

URINARY INCONTINENCE SCREENING BY PRIMARY CARE PROVIDERS: HOW CAN WE ENHANCE CURRENT PRACTICES?

Hypothesis / aims of study

Urinary incontinence (UI) is a prevalent condition associated with several medical co-morbidities with an estimated direct cost of \$20 billion per year in the United States. The majority of women with UI can be successfully treated. Yet incontinence remains a topic both patients and health care providers are reluctant to discuss. Many patients fail to report incontinence symptoms due to embarrassed or the erroneous beliefs that incontinence is not a serious medical problem or an inevitable part of aging.^{1,2} The reluctance of patients to report symptoms emphasizes the importance of physician screening. The purpose of this study was to evaluate screening practices among primary care providers in our community.

Study design, materials and methods

All primary care providers (PCP) in the surrounding county were identified from a database maintained by the university medical center. Health care providers in Internal Medicine (IM), Family Practice (FP), and Obstetrics and Gynecology (OB-GYN) were included. A questionnaire was mailed to all identified providers. The questionnaire included information regarding provider demographics, patient population demographics, screening practices including both frequency and methods of screening, provider level of comfort with treating incontinence, and referral practices. Data were evaluated using descriptive statistics.

Results

From the university medical center database, 1,466 primary care providers practicing in the surrounding county were identified. A total of 554 questionnaires were returned. The majority of responding providers were 35-54 years of age (65%), male (61%), and Caucasian (83%). Most identified themselves as private practitioners (59%), while 20% practice in a university setting and 6% in publicly-funded clinics. Practice speciality was IM for 43%, FP for 28%, and OB-GYN for 23%. Six percent of IM providers practice only geriatric medicine. Approximately half of the providers have been in practice between 11 and 30 years, 37% 10 years or less, and 10% for more than 30 years. Overall, most providers identified UI as a very (42%) or somewhat (56%) important health problem, while 2% felt it is not important. More female than male providers considered UI a very important problem (49% vs. 38%), but only 3% of male and 1% of female providers considered UI unimportant. Among specialities, 43% of IM, 30% of FP, and 58% of OB-GYN providers considered UI very important. The majority (63%) of geriatricians considered UI very important. There was no notable difference in importance of UI according to practice type, age, or years in practice.

	All PCP	IM	Geriatrics	FP	OB-GYN	Male PCP	Female PCP
Always or Most of the Time	60	60	88	53	89	57	68
Occasionally	26	26	8	33	9	27	22
Rarely or Never	14	14	4	14	2	16	10

Table 1: Frequency of screening for UI.

Screening rates increased from 45% at provider age 35 or less to 67% at age 65 or older. With increasing number of years in practice, screening increased from 55% for less than 10 years to 68% after 30 years of practice.

	All PCP	IM	Geriatrics	FP	OB-GYN	Male PCP	Female PCP
Method							
Provider Question	79	78	69	85	59	80	80
Staff Question	2	2	4	2	2	2	3
Questionnaire	8	9	4	7	16	8	10
Timing							
New Patients	11	11	23	6	9	12	10
Every Visit	8	8	15	<1	23	9	7
Annually	43	45	23	47	51	39	53
Randomly	24	24	19	38	2	30	18

* Percentages may not equal 100%; only most commonly chosen categories displayed.

Table 2: Screening methods

The majority of providers (96%) feel very or somewhat comfortable screening for UI. OB-GYN's and geriatricians report more commonly being very comfortable with diagnosing UI (76% and 82%) compared to IM and FP (58% and 55%). Overall, 85% of providers are very or somewhat comfortable with conservative management of UI. Providers under 35 years of age are less often very comfortable (12%) and more often not at all comfortable (24%) than older providers. OB-GYN's and geriatricians are more commonly very comfortable with conservative management (68% and 54%) than IM (34%) and FP (24%) providers. Only 32% of OB-GYN providers are very comfortable with surgical

management of UI. Only 36% of providers always or usually refer patients to specialists for evaluation of UI, and 62% refer sometimes. Five percent of providers refer immediately after patient complaint, 6% refer after repeated complaints, and 85% refer after initial treatment results are unsatisfactory. Nearly three-quarters of providers are interested in learning more about UI, although only 35% think increased knowledge would change their practice behavior. With increased provider age and number of years in practice, fewer providers are interested in learning more. More than 80% of providers under the age of 35 and in practice for less than 10 years are interested in learning more about UI. More female providers (81%) are interested in learning more than male providers (68%), and fewer geriatricians are interested (58%) than IM (73%), FP (74%) and OB-GYN (80%) providers.

Interpretation of results

Despite 98% of providers considering UI very or somewhat important, only 60% screen their patients always or most of the time. Nearly 15% rarely or never screen for UI. Considering UI a very important health problem is associated with higher rates of always screening. Higher rates of screening for UI are associated with provider comfort with both diagnosis and conservative management. Most primary care providers will initiate treatment of UI before referring for specialty evaluation. Younger providers and those in the early years of practice are less likely to screen for UI, less comfortable with diagnosis and treatment, and more interested in learning more.

Concluding message

Urinary incontinence is an important health concern and screening rates among primary care providers can be improved. Increasing knowledge among providers regarding impact of urinary incontinence on patients' health and quality of life as well as diagnosis and conservative management of urinary incontinence may lead to increased screening rates. Continuing medical education programs should be developed for all primary care providers, with special focus on young and new providers.

References

1. Dugan E, Roberts CP, Cohen SJ, et al. Why older community-dwelling adults do not discuss urinary incontinence with their primary care physicians. *J Am Ger Soc* 2001;49(4):462-5.
2. Horrocks S, Somerset M, Stoddart H, Peters TJ. What prevents older people from seeking treatment for urinary incontinence? A qualitative exploration of barriers to the use of community continence services. *Fam Pract* 2004;21(6):689-96.

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HUMAN SUBJECTS: This study was approved by the Internal Review Board at the University of Rochester and followed the Declaration of Helsinki Informed consent was not obtained from the patients.