

Nursing essays - progressive urge incontinence



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Care study of a woman with a care issue which related to the module content. You are expected to analyse the evidence base, which informs choices and practice and evaluates client care, making recommendations for improvement.

Introduction

In this essay we shall consider the case of Mrs. J. a 32 yr. old primigravid mother who has had a totally uneventful pregnancy. She is a large caucasian lady with a BMI of about 30. Her blood pressure and biochemistry were normal throughout her pregnancy. She is a non-smoker.

Her major problem was that she has suffered from progressive urge incontinence as her pregnancy progressed, which developed into stress incontinence by about the 33rd week. She subsequently had a normal vaginal delivery of an 8lb 2oz baby boy, which proved to be unexpectedly rapid so there was no time to do an episiotomy. She suffered a few small 1st degree tears. Post natally her stress incontinence got very much worse and now (six months post delivery) it is a major problem for her.

Stress incontinence

Stress incontinence is a common post partum condition which can occur over a full range of severity from subclinical to catastrophic. It is usually described as “ the involuntary passage of urine associated with a sudden, or impulse, rise in the intra-abdominal pressure” (Arya et al. 2001)

It occurs in about 11-13% of post partum women (Cammu et al 1997)). Other authorities such as Norton (1996) put the prevalence of the condition in the whole adult population at about 40 per 1000. The Continence Foundation

(2000) estimates that there are about 3 million women who are over the age of 40 who suffer from varying degrees of the condition.

Aetiology of the condition

Pelvic floor trauma during childbirth has been recognised for a long time as being a major contributory component (if not an actual cause) of stress incontinence. Many studies have been done to try to ascertain the most effective modalities of treatment and others have looked at the factors associated with pregnancy and childbirth which are germinal to the condition. In this essay we shall consider the work that has been done in specific relation to the case of Mrs. J.

The first factor to consider in respect of Mrs. J. is the fact that she is pregnant. This may seem to be blindingly obvious at first sight, but it has only recently begun to be recognised that quite apart from post natal and delivery-related factors, there are a number of antenatal factors that relate directly to stress incontinence. Rortveit (et al 2003) produced a carefully executed study which pointed to the fact that, even if no other factors were apparent, pregnancy, by itself, was an independent variable for the development of stress incontinence. This study showed an increased incidence of 1.7 times the incidence for nulliparous women when corrected for all other variables. This study supersedes (in both time and quality) previous studies by Nielsen (1988) and Olsen (1997) which looked at the same issue but could not produce a statistically significant answer.

If we consider the actual mode of delivery we see that Mrs. J. had a fairly precipitate delivery of a large baby without the benefit of an episiotomy. We

might observe that she was fortunate not to sustain a major perineal tear. There have been many studies (of variable quality) which have looked at the issue of the relationship between the mode of delivery and the eventual incidence of stress incontinence.

A recent study by Burgio (2003) found that there were a number of independent variable factors that were predictors of an eventual increased incidence of stress incontinence. These included “ smoking during pregnancy, length of time spent breast feeding, a vaginal delivery, the use of forceps to assist delivery , the frequency of urination prior to delivery and BMI”. In specific relation to Mrs. J. we can see that a number of these identified factors are present. She had a vaginal delivery, suffered from urge incontinence prior to delivery and has a high BMI.

Other factors such as a large birth weight baby, (Groutz et al. 1999) precipitate delivery (Perry et al 2000) and lack of episiotomy (Reilly et al. 2002) have also been identified by other investigators as being potent causative agents in the development of stress incontinence.

The study by Perry (et al 2000) considered the intra-partum factors that influenced the eventual incidence of stress incontinence and concluded that factors such as a precipitate delivery (together with malpresentations and malrotations) increased the incidence of perineal floor damage which was a prime factor in the aetiology of stress incontinence.

This factor was examined further by Reilly (et al. 2002) who came to the conclusion that episiotomies exert a protective effect on the perineum (by minimising damage in labour and by allowing the various structures to be

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safely surgically repaired), and the presence of an episiotomy statistically reduced the eventual incidence of stress incontinence.

The issue of the relationship between BMI and stress incontinence was settled by Seim (et al 1996) whose study showed a statistically significant increase in the incidence of stress incontinence with increasing BMI.

The study by Handa (et al. 2000) ties many of these factors together in a well constructed and meticulously executed study. The additional factors that this study can add to our discussion are the relationship between birth weight, head circumference and speed of delivery to the eventual development of stress incontinence. All of these factors are found to be positively associated with its development.

Care issues

We have examined the literature on the subject and have been able to identify the various factors that are relevant to the case of Mrs. J. In line with the guidance of reflective practice (Gibbs 1998) we can reflect on the factors that may have contributed to the subsequent morbidity in Mrs. J. and equally consider how they could have been minimised or avoided so that further practice can be guided by the experience. Equally, we must not lose sight of the fact that it is not just the mechanical management of a case that is important, it is the understanding of why decisions are made and the appreciation of the evidence-base that defines those decisions (Kuhse et al 2001).

Some of the factors that are relevant to Mrs. J. are potentially avoidable, such as the increased BMI. Sensible pre-natal or antenatal advice to loose <https://assignbuster.com/nursing-essays-progressive-urge-incontinence/>

some weight may well have reduced her risk factors (not only for stress incontinence, but also for other conditions such as hypertension and eclampsia).

Other factors such as the size of her baby are clearly unavoidable, although, given the fact that it was known that the baby was large, it would have perhaps been sensible to have considered and performed an episiotomy to allow controlled descent of the head together with avoidance of potential damage to the perineum.

We have not got any information on prophylactic measures that could have helped reduce the incidence of stress incontinence in the case of Mrs. J. Pelvic floor exercises have been shown to exert a beneficial effect on the incidence of stress incontinence.

There is evidence to show that both ante natal (Salvessen et al 2004) (Morkved et al 2003) and post natal (Chiarelli et al. 2002) pelvic floor exercises will reduce the incidence of post partum stress incontinence. It would appear that the effect of these exercises is accumulative. In short, the more that are done, the better the result. It would also appear that antenatal exercises are marginally more effective than post natal ones (Wilson et al. 2001).

There is also considerable evidence to show that patient compliance with pelvic floor exercises is not intrinsically good and that high rates of encouragement are required to achieve good patient compliance. (Viktrup et al. 1992)

This really comes under the heading of empowerment and education of the patient. If the patient realises why they are being asked to do something, there is a much greater chance that they will do it than if they are simply told to do something. (Marinker 1997)

Some sources argue that pelvic floor exercises create a strong pelvic floor that could hinder delivery. This argument was shown to be false by Slavessen (et al 2004) who conclusively showed that a strong pelvic floor actually helps to control the descent of the head and minimises perineal damage

Recommendations for improvement

We have discussed the case of Mrs. J. and examined the evidence to support the identification of the risk factors that are relevant in her case. We have also looked at the possibility of correcting those factors in subsequent management. To a large extent we have considered the possibilities for improvement as we have discussed the various issues that are relevant.

One issue that we have not covered however, is the fact that it is very easy for a midwife to overlook the fact that a patient has developed stress incontinence. (Mason et al 2001). Women are surprisingly reluctant to discuss the issue and often believe that they are unusual in developing, what they see as a very embarrassing and awkward complaint. The corollary of this is that midwives should be aware that they can easily overlook a source of considerable morbidity simply because they don't specifically enquire about it.

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