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URINARY INCONTINENCE AND ITS MANAGEMENT – DO URODYNAMIC STUDIES PLAY AN ESSENTIAL ROLE?

Hypothesis / aims of study
To assess local compliance with NICE (National Institute for Health and Clinical Excellence) CG 40 guideline, regarding the management of urinary incontinence in women.

Study design, materials and methods
Sample was selected from patients who had attended urodynamic studies at an university teaching hospital between January 2011 - April 2011. Women who were new patients and had no recent urogynaecological surgery were included. A retrospective audit of their notes was conducted and compared to the standards set by the NICE (CG 40) urinary incontinence guideline.

Results
42 women fulfilled the selection criteria. Their age range was from 29-81 years old. Thirty-two (76.1%) women initially presented with mixed urinary incontinence, whilst six (14.3%) had symptoms of stress urinary incontinence and two (4.8%) with urge urinary incontinence.

Initial investigations: thirty-two women (76.2%) kept a bladder diary for three days, thirty-eight (90.5%) had a mid-stream urine specimen analysed and thirty-seven women (88.1%) had a post-void residual volume measured.

Women were treated with conservative measures. Forty-two women (100%) were advised to undertake 3 month course of pelvic floor exercises, whilst thirty-four (81%) undertook a 6 week course of bladder drills/ retraining. They also advised to implement lifestyle measures. Twenty-two women (52.4%) were advised to reduce their fluid intake, 17 (40.5%) to reduce their caffeine intake. Only two women with BMI >30 (4.8 %) were asked to lose weight. However, thirty women (71.4%) did not have their BMI documented in the notes.

Treatment with anti-cholinergics was commenced in twenty-five (59.5%) women, with only 3 of those after completing a course of bladder drills.

Thirty-three (78.5%) women were referred for urodynamic studies (UDS) as there was a suspicion of overactive bladder, 6 for anterior compartment prolapse, 1 for voiding dysfunction and 2 women had no clear indication.

UDS showed that twelve (28.6%) of women had stress urinary incontinence, 4 (9.5%) had mixed urinary incontinence, 10 (23.8 %) had overactive bladder/ sensory urgency, 12 (28.6%) had normal bladders and 4 had other diagnoses.

After UDS selected women were offered definitive surgical treatment (vaginal wall repair/ botox/TVT-O/ cystoscopy). Sixteen (38.1%) women accepted surgery. However, five women (11.9%) declined this option.

Interpretation of results
Our audit of notes revealed that improved documentation was required with regards to BMI, advice given for weightloss, reduction in fluid intake or caffeine. Local oestrogen cream could have been offered to more women who were post-menopausal with over active bladder symptoms.

A significant proportion of patients who were referred for UDS declined definitive surgical treatment

Concluding message
The question that we pose is urodynamic studies necessary in all cases? It is an investigation that many women do not actually understand what it entails. It is a long embarrassing invasive procedure, lasting up to 45 minutes with the associated risk of infection and bleeding. Many units may have long waiting lists for this procedure and it has never been proven that undertaking UDS actually improves the eventual outcome. NICE actually states that UDS is not needed in cases of severe isolated stress urinary incontinence.

Hence we need to be more selective about which cases we refer for urodynamic studies. It should be conducted on women who are willing to undergo surgery.

References
1. Urinary Incontinence (CG 40) – NICE 2006

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