

Letters to the Editor

NICE guidelines on urinary incontinence in women

SIR—We read with great interest the recent NICE guidelines on the important problem of urinary incontinence (UI) in women [1], which has a large impact on frail older people. In general nursing homes UI has been found to have a prevalence 70%, and this rises to 84% of institutionalised demented people [2, 3]. However, despite these data, we feel that this guideline is more aimed towards younger women without significant co-morbidities. The multi-factorial nature (e.g. immobility, polypharmacy and cognitive impairment) of UI in older people coupled with difficulties in assessment of this population group makes this problem harder to evaluate.

The guidance suggests the use of the Abbreviated Mental Test and Mini-Mental State Examination to assess cognitive functions in those over 75 or with reasons to suspect an abnormality. Both of these have been shown to be reasonable screening tests for cognitive impairment, but it should be remembered that they are poor at assessing frontal lobe and non-dominant parietal functions. Impairments here may be particularly important to getting to the toilet, sequencing events and motor control of the bladder (e.g. UI following anterior cerebral artery infarction). Trials that have recruited older patients have tended to exclude those with cognitive impairment [4–6], and evidence for efficacy of interventions among patients with dementia is limited [3].

The urge subtype of UI has been found to be the most common form in the institutionalised elderly [7]. The guidance recommends bladder retraining as the first-line intervention for this form of incontinence. The occurrence of cognitive problems will clearly make patient cooperation with this difficult and, therefore, potentially ineffective. The second-line strategy of anticholinergic medications may also cause problems. Trials of these drugs often report only dry mouth and blurred vision as significant side effects but they are usually of short duration and lack any formal cognitive follow-up [6, 8]. Anticholinergic medications have been associated with cognitive deterioration and delirium in elderly patients, particularly those with baseline cognitive impairment [9–15]. They may also provoke orthostatic hypotension, thereby increasing the risk of falls. We believe there are subgroups of the elderly in whom these medications should be avoided altogether and those in whom they are commenced should be carefully monitored for the development of cognitive impairment and symptoms of orthostatic hypotension.

Also, the guidance does not cover overflow incontinence, which in the elderly may be due to non-neurological causes such as faecal impaction. Nor does it cover the management of functional incontinence provoked by environmental or mobility issues. Clearly there are limits to the feasible extent of

any review, but we feel that this should be reflected in the title of the guidance (and therefore its intended scope)—perhaps a more fitting title would have been ‘Urinary incontinence: the management of urge, stress and mixed types of urinary incontinence in women without significant co-morbidities.’ In summary, the guidance represents an excellent guide to the assessment and management of some forms of UI occurring in some subgroups of women. It does not appear to represent the needs of all women with UI, especially the frail elderly.

We have written formally to NICE, and their response is that they had to keep within very narrow confines for their review and that clinicians should assess the needs each patient prior to commencing any therapy. We believe that to be clinically relevant more attention should have been given to frail older people as they are the largest patient group affected.

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Impaired glucose tolerance and the risk of ischaemic stroke: another focus

SIR—We applaud Kaarisalo *et al.* in their efforts to link the risk of impaired glucose tolerance (IGT) with the increased likelihood of ischaemic stroke [1]. Their study demonstrates that statistically significant risk factors for stroke in elderly people are previous transient cerebral ischaemic attacks (TIA) or stroke, diabetes mellitus (DM) and atrial fibrillation (AF). However, strokes tended to happen more often in the IGT group than in the normal group, but the difference was not statistically significant [1]. This has particular inference from a cardiovascular perspective, given the role of deranged glucose metabolism and the risk of new-onset AF [2, 3].

Indeed, previous reports have demonstrated that high glucose levels had a positive significant association with the risk of AF. Nearly a decade ago, Psaty *et al.*, using step-wise models, demonstrated that high glucose levels were associated with AF [2]. Of note, the Framingham study found that DM was a significant independent risk factor for AF with an Odds Ratio of 1.4 and *levels of blood glucose* were more important predictors than the diagnoses of DM [2]. More recently, in a large-scale study involving a far larger number of patients over a long duration of 10 years, Movahed *et al.* [2] showed that AF occurred in 43,674, (14.9%) patients with DM versus 57,077, (10.3%) in the control group ($P < 0.0001$). Atrial flutter occurred in 11,852, (4%) patients with DM versus 13,554, (2.5%) of the control group ($P < 0.0001$) and using multi-variant analysis, DM remained independently associated with AF with an OR = 2.13, (95% CI: 2.10–2.16; $P < 0.0001$) and atrial flutter (OR = 2.20, 95% CI: 2.15–2.26; $P < 0.0001$). The fluctuating level of glycaemic control may be a putative association, if we take into consideration the perspectives on epidemiological and pathophysiological links between DM and AF [3].

We should not forget that the pathophysiology of complications in the setting of DM is multifactorial, and in addition to the high coexistence of ‘conventional’ cardiovascular risk factors (such as hypertension, dyslipidaemia and

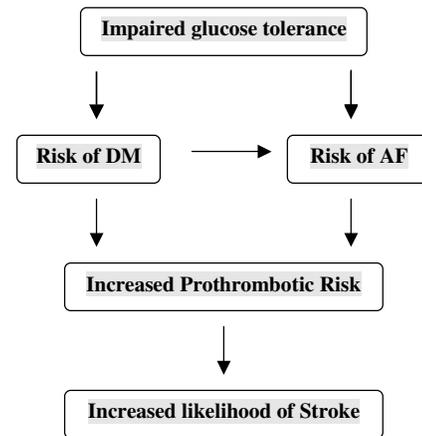


Figure 1. The association between impaired glucose tolerance, diabetes mellitus (DM), atrial fibrillation (AF), the prothrombotic risk and stroke.

obesity) in patients with DM, there are other processes such as urine albumin excretion, endothelial damage/dysfunction, and chronic inflammation which are implicated [4]. These are closely inter-related processes that develop in parallel, progress with time, and are strongly and independently associated with the risk of death in a background of deranged glycaemic control [4]. Interestingly, the prothrombotic risk of DM in the setting of AF (Figure 1) has been demonstrated to be of significant relevance lately, and DM has been found to independently contribute to the endothelial damage/dysfunction seen in patients with AF [5]. The presence of DM as an additive risk factor for endothelial damage/dysfunction may reflect the increased prothrombotic and vascular risk seen in this high-risk population [1, 5], hence IGT will undoubtedly and invariably be pertinent in the context of risk factors for stroke.

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