CONDITION

# Urinary incontinence in women

Urinary incontinence is accidental urine leakage caused by problems storing or emptying urine.

**WHAT IT IS**
Accidental leakage of urine

**BODY SYSTEM**
Urinary system and pelvic floor

**MAIN SYMPTOMS**
Leakage with activity, sudden urgency, frequent urination, nighttime leakage

**WHAT CAUSES IT**
Pelvic support weakness, bladder overactivity, or poor emptying

**HOW IT IS DIAGNOSED**
History, bladder diary, examination, urine testing, sometimes bladder tests

**MAIN TREATMENT**
Pelvic floor and bladder training, medicines, or procedures

**CAN IT BE CURED?**
Sometimes - treatment can stop leakage

**IS IT AN EMERGENCY?**
Sometimes - new leakage with saddle numbness or leg weakness

**LONG-TERM OUTLOOK**
Often manageable with treatment matched to the type

## Overview

Urinary incontinence means leaking urine when you do not intend to. It can range from a few drops during exercise to being unable to reach a toilet in time.

It is common enough that some people assume it is a normal part of ageing, pregnancy, or childbirth. It is not something you simply have to accept. Symptoms can often be improved, and some causes can be corrected.

The main types are:

Urgency, frequent urination, and nighttime urination may be described as overactive bladder . This refers to a group of symptoms rather than one specific disease.

Incontinence can affect sleep, exercise, work, travel, sex, and emotional well-being.

Embarrassment may delay care, but clinicians regularly assess this condition.

- Stress incontinence: leakage when pressure rises in your abdomen, such as during coughing, laughing, lifting, running, or jumping
- Urgency incontinence: leakage linked to a sudden, difficult-to-control need to urinate
- Mixed incontinence: a combination of stress and urgency symptoms
- Overflow incontinence: leakage because the bladder does not empty properly and becomes too full
- Functional incontinence: difficulty reaching or using a toilet because of reduced mobility, memory problems, medicines, or environmental barriers

## Symptoms

The pattern of leakage can help identify the type of incontinence.

Stress incontinence usually causes small or moderate leaks during movement or effort. Common triggers include sneezing, coughing, laughing, lifting, and exercise. There may be no warning urge beforehand.

Urgency incontinence causes a sudden need to urinate followed by leakage before you reach a toilet. Running water, arriving home, or putting a key in the door may trigger urgency. You may also urinate frequently or wake several times at night.

Overflow incontinence can cause frequent dribbling, a weak urine stream, trouble starting, or a feeling that the bladder remains full. Some people have little awareness that the bladder is full.

Other symptoms can point to a separate or contributing problem. These include pain or burning during urination, pelvic pressure, a bulge in the vagina, constipation, blood in the urine, or repeated urine infections.

Temporary leakage can occur during a urinary tract infection, severe constipation, a period of reduced mobility, or after starting certain medicines. It may improve when the underlying problem is treated.

## Causes and risk factors

Urine is stored in the bladder and held back by the urethra, the tube through which urine leaves the body. Pelvic floor muscles and supporting tissues help keep the urethra closed. Nerves coordinate bladder filling and emptying.

Stress incontinence develops when the urethra and its supporting tissues do not resist increases in abdominal pressure well enough. Pregnancy and vaginal birth can stretch pelvic tissues and nerves, although women who have never given birth can also develop it. Ageing, pelvic surgery, chronic coughing, and higher body weight may contribute.

Urgency incontinence occurs when the bladder muscle contracts at an unwanted time. Often, no single cause is found. It can also be associated with bladder irritation, menopause-related urinary changes, or conditions affecting the brain, spinal cord, or nerves.

Poor bladder emptying may result from pelvic organ prolapse, narrowing or blockage of the urinary outlet, previous surgery, nerve conditions, diabetes-related nerve damage, or medicines that affect the bladder.

Risk tends to increase with age, but age alone is not the cause. Menopause can make tissues around the vagina and urethra thinner and drier. Constipation and repeated straining can place added pressure on the pelvic floor.

Medicines may worsen leakage or make toilet access harder. Examples include water tablets like furosemide or hydrochlorothiazide , sedatives, and some medicines that affect bladder emptying. Do not stop a prescribed medicine without discussing it with the clinician who manages it.

## Diagnosis

There is no single test needed for every person. Assessment usually begins with a detailed discussion of when leakage occurs, how much urine is lost, and whether you have urgency, pain, trouble emptying, or nighttime symptoms.

You may be asked to keep a bladder diary for several days. This records what and how much you drink, when you urinate, episodes of urgency, and any leakage. It can reveal patterns that are difficult to remember during an appointment.

A urine sample can check for infection and blood. A physical examination may assess pelvic floor muscle function, vaginal tissues, pelvic organ prolapse, and whether coughing causes leakage.

A post-void residual test measures how much urine remains after you urinate. It is often done with a bladder ultrasound and is particularly useful if you have a weak stream, repeated infections, or symptoms of incomplete emptying.

More specialised testing is not always required. Urodynamic testing measures bladder pressure, filling, and emptying. It may be considered when the type of incontinence is unclear, symptoms are complex, previous treatment has not worked, or certain procedures are being

considered.

A camera examination of the bladder, called cystoscopy, and imaging scans are usually reserved for specific concerns such as blood in the urine, suspected blockage, or another urinary tract condition.

## Treatment and management

Treatment is matched to the type of leakage, its effect on your life, and your preferences. More than one approach may be used.

Pelvic floor muscle training is a first treatment for stress and mixed incontinence. These exercises strengthen the muscles that support the bladder and urethra. Correct technique matters: squeezing the abdomen, buttocks, or thighs is not the same as contracting the pelvic floor. A pelvic health physiotherapist can check technique and build a structured programme.

Bladder training is commonly used for urgency incontinence. It involves gradually increasing the time between planned toilet visits and using strategies to settle urgency. Going to the toilet repeatedly "just in case" can sometimes train the bladder to hold smaller amounts.

Fluid intake may need adjusting, but sharply limiting fluids can lead to dehydration and concentrated urine, which may irritate the bladder. Reducing caffeine may help urgency and frequency. Managing constipation, chronic cough, and mobility barriers can also reduce leakage. If higher body weight contributes to symptoms, gradual weight loss may improve stress incontinence.

Absorbent pads, protective underwear, washable products, and bed protection can help while treatment takes effect or when leakage continues. They manage symptoms but do not treat the cause.

Medicines may be offered for urgency incontinence or overactive bladder. Antimuscarinic medicines calm bladder contractions but may cause dry mouth, constipation, blurred vision, or cognitive side effects. Beta-3 agonists relax the bladder during filling and can affect blood pressure or have other side effects. The choice depends on your health, other medicines, and treatment goals.

Local vaginal estrogen may help some people after menopause who also have vaginal dryness, irritation, or urinary symptoms. It is different from whole-body hormone therapy and still requires an individual safety discussion.

Procedures for stress incontinence include urethral bulking injections and operations that support the urethra, such as sling procedures or colposuspension. Each has different benefits, recovery needs, and risks. Some sling procedures use synthetic mesh, so informed discussion

about mesh and non-mesh options is important.

For urgency incontinence that has not improved with initial treatments, options can include bladder injections with botulinum toxin, stimulation of a nerve near the ankle, or an implanted sacral nerve stimulator. Bladder injections can sometimes cause difficulty emptying or urinary infection.

Overflow incontinence requires treatment of the reason the bladder is not emptying. Management may include changing a contributing medicine, treating prolapse or blockage, or using a catheter to drain urine safely.

## Complications

Ongoing leakage can irritate the skin, causing soreness or rashes. Promptly changing wet products, gentle washing, careful drying, and a suitable barrier product may protect the skin.

Urgency can increase the risk of falls if you rush to the toilet, especially at night. Clear pathways, good lighting, easy-to-remove clothing, and a bedside commode can reduce this risk.

Incontinence can also affect confidence, sleep, intimacy, physical activity, and social life. Anxiety about odour or finding a toilet may lead some people to avoid leaving home. These effects are valid reasons to seek treatment.

Poor bladder emptying can raise the risk of urinary infections and, when severe and prolonged, may affect the upper urinary tract. This is different from uncomplicated stress or urgency incontinence.

## Prevention

Urinary incontinence cannot always be prevented. Childbirth, ageing-related tissue changes, inherited differences, neurological conditions, and necessary pelvic treatments are not fully controllable.

Pelvic floor muscle training during and after pregnancy may reduce the chance or severity of some leakage. Correct technique is more useful than repeatedly doing uncertain contractions.

Maintaining bowel regularity, avoiding repeated straining, treating chronic cough, and not smoking may reduce ongoing pressure on the pelvic floor. Staying physically active and maintaining a weight that is healthy for you may also lower the risk of stress symptoms.

These steps cannot guarantee prevention, and developing incontinence does not mean you

caused it.

## Living with it and what to expect

The course differs according to the type and cause. Temporary leakage from infection, constipation, or a short-term medicine effect may settle when that issue is treated. Stress or urgency incontinence may persist for months or years but often improves with consistent, correctly targeted treatment.

Pelvic floor and bladder training usually require regular practice rather than producing an immediate change. A bladder diary can help you notice gradual progress, such as fewer leaks, longer gaps between toilet visits, or less pad use.

Symptoms can change after pregnancy, menopause, pelvic surgery, illness, or changes in mobility. A treatment that worked before may need review if the pattern changes.

Many women remain active, work, exercise, travel, and have satisfying relationships while managing incontinence. Practical planning can help, but you should not have to rely only on pads or restrict your life if symptoms remain bothersome. Routine follow-up is appropriate when treatment is not helping, side effects occur, or you want to discuss other options.

## When to get medical help

Arrange a routine appointment if leakage is new, persistent, worsening, or affecting sleep, activity, work, or emotional well-being. You should also seek assessment if you have trouble emptying your bladder, repeated urine infections, pelvic pressure, or a vaginal bulge.

Contact a healthcare service promptly if you have visible blood in your urine, pain when urinating, fever with urinary symptoms, or new difficulty passing urine. These symptoms need assessment for infection, retention, stones, or another urinary condition.

Seek emergency care for sudden loss of bladder control together with new leg weakness, numbness around the genitals or buttocks, severe back pain, or loss of bowel control. This combination can indicate serious pressure on nerves at the bottom of the spinal cord.

Sudden incontinence with facial drooping, arm weakness, trouble speaking, confusion, or a severe new headache also requires emergency help because these can be signs of a stroke.

## Common questions

Can urinary incontinence go away on its own?

Temporary leakage may stop when an infection, constipation, or another short-term cause resolves. Stress and urgency incontinence are less likely to disappear without targeted management, although their severity can change over time.

Do pelvic floor exercises really work?

They can improve or stop leakage for many women with stress or mixed incontinence. Results are more likely when the correct muscles are used and training is continued consistently. A pelvic health physiotherapist can help if you are unsure about technique.

Should I drink less water to stop leaking?

Not usually. Excess fluid can worsen frequency, but too little can cause dehydration, constipation, and concentrated urine that irritates the bladder. A bladder diary can help identify whether the amount or timing of drinks contributes to symptoms.

Is urinary incontinence a normal part of getting older?

No. The risk increases with age, but incontinence is not an unavoidable or untreatable part of ageing. New or bothersome leakage deserves assessment.

Will I need surgery?

Most people begin with non-surgical treatment. Surgery may be considered for stress incontinence when symptoms remain troublesome and you understand the available options. Urgency incontinence is usually treated with bladder training, medicines, or bladder-directed procedures rather than standard stress-incontinence surgery.

Can sex make incontinence worse?

Some women leak during penetration or orgasm. This may be related to stress incontinence, urgency, or pelvic floor problems. It is a recognised symptom and can be discussed during a routine assessment. Treating the underlying type of incontinence may help.

## Sources

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