fracture, and urinary incontinence in women (10). Prospective review of these findings support the hypothesis that the greater physical effort required by females in preparing for micturition may increase the risk of incontinence in women with restricted mobility or reduced exercise tolerance. In contrast, men require relatively less mechanical effort and minimal change in posture during micturition,
thereby favoring the preservation of urinary continence. However, male subjects with diarrhea, in the same study cohort, demonstrated an increase in urinary incontinence. This association may also be explained by anatomical gender differences. Conceivably, chronic diarrhea may result in adnexal inflammation of the prostate and prostatic urethra, resulting in an increased likelihood of urgency and incontinence (8). Additionally, in older men with prostatic enlargement, this may exacerbate the effect of benign prostatic hyperplasia on urgency and incontinence. Available evidence indicates that gender differences in bladder function and control extend beyond gross anatomical differences. Studies have identified age-related gender variations in detrusor muscle histology. Women are more likely to demonstrate excessive age-related hypertrophy of detrusor muscle fibers on histological examination. In addition, increased collagen and elastic fiber deposition resulting from degenerative changes are more likely to occur in women. Women are also more likely to develop laxity of the pelvic floor muscles, reduced bladder capacity, and abnormal detrusor contractility. Although the precise reasons for these changes are unclear, parturition, gynecological procedures, and hormonal changes accompanying menopause are likely contributory factors (11).

Medical consequences of incontinence are well recognized; these include an increased risk of hospital admission, depression, and increased mortality (12). The association between urinary incontinence and an increased risk of institutionalization has been made previously. However, evidence indicating a convincing gender bias in this association has been lacking (12–14). This gender differential is rendered even more sinister by the findings of several researchers indicating an increased risk of mortality among incontinent men (11,15). Viewed from this perspective, urinary incontinence could arguably be considered a more aggressive disease in men. Although reasons for this are not immediately evident, available data suggest that the increased malignant potential of urinary incontinence in men results from psychosocial, rather than biological factors.

Nuotio and colleagues, in an earlier study, examined gender differences in voiding symptoms between men and women. Within the cohort studied, men were more likely than women to experience incontinence in the presence of urgency. Although interesting, these findings are confounded by the inclusion of men with prostatism, thereby obviously rendering women an inadequate control group and precluding objective gender comparison (16). Temml and colleagues, exploring the effect of incontinence on quality of life of older men and women, found that men are more likely than women to experience an impairment of their sexual life as a result of urinary incontinence (17). Several studies have also identified a link between urinary incontinence and psychological and mood disorders (18–22). For reasons that are unclear, most of these studies focused on female cohorts. Similar attempts to feminize urinary incontinence occur within the realm of consumer advertising and commercial marketing. Media advertising of intervention strategies for urinary incontinence tend to portray women as exclusive “victims” of this problem. This is likely a reflection of the traditional, though, unjustified view of incontinence as a disease with a predilection for women. Unfortunately, such trends have a tremendous negative impact on the care of older men with incontinence, who may consequently find it difficult and socially threatening to cope with a disease that society perceives as feminine. This problem is further compounded for the older man, by poor patient–physician communication with regard to incontinence. Cohen and others aptly describe this as a “don’t ask, don’t tell approach—primary physicians don’t ask and patients don’t tell.” Possible reasons for this failure of communication include decreased awareness of the prevalence of incontinence and embarrassment on the part of patient and physician alike. Findings from their study suggest that physicians are more likely to ask women about incontinence than men. In addition, their results show that although women are more likely to experience loss of large amounts of urine, men report a greater number of incontinent episodes per day (23).

Available data indicate that less than one half of affected men and women with urinary incontinence seek medical attention. Older adults have been shown to initiate behavioral, dietary, or environmental modification in an attempt to thwart the negative impact of urinary incontinence. The use of appropriate collection devices and protective pads are also adopted by a significant number of affected older adults. Such self-care practices create a nexus between the individual’s compromised bladder function and preservation of social function and integrity. Disturbingly, within this realm of self-care practices, men function and cope less efficiently. Available data indicate that men are five times less likely than women to use disposable pads and four times as likely to require help in changing them. Men are also more likely than women to request assistance in changing bedding, outer garments, disposable pads, or using a urine collection device. Evidence also supports the logical conclusion that men are therefore more likely to limit social interaction outside the home as a result of urinary incontinence. Evidence indicates that men are 90% more likely to limit outings as a result of incontinence, thereby increasing the threat of social isolation (24).

Data examining the specific psychological impact of urinary incontinence on men is lacking. However, the coexistence of a disease perceived as stigmatized, loss of independence, social isolation, and inadequate professional assistance creates fertile ground for psychological dissoultion. Indeed, Bogner and colleagues, examining the association between urinary incontinence and psychological symptoms in community-dwelling older adults, found an increased risk of psychological distress when condition-specific functional loss was associated with urinary incontinence (25). Within the context of their study, subjects were considered to have condition-specific functional loss if, as a result of incontinence, they avoided travel, social gatherings, shopping, or physical activity. The association between condition-specific functional loss resulting from urinary incontinence and psychological distress held true in both genders. However, it is plausible that the specter of urinary incontinence may loom larger in men as a result of inefficient modification of intrinsic and extrinsic factors,
Ultimately resulting in an overwhelming psychosocial burden.

Understanding the critical link between urinary incontinence and quality of life is pivotal to the efficacy of screening and early intervention strategies. Older adults rank urinary incontinence among the 4 most “distressing” disorders after angina, difficulty with ambulation, and psychiatric disorders (26). Furthermore, although health professionals frequently focus on the medical and financial impact of urinary incontinence, several studies, utilizing both quantitative and qualitative measures, reveal that the major effect of urinary incontinence lies within the psychosocial domain (27,28). Urinary incontinence is often perceived as evidence of incompetence and may thereby adversely affect self-esteem in the older adult (29,30). For the older man who exists as the critical and central figure within the traditional family caucus, this perception of incompetence may be magnified. Nuotio and colleagues’ findings, implicating urinary incontinence as a predictor of institutionalization in older men, are a reflection of the failure of health professionals to adequately address urinary incontinence, specifically in relation to sociocultural roles, psychological well-being, and functional status.

In order to approach the management of urinary incontinence from a holistic perspective, health professionals must be cognizant of the fact that effective intervention must include psychological, behavioral, and sociocultural interventions. Preventive strategies directed toward incontinence should adopt a double-pronged approach aimed not only at preventing the mechanical event of urinary leakage, but also at stemming the tide of the psychological devastation that often accompanies the onset of urinary incontinence. Strategies that minimize the importance of incontinence as an index of self-esteem should be encouraged. Aggressive therapeutic efforts should be directed toward the development of innovative lifestyle adjustments to negate the effect of incontinence on social activity. Older adults with urinary incontinence must be educated and counseled regarding the legitimacy of urinary incontinence as a treatable disease process. In addition, efforts must be made to dispel the unhealthy notion held by many caregivers, and an alarming proportion of health professionals, that urinary incontinence is a reflection of advanced aging. Available evidence indicates that approximately 50% of nurses may cite advancing age as a cause of urinary incontinence (31). Such attitudes on the part of health professionals permit the injection of ageist and judgmental themes into management decisions, resulting in counterproductive therapeutic efforts.

To the chagrin of most dedicated geriatric health professionals, “successful” management of urinary incontinence has been described in the literature as “the extent to which the secret [of incontinence] can be kept without sacrificing the social persona” (32). Indeed, far too often, caregivers, health professionals, and patients engage in a therapeutic “conspiracy of silence” based on their misperception of urinary incontinence as a social disease. The findings of Nuotio and colleagues remind us all that urinary incontinence is not a “dirty little secret” but a potentially devastating disease, for men and women alike.

Acknowledgment

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