

Improving care and outcomes for patients with bladder conditions

How to overcome stigma and other care barriers in healthcare and community settings.

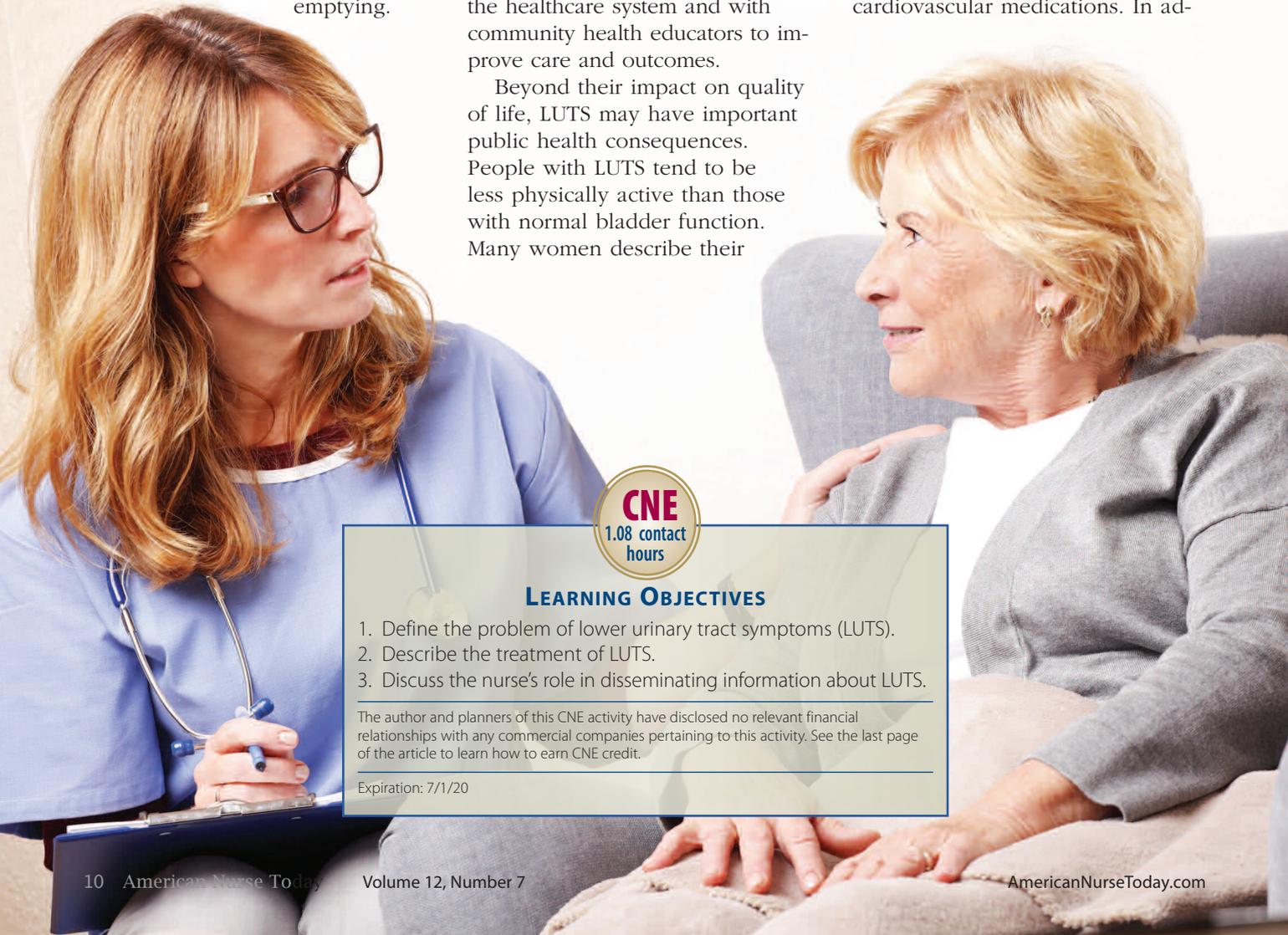
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COMMON in both men and women, lower urinary tract symptoms (LUTS) include urinary incontinence (UI), daytime and nocturnal frequency with or without urgency, difficulty urinating or emptying the bladder, and pain associated with bladder filling and emptying.

Unfortunately, the social stigma and misperceptions surrounding LUTS prevent many people from seeking treatment, creating a significant but underacknowledged public health burden. This article reviews LUTS as a public health problem and discusses how nurses can work within the healthcare system and with community health educators to improve care and outcomes.

Beyond their impact on quality of life, LUTS may have important public health consequences. People with LUTS tend to be less physically active than those with normal bladder function. Many women describe their

symptoms as a barrier to physical activity and thus a cause of weight gain. Decreased physical activity helps explain the strong association between UI and obesity and diabetes in women. Also, diuretics exacerbate LUTS and may decrease adherence to commonly prescribed cardiovascular medications. In ad-



LEARNING OBJECTIVES

1. Define the problem of lower urinary tract symptoms (LUTS).
2. Describe the treatment of LUTS.
3. Discuss the nurse's role in disseminating information about LUTS.

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dition, in older adults, nocturia and urgency are linked to increased risk for falls and fractures. LUTS also may contribute to social isolation.

Underacknowledged and undertreated

Although treatable, LUTS may go untreated largely because payers, policy makers, and other key healthcare players don't recognize the symptoms, even when individuals present for care. Many people with symptoms don't even seek care, creating another barrier to treatment. Several studies of patients with LUTS across multiple cultures show that no more than one-third seek treatment. Those with multiple symptoms are the most likely to seek treatment, but even among people with three or more symptoms, fewer than one-third seek treatment.

Lack of care-seeking may lead to negative coping behaviors, such as restricting fluids, avoiding physical activity, and not adhering to diuretic medications. Although more pronounced LUTS severity and inconvenience are associated with greater care-seeking, they don't fully explain individual choices to seek or not seek treatment.

Misperceptions about LUTS—such as believing the symptoms are normal, temporary, an unavoidable consequence of aging or childbirth, not a medical problem, or not treatable—are common across diverse countries and cultures. Other barriers to seeking care include embarrassment and certain social determinants of health (such as low socioeconomic status and limited healthcare access).

Despite the high prevalence of LUTS, many sufferers—especially those with UI—experience considerable social stigma. In a study of 150 healthy Austrian adults, most considered UI to be taboo and more embarrassing than depression or cancer. The stigma may stem

Did you know?

- People with lower urinary tract symptoms report low quality-of-life scores similar to those of people with hypertension, diabetes, cancer, and (when severe) myocardial infarction and stroke.
- In a cohort of patients age 60 or older who were hospitalized with a serious illness, more than two-thirds said that having bladder or bowel incontinence would be worse than or on par with dying.

from societal norms around toileting—including punishment for wetting accidents in children and association of LUTS with uncleanness, lack of self-control, childishness, and frailty. (See *Did you know?*)

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Treatment

A positive treatment response is based on reduction of the disruptive symptoms (for example, frequent urination or UI) as well as maintenance or restoration of physical and social activities. First-line treatment for most patients with LUTS includes self-directed behavioral strategies, such as altering the quantity and types of fluids they consume, avoiding acidic and spicy foods, urinating on a schedule (timed voiding) rather than waiting for a strong desire, gradu-

ally increasing the time interval between urinations (bladder training), and strengthening the pelvic-floor muscles (Kegel exercises) to help maintain continence.

When these behavioral strategies aren't adequate, a nurse specialist can provide education, coaching, and enhanced pelvic-floor rehabilitation, which may include biofeedback to improve the patient's ability to contract the correct muscles or electrical stimulation to passively enhance muscle contractions. These behavioral strategies can be effective for management of most LUTS.

In addition to behavioral strategies, and primarily for overactive bladder (OAB) syndrome (urgency with or without urgency incontinence, usually with frequency and nocturia), antimuscarinic medications are prescribed. Also for treatment of OAB syndrome, posterior tibial nerve stimulation can be performed in the provider's office. In postmenopausal women, topical estrogens are commonly used to treat LUTS associated with genitourinary syndrome of menopause.

For patients who haven't met their treatment goals with behavioral strategies and medications, in-office intravesical injection of botulinum toxin A is an option. Also, sacral neuromodulation can be used to treat refractory OAB syndrome.

Outpatient surgical options for treating stress UI (leakage with coughing, sneezing, bending, lifting), such as a urethral sling, can restore support to and compress the urethra.

While the goal of all LUTS treatments is to resolve the problem, this may not be realistic given the multiple causes and contributing factors. Realistic expectations on the part of the patient, family, and provider are important. For example, although a provider would hope to clinically resolve a patient's problem, the patient and her family might be pleased that simply by wearing a

CASE STUDY: Nursing actions aid a patient with bladder problems

Johanna Jones, age 53, presents for a routine follow-up visit to her primary care provider. Married with three children, she states that she drinks about 8 ounces of wine every 2 weeks and doesn't smoke. She has a family history of type 2 diabetes, and her father died from a stroke at age 71. Ms. Jones has poorly controlled hypertension, with a blood pressure of 161/92 mm Hg, and her body mass index of 31.4 indicates obesity. Her laboratory test results are unremarkable except for an elevated glycated hemoglobin of 9.2%.

At previous visits, Ms. Jones was counseled on the need to lose weight and follow the Dietary Approaches to Stop Hypertension (DASH) diet. The physician suggested that taking her medications (metformin 850 mg/day, lisinopril 10 mg/day, and chlorthalidone 25 mg/day) first thing in the morning might help her remember to take them. Today, because Ms. Jones' hypertension remains uncontrolled, the physician increases her lisinopril dosage to 20 mg/day.

The nurse, Alice Monroe, asks Ms. Jones whether she's taking her medications as prescribed. She reminds her that taking them every day will help control her blood pressure, which in turn may prevent heart and blood vessel complications. Alice also cautions her not to increase dosages on her own because doing so could lead to side effects.

Knowing Ms. Jones is a teacher, Alice asks how she handles bathroom breaks and if her school schedule interferes with taking her medications. Ms. Jones tells Alice that sometimes she has a sudden, strong need to urinate and accidentally leaks urine. She says she's nervous about leaking in front of her students and complains that taking the pills in the morning makes holding her urine in the classroom harder. A few times, she has even had to leave her students unattended to dash to the bathroom. She tells Alice that because she

wasn't sure which pill made her leak, she has stopped taking all of her pills.

Alice thanks Ms. Jones for her honesty and explains that leaking urine is common. She explains that they can work with the physician to find alternative medications to help reduce leakage. She also tells her she may be able to reduce her symptoms with behavior changes and—if needed—certain medications. She gives Ms. Jones information on pelvic-floor muscle (Kegel) exercises and refers her to a continence program at the YMCA.

Alice works with the physician to provide Ms. Jones with a referral to a local urologist to discuss additional treatment options. She gives Ms. Jones a bladder diary, which she found online from the National Institute of Diabetes and Digestive and Kidney Diseases, to take with her to her urologist appointment.

Alice flags Ms. Jones' poor medication adherence for the prescribing physician, who cancels the order to increase lisinopril. She tells Ms. Jones that taking her chlorthalidone when she returns home from school rather than in the morning is fine.

Consistent use of chlorthalidone in the late afternoon combined with lisinopril 10 mg/day adequately controls Ms. Jones' blood pressure. Although she now has to get up at least once a night to urinate, she falls back to sleep easily. In addition, Ms. Jones is learning to use her stronger pelvic-floor muscles to suppress urgency when it occurs. And while she hasn't had to leave her classroom unattended, Ms. Jones still worries about leaking and plans to discuss a medication trial for overactive bladder with the urologist at her next appointment.

(Note: Names in this case study are fictitious.)

pad, she's gained the confidence to enjoy socializing again.

Nurse's role

Over the past two decades, significant efforts have been made to increase LUTS management in the primary care setting. However, the need to manage chronic conditions, such as hypertension, coronary disease, and diabetes in short appointment times leaves no time to identify and manage LUTS, especially when patients may be too embarrassed to admit they have bladder problems.

As a nurse, you can help fill this gap in care by remaining sensitive to and vigilant for potential bladder problems in patients, providing a comfortable environment for them to acknowledge their symp-

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toms, and encouraging them to seek treatment. Letting patients know there are treatment options that don't involve medications or surgery can be helpful. The holistic perspective of nursing practice can help nurses recognize a bladder

problem that's limiting a patient's physical or social activities or medication compliance. (See *Case study: Nursing actions aid a patient with bladder problems.*)

Educate patients about ways to reduce LUTS, including pelvic-floor muscle training for UI, timed voiding to reduce urgency, and limited fluids before bedtime to decrease nocturia. Also encourage them to discuss their symptoms with their primary care provider or a urology specialist and help them advocate on their own behalf.

Community-level intervention

Reaching patients with LUTS may require public health interventions at the community level. Local, interpersonal networks—including faith organizations, barber shops,

yoga studios, and other community-based settings—provide a unique opportunity to overcome barriers to seeking treatment. Such networks help normalize LUTS as a common health issue, correct misperceptions by disseminating evidence-based information, and reduce social stigma.

Participation in faith organizations has been linked to improved health. Such organizations increase resilience within communities and may reduce mistrust of the healthcare system. Implementing community-based public health interventions can be challenging, but when well researched and planned, these interventions are effective in addressing stigma and are especially important for populations with poor access to health care.

Efforts to bring LUTS information to the community include those by health ministers. This largely untapped resource has been the focus of recent efforts by the Department of Health and Human Services' (HHS) Center for Faith-based and Neighborhood Partnerships (Partnership Center) to raise awareness about important health issues. In partnership with the Wesley Theological Seminary in Washington, DC, and several other federal health agencies, the HHS Partnership Center is developing a series of educational documents on a variety of healthcare issues. These health minister guides (including one on bladder health) will fill a void in community health and seminary education. By educating and equipping health ministers—including ordained, certified, and lay health ministers—HHS is building a cadre of public health workers. (See *What's a health minister?*)

Nurses in the community

Through organizations like Chi Eta Phi Sorority and One Nurse At A Time, nurses have a long tradition of engaging with their communities to promote public health. The

What's a health minister?

Depending on the setting, a health minister can be someone who's recognized within a faith institution as a faith-based health advocate and educator or, as defined by the Health and Human Services' Partnership Center, "someone dedicated to and/or engaged in improving the public health within their community." A health minister can be anyone from a healthcare professional, barber, or stay-at-home parent to a faith leader, lay clergy, yoga instructor, lawyer, social worker, nutritionist, or accountant.

Whatever their background, all health ministers share a deep and direct connection to their community. As first responders and vital actors in an integrated, prevention-focused healthcare delivery system, they assist community members by:

- promoting health knowledge and behaviors
- helping members know when and where to seek care
- maintaining the community's understanding of health—the community healthview
- reaching vulnerable, underserved populations, especially in communities with high medical mistrust
- serving as trusted resources and messengers
- accompanying members to medical appointments
- hosting support groups
- conducting interactive health education presentations
- planning or participating in health fairs
- supporting advocacy efforts.

Health ministries in faith communities

Many faith communities have or are developing organized health ministries that take a holistic approach, integrating physical and mental health with emotional, social, and spiritual considerations. Reflecting the faith community and its members, effective health ministries meet regularly to discuss and plan activities and services that benefit the congregation as well as the community. They also connect members with appropriate health resources and medical care.

community-based role of nursing is exemplified by the emergence and growth of the faith community nurse, a licensed RN who engages in personal, communal, and multi-sector faith and health interactions. (See *Understanding faith community nursing*.)

As respected sources of health information, all nurses can play a role in increasing LUTS awareness by emphasizing it at local public health events, such as community health fairs, organized health ministries trainings, and local community centers. You also can advocate for making safe, clean, and accessible bathrooms available in community spaces. And in your day-to-day life, you have opportunities to identify bladder problems in members of your community by staying

alert for potential signs of bladder dysfunction, such as avoidance of physical activity or withdrawal from regular community events.

It takes a community

To help achieve optimal care for patients with LUTS, you can enhance your own and your patients' awareness of the problem, work for greater recognition of LUTS within the health system, provide patient education, and reduce stigma at the community level. Through both clinical and community roles, nurses have the opportunity to improve LUTS awareness, education, and outcomes. ★

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Understanding faith community nursing

Since the late 1990s, the American Nurses Association (ANA) has worked with the Health Ministries Association to develop the scope and standards of practice for faith community nurses. In 2014, ANA approved an RN certification program for faith community nurses, which allows active licensed RNs who meet eligibility criteria to obtain a specialty practice certificate by submitting a portfolio that contains evidence of their expertise. The portfolio is peer-reviewed by board certified faith community nurses and evaluated across four domains: professional development, professional and ethical practice, teamwork and collaboration, and quality and safety. Those who meet eligibility requirements and successfully pass the portfolio review process receive the credential Registered Nurse-Board Certified (RN-BC). For more information about certification, visit <http://nursecredentialing.org/FaithCommunityNursing>.

With the increased focus on population-based care and community-based healthcare management, the faith community nurse role represents a promising new professional practice for helping patients maintain optimal health and providing cost-effective care and support. Faith community nurses support patients and communities in various settings, including faith communities, healthcare systems, interfaith alliances, nonprofit organizations, and public health organizations. For patients with lower urinary tract symptoms, faith community nurses can serve as specialized health ministers, bringing bladder health messages that raise awareness, increase knowledge, and reduce stigma.

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Please mark the correct answer online.**1. Which statement about the effects of lower urinary tract symptoms (LUTS) is correct?**

- In many women, the symptoms lead to weight loss.
- In many women, the symptoms lead to weight gain.
- Physical activity is higher among those with LUTS.
- Diuretics do not exacerbate the problem of LUTS.

2. Among those with LUTS,

- more than 80% seek treatment.
- more than 70% seek treatment.
- no more than one-quarter seek treatment.
- no more than one-third seek treatment.

3. Which statement about the psychological effects of LUTS is correct?

- In a study of patients age 60 and older who were hospitalized with a serious illness, 20% said that having bladder or bowel incontinence would be worse than or on par with dying.
- In a study of patients age 60 and older who were hospitalized with a serious illness, 40% said that having bladder or bowel incontinence would be worse than or on par with dying.
- People with LUTS report quality-of-life scores similar to those of people with hypertension, diabetes, cancer, and stroke.
- People with LUTS report quality-of-life scores higher than those of people with hypertension, diabetes, cancer, and stroke.

4. All of the following are barriers to seeking help for LUTS except

- belief that the condition is an unavoidable consequence of childbirth.
- belief that the condition is an unavoidable consequence of aging.
- limited healthcare access.
- high socioeconomic status.

5. Not seeking help for LUTS can cause patients to

- drink too many fluids.
- not adhere to diuretics.
- increase physical activity.
- reduce their food intake.

6. Which of the following is a self-directed behavioral strategy for managing LUTS?

- Increasing intake of acidic foods
- Increasing intake of spicy foods
- Urinating on a schedule (timed voiding)
- Shortening the time between urination

7. In addition to behavioral strategies, initial treatment of overactive bladder (OAB) syndrome includes

- posterior tibial nerve stimulation.
- anterior tibial nerve stimulation
- muscarinic medications.
- oral estrogen medication.

8. Treatment of refractory OAB syndrome includes

- topical androgens.
- topical estrogens.
- lumbar neuromodulation.
- sacral neuromodulation.

9. Patient education for patients with LUTS may include all of the following except

- pelvic-floor muscle training.
- increasing fluids at bedtime.
- explaining treatment options.
- explaining that LUTS is common.

10. Which statement about health ministers is correct?

- They work to improve the public health in their community.
- They avoid hosting support groups in the community.
- They function independently of faith communities.
- They need to have a health professional background.

11. Which statement about certification of faith community nurses is correct?

- Nurses must take a test to become certified in the specialty.
- There is currently no certification program for the specialty.
- The American Nurses Association has an RN certification program for the specialty.
- Health and Human Services has an RN certification program.

CASE STUDY: Helping a patient with LUTS in the community

Roberta Davis, age 76, has nocturia and urgency urinary incontinence (UI). She believes her symptoms were inevitable: Her mother and grandmother both leaked urine, and she has given birth to four children.

Even though Ms. Davis is embarrassed and bothered by her symptoms, she doubts anything can be done, so she hasn't mentioned them to her primary care provider. For years, she has dealt with nightly sleep interruptions by taking naps during the day, and she wears sanitary pads to protect her clothes and furniture from urine leaks. She has also severely limited her fluid intake, even though she often feels thirsty. In addition, she has gradually cut back on social activities for fear of having an accident in public where people might smell her soiled pads. The only activity she has continued is attending church every Sunday.

Recently, however, Ms. Davis's symptoms have worsened. She frequently wets herself during the Sunday service, and she's convinced people notice the smell. She reluctantly decides to skip the service one week, and then the next, and then the next.

Fortunately, Fiona Parker, a nurse who attends the same church, notices Ms. Davis's absence. Concerned about her health, Fiona calls her. She asks Ms. Davis if any health issues are keeping her from church, sharing the story of a friend who avoided social functions because of bladder problems. Ms. Davis reveals her history of nocturia and UI. Fiona tells her these bladder problems are common and treatable. She helps her schedule an appointment with her primary care provider and works with her to develop a list of questions and concerns. She also gives her information on bladder health and pelvic-floor muscle training and invites her to attend a bladder health support group she's hosting at the church.

After reading through the materials, Ms. Davis realizes that her fluid restriction has only made things worse. Dehydration caused constipation and gave her urine a stronger odor. By gradually increasing her water intake and working with timed voiding, bladder training, and pelvic-floor muscle exercises, she notices gradual improvement over several weeks and is able to comfortably attend church services.

(Note: Names in this case study are fictitious.)