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PRIMARY CARE PROVIDER OPINIONS AND PRACTICES REGARDING SCREENING FOR URINARY AND FAECAL INCONTINENCE (ACCIDENTAL BOWEL LEAKAGE)

Hypothesis / aims of study

To determine opinions and practices of primary care providers regarding the screening and treatment for urinary incontinence (UI) and accidental bowel leakage (ABL).

Study design, materials and methods

An electronic survey was conducted of primary care providers at an academic institution in the mid-west United States. Eligible participants were sent up to three emails over a six-week period inviting them to participate, and those who did not provide primary care were excluded. Descriptive analyses were performed to compare opinions and screening practices for UI and ABL. Backwards conditional logistic regression was used to identify factors associated with screening for ABL. All factors with a p value <.10 on univariate analysis were included in the initial multivariate model, and two were ultimately removed because of small sample size.

Results

Response rate was 27% (185/696), of whom 83% (154/185) were eligible as primary care providers (PCPs): 47% (73) family medicine, 32% (50) internal medicine, 16% (25) OB/GYN, and 4% (6) geriatrics. Attending physicians or consultants comprised 48% (74); 36% (55) were trainees, and 16% (25) were advanced practitioners. Attitudes, opinions, and screening practices are detailed in Table 1. When informed of the prevalence of ABL, 75% (114) of PCPs felt it was higher than they expected and 66% (100) reported that this prevalence made them feel screening was more important. Verbal screening was preferred by 49% (74). Overall, 35% (53) screened at least some patients for ABL. Table 2 provides factors associated with screening for ABL on univariate analysis as well as multivariate logistic regression. To assess knowledge about ABL, respondents were given a list of potential risk factors and asked to characterize their importance. Correctly identified as very important risk factors were age (86%, 130/152), prior therapy for prostate cancer (83%, 125/150), diarrhoea (83%, 125/151), childbirth (81%, 123/152), constipation (78%, 119/152), and diabetes (38%, 58/152). Female sex was cited by 46% (69/151) and hypertension by 11% (16/152) as important risk factors. Those who identified age and diabetes as risk factors for ABL were significantly more likely to screen for ABL on univariate but not multivariate analysis.

Table 1: PCP opinions and practices regarding UI and ABL screening and treatment (N=154)

Questions	Answers	UI % (n)	ABL % (n)	p-value
Importance of screening	Very/extremely	48 (74)	37 (56)	0.037
	Somewhat	38 (59)	40 (61)	
	Slightly/not at all	13 (20)	23 (35)	
Frequency of screening	Every/most patients	28 (42)	8 (13)	
	Some patients	47 (71)	26 (40)	<0.00001
	A few or none	25 (39)	66 (99)	
Reasons I don't screen (N=110 for UI) (N= 139 for ABL)	Too many other issues	83 (91)	73 (101)	0.06
	Patients will bring up if bothered	44 (48)	38 (53)	0.38
	Don't have time	35 (38)	35 (49)	0.91
	It is not common in my patients	17 (19)	37 (51)	0.0007
	I don't have good treatments	12 (13)	29 (41)	0.0008
Feel informed about treatment options	Very/extremely	27 (42)	4 (6)	0.00001
	Somewhat	55 (84)	32 (49)	
	Slightly/not at all	17 (26)	64 (97)	
Helpful Tools	Patient education materials	79 (120)	77 (116)	0.65
	Diagnosis & treatment algorithm	77 (116)	75 (112)	0.66
	Provider education materials	52 (79)	69 (103)	0.004
	Condition-specific order set	51 (77)	44 (66)	0.22

Table 2: Factors associated with screening for accidental bowel leakage (faecal incontinence)

	Screens for ABL % (n)	p-value	Adjusted Odds Ratio (95% Confidence Interval)	p-value
Specialty		.081*		
Internal Medicine	32 (16)			
Family Medicine	32 (23)			
Obstetrics & Gynaecology	38 (9)			
Geriatrics	83 (5)			
Clinician type		.017		.042
Attending physician	41 (30)		1.00 (Referent)	
Advanced practitioner	48 (12)		2.48 (.69, 8.89)	
Resident / fellow	20 (11)		.449 (.16, 1.27)	
Screens for UI	47 (53)	<0.001*		

Perceives screening for ABL as very important	54 (30)	<0.001	3.87 (1.52, 9.85)	.003
Feels somewhat informed about treatment for ABL	67 (37)	<0.001	14.32 (5.20, 39.41)	<.001
Prefers to screen verbally	49 (38)	<0.001	3.62 (1.42, 9.27)	.005
Preferred Terminology				
Faecal incontinence	34 (53)	.543		
Bowel incontinence	36 (20)	.453		
Bowel control issues	42 (38)	.022	3.76 (1.41, 9.99)	.005
Accidental bowel leakage	56 (15)	.013	--	
Identifies risk factor:				
Age	39 (50)	.018	--	
Diabetes mellitus	48 (28)	.006	--	
Constipation	35 (42)	.504		
Diarrhoea	38(47)	.055	--	
Prostate Disease	36 (45)	.300		
Female sex	41 (28)	.131		
Childbirth	34 (42)	.428		
Hypertension	50 (8)	.144		

* Not included in multivariate model due to small sample size in individual cells

Interpretation of results

PCPs are significantly more likely to prioritize and screen for UI and feel more comfortable managing UI as compared to ABL. Competing issues to address during the visit and not having enough time are large barriers to screening for both UI and ABL. Perception of the condition as uncommon and lack of awareness of treatment options are more significant barriers for ABL screening. While more than 50% of women with UI or and 70% of women with ABL do not seek care (1), many PCPs assume that patients will bring up these issues if bothered. Feeling informed about treatment options is the strongest predictor of screening for ABL, followed by feeling that screening is important. The demand for patient information, provider information, and provider algorithms for both UI and ABL is high. Providing these tools has a strong potential for positive impact, especially for ABL.

Concluding message:

Information for patients and providers about UI and ABL prevalence, risk factors, diagnosis, and management should be disseminated to primary care providers. These tools will facilitate increased screening and treatment for these undertreated conditions, with a larger potential impact for ABL.

References

1. Brown HW, Wexner SD, Segall MM, Brezoczky KL, Lukacz ES. Quality of life impact in women with accidental bowel leakage. Int J Clin Pract. 2012 Nov;66(11):1109-16. doi: 10.1111/ijcp.12017.

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