4.5 Continence

Loss of bladder and bowel control is common in the acute phase of stroke and may persist. Incontinence of urine greatly increases the risk of skin breakdown and pressure ulceration. Incontinence of faeces is associated with more severe stroke and is more difficult to manage. Constipation is common, occurring in 55% of people within the first month of stroke, and can compound urinary and faecal incontinence.

Incontinence has a detrimental effect on mood, confidence, self-image and participation in rehabilitation and is associated with carer stress. Incontinence is an area of stroke that has received little research interest, despite its substantial negative impact. It needs to be managed proactively to allow people with stroke to fully participate in their own care and recovery both in the acute phase and beyond e.g. people with mental capacity (Section 4.8) should be involved in decisions around the use of catheters and sheaths.

Evidence to recommendations

A 2013 review of bowel management strategies (Lim and Childs, 2013) identified three small studies of varying quality, and concluded that the evidence was limited but a structured nurse-led approach may be effective. In a review of therapeutic education for people with stroke, Daviet et al (2012) concluded from small non-randomised studies that a nurse-targeted education programme may improve longer term continence. A small RCT by Moon et al (2012) provided no evidence for bladder reconditioning with intermittent clamping. A small study by Guo et al (2014) examined the use of transcutaneous electrical nerve stimulation for the treatment of urinary incontinence over six months and found an improvement in nocturia, urgency and frequency. Thomas et al (2015) demonstrated the feasibility of a cluster RCT of a systematic voiding programme for urinary incontinence and proposed a definitive trial. Recommendations are therefore largely based on NICE guidance and Working Party consensus.

4.5.1 Recommendations

A Stroke unit staff should be trained in the use of standardised assessment and management protocols for urinary and faecal incontinence and constipation in people with stroke.

B People with stroke should not have an indwelling (urethral) catheter inserted unless indicated to relieve urinary retention or when fluid balance is critical.

C People with stroke who have continued loss of bladder and/or bowel control 2 weeks after onset should be reassessed to identify the cause of incontinence, and be involved in deriving a treatment plan (with their family/carers if appropriate). The treatment plan should include:

- treatment of any identified cause of incontinence;
- training for the person with stroke and/or their family/carers in the management of incontinence;
- referral for specialist treatments and behavioural adaptations if the person is able to participate;
- adequate arrangements for the continued supply of continence aids and services.

D People with stroke with continued loss of urinary continence should be offered behavioural interventions and adaptations such as:

- timed toileting;
- prompted voiding;
- review of caffeine intake;
- bladder retraining;
- pelvic floor exercises;
- external equipment

prior to considering pharmaceutical and long-term catheter options.

E People with stroke with constipation should be offered:

- advice on diet, fluid intake and exercise;
- a regulated routine of toileting;

- a prescribed drug review to minimise use of constipating drugs;
- oral laxatives;
- a structured bowel management programme which includes nurse-led bowel care interventions;
- education and information for the person with stroke and their family/carers;
- rectal laxatives if severe problems persist.

F People with continued continence problems on transfer of care from hospital should receive follow-up with specialist continence services in the community.

4.5.2 Sources

A,B Working Party consensus

C Thomas et al, 2008; Working Party consensus

D NICE, 2013c, 2015

E NICE, 2007b; Coggrave et al, 2006; Working Party consensus

F Working Party consensus