



# Best Practice

Identifying  
and Managing  
Male Continence  
Problems

**Nursing  
Times**

OCTOBER 2019

Published by Nursing Times  
Funded by an unrestricted  
educational grant from Essity

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## Best Practice: Identifying and Managing Male Continence Problems

OCTOBER  
2019

A NURSING TIMES  
SUPPLEMENT  
VOL 115 | ISSUE 10

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### Published by

*Nursing Times*  
Emap Publishing Ltd  
4th Floor, Telephone House  
69-77 Paul Street  
London EC2A 4NQ  
© Emap Publishing Ltd 2019

**Nursing  
Times**

Development of this document was funded by an unrestricted educational grant from Essity



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This version of the Document was Endorsed by ACA in  
September 2019

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### How to cite this document

*Nursing Times* (2019) Best Practice: Identifying and Managing Male Continence Problems. *Nursing Times* (supplement); 115: 10.

Available to download from [nursingtimes.net/continence](http://nursingtimes.net/continence)



# ‘We need to understand the male experience of incontinence’

Healthcare is complex, dynamic and infused with deep-rooted behaviours, cultures and politics – and it is continually changing. For that change to be truly meaningful and striving for the better, it must include a passion for learning (Braithwaite, 2018). In the context of continence care, learning and curiosity are essential factors; meeting the needs of both male and female patients can be challenging, especially when incontinence is viewed, predominantly, as a problem in females. Furthermore, individual characteristics, social circumstances and health beliefs are key influencing factors, affecting quality of life (Llewellyn et al, 2019).

We should not assume that continence care policy and clinical guidance is currently adequate for the male population; advancing this debate is the inaugural men’s health strategy by the World Health Organization in Europe (Baker, 2019). The strategy has five broad intentions, one of which is to make “health systems gender responsive; for example, by understanding men’s health needs and patterns of health-seeking behaviour, addressing men’s health challenges, improving health services delivery and reaching out to men”. It provides additional leverage to tackle male incontinence.

Compared with female incontinence, male incontinence has received little attention. Female incontinence dominates the socio-cultural context; it is now time to increase attention on, and understanding of, male incontinence. Studies comparing the prevalence of urinary incontinence in men and women generally find that it is three times more common in women than in men (Milsom and Gyhagen, 2019); however, prevalence studies may need to be viewed with caution, as underreporting by men may go some way to explaining the differences.

It is important to bear in mind that men experience incontinence differently to women (Esparza et al, 2018), so research is needed to establish the causes of, and solutions to, male incontinence. For example, an interesting

quasi-experimental study investigated the characteristics and risk factors associated with male incontinence, assessing the impact of pelvic floor muscle training: 61 men were treated with physiotherapy, which was shown to improve symptoms. One key finding was that incontinence was significantly associated with urological and abdominal surgery (Fernández-Cuadros et al, 2016).

Changes in healthcare provision, clinical curiosity to learn about lower-profile topics such as male incontinence, and the importance of ensuring healthcare is evidence based should drive the quest for credible information on which to base clinical practice. This supplement provides an impressive compilation of current thinking, information and recommendations on male incontinence upon which healthcare providers can draw. Part 1 highlights why incontinence is a hidden problem in men and boys; Part 2 explains what good continence care should look like for men and boys, and Part 3 advises what nurses can do to improve male continence care. Each part provides examples of good practice to help individualise clinical care, shape our local practice and drive better standards for all, and each one is accompanied by a case study highlighting the effect of continence problems on males across the age spectrum.

Drivers for better standards – such as NHS England’s (2018) *Excellence in Continence Care* and the many preceding national documents – aim to build profile, principles and productivity to advance continence care. Fundamentally, any recommendations from these documents must reach those who actually deliver care. The male population deserves to see its own continence potential achieved. We applaud and embrace individuality in our society and, as such, focusing on male incontinence is a logical step to help boys, adolescents and men. **NT**

*Sharon Eustice, nurse consultant, Bladder and Bowel Specialist Service, Cornwall Partnership NHS Foundation Trust*

“We should not assume that continence care policy and clinical guidance is currently adequate for the male population”

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# Coping with continence problems as a teenager

Jamie Gane\* is 25. As a teenager, he had complex regional pain syndrome in his foot, confining him to a wheelchair. At 15, he developed bowel and bladder incontinence after spinal surgery. He eventually had his leg amputated and now uses a prosthetic limb. Mr Gane is now an inspirational speaker and para-athlete, competing in martial arts and various endurance races, which include mud and water obstacles.

\*The patient's name and image has been used, with his permission



*“It felt like a really horrible and dirty secret and, on a practical level, it was very difficult”*

“When I first noticed my bowel and bladder problems I kept it to myself as I didn’t understand what was going on. No one had explained this might happen. I had a catheter after surgery and I assumed it’s what happens when the catheter is first taken out. But, after a few weeks, I thought ‘maybe this isn’t right’. I asked a friend’s mother, who was a nurse, and she suggested some products I could buy.

“I was too embarrassed to tell my parents or talk to the specialist with my mother present, and none of the health professionals asked me if I had toileting problems. It felt like a really horrible and dirty secret and, on a practical level, was very difficult. I managed to hide it with products from the pharmacy that I’d hidden in my bag at school, but it was stressful – and expensive.

“Before my amputation, I was in and out of hospital. I ended up taking in my own products and avoided telling the nurses – I was tired of having to repeat the whole story, and staff trying to put me into the hospital routine. Once, I did find a nurse to confide in, and suddenly the whole team knew. There was a lack of sensitivity. Some of the comments from staff were terrible – one healthcare assistant said: ‘So you are basically telling me you \*\*\*\* yourself’. Another said: ‘You’re too young to have continence problems’.

“It wasn’t until university, when I was really broke, that I decided to tell my doctors and was referred to a specialist continence service. The nurses were reluctant to help at first and asked me why I hadn’t sought help sooner. They assumed I was still struggling to come to terms with it – but I was 19 years old and had been dealing with it for four years. I had worked out my own man-

agement plan and was doing fine. I had even told my university friends, which was a huge relief. I just wanted some financial help.

“They started me on the smallest pads, but I am an active person and drink about 4L of water a day so I wanted a pad large enough not to have to worry. They didn’t listen, so I had to supplement them with pads of my own. They gradually moved me to bigger pads, but it was months before I received products that worked. It was a tick-box approach.

“I’m now with a different continence service. It was easy to transition as I had been medically assessed. I told them what I was using and they got me the equivalent products. Right now, I’m really happy with the programme I’m on. I’m self-sufficient and proud that I figured out how to manage my incontinence myself – but for a lot of young people that would be way too much.” **NT**

## Learning points

- Young men may be reluctant to divulge information about their health, especially sensitive problems such as incontinence. Nurses and other staff need to ask the right trigger questions as part of a holistic assessment, and know how to act on that information
- All healthcare staff should be made aware that continence problems are not confined to women and older people, and that young men may have problems; they should also know how to communicate about such issues sensitively and appropriately
- Explaining all the options and trying to meet young people’s preferences for managing their incontinence is important; when their preferences cannot be met, it is crucial to explain why and find the most acceptable alternative
- Professionals should discuss potential complications following spinal surgery with patients pre- and post-operatively to make sure they are aware of the risks and possible consequences

# How incontinence affects men and why it is a hidden problem

## Key points

**Incontinence is thought of as a female problem, with the risk that male needs are neglected**

**Male incontinence is rising because of an ageing population: one in three older men experience bladder problems and 12% have faecal incontinence**

**Incontinence can also affect boys, adolescent males and younger men, but this is frequently overlooked**

**Males at all stages of life can experience barriers to accessing high-quality continence care, but research on this is lacking**

**Services need to take gender differences into account to ensure both males and females receive good-quality continence care**

**Abstract** Incontinence is generally thought of as a female problem, but it can affect males of all ages. One in three older men have bladder problems and 10-15% of men treated for prostate cancer experience persistent urinary incontinence. Incontinence can also affect boys, adolescent males and younger men, but this is less well recognised. Males of all ages can experience barriers to accessing high-quality continence services, but these have not been adequately explored. More research is required, and services need to take gender differences into account to ensure appropriate male and female continence care is delivered.

**Citation** *Nursing Times* (2019) How incontinence affects men and why it is a hidden problem. *Nursing Times* (Best Practice: Identifying and Managing Male Incontinence Problems, supplement); 115: 10, 5-7.

Bladder and bowel problems are common and can affect males and females of all ages, with profoundly negative consequences (Box 1). However, incontinence is widely seen as a female problem, and there is a risk that male continence needs are neglected (Stenzelius, 2005; Perry et al, 2002). There is far less guidance and research focusing on male continence problems than on female continence problems (Tikkinen et al, 2013), even though male incontinence is relatively common, burdensome and strongly age related (Victor, 2001; Perry et al, 2000). An ageing population means male incontinence is likely to increase, and this increase needs further examination.

## The extent of the problem

An estimated 14 million people in the UK live with bladder problems and 6.5 million have a bowel-control problem; an estimated 900,000 children and young people are also affected (NHS England, 2018). One in three people in residential care, and two in three in nursing homes, experience bowel and bladder incontinence (NHS England, 2018). There is a lack of awareness among health professionals that urinary incontinence is not a normal part of ageing and can be treated (Vethanayagam et al, 2017).

## Urinary incontinence

### Prevalence

Urinary incontinence affects about half as many men as women, but differences in prevalence become less marked in the

older age groups because male incontinence is more strongly age-related (Victor, 2001; Perry et al, 2000). One in three older men experience bladder problems (Buckley and Lapitan, 2010), but boys, adolescent males and younger men can also be affected (Box 2).

A systematic review found a steady rise in the prevalence of male incontinence, from 5% in younger men (19-44 years) and 11% in 45-64-year-olds, rising to 21% in older men (over 65); 8.3-9.3% of men aged >65 years experienced daily incontinence, and in 4% symptoms were severe (Shamliyan, 2009). Prevalence studies identify that ethnicity is also a factor – for instance, a US-wide survey found prevalence of urinary continence was 21% in African American men compared with 17% in white men (Anger et al, 2006); however, the reason for an ethnic predisposition is unclear.

## Causes and types of urinary incontinence

A report by the International Continence Society (ICS) defines male urinary incontinence as “involuntary loss of urine experienced during the bladder storage phase” and provides an updated description of the most common types, as “an aid to clinical practice and a stimulus for research” (D’Ancona et al, 2019).

While stress urinary incontinence is more common in women, relating to childbirth and the menopause, men are increasingly likely to experience bladder problems as they age due to prostate gland enlargement. In one review, urgency

## Best practice

# Male continence

### Box 1. The impact of incontinence

Incontinence can have a profoundly negative effect on quality of life but, often, it is preventable or can be cured or greatly improved. It is an important factor in hospital and residential care admissions; poorly managed incontinence contributes to ill health, falls and fractures, severe infections, pressure ulcers and even deaths – particularly in older people and those who are disabled (NHS England, 2018; John et al, 2016; All-Party Parliamentary Group for Continence Care, 2013). Dementia and lack of mobility in older people increase the likelihood of incontinence by preventing them getting to the toilet (Leung and Schnelle, 2008; Case study, page 12).

Incontinence impairs psychological and emotional wellbeing, and is linked with high rates of anxiety and depression; it also affects daily activities, sexual function and work productivity (Rigby, 2014). Males with urinary incontinence can experience a decline in sexual desire and an increase in erectile and orgasm difficulties, and other sexual problems (Lee et al, 2018).

### Glossary

#### Anorectal dysfunction

Involuntary loss of flatus or faeces

#### Faecal incontinence

Involuntary loss of liquid or solid faeces

#### Mixed urinary incontinence

Presence of stress and urgency (urge) urinary incontinence

#### Lower urinary tract symptoms

Symptoms related to the lower urinary tract that may originate from the bladder, prostate, urethra, and/or adjacent pelvic floor or pelvic organs

#### Stress urinary incontinence

Involuntary loss of urine on effort or physical exertion, including sporting activities, or on sneezing or coughing

#### Urgency

Sudden, compelling desire to pass urine, which is difficult to defer

#### Urgency urinary incontinence

Complaint of involuntary loss of urine associated with urgency

#### Urinary incontinence

Involuntary loss of urine experienced during the bladder storage phase

Source: Adapted from D'Ancona et al (2019)

(urge) incontinence was the prominent symptom in men (40-80%); this was followed by mixed urinary incontinence (10-30%), while stress urinary incontinence on its own accounted for <10%. Stress urinary incontinence was associated with prostate surgery, trauma or neurological injury (Victor, 2001).

Although severe incontinence in men aged 70-80 years was half that in women, urgency incontinence was often considerably more bothersome to patients than similar degrees of stress urinary incontinence. Another study found 20% of older men had “unpredictable incontinence” compared with 16% of older women (Stoddart et al, 2001).

Around 10-15% of men experience persistent urinary incontinence after prostate cancer surgery (Macaulay et al, 2015). Lower urinary tract (LUT) problems also make urinary incontinence more likely, with 30% of men aged >65 reporting “bothersome LUTs” (National Institute for Health and Care Excellence, 2010). Other risk factors are listed in Box 3.

### Faecal incontinence

The ICS defines male anorectal dysfunction as a “complaint of involuntary loss of flatus or faeces” (D'Ancona et al, 2019). It is estimated that one in 10 adults are affected



**8.3-9.3%**  
Men aged >65  
who experience  
incontinence  
daily

by faecal incontinence and in 0.5-1.0% of people this regularly affects quality of life (NICE, 2014). Prevalence increases with age. A Swedish literature review of people aged >75 in the community found male prevalence was 3.7-11.6% and 3.7-17.8% in

women; prevalence among all people in nursing homes was 45% (Stenzelius, 2005). Nearly two-thirds of people with faecal incontinence also have urinary incontinence (double incontinence), although the management of these two symptoms is often distinct (NICE, 2014).

Risk factors are similar to those for urinary continence (Box 3), but may also include: chronic constipation or diarrhoea; or muscle injury/weakness/nerve damage to the anus, pelvic floor or rectum (NICE, 2014). One study found that anorectal surgery was the most common risk factor in men; faecal incontinence was frequently severe and men took longer than women to seek medical attention (Muñoz-Yagüe et al, 2014). In 40% of men and women, chronic diarrhoea was a predisposing factor and, in both sexes, response to treatment for faecal incontinence was good. Evaluation and treatment of faecal incontinence has been shown to improve symptoms in more than half of men (Christoforidis et al, 2011).

### Box 2. Incontinence in children and young people

One in 10 children and young people in the UK experience bowel and bladder problems (NHS England, 2018), but there is a lack of information about it in boys, adolescent males and young men. Urinary incontinence affects 2-3% of teenagers and 1.15% experience soiling (Whale et al, 2018). Incontinence is among the most common long-term condition of childhood, and its impact on quality of life is comparable to conditions such as asthma and epilepsy (Bachmann et al, 2009). However, the mistaken belief that problems are likely to resolve with age, and the associated stigma that leads young people to conceal their problem, often cause delays in seeking treatment (All-Party Parliamentary Group for Continence Care, 2018; Whale, 2016).

Continence problems in young people can negatively affect their social interactions, educational attainment and psychological wellbeing (Whale et al, 2018; Whale, 2016) and, if not tackled in childhood, are more likely to continue into adolescence (Heron et al, 2017). Poor recognition of male incontinence and incontinence in young people makes young males particularly vulnerable. Common barriers encountered by children and young people include:

- A lack of early intervention in diagnosing and treating bladder and bowel conditions in young people
- Regional variation and gaps in specialist children's bladder and bowel services
- Insufficient support in the transition from child to adult services causing young people to disengage from services (APPG, 2018)

**“An ageing population means male incontinence is likely to increase, and this increase needs further examination”**

**Barriers to good continence care**

Many people with incontinence do not seek help due to embarrassment, lack of awareness of treatment options, fear of surgery or because they consider incontinence to be a normal part of ageing (Shaw et al, 2001). There are also professional and service barriers to accessing high-quality continence care (All-Party Parliamentary Group for Continence Care, 2018; Whale et al, 2018; Royal College of Physicians, 2010; Boxes 2 and 4). The case studies on pages 4, 8, and 12 show how males of all ages can experience particular barriers, some of which may be gender related. However, the evidence base is weak, particularly for boys, adolescent males and young men, and it is unclear how these barriers operate.

**Research**

Research in people aged >75 years concluded that men’s continence needs were different from women’s, but more likely to be overlooked as incontinence was seen as a female problem (Stenzelius, 2005). A large community study in Leicestershire found faecal incontinence was “as much of a problem in men as it is in women, while the level of unmet need in this group [men] is high”, and “although women may predominate in specialist clinics, this may

reflect differences in consultation behaviour and referral patterns rather than the actual prevalence of faecal incontinence in the general population” (Perry et al, 2002).

Shamliyan et al (2010) found that only a small proportion (22%) of men with weekly urinary incontinence episodes ever sought medical help, and 40% of treated men reported moderate-to-great frustration with continued leakage. In the US, Fuchs et al (2018) found men often tolerate stress urinary incontinence for over two years before seeking medical help and a third put up with it for five years; symptoms, it was noted, were a common cause of anxiety and depression after prostate cancer treatment.

UK research found South Asian men experienced more urinary problems than white men but were only half as likely to seek help (Taylor et al, 2006). Other studies suggest men are less likely than women to protect themselves against leakage (Stenzelius, 2005; Stoddart et al, 2001), perhaps because of poorer knowledge of, and access to, devices (Stoddart et al, 2001).

Research on conservative management of continence problems, such as pelvic floor muscle training exercises, has focused more on women (Lucas et al, 2015). Pelvic floor exercises help to strengthen the muscles supporting the bladder and bowel. A Cochrane review found “insufficient evidence as to whether or not conservative management [using pelvic floor muscle training] is effective in treating or preventing post-prostatectomy urinary incontinence”, saying “well-designed trials are needed” (Anderson et al, 2015).

**The effect of gender**

Understanding how gender role norms, and other gender-related factors, can affect men’s health, wellbeing and access to healthcare is growing (Queen’s Nursing Institute, 2018). A *Nursing Times* roundtable of health professionals with a special interest in continence, third-sector professionals and patient representatives identified the following barriers:

- Low public awareness of male incontinence, particularly in younger men, and lack of male health-promotion strategies;
- Lack of research on male continence needs and how these can be met;
- Information on bowel/bladder control that is often aimed at females or hard for males to access/engage with;
- Services failing to consider male attitudes, behaviours, needs and preferences;

**Box 4. Adult services**

In 2010 the *National Audit of Continence Care* found many adult services were not providing sufficiently high standards of continence care, particularly for older people (Royal College of Physicians, 2010). Problems included poor service integration, lack of staff training and poor adherence to guidance from the National Institute for Health and Care Excellence.

Continence products were supplied on the basis of cost, rather than clinical and patient need, and patient choice was often limited. Specialist continence nurses were falling in number and many health staff were failing to:

- Ask the right screening questions
- Provide assessment, diagnosis and follow-up, even when incontinence was identified
- Communicate with patients about causes, treatments and goals
- Assess the impact of incontinence on quality of life
- Make care plans and share these with patients

- Lack of staff training and awareness of male continence, and embarrassment among female nurses about raising the issue with men – and young men in particular;
- Staff not asking the right questions or communicating in a way that makes males of all ages feel confident enough to talk about bowel and bladder problems;
- Insufficient signposting to male-orientated support, such as male support groups and health charities;
- Lack of pathways and models of care that recognise male continence needs and health-seeking behaviour patterns for early recognition, assessment and timely intervention.

**Conclusion**

Incontinence is not just a female problem; it also affects males of all ages, particularly older men. Raising professional and public awareness of male continence is a first step towards improving prevention, detection and management. Appreciating gender-related differences will help ensure appropriate management for both sexes, but more information is needed on male continence, particularly in younger age groups. **NT**

**Box 3. Risk factors for male incontinence**

**Urinary incontinence**

- Poor general health
- Comorbidities
- Physical disabilities
- Cognitive impairment
- Stroke
- Urinary tract infections
- Prostate problems
- Diabetes
- Neurological conditions (Shamliyan et al, 2009)

**Faecal incontinence**

- Advancing age and frailty
- Diarrhoea from any cause
- Neurological problems
- Severe cognitive impairment
- Urinary incontinence
- Pelvic organ/and or rectal prolapse
- Colonic resection or anal surgery
- Pelvic radiotherapy
- Perianal soreness, itching or pain
- Learning disabilities (National Institute for Health and Care Excellence, 2014)

# Living with urinary incontinence following prostate surgery

Peter Howard,\* aged 61, developed severe urinary incontinence after having a radical prostatectomy.

The patient's name and image have been changed



*“It feels like I’ve lost two years of my life and I want to make the best of the time I have left”*

“In 2017 I was diagnosed with prostate cancer; within two weeks I’d had my prostate removed. The operation saved my life, but I wasn’t prepared for the massive change in my circumstances once the catheter was removed. I didn’t know I would be left severely incontinent and that I would lose my sex life.

“The incontinence was the worst. The pads I got on the NHS had to be changed every half hour, otherwise they became so wet they fell out. Then I would have urine running down my leg, soaking my tracksuit bottoms. I felt helpless and was scared to go out.

“I was told to do pelvic floor exercises, but it was impossible – that’s when the floodgates opened. Nurses visited my home and suggested catheters, urinary sheaths or penile pouches, but they weren’t any good. I own a taxi business and wanted to keep working. A drainage bag strapped to your leg doesn’t work when you’re driving and tubes can pull out. It might have been different if I was past retirement age like most men I see in the urology clinic, but I’m only 61 and not ready to retire.

“Previously I’d been a regular at my working men’s club and enjoyed weekends away at the football with the lads. I’d also bred and showed dogs. Suddenly I was housebound. I became depressed and started drinking heavily. I felt my life had stopped. I even considered putting my taxi business up for sale. I felt abandoned – I didn’t know where to turn. Then I read on the internet about men’s incontinence pants. I tried them and found I could go three to four hours without changing them. This gave me the confidence to go out and meant I could work. The downside is the NHS won’t fund them. Buying them in bulk costs me over £100 a month, but what can I do? Even now, I’m still afraid to drink much when I’m working and have constant urinary infections.

“I was having blood tests at the hospital every three months and, after nine months, my patience ran out. I lost my head and shouted at the consultant. I was upset no one had told me what to expect. I’m dyslexic, so leaflets aren’t much good. It wouldn’t have stopped me having the operation, but at least I would have been prepared in my head. They kept saying the operation had saved my life, but I wanted to know how they could make my life worth living.

“I have since been referred to another hospital for an operation to help restore my bladder control. I am 22 stone and the surgeon has asked me to lose two stone – I am determined to do it. He also gave me some tablets and I can see an improvement already. It’s only small, but it makes a big difference to me. I’d really like to talk to someone who’s had the operation. I heard about a support group on the radio and hope to attend their next event.

“I’m now driving my cab seven days a week. My wife left me in November and, if I couldn’t work, I would be suicidal. Every Sunday I go to the club with the lads for two or three hours. I drink Bacardi instead of pints – it’s the highlight of my week. All the lads know. It helps to be honest and I’ve discovered I’m not the only one.

“My Dad died of prostate cancer aged 75. The cancer spread to his brain. That’s why I wanted this operation. It feels like I’ve lost two years of my life and I want to make the best of the time I have left.” **NT**

## Learning points

- Men should be offered high-quality information and support before and after prostate cancer surgery to prepare them for possible side-effects, such as incontinence, and give them options for managing those side-effects
- After surgery, men should receive specialist assessment and management that considers their physical, mental and social needs, as well as being supported to self-manage, or being referred to timely specialist help if needed
- Staff should take men’s individual needs, preferences and circumstances into account when helping them manage their incontinence, and signpost patients to voluntary organisations such as Prostate Cancer UK for additional information and support
- Men should be advised that restricting fluids to manage continence symptoms can result in urinary tract infections, which are associated with a risk of sepsis. Preventative action reduces the need for antibiotic use



# What should a high-quality male continence care service look like?

## Key points

**NHS guidance makes little reference to male incontinence and there is a lack of evidence to support good practice**

**Male continence care needs to be part of integrated adult and children's continence services**

**Proactive strategies and interventions are needed to raise awareness of male bowel and bladder health, and ensure male continence needs are met**

**Holistic assessment is crucial in meeting male physical, social and psychological continence needs**

**Improved continence support for men following prostate cancer surgery could have lessons for managing incontinence in other men**

**Abstract** Male continence problems often go unrecognised and there is a need for proactive strategies and interventions to raise awareness of male bowel and bladder health, and ensure male continence needs are met. NHS guidance makes little reference to male continence and there is a lack of evidence to support good practice. Work to support men after prostate cancer surgery has features that could be adopted by services for other men with continence problems.

**Citation** *Nursing Times* (2019) What should a high-quality male continence care service look like? *Nursing Times* (Best Practice: Identifying and Managing Male Incontinence Problems, supplement); 115: 10, 9-11.

The experience of males with bowel and bladder problems demonstrates that they can encounter particular barriers in accessing high-quality continence care and that male continence problems often go unrecognised (Case studies, pages 4, 8 and 12). Proactive strategies and interventions are needed to raise awareness of male bowel and bladder health, and ensure boys and men receive the physical and psychological support and care they need. However, there is a lack of evidence to guide best practice and NHS guidance makes little reference to male continence.

National Institute for Health and Care Excellence guidelines on incontinence focus more on women than men, and there are fewer disease-specific NICE guidelines addressing male continence. In the UK, successive reports have highlighted unacceptable variations in the quality of continence care for adults and children (All-Party Parliamentary Group for Continence Care, 2018; Royal College of Physicians, 2010); UK countries have responded with initiatives to drive service improvements.

NHS England's (2018) *Excellence in Continence Care* collates the latest evidence-based resources and research to help commissioners and providers raise continence care standards but, while it highlights the need to meet the "diverse needs of children, young people, adults and older people", it does not address gender differences (Box 1). NHSE's (2019) *NHS Long Term Plan* puts an emphasis on prevention and keeping people well for longer, but the only reference to continence is pelvic floor dysfunction in women after childbirth.

## Ideal services for young males

Successive reports have emphasised the need for early intervention and specialist care to help children, young people, and their families and carers to deal with continence issues (APPG, 2018; NHSE, 2018). They emphasise the role of community paediatric continence services, school nurses, health visitors and GPs in picking up problems early, and the importance of a good transition from children's to adult services. However, there is a lack of information on the needs of boys, adolescent males and young men.

Continence problems in young people can lead to social isolation and psychological problems – the case study on page 4 shows how one young man went to great lengths to hide his incontinence. The impact of incontinence on sexuality may also be important to adolescent males and young men, who may feel awkward asking about it; health professionals need to be able to communicate on such issues with skill, tact and sensitivity, and ensure appropriate assessment and support.

ERIC, the children's bowel and bladder charity, has developed a generic Children's Continence Pathway; it describes a child's journey through continence care and includes all the necessary tools ([Bit.ly/ERICPathway](http://Bit.ly/ERICPathway)). The Paediatric Continence Forum has also developed a commissioning tool ([Bit.ly/PCFGuide](http://Bit.ly/PCFGuide)).

The APPG (2011) describes what children's integrated continence care should look like, including a well-planned transition into adult care; this is done through the experience of David, a boy with spina bifida ([Bit.ly/APPGCommissioning](http://Bit.ly/APPGCommissioning)). David

## Best practice

# Male continence

### Box 1. What constitutes good continence care?

NHS England's *Excellence in Continence Care* says there should be greater collaboration between health and social care, working in partnership with the third sector. It says the number of children and adults with incontinence and the severity of problems could significantly reduce with the following: local strategies for improving public health and awareness; increased preventative services; high-quality, easily available patient information; and greater integration of services across health, care and education. It stresses the need to address shortfalls in specialist continence nurses and train non-specialists in continence care, and the role of multidisciplinary teams (including nurses, physiotherapists and occupational therapists) in specialist assessment to maximise conservative measures. It says all people with continence problems should:

- Receive high-quality, professional assessment in the community and timely intervention by staff trained in continence care
- Have conservative management, such as dietary advice, bladder retraining and pelvic floor muscle exercises, as a first-line treatment once warning signs of underlying conditions are excluded
- Receive timely referral to specialist services if they have more complex problems or do not respond to treatment
- Be involved in decision making and their own care
- Be treated with empathy and respect, and be heard and listened to (NHSE, 2018)

All children and young people with bowel and bladder problems need:

- Access to integrated, community-based paediatric continence services
- Clear and effective referral and care pathways, including to secondary care, education, children and adolescent mental health services and social services
- Well-planned transition from children's to adult services (NHSE, 2018; Paediatric Continence Forum, 2014)

benefitted from a transitional service run by Alder Hey Children's NHS Foundation Trust and Aintree University Hospital NHS Foundation Trust that provided structured, fully integrated care across health, education and social care to ensure "a smooth and gradual transition" as recommended by NICE (2016). The service sees young people aged 11-19 years, depending on their "maturity, readiness and awareness". It places the young person at the centre of decision making on physical, emotional, sexual and relationship needs, and supports family and carers to step back so young people can start taking responsibility for their care and wellbeing.

### Ideal services for men

As the case study on page 8 shows, it is crucial to consider the emotional, psychological and social burden of incontinence, and men's need for support in the workplace, as well as looking after their physical needs. All this must be carefully assessed, and appropriate referrals made.

For men with urinary incontinence, advice and support about their sexual health is also important (Lee et al, 2018). When indwelling catheterisation is advised, male patients should be given the chance to discuss any problems about body image, sexuality and sex life (Chapple et al, 2014; Case study, page 8).

Awareness is growing that health programmes that account for gender differences, as well as male and female sensibilities, can work better than "one-size-fits-all" approaches: a men's health initiative by the Queen's Nursing Institute (2018) cites "robust evidence" on how to

deliver health services that meet men's needs effectively.

It outlines the importance of taking men's needs, attitudes, behaviours and preferences into account, and brings together lessons from nine nurse-led projects in the community that "helped define proactive strategies and interventions promoting better self-care and reversing the negative impact of undetected and untreated longer-term health problems in men". As an example, My PSA Passport, is a patient hand-held paper resource developed by South West London Health and Care Partnership to support men living with, and beyond, prostate cancer to self-manage; it was designed in partnership with service users.

The QNI report shows how men's health can be addressed effectively within current structures, and offers nurses useful tips for working with men, particularly around communication and engagement (Box 2).

There are few men's health initiatives specifically for male continence, but the All Wales Continence Forum is addressing a skills gap in male pelvic floor assessment (Box 3). Most work on male continence is in prostate cancer, as bladder problems are common after prostate cancer surgery (Box 4; Case study, page 8).

As part of its best-practice pathway, Prostate Cancer UK offers a bespoke support pathway, and describes supportive care for men to achieve a better quality of life and prevent recurrence or complications from unmanaged consequences of treatments, including incontinence (Bit.ly/ProstateCancerSupport). With interven-



### Box 2. Tips for working with men

- Adopt targeted approaches for specific groups of men
- Sensitively explore staff skillsets and attitudes as these will vary with age, time in service and experiences – upskilling may be needed
- Be proactive and persistent, do not expect men to come to you
- Give men information and let them process it for themselves
- Do not confront men with questions about their health – they may find this challenging or immediately off-putting
- Always consider what you are offering, and the tone you strike, from the man's perspective
- Men are often reluctant to divulge information about their health, so be prepared to ask the same question in several different ways to get the answer
- Try to give men options and choices in their treatment
- Listen, rather than talk
- Remember: men often reveal the key issue when hovering at the door to leave

Source: Adapted from Queen's Nursing Institute (2018)

### Box 3. Developing new outcome measures

The All Wales Continence Forum is piloting outcome measures for bowel and bladder in a single questionnaire, which is simple and practical for patients to use, and helps services provide high standards of continence care. The two-page form is adapted from International Continence Society forms for bowel and bladder, and includes symptoms, pain and quality-of-life indicators. There are also questions on age and gender. The form is sent to patients before their first appointment and helps structure their first consultation.

Initial feedback is positive: clinicians and patients describe it as comprehensive, and easy to use and understand, saying it gives an opening to discuss potentially embarrassing topics and contributes to good care. There are also signs that it reduces consultation time.

Patient experience forms (“Two minutes of your time”) have also been designed for different care settings, including one asking people how well their toileting needs have been met in hospital. In addition, training is being developed for specialist nurses and physiotherapists in male bowel and bladder pelvic floor assessment to address a countrywide gap in skills and training provision – current provision focuses on women.

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tions such as holistic needs assessments, and care planning and tailored rehabilitation programmes incorporating self-management, it stresses the need for psychological and peer support, and says specialist nurses and high-quality patient information are key. It also advocates tailoring self-management and support to men with similar conditions, such as urinary dysfunction, but says “the treatment men have received, their economic status, social support and ethnicity [should] be taken into account explicitly in developing, targeting and evaluating programmes”.

Interventions to improve support for men after prostate cancer surgery could have lessons for managing incontinence in other men (Box 5).

### Box 4. Supporting recovery after prostate cancer surgery

One-to-one specialist nurse support and physiotherapy intervention at Belfast Health and Social Care Trust is helping men cope with the physical, sexual and emotional consequences of prostate cancer surgery, including bladder problems.

Previously, a local Transforming Cancer Follow-Up prostate audit showed only 32.6% of men felt supported to make lifestyle changes to maximise health and wellbeing. Men received verbal advice on pelvic floor muscle exercises before surgery, a consultant review afterwards and referral to the community continence service for bladder problems, where the focus was on managing incontinence rather than a return to continence. Specialised continence physiotherapy was commissioned for women through obstetrics and gynaecology, but was not available for men.

Now, all men having prostate surgery attend a pre-operative clinic with the uro-oncology clinical nurse specialist (CNS) and specialist continence physiotherapist, who prepare them psychologically and physically. Men receive information about their upcoming surgery and what to expect afterwards. With their consent, they are then examined to assess pelvic floor muscle function and given a programme (pelvic floor exercises, physical activity, diet and fluid advice) to follow before and after surgery. Contact details for the CNS and physiotherapist are also given.

Most men experience moderate incontinence immediately post-operatively, but have minimal leakage by 12 weeks. Three-monthly follow-up appointments with the CNS in the first year ensure patients receive holistic needs assessments and are supported to self-manage or referred to specialist help if needed.

The National Institute for Health and Care Excellence (2010) recommends supervised pelvic floor muscle exercise training for stress urinary incontinence after prostate cancer surgery and to continue exercises for at least three months before considering other options.

### How to improve services for older men

The incidence of incontinence increases in older men and it is important that health professionals assess bowel and bladder function at every interaction using the right trigger questions. Symptoms of incontinence are common in people who have dementia due to their deteriorating mental and physical abilities.

The British Geriatrics Society has guidelines for managing continence in residential and nursing homes, including holistic assessment (BGS, 2018). General guidelines should be supplemented by an awareness of men’s specific needs (Case study, page 12), such as issues around the inappropriate passing of urine in public places and the need for careful product

selection to give appropriate protection. As the case study shows, poor management of incontinence can cause huge distress and erode people’s dignity, as well as contributing to rapid deterioration of their physical and mental state.

### Conclusion

Male continence care needs to be part of an integrated adult and children’s continence service, but services should take gender differences into account to ensure male and female needs are met. More research is required on the continence needs of boys and men of all ages; in addition, health services need to focus on the good work in prostate care, and consider what can be learned in terms of engaging with all men about their bowel and bladder health. **NT**

### Box 5. Learning from prostate cancer services

A number of features of prostate cancer work could be adopted for men who have continence problems as a result of other causes:

- Targeted information on incontinence for men
- Signposting to gender-appropriate support services
- Holistic assessment and care planning addressing men’s psychological, social and physical needs
- Tailored rehabilitation programmes, incorporating self-management
- Peer support

# Incontinence and loss of self-identity and dignity in older age

Arthur Green,\* aged 78, is a retired policeman, who has lived in a care home for five years. He is widowed and has a general diagnosis of dementia. On arrival, Mr Green had good mobility and could perform most activities of daily living with minimal support, including independent toileting. He was smart and gentle, and took pride in his appearance.

\*This case study is based on the experiences of a number of patients the author encountered in his clinical practice

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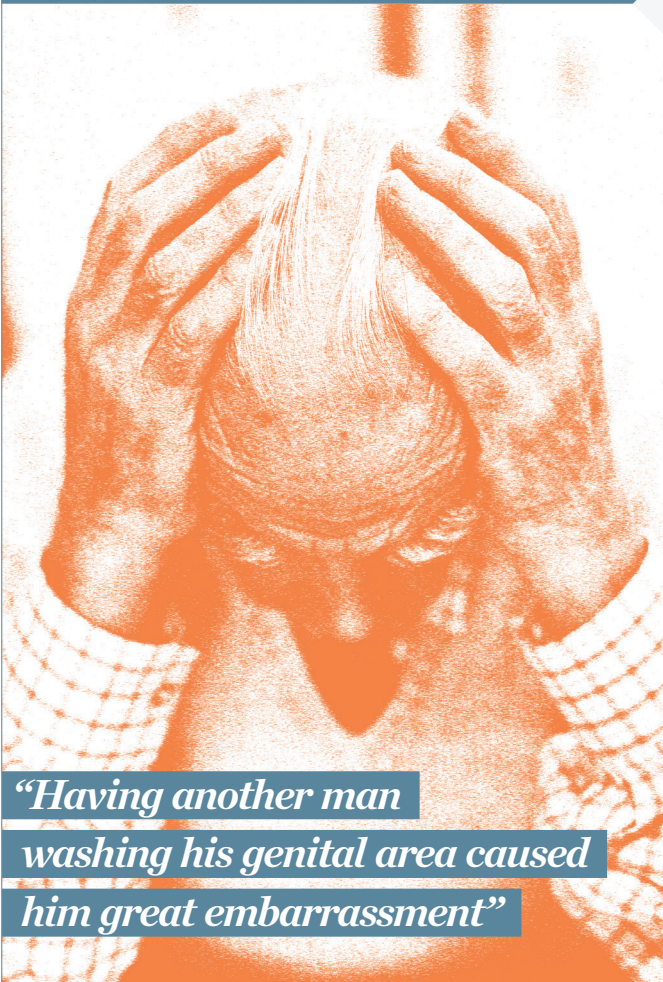
Staff at Mr Green's care home noted that he was often disorientated when trying to get to the bathroom, leading to incontinence, which embarrassed him greatly. Staff suggested he wore small incontinence pads but, without constant adjustments, urine would come up and soak the front of his shirt when he failed to get to the bathroom in time; he also found net knickers, used to hold the pad in place, uncomfortable. Staff advised him to wear jogging bottoms instead of trousers, which made adjustment easier, but eroded his remaining sense of identity. A year later he was diagnosed with depression, which staff wrongly attributed to his dementia.

Mr Green tried to remain as independent as possible. On one occasion, he was desperate for the toilet but could not find the door. His declining eyesight and disorientation caused him to mistake a sink at the end of the corridor for a urinal, at which point a member of staff shouted loudly: "Mr Green stop weeing in the sink, that is not OK. All the ladies can see you". Overcome with embarrassment, and tearful, he hurried back to his chair, avoiding eye contact with everyone. He did not eat his supper and went to bed early. On another occasion, Mr Green found the bathroom, but the lack of contrasting colours meant he struggled to see the toilet and he urinated in the bin.

Mr Green's dementia advanced to the point that he was immobile. He was wearing continence pads and needed two members of staff to change him and assist him with most activities of daily living. The home assumed he would prefer a male staff member supporting him, but having another man washing his genital area caused him great embarrassment.

Mr Green's dementia progressed. Staff were concerned about pressure ulcers and put in place risk-reducing measures, including use of a urinary sheath. Mr Green's understanding of this was poor, but staff decided it was in his best interests to go ahead. He found application of the sheath embarrassing and upsetting despite the staff's efforts to reassure him and, by the next morning, it had fallen off. A decision to catheterise Mr Green was made in his best interests. Although staff tried to explain this to Mr Green he gave no indication of having understood them, and had to be restrained during the procedure. Later that night staff found Mr Green, distressed, confused and obviously in pain, having pulled his catheter out with the balloon still inflated.

On reflection, the staff were aware that his dignity and identity has been compromised by his plan of care, and spent time discussing and exploring how it could be improved. **NT**



**"Having another man washing his genital area caused him great embarrassment"**

## Learning points

- Environmental cuing and good signage to the toilet – using a combination of words and symbols/pictures – are important, especially to support continence in the early stages of dementia, when disorientation is common
- Staff need to be aware of men's specific needs, such as issues around inappropriate passing of urine in public places and the need for careful product selection to give appropriate protection
- Staff should avoid making assumptions about what is best for people, such as male patients prefer male staff, or a man with incontinence will manage better in tracksuit bottoms; patients should be asked what they want, and their needs and preferences noted
- Continence care in men with dementia is as much about dignity as it is about practicalities: being incontinent and the way it is managed can have negative effects on their experience, identity, and psychological and social wellbeing

# What can health professionals do to improve male continence care?

## Key points

**Male incontinence often goes unrecognised and male needs are rarely considered when designing continence services**

**New strategies and interventions are needed to promote better self-care for males of all ages with bladder and bowel problems, and to reverse the negative impact of undetected and untreated incontinence**

**A new men's health strategy by the World Health Organization could help nurses make the case for commissioning and developing men's continence projects**

**Raising public, patient and professional awareness of male continence, and including it in staff training, would help improve standards of care**

**There could be a role for nurse-led educational interventions in continence care, as adopted in Canada and by some UK prostate cancer services**

**Abstract** Lack of recognition and understanding of male incontinence can cause continence care for boys, adolescent males and men to slip below expected standards. All healthcare staff should be aware of issues around male continence, and that bowel and bladder problems affect not just older men, but young males too. Building up an evidence base, considering male needs in service development and improvement plans, raising public and patient awareness of male incontinence, and including it in staff training and nurse-led interventions to promote better self-care and equity of access could all help improve standards of male continence care.

**Citation** *Nursing Times* (2019) What can health professionals do to improve male continence care? *Nursing Times* (Best Practice: Identifying and Managing Male Incontinence Problems, supplement); 115: 10, 13-15.

Male voices, at the heart of this document, describe the impact of incontinence on their lives, and the social, professional and service barriers they encounter trying to access the care they need (Case studies, pages 4, 8, and 12). It is evident that being male can sometimes be a barrier itself – this needs to be acknowledged and addressed in the design and delivery of services to ensure males and females receive equally high standards of continence care.

As an ageing population leads to a rise in the number of people with bowel and bladder problems, concerted effort is needed nationally and locally to build on work in UK countries – such as the recommendations of NHS England's (2018) *Excellence in Continence Care* – to improve standards of care and make continence services a higher priority. Despite this, the need for gender-responsive services that meet both male and female needs has yet to be acknowledged and addressed. So how do nurses and other health professionals address the difficulties that males of all ages can experience in accessing good-quality continence care? And how do they build on men's strengths and work with them in a positive and supportive way?

## Meeting men's needs

Men's health is rising up the agenda, and there is a recognition that men may need new strategies and interventions to promote better self-care and reverse the negative impact of undetected, untreated longer-term health problems. According

to Global Action on Men's Health, "The stars may now be aligning more favourably for a new and more systematic approach to men's health" (Baker, 2019). Last year, the World Health Organization launched the first men's health strategy for the European region, and Northern Ireland is the first UK country to develop a National Men's Health Action Plan. The Queen's Nursing Institute (2018) believes this "could help create a climate in which it is easier for nurses and other health professionals to make the case for commissioning and developing men's health projects and initiatives".

Among the action points identified by a *Nursing Times* roundtable were: building up an evidence base; considering male needs in development and improvement plans for continence services; raising public, patient and professional awareness of male continence, and including it in staff training; considering nurse-led interventions to promote better self-care (Box 1) and ensure equity of access. Prostate cancer services are leading the way in addressing male continence problems and there are lessons here for wider service development (see page 9).

The TReating Urinary Symptoms in Men in Primary Healthcare (TRIUMPH) study, currently under way, is exploring non-pharmaceutical and non-surgical nurse-led interventions for managing lower urinary tract symptoms in men. The outcomes will add to the evidence base on male continence and could inform service development ([Bit.ly/TRiumphStudy](http://Bit.ly/TRiumphStudy)).

# Best practice

## Male continence

### Recommendations

The following recommendations are based on the evidence presented in this document and discussions at the *Nursing Times* roundtable earlier this year.

#### Build up an evidence base

- Identify research priorities for male continence (Box 2).

#### Raise public awareness

- Include male bowel and bladder health in local public-education and awareness strategies, including directing males of all ages to support, information and treatments so they feel more able to present to health services;
- Raise the profile of male continence with education and youth organisations, male health charities and other third-sector organisations, with a view to developing targeted health campaigns, information and support.

#### Identify unmet need

- Consider male needs as part of local development and improvement plans for continence services, co-produced with the public, service users and carers, to identify service gaps and whether targeted interventions are required to ensure equity of access;
- Ensure male voices are heard and that economic status, social support and ethnicity are taken into account when developing, targeting and evaluating men's health programmes;
- Collect information at a service level to ensure services are delivering high-quality male continence care, including developing outcome measures for male continence and surveying males' experiences of continence services.

#### Provide staff training and education

- Ensure all clinical staff are trained and educated in men's bowel and bladder health, and male patients have access to continence specialists with sufficient expertise in male holistic assessment and management, including pelvic floor assessment and pelvic floor muscle training for stress incontinence;
- Ensure clinicians ask the right trigger questions and use interactions with male patients to ask about their bowel and bladder health, as recommended in *Making Every Contact Count* (Public Health England, 2016). Give nurses training and guidance on incorporating this into their routine, including

### Box 1. Nurse-led interventions

A report on the continence needs of people with long-term conditions and older people highlights the potential for nurse-led educational interventions in continence care. It points to Canada, where patients attend group sessions led by nurses promoting helpful lifestyle modifications. These sessions are mandatory before a continence specialist can be seen ([Bit.ly/ContinenceCollaboration](https://bit.ly/ContinenceCollaboration)).

Such nurse-led interventions can provide education towards self-management and peer support for men with continence problems. This is already happening in some prostate cancer services. As an example, Cardiff and Vale University Health Board in Wales holds group sessions for men about to undergo prostate surgery; they include information on the surgery, sexual function, catheter care (including catheter passport) and pelvic floor exercises prior to surgery.

strategies to communicate effectively with male patients of all ages.

#### Ensure high-quality patient information

- Review information for patients and carers to ensure it includes clear, accessible and appropriate information on issues around male continence, including signposting to gender-appropriate advice and support.

#### Meet patients' holistic needs

- Assess male patients' physical, social and psychological needs, as well as the

need for support, including timely referral to specialist care where needed – this should include advice and support for comorbidities such as sexual problems (including erectile dysfunction), emotional and mental health problems, and support in education and the workplace;

- Consider structured approaches to holistic assessment, including questionnaires male patients can fill out beforehand, to focus discussions with health professionals and help men open up about potentially embarrassing problems such as incontinence, sexual and mental health problems, and assist clinicians in timely referral to specialist care;
- Provide psychological and physical support for patients if incontinence is a known risk/consequence of treatment; this will ensure they are well prepared and receive supportive care to achieve a better quality of life and prevent recurrence and complications from unmanaged consequences of treatment;
- Consider the role of peer support – this could include: group sessions for male patients, families and carers; buddying services; or signposting to other sources of help and support, such as bowel and bladder charity helplines, online forums or community groups.

#### Follow best practice in care provision

- Follow best-practice guidelines on managing male bowel and bladder problems, including that from the National Institute for Health and Care Excellence (2010), the British Geriatrics Society's (2018) guidelines for residential and nursing homes, and best-practice pathways such as those

### Box 2. The need for research

More research is needed on issues around male continence, in particular in boys, adolescent males and young men, as most existing studies are on older men. It should include research on unmet needs and male attitudes, behaviours, needs and preferences. A first step towards this could be setting up a collaborative workshop, involving researchers, patients, carers, the NHS, health professionals and third-sector organisations.

A similar event was run in 2018 to look at the continence needs of people with long-term conditions and older people. Participants identified a number of priorities for research. Among these were more research into self-management techniques, comorbidities, continence assessment and products, and the impact of education. Participants also recommended that researchers involve patients and carers at an earlier stage when planning studies. The workshop resulted a number of new research proposals, including a successful proposal funded by the Alzheimer's Society ([Bit.ly/ContinenceCollaboration](https://bit.ly/ContinenceCollaboration)).

provided by Prostate Cancer UK ([Bit.ly/ProstateCancerSupport](http://Bit.ly/ProstateCancerSupport)) and ERIC ([Bit.ly/ERICPathway](http://Bit.ly/ERICPathway));

- Make screening for bowel and bladder problems routine for all males at risk of incontinence (see page 7 for risk factors), including younger patients, as well as part of the care of older people and long-term conditions management;
- Ensure accurate diagnosis in men who have cognitive impairment to ensure the right support and management is offered (Case study, page 12);
- Provide male patients with information and advice towards supported self-care, including lifestyle advice and appropriate exercise programmes, such as pelvic floor exercises for stress incontinence;
- Consider the option of nurse-led educational programmes for men (Box 1);
- Involve male patients and their carers in decisions about their care, and ensure their individual needs and preferences are taken into account;
- Ensure patients with complex needs are referred to specialist services where they will have access to a multidisciplinary team that can ensure necessary investigations are done, all treatment options are considered and patients receive care that has a multidisciplinary approach;
- Ensure male patients receive continence products appropriate to their needs and support in how to use them. Be honest about what the NHS can/cannot provide and signpost people to sources of independent advice on product selection if they want to explore other options and purchase products themselves ([Bit.ly/ContinenceProducts](http://Bit.ly/ContinenceProducts));
- Remember: indwelling catheters are a last resort and patients need careful instruction on their use.

## Conclusion

Nurses and other health professionals must be more aware of issues around male continence, and that bowel and bladder problems do not just occur in older men but can affect young males too. Males of all ages experience barriers to accessing high-quality continence care; however, health professionals can do much to help reverse the negative impact of undetected and untreated male continence problems to ensure all male patients have their needs met and receive high standards of treatment and care. **NT**

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4th Floor, Telephone House,  
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Development of this document was funded by an unrestricted educational grant from Essity.

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