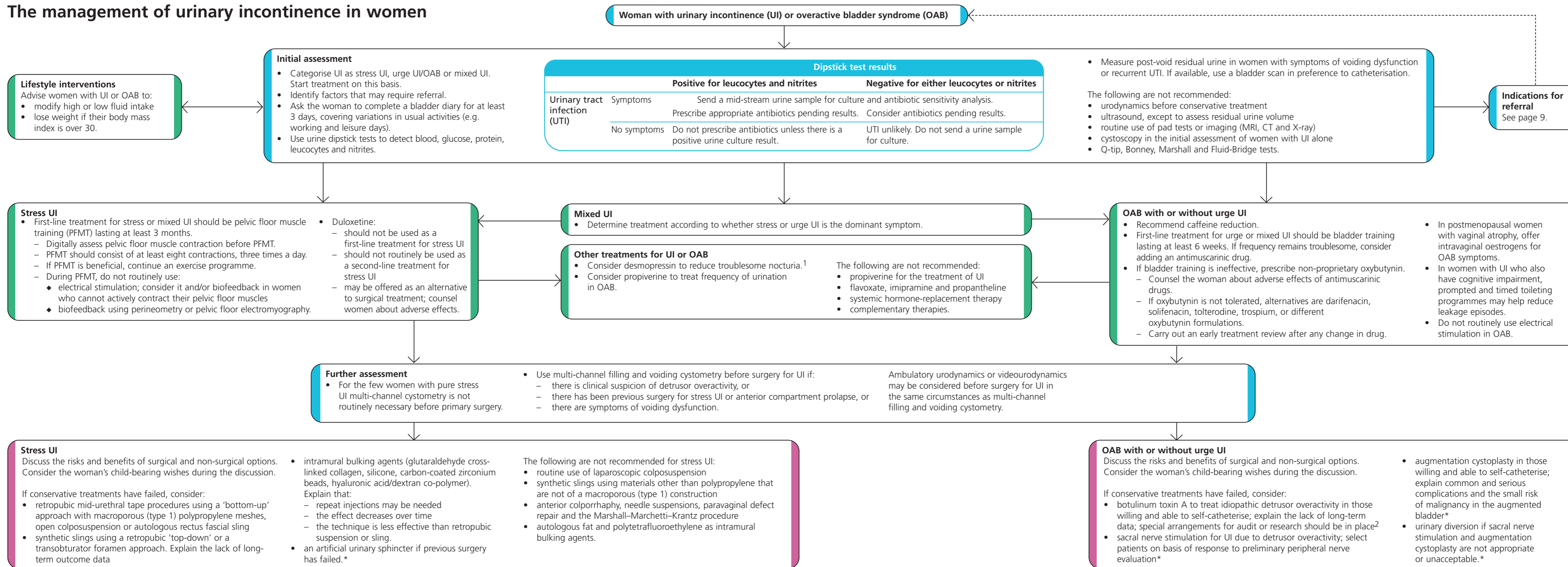


## The management of urinary incontinence in women



<sup>1</sup> The use of desmopressin for idiopathic UI is outside its UK marketing authorisation. Informed consent to treatment should be obtained and documented.

<sup>2</sup> The use of botulinum toxin A for this indication is outside its UK marketing authorisation. Informed consent to treatment should be obtained and documented.

Do not use botulinum toxin B. \*Provide life-long follow-up after this procedure.

### Indications for referral

Urgently refer women with any of the following:<sup>3</sup>

- microscopic haematuria if aged 50 years and older
- visible haematuria
- recurrent or persisting UTI associated with haematuria if aged 40 years and older
- suspected pelvic mass arising from the urinary tract.

Refer women with:

- symptomatic prolapse visible at or below the vaginal introitus
- palpable bladder on bimanual or physical examination after voiding.

Consider referring women with:

- persisting bladder or urethral pain
- clinically benign pelvic masses
- associated faecal incontinence
- suspected neurological disease
- voiding difficulty
- suspected urogenital fistulae
- previous continence surgery
- previous pelvic cancer surgery
- previous pelvic radiation therapy.

<sup>3</sup> NICE's 'Referral guidelines for suspected cancer' ([www.nice.org.uk/CG027](http://www.nice.org.uk/CG027)) define urgent referral as the patient being seen within the national target for urgent referrals (currently 2 weeks).

### Non-therapeutic interventions

#### Bladder catheterisation

Consider catheterisation in women with persistent urinary retention that causes incontinence, symptomatic infections or renal dysfunction that cannot otherwise be corrected.

- Use intermittent urethral catheterisation if the woman or her carer can perform the technique.
- Consider the impact of long-term indwelling urethral catheterisation and discuss its benefits and risks. Indications include:
  - chronic retention in women unable to manage intermittent self-catheterisation
  - urine contamination of skin wounds, pressure sores or irritations
  - distress and disruption caused by bed and clothing changes
  - woman's preference for this form of management.
- Consider indwelling suprapubic catheters as an alternative to long-term urethral catheters. Explain that they may cause lower rates of urinary tract infection, 'by-passing' and urethral complications.
- Explain that indwelling catheters may not result in continence in urge UI.

#### Other strategies

- Absorbent products, hand held urinals and toileting aids are not a treatment for UI. Use them only as:
  - a coping strategy while awaiting definitive treatment
  - an adjunct to ongoing therapy
  - long-term management of UI only after treatment options have been explored.
- Do not routinely use intravaginal and intra-urethral devices to manage UI. They may be useful occasionally to prevent leakage, for example during physical exercise.

### Key priorities for implementation *continued*

- Retropubic mid-urethral tape procedures using a 'bottom-up' approach with macroporous (type 1) polypropylene meshes are recommended as treatment options for stress UI where conservative management has failed. Open colposuspension and autologous rectus fascial sling are the recommended alternatives when clinically appropriate.

*Many procedures have been described for the treatment of stress UI; although there is no strong evidence of superior effectiveness of any one, the best available data support the use of retropubic mid-urethral tape procedures, colposuspension and autologous rectus fascial sling. Retropubic mid-urethral tape procedures consume fewer hospital resources and are associated with faster recovery than the other two procedures. (See section 5.2 of the full guideline.)*

#### Competence of surgeons performing operative procedures for UI in women

- Surgery for UI should be undertaken only by surgeons who have received appropriate training in the management of UI and associated disorders or who work within a multidisciplinary team with this training, and who regularly carry out surgery for UI in women.

*The expertise of the surgeon is one of the factors that influence surgical outcomes. The best outcomes are achieved when surgeons and/or their multidisciplinary team have specialist training and regular practice in continence surgery. (See section 6 of the full guideline.)*