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## Your Symptoms Matter

# Prostate Cancer (EPIC patient questionnaire) Clinician Guides



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**This toolkit includes five guides. Each guide provides clinical direction on the management of one symptom domain addressed in the Your Symptoms Matter, the Prostate Cancer (EPIC) patient questionnaire, including:**

- Urinary incontinence;
- Urinary irritation & Obstruction;
- Bowel function;
- Sexual function; and
- Hormonal symptoms/Vitality.

Although symptom management is often addressed with an interdisciplinary team, these guides are primarily aimed at allied health.

These guides are created to compliment your skills as a clinical practitioner. They will assist in providing education and encourage time for a clinical interaction. Should you need a specialized service, the guide also provides suggestions as to when this may be considered.

Patients who report experiencing any of the above symptoms may feel embarrassed and/or uncomfortable discussing them beyond the questionnaire. Understanding this will help providers communicate with and support patients who may have feelings of shame or emasculation in a sensitive manner. Sexual side effects and hormonal/vitality symptoms are particularly sensitive topics. The psychological distress of this can manifest in different ways (anger, substance abuse, depression, etc.), and awareness of this is critical to supporting to the patient, beyond biomedical treatment (i.e. PDE5 inhibitors). Emotional or psychological symptoms are often (though not always) a response to the physiological side effects and addressing these first is therefore recommended.

Given the sensitivity of symptoms addressed in the Your Symptoms Matter Prostate Cancer questionnaire, we would like to emphasize the importance of balancing patient preferences and wants with their needs as you provide care.

- Gauge symptom impact: Understanding the impact of symptoms and their importance to the patient is pivotal to management. In some cases patients may report a symptom, but the impact of the symptom or the bother of that symptom may be negligible. These patients may not feel a need or want to receive any degree of symptom management.
- Seek patient permission: Even if symptoms are bothersome, patients may not want to discuss further, especially for certain symptoms. It is important to seek permission before delving into assessment and management. Even if a patient declines discussion on a particular visit, the door has been opened for discussions on a subsequent visit.

## Your Symptoms Matter

# Prostate Cancer (EPIC questionnaire) Urinary Incontinence



Urinary incontinence is the involuntary leakage of urine and can be classified into four types of incontinence. Each type is defined in the table below.

### Symptoms and Characteristics of Urinary Incontinence (UI) types

#### Stress UI

- The most common type of UI following surgical treatment of prostate cancer
- Involuntary loss of urine with sudden pressure on the bladder by coughing, sneezing, laughing, etc.

#### Urge UI

- Sudden, intense urges to pass urine
- Involuntary loss of urine following the urge desire to urinate
- Needing to urinate often, including throughout the night

#### Mixed UI

- The combination of urge and stress incontinence
- Frequent or constant dribbling of urine due to a bladder that doesn't empty completely

#### Overflow UI

- Involuntary release of urine from an overfull bladder, without the urge to urinate
- A full feeling in the bladder even after urination
- Leakage of urine while sleeping
- A urine stream that stops and starts during urination
- Difficulty urinating even while feeling the urge to urinate

## Step 1:

Check the patient's EPIC scores for questions 2-4. If patients reports these symptoms to any degree (score of 1-4), proceed to Step 2.

#### Urinary control (Q2):

Occasional dribbling, frequent dribbling, or no urinary control.

#### Urinary leakage (Q3):

One or more pads per day.

#### Urinary dripping or leakage (Q4):

Very small problem, small problem, moderate problem, or big problem.

## Step 2:

Conduct an initial assessment of the type and severity of incontinence, as treatment varies accordingly.

#### A. Take a clinical history

Systematically assess symptoms using the OPQRSTUV Acronym. Obtain a detailed history including:

- Medical history
- Comorbidities
- Concurrent medication
- Diet and fluid intake (hydration)
- Physical dexterity and mobility
- Environmental factors (privacy, toilet accessibility)
- Functional ability (exercise patterns)
- Characteristics, timing and severity of UI
- Other urinary symptoms, if any

#### B. Conduct a physical examination

- Perform an abdominal examination to check for masses, distension, tenderness
- Do a cough stress test (to identify stress UI)

#### C. Ask patients to complete a urinary frequency volume chart

For: Patients unable to provide accurate intake/voiding information. The chart collects baseline information on:

- Incontinence episodes
- Fluid intake
- Frequency
- Urgency

Typical duration is 3 days.

#### D. Do a urine dipstick test

A urinalysis can detect possible infection.

- Nitrite and leucocyte esterase may indicate a UTI
- Protein may indicate infection and/or renal disease
- Blood may indicate infection or malignancy
- Glucose may indicate diabetes mellitus

#### E. Collect a urine culture

A urine culture can identify bacteria or yeast in the urine linked to infection.

#### F. Conduct a post void residual if equipment is available.

Post void residual volume is the amount of urine that remains in the bladder after voiding.

- Indicates poor voiding efficiency / chronic urinary retention
- Can be measured with an ultrasound bladder scanner (or catheterisation) immediately after the patient voids

## Step 3:

Identify treatment steps specific to the patient's UI type.

### Stress UI:

- PROCEED TO 4A
- Can take up to a year for patients to experience relief with conservative treatment.

### Mixed UI:

- PROCEED TO 4A for stress component of mixed UI; and
- PROCEED TO 4B for urge component of mixed UI.

### Urge UI:

Suggest conservative (behavioral or lifestyle) interventions as first-line treatment:

- PROCEED TO 4A; and
- PROCEED TO 4B.

Note: UI treatment should include both conservative and pharmacological treatment up front.

### Overflow UI:

- CONSULT with urologist for further assessment.
- Do not suggest conservative treatment.

**STOP & CONSULT**

## Step 4A:

Consider the following conservative (behavioral or lifestyle) interventions as first-line treatment.

### A. Pelvic floor muscle training (PFMT)

i.e., kegels. To augment PFMT as needed, and to further instruct, assist and encourage patients to practice kegels correctly and consistently, consider:

- Biofeedback
- Electrostimulation; and/or
- Pelvic physiotherapy

**B. Bladder retraining:** Voiding according to a fixed schedule, using distraction and self-assertion.

**c. Fluid management/modification:** for patients with high or abnormally low fluid intake.

**d. Limited caffeine intake**

**e. Limited alcohol intake**

**f. Smoking cessation**

**g. Weight loss**

### Stress UI:

Proceed to 4B if:

- Symptoms don't resolve or worsen in a year;
- Patient is suffering a poor quality of life with symptoms; and/or
- Patient prefers medication.

## Step 4B:

Consider pharmacological therapy.

- Consider anticholinergics or beta-3 agonists; or
- Consider combination therapy (if patient is refractory to the above).

## Step 5:

Consult an urologist if...

- There is uncertainty about the optimal pharmacological approach;
- Symptoms persist or worsen (after 1-2 weeks of medication); and/or
- Infection occurs.

# Annotated Reference List

## Step 2:

**Conduct an initial assessment of the type and severity of incontinence, as treatment varies accordingly.**

### a. Take a clinical history

- 1: Guideline Statement 1, p. 8
- 2: Sections 3 & 3.1 (p. 7)
- 3: Section 2.1 (p. 11) & Section 3.1.2 (p. 31 re: drug history)
- 7: Table 13.2 (p. 81)
- 8: Recommendation 1.1.1 (p. 9)
- 9: Recognition, Steps 1 & 2

### b. Conduct a physical examination

- 1: Guideline Statement 1, p. 9
- 2: Sections 3 & 3.1
- 3: Section 2.1 (p. 11)
- 7: Table 13.2 (p. 81)
- 8: Recommendation 1.1.2 (p. 9)
- 9: Recognition, Step 4

### c. Ask patients to complete a urinary frequency volume chart

- 1: Guideline Statement 1 (p. 8) & Statement 2 (p. 9)
- 2: Sections 3 & 3.1 (p. 7)
- 3: Section 2.3 (p. 14)

### d. Do a urine dipstick test

- 1: Guideline Statement 1 (p. 9)
- 2: Sections 3 & 3.1 (p. 7)
- 3: Section 2.4 (p. 16)
- 7: Table 13.2 (p. 81) – dipstick
- 8: Recommendation 1.1.4 (p. 9)

### e. Conduct a urine culture

Expert Opinion

### f. Conduct a post void residual if equipment is available

- Expert Opinion
- 2: Section 3 (p. 7)

## Step 4A:

**Consider conservative (behavioral or lifestyle) interventions as first-line treatment.**

### a. Pelvic floor muscle training

- 1: Guideline Statement 6 (p. 13)
- 2: Section 4 (p.8); Section 5.2 (p. 13)
- 3: Section 3.3.7 (p. 48)
- 4: Treatment/Management, number 2 & Strategies for Specific Problems
- 8: Recommendation 1.3.6 (p. 13)
- 9: Management, Step 9

#### • Biofeedback

- 1: First line treatments, behavioral therapies (p. 13)
- 2: Sections 5.2 (p. 13) & 9.2 (p. 16)
- 3: Section 3.3.2 (p. 42 & p.45)
- Expert Opinion

#### • Electrostimulation

- 1: First line treatments, behavioral therapies (p. 13)
- 3: Section 3.3.4 (p. 45)
- Expert Opinion

#### • Pelvic physiotherapy

Expert Opinion

### b. Bladder training

- 1: Guideline Statement 6 (p. 13)
- 2: Section 4 (p.8)
- 3: Sections 3.3.1 (p. 42) & 3.3.7 (p. 48)
- 4: Treatment/Management, number 2 & Strategies for Specific Problems
- 8: Recommendation 1.3.4 (p. 12)
- 9: Management, Step 9

### c. Fluid management

- 1: Guideline Statement 6 (p. 14)
- 2: Section 4 (p.8)
- 3: Section 3.2.6 (p. 41)
- 4: Treatment/Management, number 2
- 8: Recommendation 1.3.4 (p. 12)

### d. Limited caffeine intake

- 2: Section 4 (p.8)
- 3: Section 3.2.1 (p. 36) & Section 3.2.6 (p. 41)

### e. Limited alcohol intake

Expert Opinion

### f. Smoking cessation

- 2: Section 4 (p.8)
- 3: Sections 3.2.5 & 3.2.6 (p. 41)

### g. Weight loss

- 1: Guideline Statement 6 (p. 14)
- 3: Section 3.2.4 (p. 39)

## Step 4B:

**Consider pharmacological therapy. Anticholinergics**

- 1: Guideline Statement 8 (p. 15)
- 2: Section 4 (p. 8-9)
- 3: Section 4.10 (p. 72)
- Expert Opinion

### Beta-3 agonists

- 1: Guideline Statement 8 (p. 17)
- 2: Section 4 (p. 9)
- 3: Section 4.6 (p. 66)
- Expert Opinion

### Combination therapy

Expert Opinion

# References

1. E. Ann Gormley, Deborah J. Lightner, Kathryn L. Burgio, Toby C. Chai, J. Quentin Clemens, Daniel J. Culkan, Anurag Kumar Das, Harris Emilio Foster, Jr., Harriette Miles Scarpero, Christopher D. Tessier, Sandip Prasan Vasavada. Diagnosis and Treatment of Overactive Bladder (Non-Neurogenic) in Adults: AUA/SUFU Guideline. 2014; American Urological Association Education and Research, Inc.
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9. American Medical Directors Association (AMDA). Urinary incontinence in the long term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2012. 33 p. [95 references]
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