WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
Coden USA: WJPRAP Impact Factor 8.63
Volume 15, Issue 11, 2481-2501. Review Article ISSN 2277–7105

A COMPREHENSIVE REVIEW OF URINARY INCONTINENCE AND ITS HOMOEOPATHIC MANAGEMENT

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Article Received on 05 May 2026,
Article Revised on 25 May 2026,
Article Published on 01 June 2026,

https://doi.org/10.5281/zenodo.20536883

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How to cite this Article: Dr. Arun Nishad*[1], Dr. Jyoti Sharma[2], Dr. Yash Chotia[1], Dr. Vandana Yadav[3], Dr. Chitransha Kanwar[4], Dr. Manasvi Choudhary[4] (2026). A Comprehensive Review Of Urinary Incontinence And Its Homoeopathic Management. World Journal of Pharmaceutical Research, 15(11), 2481-2501.

ABSTRACT

Urinary incontinence (UI) is a prevalent but frequently under-reported condition that has a substantial impact on social, psychological, and physical well-being, especially in women and the elderly. Hormonal fluctuations, neurological conditions, lower urinary tract dysfunction, and pelvic floor weakness are some of the multifactorial causes. The patho-physiological categorization, clinical evaluation, diagnostic methods, and epidemiology of urinary incontinence are described in this review. The importance of customized homoeopathic treatment is also covered, with a focus on clinically specific and frequently prescribed treatments for various forms of urinary incontinence.

KEYWORDS: Urinary incontinence, Stress incontinence, Overactive bladder, Homeopathy, Pelvic floor exercise, Enuresis.

INTRODUCTION

Urinary incontinence (UI) is a common yet frequently under-reported condition characterized by the involuntary leakage of urine. It significantly affects physical health, psychological well-being, and social functioning. Although UI can occur at any age, it is more prevalent among women and older adults. The etiology of UI is multi-factorial and includes pelvic floor weakness, hormonal changes, neurological disorders and dysfunction of the lower urinary tract. Many patients delay seeking medical attention due to embarrassment, social stigma, or lack of awareness, which often results in reduced quality of life. Effective management requires accurate diagnosis, identification of reversible causes, and individualized treatment. In recent years, holistic and non-invasive approaches, including lifestyle modification and complementary therapies such as homeopathy, have gained attention for their potential role in managing urinary incontinence.[1-2-3]

EPIDEMIOLOGY - The true prevalence of urinary incontinence is likely underestimated, as many individuals do not report symptoms to healthcare providers.

- **Global Prevalence:** A meta-analysis involving 518,465 women aged 55–106 years reported a pooled prevalence of 37.1%. The highest prevalence was observed in Asia.[4]
- **Gender-Based Prevalence:** According to the 4th International Consultation on Incontinence, UI affects 25–45% of women. In men, prevalence increases with age.[5]
- **Indian Data:** Community studies report prevalence between 16–34% among women, pregnant women, and sportswomen. study in Coimbatore (Tamil Nadu), prevalence among women was 33.8%.[6] In a study of post-menopausal women in India the prevalence of UI was reported at 26.47%**,** with stress incontinence 13.9%, mixed UI 7.2%, and urge UI 5.4%.[7] Among pregnant women in central India (Indore), the prevalence during the current pregnancy was found to be 16.4%.[8] In a study of nulliparous Indian sportswomen (n=560), UI prevalence was 22.5% for stress UI, 8.8% for mixed UI, 8.4% for urge UI.[9]

ETIOLOGICAL CLASSIFICATION OF URINARY INCONTINENCE

Urinary incontinence (UI) is a complex condition with multifactorial etiopathogenesis, including anatomical, neurological, hormonal, genetic, and molecular influences. Stress urinary incontinence; urge urinary incontinence, mixed urinary incontinence, overflow incontinence, and functional incontinence. Initial evaluation typically does not require urologic or gynecologic assessment, but reversible causes should be ruled out.[10]

1. Stress Urinary Incontinence (SUI) - Stress urinary incontinence is the involuntary leakage of urine that occurs with increased intra-abdominal pressure during activities such as exertion, straining, Valsalva, sneezing, or coughing. Young women active in sports may experience this type of incontinence pregnant women and women who have experienced childbirth may be prone to stress urinary incontinence. Stress incontinence in men is typically a complication of prostate surgery, resulting in sphincteric insufficiency.[11]

Following Factors are Responsible for (SUI)

Urethral Hypermobility - Weakening of **pelvic floor muscles and connective tissue** leads to **descent of the bladder neck and urethra**, causing improper transmission of abdominal pressure to the urethra this result from.

- Childbirth trauma, which stretches or injures the pelvic supports.
- Aging and menopause, which reduce collagen and muscle tone.
- Pelvic surgery, causing structural damage to supportive fascia.

When pressure increases during exertion, the urethra fails to stay closed, leading to leakage.[12-13]

Intrinsic Sphincter Deficiency (ISD) - In ISD, the **urethral sphincter mechanism itself becomes weak**, unable to maintain adequate closure pressure even in normal conditions.[13-14]

This may occur due to

- Denervation or neuromuscular injury (e.g., after childbirth or chronic straining).[13]
- Estrogen deficiency, leading to atrophy of urethral mucosa and smooth muscle.[12-15]
- Pelvic radiation or previous anti-incontinence surgery, damaging sphincter tissue.[14]

2. Urge Incontinence - Urge incontinence is also known as (OAB) over active bladder defined as the involuntary leakage of urine that is typically associated with a sudden and compelling urge to void.[16] the development of urge incontinence at the cellular and neurophysiological level is a multifactorial process, primarily related to detrusor overactivity.[17] This overactivity may result from irritation or increased sensitivity of the bladder urothelium and interstitial (myofibroblast) cells**,** leading to excessive afferent signaling and a reduction in central inhibitory neurological control over bladder contractions.[16-17] Urge incontinence may occur due to detrusor instability**,** overactive bladder syndrome, or neurological conditions such as stroke, Parkinson's disease, or multiple sclerosis.[18-19]

Following Factors are Responsible for Urge Incontinence

- **Neurogenic factors** - Damage or dysfunction of neural pathways that control bladder storage and voiding reflexes can lead to detrusor overactivity due to Neurological injury or disease causes loss of inhibitory control, resulting in uninhibited detrusor contractions**.**
- **Urothelial and Afferent Nerve Factors** - The urothelium is not just a passive barrier—it actively participates in bladder signaling. Damaged or inflamed urothelium releases adenosine triphosphate (ATP) and acetylcholine (ACh)**,** which activate afferent C-fibers. This increases bladder sensation and triggers premature detrusor contractionns**.** Chronic irritation (infection, stones, tumors, radiation) enhances this mechanism.[20]
- **Age-Related Factors** - Aging affects the structure and function of the bladder and its neural control. Reduced bladder capacity and compliance. Increased afferent C-fiber excitability and altered neurotransmitter balance**.** Decline in estrogen (in women) → atrophic changes in bladder and urethra. Vascular insufficiency → detrusor ischemia and oxidative stress.[21]
- **Local Bladder Pathologies** – It also affects both the structure and function of the bladder and its neural control. Following conditions activate sub-urothelial sensory nerves lowering the threshold for detrusor contractions.[22]

Examples - Urinary Tract Infection (UTI), Bladder stones or neoplasms, interstitial cystitis/bladder pain syndrome, Radiation cystitis, Postoperative inflammation.

- **Medication-Induced Functional Factors** - Certain drugs exacerbate urge symptoms.

- Diuretics**:** Increase urine production.
- Cholinergic agents**:** Directly stimulate detrusor muscle.
- Alpha-blockers**:** Relax bladder neck and promote leakage.
- CNS depressants**:** Diminish awareness of bladder filling.

- **Functional Triggers** - Anxiety or stress**,** cold weather**,** or running water sound can trigger bladder contractions via autonomic reflex pathways.[23]
- **Idiopathic Detrusor Overactivity** - When no underlying cause is identified, the condition is termed idiopathic but at the cellular and neurochemical level, following factors are associated

- Upregulation of M2/M3 muscarinic receptors
- Increased neurotransmitter (ATP, ACh) release
- Altered sensory signaling in C-fibers
- These contribute to heightened bladder sensitivity and involuntary contractions.[24]

3. Mixed Urinary Incontinence (MUI) - (MUI) is characterized by the involuntary leakage of urine associated with both physical exertion (stress incontinence) and urgency (urge incontinence). It results from a combination of urethral sphincter weakness and detrusor overactivity, commonly seen in women, particularly after childbirth or menopause. Factors such as pelvic floor dysfunction**,** hormonal changes**,** aging, and neurological impairment contribute to its development. Diagnosis involves clinical evaluation and urodynamic studies, while management includes behavioral therapy, pelvic floor exercises, pharmacotherapy, and surgical interventions based on the predominant component.[25]

Following Factors Are Responsible For (MUI)

Mixed urinary incontinence (MUI) develops due to the coexistence of factors that contribute to both stress urinary incontinence (SUI) and urge urinary incontinence (UUI)**.** It involves a combination of urethral sphincter incompetence and detrusor overactivity**,** influenced by anatomical, neurological, hormonal, and age-related changes.

- **Pelvic Floor Muscles Weakness -** Weakness or laxity of the pelvic floor muscles and connective tissue reduces urethral support, leading to stress leakage. Common after vaginal delivery**,** pelvic surgery, or chronic increases in intra-abdominal pressure (from obesity, constipation, or chronic cough).[26]
- **Urethral Sphincter deficiency** - Intrinsic sphincter deficiency (ISD) or loss of urethral coaptation pressure causes leakage during exertion may result from estrogen deficiency**,** aging, or trauma.[1]
- **Detrusor Overactivity** - Involuntary contractions of the detrusor muscle during bladder filling lead to urgency and urge leakage. Can be idiopathic or secondary to neurological diseases (stroke, Parkinson's disease, multiple sclerosis) or bladder irritation (infection, stones, and tumors).[22]
- **Hormonal and postmenopausal changes -** Estrogen deficiency causes atrophy of the urethral mucosa and bladder trigone, reducing urethral closure pressure and bladder compliance. Common in postmenopausal women, contributing to both stress and urge components.
- **Neurological and sensory dysregulation** - Central or peripheral neurological dysfunction affects bladder inhibition and sphincter control. Conditions like stroke**,** spinal cord injury, or diabetic neuropathy impair normal micturition reflex coordination, promoting mixed leakage.

- **Age Related structural changes** - Aging causes loss of connective tissue elasticity**,** diminished urethral pressure**,** and impaired detrusor compliance**.** These changes predispose older women to both types of incontinence.
- **Functional and life style factors** - Obesity**,** chronic cough**,** smoking**,** excessive caffeine or alcohol intake**,** and sedentary lifestyle increase bladder pressure or irritability, aggravating both stress and urge symptoms.[15]

4. Overflow urinary incontinence (OAB) - (OAB) is the involuntary leakage of urine from an over distended bladder due to impaired detrusor contractility and bladder outlet obstruction. Neurologic diseases such as spinal cord injuries, multiple sclerosis, and diabetes can impair detrusor function, resulting in a hypotonic neurogenic bladder. Bladder outlet obstruction can be caused by external compression by abdominal or pelvic masses, urethral strictures, and pelvic organ prolapse, among other causes. A common etiology in men is benign prostatic hyperplasia. Overflow urinary incontinence is the only type of urinary incontinence considered directly physically dangerous, as it can lead to renal failure and permanent bladder damage.[10]

Factors Responsible for Overflow Urinary Incontinence

- **Bladder Outlet Obstruction** - These conditions physically block urine flow, causing the bladder to overfill.

Examples

- Benign prostatic hyperplasia (BPH) — most common in older men
- Urethral stricture
- Bladder neck obstruction
- Pelvic organ prolapse (cystocele, uterine prolapse) in females
- Tumors of bladder, urethra, or prostate
- Severe constipation compressing the urethra

- **Detrusor Underactivity (weak bladder muscle)** - The bladder muscle becomes too weak to generate adequate contraction due following conditions

- **Aging / age-related myogenic failure**
- **Long-standing bladder over distension**
- **Chronic diabetes mellitus** (diabetic cytopathic)
- **Chronic alcoholism**
- **Medications** – Causing decreased bladder contractility such as

- Anticholinergics
- Antihistamines
- Tricyclic antidepressants
- Calcium channel blockers
- Muscle relaxants

➢ **Neurogenic Causes** - Neurological disorders such as diabetic neuropathy, spinal cord injuries (especially lower motor neuron lesions), multiple sclerosis, Parkinson's disease, stroke with LMN involvement and post-surgical pelvic nerve injury can impair the detrusor's ability to contract.

➢ **Functional Causes** - Functional limitations such as severe mobility impairment, advanced dementia, or profound psychological conditions (like severe depression) can lead to infrequent voiding and progressive bladder overfilling.

➢ **Medications That Increase Outlet Resistance or Reduce Bladder Contractility** Medications such as alpha-agonists (phenylephrine, pseudoephedrine), opioids, NSAIDs, and drugs with anticholinergic effects increase sphincter tone or reduce detrusor contractility, contributing to overflow retention.[27]

Clinical Assessment & Diagnosis of Urinary Incontinence

A thorough history and physical examination are essential in evaluating patients with urinary incontinence. This comprehensive assessment helps identify the underlying causes, differentiate between types of incontinence, and guide appropriate management strategies. Clinical assessment of urinary incontinence moves through four natural stages history, physical examination, basic tests, and advanced evaluations when needed. Each stage answers a different question about "why the bladder is behaving like an overexcited.

1. History – (where the story begins)

A detailed history is essential, as it helps identify the type of urinary incontinence, assess its severity, understand its impact on daily life, and determine its duration.

Key elements include

➢ Fluid intake, caffeine, alcohol & medication - Patients should be assessed for medication and substance use, including diuretics, psychotropic agents, alcohol, and caffeine, as these can directly or indirectly aggravate urinary incontinence. their potential effects—such as altered bladder or sphincter function, increased diuresis, drug-induced cough, and impaired cognition—may all contribute to urinary leakage.

- Obstetric and gynecologic history - In female patients, a detailed gynecologic history should be obtained, including the number of births, mode of delivery (vaginal or cesarean), and current pregnancy status. Estrogen status should also be evaluated, as atrophic vaginitis and urethritis during perimenopause may contribute to reversible urinary incontinence.
- When does leakage happen? Coughing, urgency, nighttime, continuous?
- Duration and progression
- Neurological symptoms (numbness, gait issues, diabetes)
- Presence of red flags (hematuria, recurrent UTIs, pelvic pain)
- Bladder diary / Voiding diary (2–3 days) is almost magical—reveals frequency, volume, triggers, and nocturia pattern.[10]

2. Physical Examination — (where hypotheses meet reality)

Physical examination helps identify the underlying cause of urinary incontinence by assessing pelvic support, bladder distension, neurological function, prostate size, and mobility. It distinguishes between stress, urge, overflow, and functional types, guides appropriate investigations, and ensures that reversible or contributory factors are not overlooked, improving diagnosis and management accuracy.[10]

The physical examination should include assessment of the following components and clinical findings, as appropriate.

- **General Physical Examination** - The overall exam helps identify systemic contributors to urinary incontinence. Observe for blood pressure abnormalities, peripheral edema, and mobility limitations, all of which can worsen lower urinary tract symptoms (LUTS) and urgency episodes.[28]
- **Abdominal Examination** - Inspection and palpation of the abdomen—especially the suprapubic area—helps identify bladder distension, suggesting retention or overflow incontinence. Percussion over the bladder gives clues about post-void residual volume.[29]
- **Pelvic Examination (Females)** - A pelvic exam evaluates structures most responsible for stress and mixed incontinence.

Findings include

• Pelvic organ prolapse (cystocele, rectocele)

• Urethral hypermobility — often assessed via Q-tip test

• Vaginal atrophy — linked with urgency and frequency

• Pelvic floor muscle tone — measured by digital evaluation

These findings guide diagnosis of stress, mixed, or urgency incontinence.[30-31-32]

- **Genitourinary Examination (Males)** - Men require digital rectal examination (DRE) to assess prostate size, consistency, and tenderness. Prostate enlargement is a common cause of obstruction and overflow incontinence perineal sensation and anal sphincter tone help identify neurogenic causes.[32-33]
- **Neurological Examination** - Bladder control depends critically on the sacral (S2–S4) and thoracolumbar pathway assessment includes
- Lower limb reflexes
- Perineal sensation
- Bulbocavernosus reflex
- Signs of neuropathy (common in diabetes)

Neurologic dysfunction often produces detrusor underactivity or overactivity.[14-34]

- **Stress Test for Leakage** - A cough stress test or Valsalva maneuver is performed with the patient standing or semi-recumbent. Immediate leakage after coughing indicates stress urinary incontinence.[35]
- **Post-Void Residual (PVR) Estimation** - Although ultrasound is preferred, clinical suspicion of high PVR arises if the bladder remains palpable post-void or if dribbling continues. High PVR suggests overflow incontinence and bladder outlet obstruction.[33-36]
- **Gait and Functional Assessment** - Mobility problems can lead to functional incontinence, where the bladder works properly but the patient cannot reach the toilet in time. Balance, gait, and transitional movements are assessed.[37]
- **Skin Examination** - Chronic dampness may produce dermatitis, maceration, fungal infections, or cellulitis. Skin examination forms an essential part of the physical evaluation in long-standing incontinence cases.[38]

Most useful scales and questionnaires for diagnosis and assessment of urinary incontinences

Several scales and questionnaires are available for the assessment of urinary incontinence, but we have mentioned some of the most widely used and well-validated tools, including the 3IQ, ICIQ-UI SF, UDI-6, and IIQ-7 by use these we manage and assess incontinence properly.[45]

ICD-11 Classification of Urinary Incontinence[39]

(ICD-11 uses a new structure under "GB20 – Incontinence of Urine" group.)

- GB20.00 – Stress Urinary Incontinence

Involuntary leakage on effort, coughing, or sneezing.

- GB20.01 – Urgency Urinary Incontinence

Leakage preceded by sudden strong urge.

- GB20.02 – Mixed Urinary Incontinence

both stress and urgency components present.

- GB20.03 – Overflow Urinary Incontinence

Leakage due to chronic retention and over distension.

- GB20.04 – Continuous Urinary Incontinence

Persistent, uninterrupted leakage.

- GB20.0Y – Other Specified Urinary Incontinence

used for less common forms.

- GB20.0Z – Urinary Incontinence, Unspecified.

Clinical Investigations for Urinary Incontinence[40-41]

- Urinalysis (and urine culture when indicated)
- Bladder (voiding) diary / frequency-volume chart
- Post-void residual (PVR) urine measurement
- Uroflowmetry
- Urodynamic studies (multichannel / comprehensive)
- Cough stress test (or "stress test" / demonstration of stress incontinence)
- Pad test (optional / for quantification of leakage)
- Pelvic (bladder / renal) ultrasound imaging
- Cystoscopy (select advance cases)

Homoeopathic Management of Urinary Incontinence[42-43-44]

Most commonly prescribed polychrest homoeopathic medicines for (UI)

1. Apis Mellifica - Incontinence with burning and soreness in urethra when urinating. Suppressed urine loaded with casts' frequent and involuntary urination. Stinging pain and strangury scanty high colored last drops causing burn. Oedmatic swelling of lower limb and below eyelids with reduced thirst.

2. Argentum Nitricum - In this drug the neurotic effects are very marked. Symptoms of inco-ordination, loss of control. Urine passes unconsciously in both day and night. Emission of a few drops after having finished. Incontinence worse after eating sweet during stress associated with anticipatory anxiety and fear.

3. Cantharis Vesicatoria - Intolerable frequent urging and tenesmus pain in bladder. Violent paroxysms of cutting and burning in whole renal region with painful urging to urinate before during and after urinate. Urine passed drop by drop. Constant desire to urinate.

4. Causticum - Involuntary escape of urine when coughing, snezzing. Expelled very slowly and sometimes retained. Involuntary escape of urine during first sleep at night also from slightest excitement. Retention after surgical operations with loss of sensibility on passing urine Worse dry cold winds in clear fine weather, cold air from motion of carriage.

5. Equisetum Hyemale – (Principal remedy for enuresis and great action on the bladder) This remedy is useful in enuresis and dysuria with severe dull pain and a sensation of bladder fullness not relieved by urination. There is frequent urging with intense pain at the close of micturition, and urine is passed drop by drop. Sharp, burning, cutting pain is felt in the urethra while urinating. It is indicated in children who pass urine during dreams or nightmares and in elderly women with incontinence accompanied by involuntary stools. Retention and dysuria may occur during pregnancy and after delivery. The urine contains much mucus, and albuminuria with involuntary urination may be present.

6. Phosphoricum Acidum – (Incontinence with diabetes mellitus) Frequent profuse watery and milky (diabetes). Micturition proceeded by anxiety and followed by burning. Frequent urination at night with phosphaturia debility is very marked in this remedy, producing a nervous exhaustion.

7. Sabal Serrulata – (Incontinence with benign prostatic hypertrophy) Sabal is homeopathic to irritability of the genito-urinary organs unquestioned value in prostatic enlargement. Constant desire to pass urination at night.Enuresis due paralysis of bladder sphincters, difficult urination.Cystitis with prostatic hypertrophy.

8. Silicea Terra – (Nocturnal enuresis in children with worm) Bloody involuntary with red or yellow sediment. Prostatic fluid discharged when straining at stool Imperfect assimilation and consequent defective nutrition.Scrofulous, rachitic children, with large head open fontanelles and sutures, distended abdomen, slow in walking, sensitive to cold. Complaints worse in winter with great sensitiveness to taking cold.

9. Staphysagria - (Incontinence of urine with UTI) Cystitis, prolapse of uterus (cystocele). Ineffectual urging to urinate in newly married women. Pressure upon bladder, feels as if it did

not empty. Sensations as if a drop of urine were rolling continuously along the channel. Burning in urethra with frequent micturition when not urinating.Urging and pain after urinating. Incontinence due to sexual excesses.

10. Sulphur – This polychrest remedy is widely used in acute and chronic cases, especially when other medicines fail. It is indicated for frequent nocturnal urination, enuresis in untidy children, burning micturition with mucus and pus, sudden urgent urination with large amounts of colorless urine, and in patients prone to skin affections and poor hygiene.

11. Thuja occidentalis – (Incontinence with prostatic enlargement) The main action of Thuja is on the skin and genito-urinary organs producing conditions that correspond with Hahnemann's sycotic dyscrasia with hydrogenoid constitution. Frequent micturition accompanying pains. Desire sudden and urgent, but cannot be controlled. Paralysis sphincter vesicae. Pain and burning felt near neck of bladder, with frequent and urgent desire to urinate worse at night from cold, damp air.

12. Veratrum Album - Involuntary emission of urine occurs, especially during coughing and in cases of typhoid. The urine may be acrid, deep-colored, greenish, or dark red, and is passed frequently in small quantities. There is pressing pain in the bladder with a burning sensation during urination. This remedy is indicated in cases of marked debility or exhaustion due to functional or physical disturbance. Several symptoms are aggravated by rising and relieved by lying down. Sudden, general, and paralytic prostration of strength is characteristic, with excessive chronic weakness that prevents sitting or lying comfortably and is worsened by the slightest movement.

Rare and uncommon prescribed clinically specific remedies for (UI)

1. **Asparagus Officinalis –** This medicine is highly useful in cases of urinary incontinence associated with urinary tract infection. Patients experience frequent urination with fine stitching pains at the urethral orifice, along with a burning sensation and urine of a peculiar odor. It is indicated in cystitis characterized by the presence of pus, mucus, and tenesmus, as well as in lithiasis. The remedy has a marked and immediate action on the genitourinary organs, a property well recognized in Ayurvedic practice. It is particularly useful in adolescent girls presenting with extreme debility, leucorrhoea, recurrent urinary tract infections, and delayed or poor development of secondary sexual characteristics, including underdeveloped breasts.
2. **Squilla Maritima** – Incontinence of urine in both upper and lower respiratory tract infections Valuable in chronic bronchitis of old people with mucous rales, dyspnea and

scanty urine. Great urging with much watery urine. Involuntary spurting of urine when coughing. Complaints general worse with motion.

3. Tribulus Terrestris – This is an East Indian drug, also known as *Ikshugandha*, noted for its usefulness in urinary affections. It is indicated in urinary incontinence with painful and partial micturition and is beneficial in impotence arising from overindulgence, advancing age, or when accompanied by urinary symptoms. It is also useful in cases of urinary incontinence associated with a debilitated state of the sexual organs.

4. Trillium Pendulum – (Incontinence of urine with uterine diseases and after labour) In homoeopathy, *Trillium pendulum* is considered a great anti-hemorrhagic remedy and has a marked affinity for the pelvic organs, causing relaxation of the pelvic region. It is indicated in hemorrhage associated with great faintness and dizziness, with a tendency to prolapse and severe bearing-down pain in the pelvic region. Dribbling of urine after labor with copious, yellow, stringy leucorrhoea is also characteristic.

5. Triticum Rapens – Couch grass is regarded as an effective remedy for excessive bladder irritability. It is considered useful in chronic cystitis associated with gonorrhea, urinary tract infections, chronic pelvic inflammatory disease, nephrolithiasis, and prostomegaly-related prostatitis. It is especially indicated when there is intense painful urination (dysuria), marked irritability of the urinary passages, frequent urging with incontinence and dribbling of urine (strangury), often accompanied by mucus discharge.

6. Uranium Nitricum – (Incontinence of urine associated with diabetes) This homeopathic preparation is made from uranyl nitrate and is used to treat conditions related to the urinary system. Uranyl nitrate is a pale yellow, radioactive chemical compound. The remedy is primarily indicated for symptoms associated with blood sugar imbalance and urinary disorders. It supports kidney function and addresses various urinary complaints, including burning during urination, painful inability to retain urine, and the presence of mucus in the urine. It is sometimes considered in cases of diabetic nephropathy and is associated with glycosuria and increased urine output (diuresis). Marked emaciation, debility, and a tendency toward ascites and general dropsy are characteristic features.

7. Uva Ursi - Chronic vesical irritation (cystitis) is characterized by pain, tenesmus, and catarrhal discharges. Patients experience frequent urging to urinate with severe spasms of the bladder, accompanied by burning and tearing pain. The urine may contain blood, pus, and large clots of tenacious mucus. Involuntary and painful dysuria commonly occurs due to underlying urinary tract infection.

8. Verbascum Thapsus – Verbascum Thapsus, known as "mullein" in homeopathy, is traditionally described as having an affinity for sensory nerves, with urinary symptoms viewed as expressions of nerve irritability and reflex-related loss of control rather than structural pathology. For this reason, some materia medica place it among remedies used in urinary incontinence and enuresis nocturna.

9. Viburnum Opulus – A general remedy for spasmodic and congestive affections of pelvic organs. Spasmodic membranous dysmenorrhea with or without sensation after micturition as if urine continued to flow, frequent copious and profuse urination in every hour especially during menses, spurting of urine when coughing, cannot hold urine (water) on coughing or walking.

10. Xerophyllum – Xerophyllum as a strong bladder – acting remedy having distinct influence on the improving detrusor muscles and pelvic sphincter tone, weak control of bladder outlet with involuntary dribbling of urine worse at night and while walking or during active movements with dull or bearing down pain in lower abdomen and rectum.

Repertorial Approach

1. REPERTORY by Oscar E. BOERICKE, M.D[48]

1. **Atony** (See Paralysis.) -- *Ars.*, Dulc., Hep., Op., *Plumb.*, Rhus ar., Rhus t., Scilla, Tereb. **Cystocele** -- Staph.
2. **ENURESIS - Incontinence** (See Flow.) -- Acon., Agar., Apis., *Arg. n.*, Arn., Ars., Atrop., *Bell.*, *Benz. ac.*, Calc. c., Canth., *Caust.*, Cic., Cim., *Cina.*, Con., *Dulc.*, *Equis.*, Eryng. aq., Eup. perf., *Eup. purp.*, Ferr. m., *Ferr. p.*, *Gels.*, Hydrang., Hyos., *Kali br.*, Kali n., Kali p., *Kreos.*, Linar., *Lupul.*, Lyc., Mag. p., Med., *Nux v.*, Op., Petrol., Phos. ac., Physal., Plant., *Puls.*, *Rhus ars.*, Rhus t., *Sabal*, Sanic., *Santon.*, Sec., Senega, *Sep.*, Sil., Stram., *Sul.*, Tereb., *Thyr.*, Thuya, Tritic., Tub., *Uran.*, *Verbasc.*, Zinc. m.

OCCURRENCE

Diurnal -- Arg. n., Bell., Caust., Equis., *Ferr. m.*, *Ferr. p.*, Sec.

Old people [In] -- Aloe, Ammon. benz., *Arg. n.*, *Benz. ac.*, Canth., Equis., *Gels.*, Nit. ac., *Rhus ar.*, Sec., Senega, *Turnera.*

Nocturnal -- Am. c., Arg. n., Arn., Ars., *Bell.*, Benz. ac., Calc. c., *Caust.*, Cina, Coca, *Equis.*, Eup. purp., Ferr. iod., Ferr. p., Gels., Hep., Ign., Kali br., Mag. p., *Med.*, Physal., *Plant.*, *Puls.*, Quass., *Rhus ar.*, Santon., Sec., *Sil.*, *Sul.*, Thuya, Uran., Verbasc.

CAUSE

Catheterization, after -- Mag. p.

Digestive disturbances -- Benz. ac., *Nux v.*, Puls.

Sleep [during first]; child aroused with difficulty -- Caust., Kreos., *Sep.*

Moon [during full]; intractable cases; eczematous history -- Psor.

Habit the only ascertainable cause -- Equis.

Sycosis [history of] -- Med.

Hysteria -- Ign., Val. m.

Weak or paretic sphincter vesicæ (See Paralysis.) -- Apoc., *Bell.*, *Caust.*, Con., Ferr. p., *Gels.*, Nux v., Rhus ar., *Sabal*, Sec., *Strych.*

Worms -- Cina., *Santon.*, Sul.

2. The Prescriber by John Henry Clarke[49]

Urine

MICTURITION, FREQUENT

At night in old people, *Caust.* 3x, 8h.

Frequent at night ; urging to urinate, but it is a long time before he is able, *Kali c.* 6, 8h.

Urging after drinking water, *Carlsbad* 6, 8h.

After drinking coffee, *Ign.* 3, 8h.

Frequent urging with constipation, *Nux v.* 3, 2h.

Violent urging with dragging pains, *Lil. t. 30*, once a day.

INCONTINENCE OF

Simple nocturnal, in profound sleep, *Bell.* 3, 4h.

In first sleep, *Sep.* 6, 8h.

When the urine has a very strong odour, *Benz. ac.* 3x, 4h.

In children of phthisical heredity or tendencies, *Bac. test.* 30, once a week.

Incontinence, day or night, profuse emission, *Equiset.* Ø - 3x, gtt. v. 8h.

From irritation from worms, *Cina* 3, 4h.

In children when difficult to awaken, *Kreas.* 3, 8h.

From too profound sleep, *Kali brom.* gr. ii. at bedtime.

Dribbling whilst sitting and walking ; on coughing ; on emitting flatus ; in bed at night, *Puls.* 3, 4h.

Constant dribbling, *Verbasc. t.* 3, 4h.

Incontinence during the day only, or chiefly, *Ferr. phos.* 3, gr. ii. 6h.

Involuntary passage of water during coughing, laughing, sneezing, etc. (1) *Caust.* 6, 4h.; (2) *Ferr. met.* 6, or *Ferr. mur.* 3x, 4h. ; (3) *Puls.* 3x, 4h. ; (4) *Caps.* 3, 4h.

Bladder

IRRITABLE

Frequent desire to pass water, which is natural or increased in quantity and slightly burning, *Apis* 3x, 2h.; constant desire, only a few drops voided, *Canth.* 3, 2h.

Burning, cutting, or sticking pain in urethra (especially the female urethra) during and after urinating ; frequent desire, *Berb.* Ř, gtt. ii. 1/2h. - 4h.

Burning in region of kidneys, bladder, and ureter, strangury, *Tereb.* 3, 1/2h. - 4h.

Irritation of the neck of the bladder and urethra in women, *Copaib.* 3x, 4h.

Incontinence of urine, chiefly during the day, *Ferr. phos.* 6x, gr. v. 6h.

Irritable bladder in gouty or alcoholic subjects; irritability of bladder and rectum, with urging, at the same time, with little or no result, *Nux v.* 3, 4h.

Involuntary passage of urine in sleep, *Senega* 3, 6h.

In sleep during the daytime, or during the night, *Bell.* 1, 6h.

Involuntary passage of urine on coughing or sneezing, *Caust.* 1 - 6, 6h.

PARALYSIS OF

(1) *Op.* 1, 2h. (2) *Canth.* 3, 2h.

When there is a continuous sensation as if imperfectly relieved of its contents, *Secale* 1, 4h. *See also* **Strangury** >> ; *and* **Urine, RETAINED** >>.

ACUTE INFLAMMATION OF

Canth. 3, 2h.

If caused by chill in damp weather, *Dulc.* 3, 2h.

Symptomatic of kidney affection or calculus, with much secretion of mucus, *Pareira* Ř, gtt. x. 4h.

CHRONIC INFLAMMATION OR CATARRH OF

Canth. 3, 6h.

With incontinence of urine in bed at night, *Puls.* 3x, 6h.

Water smelling like horse's, (1) *Benz. ac.* 3x, 6h. (2) *Nit. ac.* 5, 4h.

If these fail, *Chimaphila* Ř, gtt. v. 6h.

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