Continence in Dementia.

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Continence

• Adequate stimulus to initiate voiding reflex
• Neuromuscular and structural integrity of system
• Cognitive ability to interpret and respond to sensation
• Motivation to hold on until appropriate to void
• Sufficient mobility to get to the toilet in time
Incontinence in Dementia

**Structural /physical**
- problems commonly associated with ageing
  - Prostate,
  - Hormonal changes
  - Vaginal atrophy
  - UTI’s
  - Detrusor Hyperactivity
  - Endocrine disorders
- Medications

**Functional Incontinence**
- Cognition
  - Memory
  - Praxis
  - Gnosis
  - Executive function
- Mood/behaviours
  - Depression
  - Apathy
  - Agitation
- Mobility.
Over 70 diseases that cause dementia
Memory

• Early symptom of Alzheimer’s disease

• Initially short term memory affected
  - Difficulty learning and retaining new info
  - Rapid forgetting.
Memory

• When more severe
  - Remembering location of toilet
  - Remembering to eat & drink
  - Recognising feeling of “needing to go”
Language

• Speaking
  - Inability to communicate the need to go

• Understanding speech
  - Inability to understand prompts, instructions or questions eg: “do you need to go to the toilet?”
• Executive Function
  - Thinking abstractly
  - Planning
  - Organisation
  - Motivation
  - Initiation
  - Social awareness

• Alzheimer’s disease
• Fronto-temporal dementias
Symptoms.

• Executive Function
  - Lack of initiative to go to toilet
  - Apathy - Reduced motivation to go
  - Disinhibition – going in inappropriate places.
• Praxis
  - Your sense of where your body is in relation to things around you.
  - Inability to use objects eg: to get dressed or adjust clothing, operate toilet.
Gnosis
- Visual perception
- Ability to recognise visual images
- Interpreting what you see.
- Difficulty recognising toilet.
- Misinterpreting objects
Gnosis & Praxis

Alzheimer’s Disease
(mod to severe symptom)

Dementia with Lewy Bodies
(early symptom)
Cognition & Incontinence

• Executive Function
  - Recognise need to go
  - Initiative & Motivation to respond
  - Ability to sequence the task
  - Social awareness and timing.
• Language
  - Ability to communicate need or respond to question of need
• Memory
  - Ability to remember location of toilet
• Gnosis
  - Ability to recognise toilet when see it
• Praxis
  - Ability to manage clothing and actions of toileting
Incontinence in Dementia

• 53% in Dementia cf 13% without dementia
  - (varies from 11 – 90% in literature)

• Typically occurs late in Alzheimer’s Dementia
  - Change in mobility is highest predictor of incontinence
  - Cognitive changes more severe and global
Incontinence in Dementia

Can occur early in some forms of dementia

- Normal Pressure Hydrocephalus
  - triad of cognition, incontinence and gait changes.
- Vascular dementia
  - Due to changes in frontal sub-cortical circuits
- Frontal Dementia
  - Damage to cortical inhibitory centre for micturition
- Dementia with Lewy Bodies.
  - Occurs early with less severe cognitive decline. Lesions in mid-frontal and cingular gyri
  - Visuo-spatial and visuo-perceptual problems early in illness
  - Parkinsonian changes affecting mobility.
So what can we do about it?

• Is it possible to do anything for incontinence in people with dementia?
Assessment

• Describe the problem
  - Detailed history
  - Voiding chart – freq, timing, amount, episodes of incontinence.

• Exclude reversible causes & evaluate for established causes
  - Physical examination
  - Medication review
  - Pathology

• Analyse other possible contributing factors
  - Mental status examination – cognitive assessment
  - Delirium, depression,
  - behavioural disturbance - Active vs Passive incontinence.
  - Mobility and ADL’s
  - Environment
• Delirium
• Infection
• Trophic vaginitis
• Psychological/behavioural
• Pharmaceuticals
• Endocrine causes
• Restricted mobility
• Tool impaction / constipation.
Management

• Rule out & treat reversible causes first.
Management

• Routines
  - Ensure adequate fluid intake, reducing in evening and before sleep
    > Avoid caffeinated drinks
  - Regular prompts to toilet (but not too often)
    > Scheduled toileting
      - Regular / fixed
      - Individualised – more successful
    > Prompted voiding
      - Asking regularly if need to go but only taken if they need to go. Praise for appropriate toileting and dryness.
      - Research positive for this approach.
  - Regular exercise to maintain mobility.
Management

• Communication
  - Short simple sentences, one concept/instruction at a time
  - Watch for non-verbal cues for need to toilet
  - Use words that the person has been used to in the past (know your patient).
  - Dignity & Respect
    > “oh dear something has spilled” vs “oh you’ve wet yourself again”
Management

• Environment
  - Toilets that are easy to see (contrasting seat)
  - Bathroom aids – rails, raised seats.
  - Signage
  - Lighting
  - Remove things that can be mistaken for a toilet
    > Waste bin, pot plant, etc.
  - Be aware of mirrors
    > May be misinterpreted as another person watching.
Management

• Clothes
  - Easy to remove
    > Elastic waist, velcro instead of buttons / zips
  - Protective garments
  - Incontinence aids (last resort)

• Skin Care
  - Perineal hygiene and care
Management

• Behavioural
  - Respect, dignity & privacy
  - Time
  - Calming music
  - Running a tap to trigger response
  - Distraction to keep person on the toilet
  - Trial & error to find what works – very individual
Summary

• Incontinence usually occurs late in dementia although there are exceptions & it can occur early in some types.
• Functional incontinence common
  – Cognitive, behavioural & mobility problems can contribute to this
  – Management strategies should address these issues
• Potentially reversible causes should always be considered & treated first
  – Don’t assume it is part of the dementia