NICE Clinical Guideline:

Urinary incontinence (update) and pelvic organ prolapse in women: management

Stakeholder Scoping Workshop

8th December 2016

Introduction and presentations
The group were welcomed to the meeting and informed about the purpose of the day. The Stakeholder Scoping Workshop is an opportunity for stakeholders to review the draft scope and give their input into whether it is clinically appropriate. The group received presentations about NICE's work, the work of the National Guideline Alliance (NGA) and the work of the patient and public involvement programme. The Clinical Leads of the guideline committee also presented the key elements of the draft scope. Following questions, the stakeholder representatives were divided into 4 groups which included a facilitator and a scribe. Each group had a structured discussion around the key issues.
Scope
General Comments
The Stakeholders were invited to make general comments on the scope of the guideline and points included: • The scope is comprehensive with a good balance between urinary incontinence and pelvic organ prolapse. • Guideline doesn't cover information provision but this is covered elsewhere as is consent for surgery. • There is a focus in the guideline scope on mesh surgery but it is not just mesh surgery which has complications • Guideline should include benefits of mesh surgery as well as complications. • There is a need for a national database on surgery and complications. The British Society of Urogynaecology (BSUG) holds a database of operations. The BSUG data submission is currently optional. • Commissioning refers to national audits and is a powerful lever. • There is inequity in commissioning across the country. • The post-surgery process and rehabilitation should be considered. • Urinary incontinence is linked to falls and fractures and there is a higher risk for women with the condition. • The current guideline is weak in terms of the review of conservative management. • There is a need for to improve implementation of the existing guideline. • There is discrepancy between what is practiced and what is recommended, and potential for cost savings if women are given the best treatment, which is also important for patient experience. • There are other options such as conservative management including lifestyle options, which should not be diminished in the guideline.

Section 3.1 Population

Groups that will be covered and groups that will not be covered

The Stakeholders discussed the groups that will be covered in the guideline including:

- Consider including pregnant teenagers.
- Should children and adolescents who receive surgery for congenital anomalies (a small group) be given special consideration?
- Consider transgender people.
- Women with female genital mutilation (FGM) and their social and medical needs: there is conflicting data on whether this group has more issues with urinary incontinence; surgical management is similar, but there are potential different social and support needs.
- Women with recurrent urinary incontinence.
- Some complications are common to all forms of stress urinary incontinence surgery, for example, pain.
- Are there specific groups for whom surgery should be avoided?

Equality considerations

The specific equalities issues and groups discussed regarding urinary incontinence and pelvic organ prolapse in women included the following**:**

- Patient choice and informed consent were raised, with particular attention to those women with cognitive impairment.
- There should be different prescribing patterns for anticholinergics in older groups at risk of dementia.
- Women with female genital mutilation (FGM) may need special consideration.
- Transgender people may need special consideration.
- Women who may go on to give birth may need special consideration, for example, whether they should have surgery or not.

Section 3.2 Settings

There were no comments on this section.

Section 3.3

Areas that will be covered

The Stakeholders discussed the main areas to be covered in the scope and the main points were:

- The section on overactive bladder surgical interventions should be expanded.
- Primary versus secondary surgical management of pelvic organ prolapse should be included.
- Area on alternative conservative management should be reviewed with a proposed question on the frequency of review of alternative treatment options for women using absorbent containment products.
- There are issues in terms of cost-effectiveness for assessment, containment products and catheters (long-term).

Areas that will not be covered

- Areas not covered should include primary prevention of incontinence and prolapse.

- The professional competencies of people performing surgery can affect the outcome considerably. There is concern about the basis for the number of procedures required for competency.
- Pharmacological treatments: duloxetine is not used any more due to side effects. Previous guidance may need updating i.e. removing.
- What about women with recurrent UI? Who manages them, a GP, a specialist?
- Fistula may be associated with mesh or tape erosion.
- Rectal prolapse: obstructive defecation syndrome should be included. It can be urological or rectal: although it is often classed as rectal it can affect urological systems.
- The antibulking agent interventional procedural guidance needs updating.

Section 3.4 Healthcare setting

There were no comments on this section.

Section 3.4 Economic aspects

There were no comments on this section.

Section 3.5 Key issues and questions

Issues that will be covered

The Stakeholders discussed the review questions and the main points were:

- Urodynamic testing: there are a wide variety of opinions and practice, including the order of interventions and assessment (some women go straight to surgery, others might have testing after surgery), especially for women with mixed urinary incontinence.
- The need to carry out urodynamics prior to surgery can cause delays due to resource issues. Licensing trials are carried out with or without this. There are other tests like residual urine fluid.
- There is variation between the guidance and doctor-driven practice, and there is need for clarity in this area.
- There is a need for a risk of falls assessment, routinely, for women with urinary incontinence (acute confusion and urinary tract infections add to the risk of falls). This could be linked to the NICE guidance on falls.
- Botulinum toxin: is urodynamics needed prior to botulinum toxin A administration? This should be added as a question. There is potential for cost and time savings here. What is the evidence for doing urodynamics first?
- Botulinum toxin A is a less invasive treatment.
- As well as dosage, there is the issue of the number of injections of botulinum toxin. Note that this is a surgical procedure.
- Perhaps the botulinum toxin section could be expanded to cover nerve stimulation. The terminology for nerve stimulation is confusing in the previous guideline and may need updating.
- The old guideline indicates that specific multidisciplinary team discussion is required for tapes and botulinum toxin, but this is not always practical.
- Treatment of overactive bladder: there is an issue of the safety of anticholinergic drugs crossing the blood-brain barrier in relation to the risk of dementia. There is a need for clear guidance for nurse and GP prescribers.
- Medical treatment for overactive bladder – there are issues about giving anticholinergics to the elderly with dementia.

- The issue of the effect of anti-muscarinics on cognitive function should be looked at.
- There are also other treatments for overactive bladder.
- The role of oestrogen prior to surgery should be considered.
- There is an issue for people on pads and incontinence treatment long-term, and for those discontinuing pharmacological treatment and seeking other long-term treatment options.
- Management should be broad and include where and by whom things should be dealt with.
- There are different types of mesh and the review should be inclusive.
- Does intermittent self-catheterisation need a recommendation?
- The PROSPECT trial is looking at mesh versus non-mesh surgery.
- Prolapse management may depend on the type of prolapse (there is a need for subgroup analysis in the review).
- What is the role for a pelvic floor exercise regime; when is it appropriate and how often? Are there groups of people that should not be offered pelvic floor exercise? Time and money may be wasted offering it to all women, including those with severe symptoms. Who are the groups that would be benefit from this? Request for new evidence on this topic.
- There is a need for more details on pelvic floor training.
- There is a need to factor in psychological impact, patient choice and health-related quality of life.
- The role of surgery to prevent urinary incontinence following prolapse surgery is an area of uncertainty and potentially contentious.
- Women undergoing laparoscopic colposuspension: the cost-effectiveness and inpatient management has changed, which may change the recommendations.
- The scope could be expanded to cover complications from all types of surgery including colposuspension.
- For concurrent urinary incontinence and pelvic organ prolapse, this is a good question in the scope. Current practice is diverse.
- For pelvic organ prolapse is a biofeedback machine being considered?
- Is there evidence for limiting exercise and activity in women with these conditions as this is often advised, but can restrict lifestyle?
- Assessment strategies for mesh complications will vary, as there are differing imaging needs and variations in personnel.
- There can be voiding difficulties as a complication following surgery.
- Who should be included in a multidisciplinary team?
- The multidisciplinary team is important in referrals.
- The assessment of complications is unlikely to be evidence based. It is more likely that recommendations will relate to the referral pathways: the best place to be managed, who and what.
- Compare best care versus mesh versus non-mesh.
- Guidance is required on long-term follow up (frequency, telephone versus face to face) – given that most mesh complications occur later.
- Need to define the time frame for assessing mesh complications, e.g. within 48 hours there may be more general issues such as infection, and long-term issues might include erosion.
- Examination is a form of assessment.
- The pelvic organ prolapse management section covers important clinical questions. (There is GP coding now for mesh complications.)
- Priorities were considered to be mesh complications and prolapse management.

Section 3.6 Main Outcomes
There were no comments on this section.

Guideline committee composition
Proposed members
Stakeholders made the following points about the proposed membership of the guideline committee: • Care of the elderly physician could be a full member of the committee. • Possibly include more than 2 lay members including one who has had successful stress urinary incontinence surgery, a member from the mesh-injured community and a member who has responded to conservative methods of treatment.
Members that should be included
The stakeholder groups each proposed other possible committee members: • Community nurse, health visitor or continence advisor. • Sexual counsellor, psychologist. • Clinical scientist to assess urodynamics. • Pathologist to talk about implants/grafts and aetiology.