

Bladder Dysfunction in Parkinson Disease: An Underrecognized Clinical Priority

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Received: September 23, 2026; **Published:** September 29, 2026

Bladder dysfunction is a frequent but often underrecognized nonmotor manifestation of Parkinson disease (PD). Urinary urgency, frequency, nocturia, and urgency urinary incontinence can substantially impair quality of life, disturb sleep, increase caregiver burden, and contribute to falls. Despite this clinical burden, urinary symptoms may receive considerably less attention than the motor manifestations of PD. Recent evidence comparing behavioral and pharmacological treatment approaches provides an important opportunity to reconsider how bladder dysfunction is assessed and managed in patients with PD.

In a randomized clinical trial published in *JAMA Neurology*, Vaughan and colleagues [1] evaluated behavioral therapy compared with pharmacological treatment with solifenacin for overactive bladder symptoms in patients with PD. The study included 77 participants and demonstrated improvement in urinary symptoms with both approaches. Behavioral therapy was not inferior to drug therapy for the primary outcome, while adverse effects such as dry mouth and falls were reported more frequently among participants receiving pharmacological treatment. These findings are clinically relevant because they highlight a treatment strategy that may improve urinary symptoms without adding another medication to an already complex therapeutic regimen.

The importance of these findings extends beyond the management of urinary urgency and frequency. Patients with PD are often older adults with multiple comorbidities and substantial polypharmacy. Antimuscarinic medications may cause dry mouth, constipation, blurred vision, urinary retention, and other adverse effects. Of particular concern is the potential for cognitive adverse effects and falls in vulnerable patients. Consequently, the decision to prescribe an antimuscarinic drug should take into account cognitive status, mobility, constipation, fall risk, and the patient's overall medication burden.

Behavioral interventions therefore deserve a more prominent role in clinical practice. Bladder training, pelvic floor muscle exercises, appropriate fluid management, and lifestyle modification are relatively low-risk interventions that can be incorporated into multidisciplinary PD care. The findings of the randomized trial suggest that these approaches should not simply be viewed as supplementary treatments but can represent an important therapeutic option for selected patients.

Nevertheless, urinary symptoms in PD should not automatically be attributed to Parkinson related autonomic dysfunction. Other causes, including benign prostatic enlargement, urinary tract infection, constipation, nocturnal polyuria, pelvic floor dysfunction, diabetes, and medication effects, may contribute to urinary complaints. A careful history and focused assessment are therefore essential. Depending on the clinical presentation, evaluation may include urinalysis, assessment of postvoid residual urine, review of fluid intake and medications, and referral to urology when indicated.

Nocturia deserves particular consideration. Repeated nighttime awakenings can worsen sleep quality and daytime fatigue. In patients with impaired balance or gait, getting out of bed repeatedly during the night may also increase the risk of falls. Management should consequently extend beyond the urinary tract and consider mobility, orthostatic hypotension, sleep disorders, cognition, and nighttime motor symptoms.

Several limitations of the current evidence should also be acknowledged. The randomized trial was relatively small and had a limited follow-up period. Longer-term studies are needed to determine whether improvements achieved with behavioral therapy are sustained and whether these interventions influence clinically important outcomes such as falls, sleep quality, continence-related quality of life, and treatment adherence. Additional research should also clarify which patients are most likely to benefit from behavioral, pharmacological, or procedural interventions.

The clinical message is straightforward: bladder dysfunction should be actively screened for and incorporated into routine PD management. A structured, individualized approach can identify potentially reversible causes, reduce unnecessary medication exposure, and improve symptoms that substantially affect daily life. Behavioral interventions provide an important treatment option, while pharmacological and other therapies remain appropriate for carefully selected patients.

Ultimately, urinary dysfunction should not be regarded as a minor or inevitable accompaniment of Parkinson disease. Recognition and treatment of these symptoms are integral components of comprehensive, patient-centered neurological care [2,3].

Bibliography

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Volume 18 Issue 9 September 2026

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