Management of Female Stress Urinary Incontinence - Full Clinical Guideline

Reference No.: UHDB/ Gynae/02:23/B5

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1. Introduction

Involuntary leakage of urine occurring during exercise or activity that raises intra-abdominal pressure, such as coughing, sneezing and laughing is termed stress urinary incontinence. It is not uncommon and is usually due to an element of weakness or damage to the muscles and/or tissues of the pelvic floor, thereby compromising urethral support and/or causing weakness to the intrinsic urethral sphincter mechanism.
Risk factors include advanced maternal age associated with the menopause, high parity relating to high number of pregnancies and deliveries, prolonged labour, obstructed labour, instrumental delivery and any pathology that results in prolonged raised intra-abdominal pressure such as chronic cough, constipation, chronic diarrhoea and any intra-abdominal tumour.

2. Purpose

This guideline covers the assessment and management of stress urinary incontinence in women aged 16 years and above.

3. Abbreviations

BSUG	-	British Society of Urogynaecology
ICS	-	International Continence Society
MDT	-	Multidisciplinary Team
NICE	-	National Institute for Health and Care Excellence
POP-Q	-	Pelvic Organ Prolapse Quantification
SUI	-	Stress Urinary Incontinence
UTI	-	Urinary Tract Infection

4. Assessment at Urogynaecology Outpatient by Named Consultant Unit

A detailed history and a thorough physical examination should be done using the specialised urogynaecology template in the outpatient clinic to categorize the woman's urinary incontinence either into stress urinary incontinence, mixed urinary incontinence or overactive bladder and also to rule out pelvic organ prolapse using the ICS POP Q classification. During the clinical assessment, identification of relevant predisposing and precipitating factors and other diagnoses is essential as this may require referral for additional investigations and treatment. It is recommended that any symptom related to bowel incontinence be offered to be addressed prior to initiating any intervention in urogynaecology. It is also recommended to undertake a routine digital assessment to confirm pelvic floor muscle contraction prior to the use of supervised pelvic floor muscle training for the treatment of urinary incontinence. Initial assessment should serve as

a guide for management of the patient's symptoms. Any significant anterior compartment prolapse [greater than/equals grade 2 on the Baden Walker grading] warrants addressing prior to any surgical intervention for urinary incontinence. Use bladder diaries in the initial assessment of women with stress urinary incontinence. Women should complete a minimum of 3 days of the diary covering variations in usual activities and should present at follow-up visit.

Urine Testing
It is recommended at the first assessment to undertake a urine dipstick test in all women presenting with urinary incontinence, to detect the presence of blood, glucose, protein, leucocytes and nitrites in the urine, which in turn may suggest a urinary tract infection. Women symptomatic for UTI with a positive urine dip test should have a mid-stream urine sample sent for microbiology, culture and analysis for antibiotic sensitivities. Appropriate course of antibiotics should be prescribed, pending the culture results. Women symptomatic for UTI with negative urine dip results should still have mid-stream urine sample sent for culture and analysis of antibiotic sensitivities. Consider the prescription of antibiotics pending culture results. Asymptomatic women for UTI with a positive urine dip should have mid-stream urine sent for culture and analysis of antibiotic sensitivities. Do not offer antibiotics without midstream urine culture. If a woman does not have symptoms of UTI and her urine tests negative for either leucocytes or nitrites, do not send a urine sample for culture. In women with history suggestive of voiding dysfunction or recurrent UTIs, measure post-void residual volume preferably by a bladder scan or by catheterization.

5. Management Options

Women with stress urinary incontinence should have all the options of management enumerated and discussed in detail during the initial visit. The management of this condition requires a discussion with the woman on the benefits of non-surgical management, including lifestyle modification prior to offering surgery.

Non-surgical management (first line)

(a) Lifestyle modification should be reinforced including weight loss, abstaining from caffeine, nicotine, and restriction of fluid intake (less than 2L per day)

(b) Pelvic floor exercise: All women should be offered a referral to the continence team for pelvic floor exercise which might include electrical stimulation, for a duration of at least 3 months.

If there were no success with conservative management, a further evaluation is warranted by the urogynaecology/urology team which could include further investigations and treatment, including urodynamics. A quality of life questionnaire is offered and patients might be invited to participate in a patient satisfaction survey subsequent to urodynamic studies.

Surgical Management (second line)
Surgical management is offered after adequate counselling and patient selection with standard patient information leaflet for named procedure, consenting, invitation and information to partake in the BSUG national database. All patients opting for surgical management, primary or secondary, are discussed and ratified at the urogynaecology MDT prior to surgery. Surgical options at this present time include bladder neck injections, colposuspension and autologous sling surgery.
There have been recent concerns regards the use of tape procedure and these procedures presently remain suspended on NHS England and thus falls beyond the scope of discussion of this guidance. For all of the procedures recommended in this section, including tape procedures, there is evidence of benefit but limited evidence on the long-term adverse effects. In particular, the true prevalence of long-term complications is unknown (NICE 2019).

A woman considering surgery for stress urinary incontinence should have her decision guided by the patient decision aid on surgery for stress urinary incontinence, as enumerated by the NICE document. The discussion should include:

- the risk and benefits of the procedure,
- the uncertainties surrounding the long-term effect for the procedure with especially those

involving the use of a mesh,
- type of anaesthesia involved, surgical incision, hospital stay and expected recovery period,
- social and psycological factors that may affect her decision,
- post-operative care and plan for follow up,
- and the offer of patient information leaflets regards the planned procedure.

Bladder neck injections:

I. This should be offered to women with stress urinary incontinence including those not suitable for extensive and invasive surgical procedures or in whom surgery is not feasible,
II. patients should be made aware that even though these agents are permanent materials, yet further injections might be necessary to achieve desirable results,
III. a procedure specific patient information leaflet should be offered to all patients with risk, benefits, success rate of procedure, complications and failure rates highlighted,
IV. Women should be given written information about the bulking agent used (name, manufacturer, date of injection, injecting surgeons name and contact details,
V. a post-operative care plan and follow up should be arranged.

Colposuspension

I. Women should be advised that this procedure could be performed via an open or a laparoscopic approach, depending on patient selection and surgeon's discretion,
II. patients should be advised that the procedure involves the use of long-lasting absorbable or permanent stitches that are placed on either side of the bladder neck and tied to the strong fibrous tissue attached to the pubic bones,
III. the procedure might warrant the use of a drain in the abdomen which is usually removed the day following surgery,
IV. women should be made aware that symptoms of an overactive bladder will not usually be helped by this procedure and in fact have a percentage of worsening post procedure,
V. the procedure has a success rate of more than 80%, especially those who are having their first operation for stress urinary incontinence,
VI. a procedure specific patient information leaflet on the risks, benefits, complications and failure rates should be offered to all patients.

Autologous Sling Procedure

I. This procedure ideally should be offered to women who have completed their family as pregnancy and/or labour post procedure have the potential of compromising the results,
II. patients to be made aware that this procedure involves taking a ribbon of fascia from abdominal wall and subsequently passing the strip of fascia onto either side of the urethra to be fixed back to the abdominal wall,
III. women to be made aware that a cystoscopy is recommended at the end of the procedure to exclude bladder injury,
IV. a urethral catheter would be needed for 1-2 days,
V. a procedure specific patient information leaflet on the risks, benefits, complications and failure rates should be offered to all patients,

Duloxetine may be offered as second-line therapy if women prefer pharmacological to surgical treatment or are not suitable for surgical treatment after ruling out any contra indications for its use. If duloxetine is prescribed, counsel women about its adverse effects and efficacy.

Contemporaneous BSUG national database entry is usually performed by the operating surgeon at the time of surgery.

6. Post Op Care / Follow Up / Survey / Audit / Governance

Post-operative follow up in nurse led/consultant outpatient clinic in 3-4 months should be arranged for all patients at the time of discharge.

A quality of life questionnaire would be completed at this follow up visit.

BSUG national database follow up entry should be completed at this visit.

A continuous audit of patients undergoing surgical procedures in urogynaecology should be done, on an annual basis.

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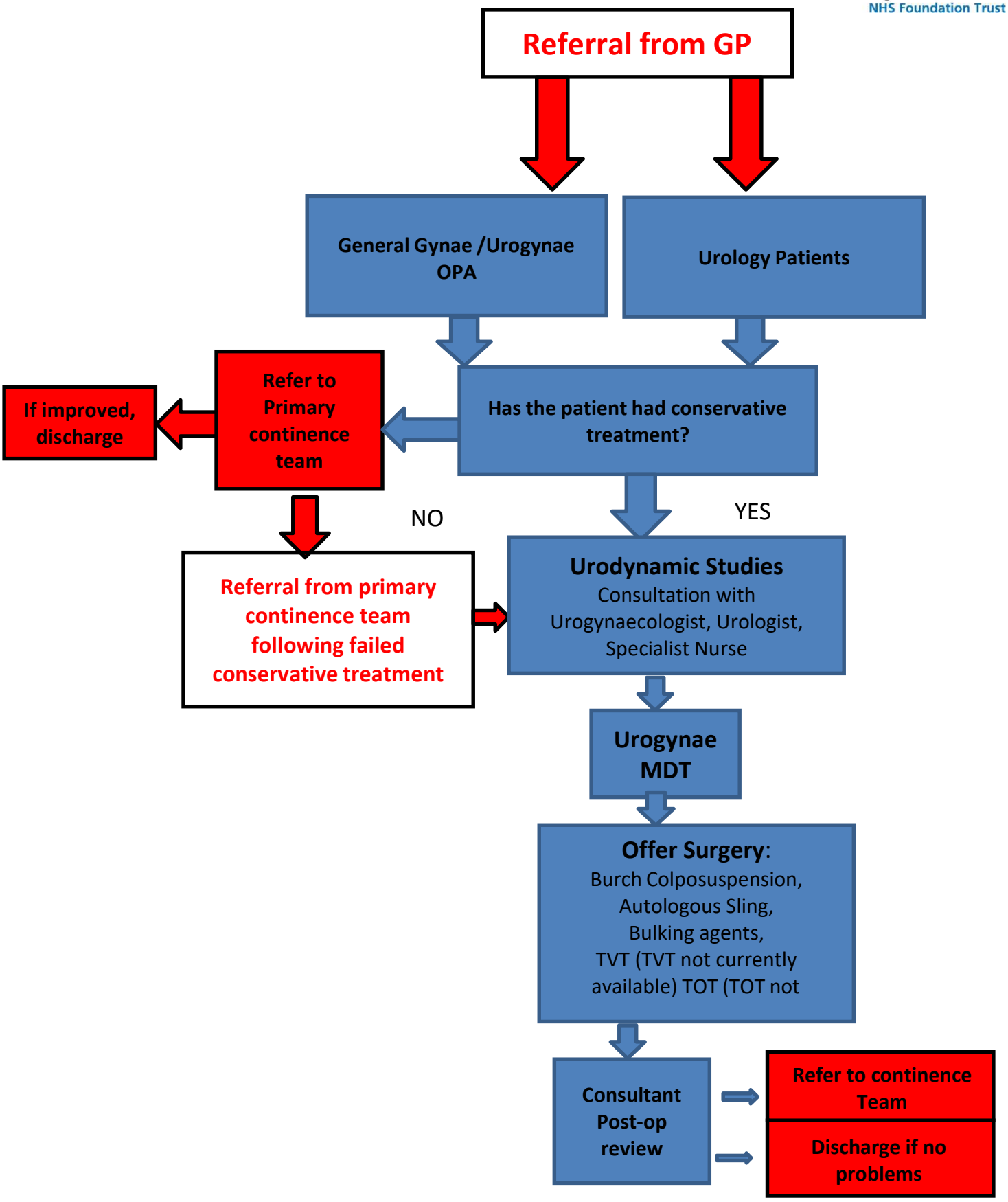
Stress Incontinence Care Pathway



National Institute for Health and Care Excellence, 2013,TheManagement of urinary incontinence in women. Clinical Guideline CG171

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