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CASE REPORT
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Urge Urinary Incontinence: Case Report

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ABSTRACT

Urge incontinence is one of the most common types of incontinence in women. Urge incontinence is described as a sudden feeling of urge to urinate and a strong urge to urinate. It usually occurs due to overactivity of the detrusor muscle. The associated risk factors such as age, frequent urination, obesity and mode of delivery were found to be compatible with the literature. The aim of this case report is to present the current status, risk factors and causes of urge incontinence in an explanatory manner.

Keywords: Case Report, Nursing, Urinary Incontinence.

INTRODUCTION

In 1979, the International Continence Society (ICS) defined urinary incontinence (UI) as "involuntary expulsion of urine or inability to retain urine and an objectively provable social and hygienic problem" (1). In 2002, ICS defined UI as "involuntary urinary incontinence" and in its last report, it was redefined as "any complaint of urinary incontinence" (2,3). More than 500 million individuals in the world have incontinence problems and the majority of them are women (4,5). UI is a widespread public health problem affecting the quality of life in women, especially in physical, sexual, social and psychological aspects (6). The prevalence of UI in women varies from society to society. The prevalence of UI in women in our country varies between 21.3% and 80%. The most common types of UI in women are stress, mixed and urge incontinence (4,7). UI risk factors include age, gender, race, smoking, factors related to childbirth, chronic constipation, menopause, obesity, spinal cord injuries, neurological diseases, hysterectomy, pelvic organ prolapse (POP), caffeine consumption, medications, diabetes mellitus (DM), radiotherapy, urinary tract infection and genetic factors (8). Behavioural and nonpharmacological treatments, pharmacological treatments and surgical treatment methods are used in the treatment of UI. Nonpharmacological and behavioural treatment methods include lifestyle changes, bladder education and pelvic floor muscles exercises Lifestyle changes include recommendations for obese individuals to löse weight, change diet, decrease caffeine and excess fluid consumption if available (9). In order for women with incontinence to maintain a healthier and more comfortable life, it is among the obligations of nurses to diagnose and evaluate incontinence, prevent its progression and take an active role in the treatment process of patients. Nurses are required to evaluate all women in the community in terms of risk factors that may cause incontinence, to provide the necessary training to women and to raise awareness of women in incontinence risk factors, findings and protection from incontinence. In addition, nurses' use of their roles as educator, researcher, manager and collaborator enables them to make the care process more effective (10-14). In the case diagnosed with urge incontinence; the patient's current condition, risk factors and causes were presented in an explanatory manner in accordance with research and publication ethics.

CASE

Ethics committee permission was not obtained for the study and the data collection phase started after verbal and written consent (informed consent form) was obtained from the individual in question.

FS, 66 years old, widowed, primary school graduate, SSK health insurance, low income, longest lived in Central Anatolia. Age at marriage was 17, age at first pregnancy was 18, gravida was 7 and parity

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was 7. All of the deliveries were vaginal deliveries with episiotomy, birth weight of the babies is unknown. FS's BMI was 36.51 and she was level II obese. The patient entered menopause naturally, has been in menopause for thirty years and has hypertension as an additional disease. She stated that she was not sexually active because she lost her husband. She uses Coversly 10 mg and Ecopirin 100 mg oral tablets. She does not use alcohol, does not smoke, has no drug and food allergies, no previous surgical operation. The patient has applied to the gynaecology outpatient clinic for a year because of a sudden feeling of tightness and strong urge to urinate and urine loss that occurs before reaching the toilet. She stated that this condition bothered her more and more every day and that she constantly changed her underwear and used pads. FS stated that she went to the toilet 8/9 times during the day and 2/3 times at night and slept for 9/10 hours on average. Since FS is a housewife, she spends her day at home, and when she goes out, she returns home in a short time with the thought that if she cannot hold her urine and cannot find a toilet outside. She stated that she often wanted to eat and drink something when she was at home and that she drank approximately 2 litres of water, 4 cups of tea and 1 cup of coffee during the day. The patient stated that his brother had childhood enuresis in his family history. In the lower urinary system questioning, he stated that he had dysuria, nocturia, urgency, susprapubic pain-sensitivity and that he was relieved with urination. She stated that she had difficulty when she started to urinate, she needed to strain for urination, she could urinate with a change in position, she had a feeling of inability to empty the bladder, and she had drip-like urine after urination. When the symptoms of prolapse were questioned, it was found that there was a palpable mass/sagging sensation in the vagina, pelvic pressure sensation and low back pain. Among the urinary incontinence symptoms, she stated that she had urge incontinence 1/2 times a day in small amounts, enuresis 1 time a day in small amounts, and nocturnal enuresis 1 time a day in small amounts. The patient was waited to urinate for urogenital system examination, the patient drank 500 ml of water, the last urination was 3 hours before the examination. The patient was taken to the examination table when he was fully congested, there was no urinary incontinence since the last urination, cough test was negative, uroflow volume was 360 ml, Qmax was 39 ml/sec, voiding time was 20 s, voiding type was bell, stress test with empty bladder was negative, urine residual amount with catheter was 10 ml, Qtip test >300, chyloral reflex is present, anal reflex is present, stage III anterior on speculum examination, suspicion of fistula stage II posterior, muscle strength 3/5 with digital palpation. Urine tests; Density 102. LES was negative, nitrite was negative, and there was no growth in urine culture. The patient underwent urodynamics in the urodynamics room of the urogynaecology service, the procedure lasted 1 hour 49 minutes, the number of urgency was 5, the number of incontinence was 11, the weight before the pad test was 20 g, the weight after the test was 37 g, the number of DAA was not monitored, the uroflow volume was 375, and the residue after uroflow was 25 ml. The patient stated that she thought that urinary incontinence was shameful and that it was a normal condition with age and that she could not share this situation with her relatives and that she had not consulted a doctor for a year. She said that this situation caused her to be introverted and stressed. As a result of anamnesis, laboratory findings and physical examination, urge incontinence was diagnosed. The patient was told to come to the examination again after two weeks. During this two-week period, she was asked to keep a bladder diary and practice pelvic floor exercises (information about bladder diary and pelvic floor exercises was given).

DISCUSSION

Incontinence risk factors such as age, birth-related factors, BMI, menopause and hypertension were present in the case. When the symptoms of the case were analysed, urge incontinence was diagnosed because the patient could not reach the toilet with sudden feeling of urge and strong urge to urinate. The amount of urine missed by women with urge incontinence is higher than in women with other urinary incontinence diagnoses. In the literature, it has been reported that urge incontinence is more common in elderly individuals (15). The age of the patient supports this information. Urinary incontinence may be observed due to reasons such as urinating 8 times a day or more, urinating at night, and inability to prevent urination (16-19). The patient stated that she urinated 10/12 times a day. Obesity, which causes an increase in intraabdominal and intravesical pressure, is an important risk factor for urinary incontinence, especially for stress and urge urinary incontinence (20-23). It was found that the BMI of the patient was high and level II. In previous studies, urge incontinence is observed more in obese women and this supports the result of this case (24-25). Urge incontinence is more common in women

who have vaginal delivery, especially in women who have episiotomy (19). Vaginal delivery and episiotomy application in the case supports this information. In studies, it has been reported that the majority of women with urinary incontinence do not apply to health institutions or apply late because of embarrassment and considering it as a normal condition due to age. Similarly, in our case she presented late because she thought urinary incontinence was shameful and normal with age.

CONCLUSION

In conclusion, the urge incontinence risk factors determined in the case were found to be compatible with the literature. The fact that the patient thought that urinary incontinence was shameful shows that urinary incontinence is an important health problem. It is among the obligations of nurses to take an active role in the diagnosis, evaluation, prevention and treatment of incontinence in order for women with incontinence to lead a healthier and more comfortable life. Nurses are required to evaluate women in terms of risk factors that may cause incontinence, give necessary trainings to women about incontinence risk factors, findings and protection from incontinence and raise awareness of women.

DESCRIPTIONS

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