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Incontinence and Pelvic Floor PT in the Primary Care Setting

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PELVIC FLOOR PHYSICAL THERAPY AS ONE OF MANY STRATEGIES FOR ADDRESSING INCONTINENCE

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MENTOR: DR. BETHANY PICKER
The AUA (American Urological Association) recommends pelvic floor physical therapy as a first line treatment for urinary incontinence and overactive bladder (Strength of Evidence Grade B).

Many patients are appropriately referred to a Urologist for further evaluation of incontinence when recognized by a PCP. However, latency between being seen in the primary care setting and follow up with a Urologist is sometimes weeks to months, with little intervention during that time.

Primary care providers can also make referrals to pelvic floor physical therapy for patients presenting with incontinence as a treatment which could be initiated before being seen by a Urologist. However, many primary care providers may overlook this step as part of the recommendation plan for incontinence.

Incontinence may also go unrecognized by a primary care provider for a long time, as many patients are not asked about the symptoms of incontinence by their primary care providers. This leads to a long delay between symptom onset and treatment.
A 2007 study demonstrated that for the 34 million people in the United States with overactive bladder and stress incontinence the total cost amounts to $65.9 billion dollars. $49.1 billion of this is due to direct medical costs, $2.3 billion of this is due to direct nonmedical costs, and $14.6 billion of this is due to indirect costs.

A large portion of the healthcare costs related to OAB and incontinence include missed work, and indirect costs are higher in employed individuals who have decreased functioning due to their incontinence.

There is a significant delay in symptom onset and treatment for many patients with OAB, likely contributing to a larger overall cost. One proposed reason for the delay between symptom onset and treatment may be related to the lack of questioning by healthcare providers about the symptoms of incontinence.
Jill Cramp, a physical therapist specializing in pelvic floor physical therapy, believes that there is a significant need for education of both patients and PCPs in the arena of pelvic floor physical therapy. Many patients are seen in her physical therapy clinic after months or years of incontinence, without having any pelvic floor physical therapy. Additionally, many patients endorse that they have gone long periods of time without addressing their symptoms with their PCP, in part because they are not asked.

Ross Watson, MD, a primary care provider at the Family Medicine Residency in Lewiston, Maine, believes that there is a under recognition of incontinence in his patient population. He believes that many patients are not being screened as thoroughly as needed, especially in the older population where incontinence is more prevalent. He states that many patients believe incontinence is just a normal part of aging. Dr. Watson agrees that educational materials for patients and providers may help identify patients with incontinence and get them the treatment that they need.
INTERVENTION AND METHODOLOGY

- Intervention consisted of an informational sheet that was distributed to primary care providers in the Family Medicine Residency as well as patient information sheet distributed to those identified with overactive bladder and stress incontinence symptoms.

- This sheet highlighted important screening questions for incontinence and OAB, as well as appropriate steps to take after incontinence has been recognized. This includes referral to physical therapy for pelvic floor PT, as well as referral to a Urologist for further workup of incontinence.

- A similar informational sheet was also given to patients at the Family Medicine Residency, highlighting symptoms of overactive bladder and stress incontinence, and encouraging patients to speak with their primary care provider about their concerns, should they have any.

- Intervention at both the provider and patient level is aimed to bridge the gap and help patients experiencing symptoms of incontinence get the referrals and treatments that will alleviate the reduction in quality of life related to incontinence.
RESULTS AND RESPONSE

- Quantifiable results for this intervention are not currently available. The response to educational materials was positive.

- One way to quantify results would be to look at the amount of physical therapy referrals for patients with symptoms of incontinence over the next year.

- Additionally, quantification of positive screenings for patients with incontinence over the next year could be compared to the number of patients with a positive screening for incontinence (on ROS) over the past year.

- Assuming the rate of incontinence in the community is not changing at a rapid rate, the above measures would likely give insight into whether or not the education of patients and providers leads to more recognition of those struggling with the symptoms of incontinence. Physical therapy referrals would also give insight as to whether or not patients were being recommended for the first line therapies for incontinence.
Pelvic Floor PT has been demonstrated to have up to a 56% “cure rate” for stress incontinence compared to 8% “cure rate” for women having no intervention.

Should the referral rate, and participation in Pelvic Floor PT increase, it would be presumed that rates of stress urinary incontinence would decrease.

Increasing identification of patients with symptoms of overactive bladder and stress incontinence would also lead to more effective interventions.

Limitations regarding this intervention include the need for patients with incontinence to actively engage in physical therapy. While identification of incontinence symptoms and referral to physical therapy are first steps, this intervention ultimately would fall short if patients are not able to attend or participate in pelvic floor physical therapy sessions.

Additional limitations include the time constraints placed on providers in the primary care settings. While many providers try their best to screen patients for all current complaints, many times visits must be problem-focused and if incontinence is not the presenting problem, it may delay recognition and treatment.
Future interventions should be focused on measuring the number of positive screenings for incontinence symptoms and referrals to pelvic floor physical therapy by primary care providers.

Additionally, as part of the education of primary care providers, incontinence screening should be stressed as an important part of the review of systems and general health of patients, especially in the older population where there seems to be the thought that incontinence is just “part of getting older”.

Many patients are not directly asked about incontinence symptoms, and the importance of direct, clear questioning should be emphasized. Instead of questions like “Any changes in urinary habits?” patients should be asked questions like “Do you ever have trouble making it to the toilet when you have to go to the bathroom?” or “Do you ever urinate without meaning to, or after sneezing, coughing, or bending over?” These questions address the actual symptomatology of urinary incontinence in a clear manner patients understand.

Incorporating this kind of language into educational sessions for primary care providers may lead to an increased recognition of urinary incontinence in the community.
Dumoulin, Chantale; Cacciari, Licia P.; Hay-Smith, E. Jean C. (2018-10-04). "Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women". The Cochrane Database of Systematic Reviews. CD005654. doi:10.1002/14651858.CD005654.pub4. ISSN 1469-493X. PMID 30288727

