CC: Urinary Incontinence x 1 week and f/u BPH/LUTS

HPI: Mr. X is a 70 year old male with PMHx of schizoaffective disorder, bipolar disorder, hyperlipidemia, chronic kidney disease, retinal detachment with legal blindness of the left eye s/p vitrectomy, PTSD, and BPH/LUTS s/p TURP (2017) was seen today at the request of nursing staff for evaluation of ongoing urinary incontinence. Nursing reports intermittent episodes of the patient voiding into his brief despite having a urinal readily available at bedside. Patient states that his previous difficulty initiating urination has resolved since starting tamsulosin and denies any current difficulty voiding. He reports adequate urinary stream and denies sensation of incomplete bladder emptying. Patient denies dysuria, hematuria, urinary urgency, urinary frequency, suprapubic pain, flank pain, fever, chills, nausea, or vomiting.

Medications

- Lithium Carbonate 300 mg PO BID
- Melatonin 3 mg PO at bedtime
- Tamsulosin 0.4 mg PO daily
- Atorvastatin 40 mg PO at bedtime
- Acetaminophen 650 mg PO PRN pain
- Vitamin D3 1000 units PO daily
- Senna 8.6 mg PO at bedtime PRN constipation

PMHx

- Schizoaffective disorder
- Bipolar disorder
- Hyperlipidemia
- Chronic kidney disease
- Retinal detachment with legal blindness of the left eye s/p vitrectomy
- Post-traumatic stress disorder (PTSD)
- Benign prostatic hyperplasia with lower urinary tract symptoms (BPH/LUTS)

PSHx

- Transurethral Resection of the Prostate (TURP), 2017, no complication
- Vitrectomy of the left eye for retinal detachment, legal blindness

Allergies: NKDA

Denies medication, environmental or food allergies.

FHx: unknown

SHx:

- Uses walker for ambulation and participates in physical therapy.

- Habits → Remote history of tobacco and alcohol use. Denies current tobacco, alcohol, or illicit drug use.
- Exercise/Activity → Participates in recreational activities and physical therapy as tolerated.

ROS

General: Denies fever, chills, weight loss, weight gain, loss of appetite, generalized weakness, fatigue, or night sweats.

Skin: Denies rash, new skin lesions, or wounds.

HEENT: Reports legal blindness of the left eye secondary to retinal detachment status post vitrectomy. Denies headache, dizziness, lightheadedness, hearing changes, tinnitus, nasal congestion,or sore throat

Neck: Denies neck pain, stiffness, masses, or decreased range of motion.

Pulmonary: Denies cough, shortness of breath, wheezing, hemoptysis, orthopnea, or dyspnea on exertion.

Cardiovascular: Denies chest pain, palpitations, syncope, or irregular heartbeat.

Gastrointestinal: Denies nausea, vomiting, abdominal pain, diarrhea, constipation, hematochezia, melena, or changes in bowel habits.

Genitourinary: Admits intermittent urinary incontinence. Denies difficulty initiating urination, urinary urgency, urinary frequency, dysuria, hematuria, nocturia, flank pain, suprapubic pain, or penile discharge.

Neurological: Denies weakness, numbness, tingling, or changes in memory or cognition.

Musculoskeletal: Denies joint pain, joint swelling, calf pain, muscle weakness, or recent falls.

Peripheral Vascular: Denies claudication, cold extremities, varicose veins, edema, or skin color changes.

Hematologic: Denies easy bruising, abnormal bleeding, history of blood transfusions, DVT, or PE.

Psychiatric: History of schizoaffective disorder, bipolar disorder, and PTSD. Denies worsening depression, anxiety, hallucinations, suicidal ideation, or homicidal ideation.

Physical Exam:

Vital Signs

BP: 127/62 Right arm

P: 76

T: 97.3 oral

R: 18

O2: 97% on room air

Height: 5'7" | Weight: 139 lb | BMI: 21.8 kg/m^2

General: Thin, Well-appearing 70 year old male founding laying in bed in no acute distress. Alert and oriented x3.

Skin: Warm and dry. No acute rashes or lesions noted.

Pulmonary: Respirations unlabored. Lungs clear to auscultation bilaterally without wheezes, rales, or rhonchi.

Abdomen: Soft, non-tender, non-distended. Bowel sounds present. No suprapubic tenderness. No CVA tenderness.

Genitourinary: No penile or scrotal lesions noted. Chaperone Urology PA

Peripheral Vascular: cap refill <2 in upper + lower extremities without clubbing/cyanosis/edema. Dorsalis pedis and posterior tibial pulses 2+ bilaterally.

<u>Imaging/Labs:</u>

UA: Negative for infection

Bladder Scan (05/28/2026)

- Pre-void volume: 325 mL
- Post-void residual: 20 mL

Assessment: Mr. X is a 70-year-old male with PMHx of schizoaffective disorder, bipolar disorder, CKD, PTSD, and BPH/LUTS s/p TURP who presents for evaluation of ongoing urinary incontinence. Patient reports improvement in urinary hesitancy since initiation of tamsulosin. UA is negative for infection and bladder scan demonstrates adequate bladder emptying with a post-void residual of 20 mL, making significant urinary retention unlikely. Clinical presentation is most consistent with functional urinary incontinence, as the patient demonstrates adequate bladder emptying and improvement with prompted toileting. Underlying BPH/LUTS appears well controlled on tamsulosin and may be a contributing factor. Functional limitations requiring ambulation with a walker may also contribute to delayed toileting and episodes of incontinence.

<u>D/Dx:</u>

1. Functional Urinary Incontinence (Most Likely)
    - Patient frequently voids into brief despite having a urinal available and demonstrates adequate bladder emptying when prompted.
    - Uses walker for movement which cause functional
    - Symptoms improve with encouragement and scheduled toileting, suggesting a behavioral/functional component rather than true obstruction.
2. BPH with LUTS

- History of BPH/LUTS and TURP. Patient previously reported urinary hesitancy that improved after initiation of tamsulosin. Underlying lower urinary tract dysfunction may contribute to symptoms.

3. Urge Incontinence
    - May present with involuntary leakage before reaching the toilet.
    - Less likely as patient denies urgency and frequency, but remains a consideration.
4. Overflow Incontinence (Less Likely)
    - History of BPH raises concern for incomplete bladder emptying; however, low post-void residual after voiding makes significant retention unlikely.
5. Urinary Tract Infection (Less Likely)
    - UTI can present with new urinary incontinence in older adults and LTC residents.
    - However, the patient denies dysuria, hematuria, fever, chills, suprapubic pain, and recent urinalysis was negative for infection, making this less likely.

<u>Plan:</u>

Functional Urinary Incontinence / LUTS

- Continue Tamsulosin 0.4 mg PO daily.
- Encourage use of bedside urinals.
- Implement timed voiding every 4 hours while awake.
- Reinforce nursing reminders and prompted toileting.
- Monitor urinary symptoms and frequency of incontinence episodes.
- Encourage adequate hydration.
- Continue incontinence care and use of absorbent briefs as needed.

BPH

- Continue current management with tamsulosin.
- Monitor for worsening LUTS.

Follow-up

- Monitor for dysuria, hematuria, fever, flank pain, urinary retention, or worsening incontinence.
- Follow up with Urology as needed.

Code status : Full Code