II. URINARY INCONTINENCE IN MEN

A. INITIAL MANAGEMENT

1. INITIAL ASSESSEMENT SHOULD IDENTIFY:

➢ **"Complicated" incontinence group**

Those with pain or with haematuria, recurrent infection, suspected or proven poor bladder emptying (for example due to bladder outlet obstruction), or incontinence following pelvic irradiation or radical surgery, are recommended for **specialised management**.

Poor bladder emptying may be suspected from symptoms, physical examination or if imaging has been performed by X-ray or ultrasound after voiding.

➢ **Four other main groups** of men should be identified by initial assessment as being suitable for **initial management**.

- Those with post-micturition dribble alone,
- Those with overactive bladder (OAB) symptoms: urgency with or without urgency incontinence, together with frequency and nocturia
- Those with stress urinary incontinence (most often post-prostatectomy),
- Those with mixed urinary urgency and stress incontinence (most often post-prostatectomy)

2. MANAGEMENT

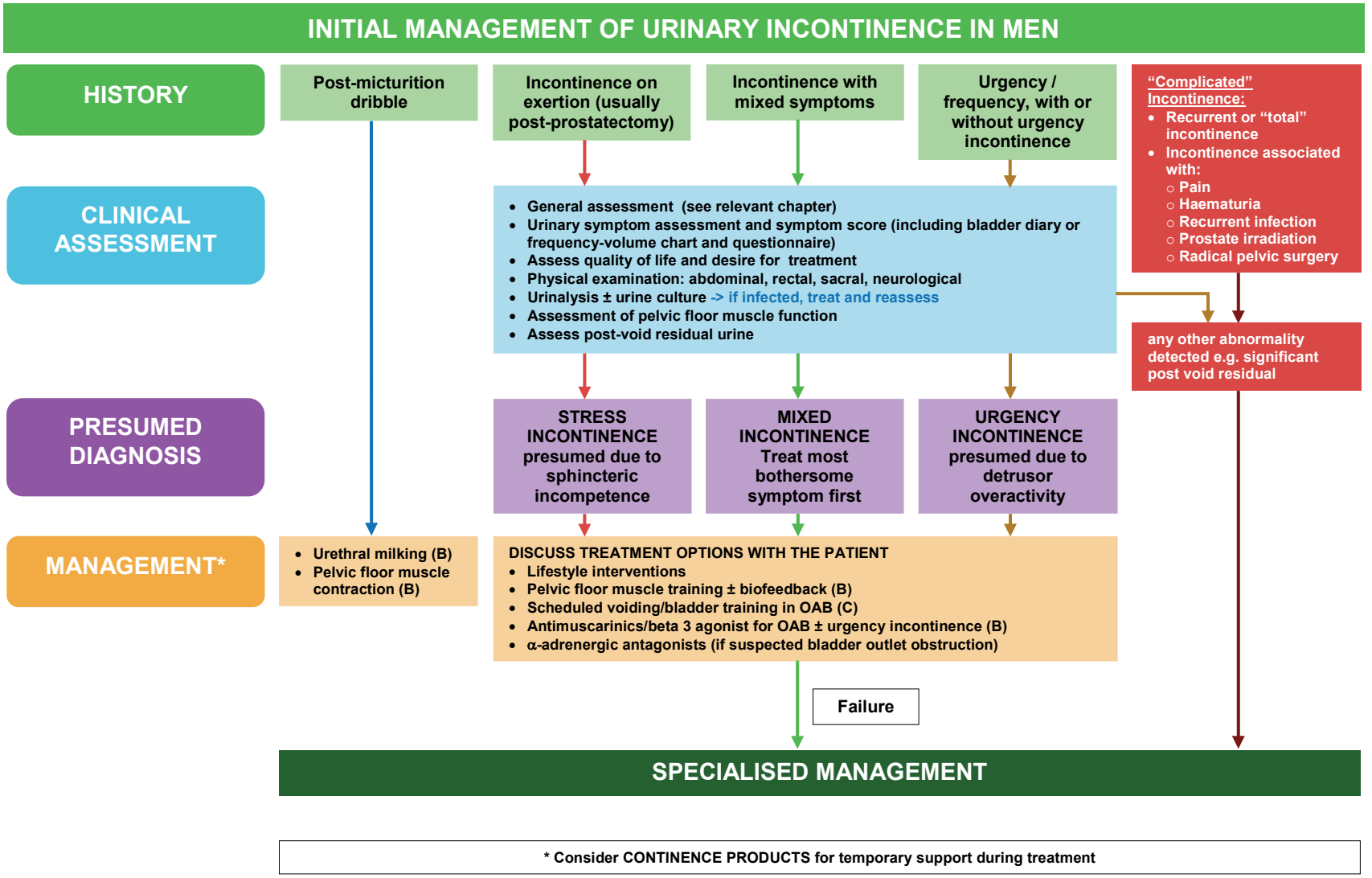
➢ For men with **post-micturition dribble**, this requires no assessment and can usually be treated by teaching the man how to do a strong pelvic floor muscle contraction after voiding, or manual compression of the bulbous urethra directly after micturition. (GoR B)

➢ For men with **stress**, **urgency** or **mixed** urgency / stress incontinence, initial treatment should include appropriate lifestyle advice, pelvic floor muscle training, scheduled voiding regimens, behavioural therapies and medication. In particular:

- Lifestyle interventions (eg weight loss GoR B)
- Supervised pelvic floor muscle training for men with post radical prostatectomy SUI accelerates recovery time(GoR B)
- Scheduled voiding regimen for OAB (GoR C)
- Antimuscarinic/beta 3 agonist drugs for OAB symptoms with or without urgency incontinence (GoR B) if the patient has no evidence of significant post-void residual urine
- α-adrenergic antagonists (a-blockers) can be added if it is thought that there may also be bladder outlet obstruction. (GoR C)

➢ **Should initial treatment be unsuccessful** after a reasonable time (for example, 8-12 weeks), **specialist advice** is highly recommended.

Clinicians are likely to wish to treat the **most bothersome symptom** first in men with symptoms of **mixed** incontinence.


INITIAL MANAGEMENT OF URINARY INCONTINENCE IN MEN
HISTORY
CLINICAL ASSESSMENT
PRESUMED DIAGNOSIS
MANAGEMENT*
Post-micturition dribble
Incontinence on exertion (usually post-prostatectomy)
Incontinence with mixed symptoms
Urgency / frequency, with or without urgency incontinence
"Complicated" Incontinence:
Recurrent or "total" incontinence
Incontinence associated with:
Pain
Haematuria
Recurrent infection
Prostate irradiation
Radical pelvic surgery
General assessment (see relevant chapter)
Urinary symptom assessment and symptom score (including bladder diary or frequency-volume chart and questionnaire)
Assess quality of life and desire for treatment
Physical examination: abdominal, rectal, sacral, neurological
Urinalysis ± urine culture -> if infected, treat and reassess
Assessment of pelvic floor muscle function
Assess post-void residual urine
any other abnormality detected e.g. significant post void residual
STRESS INCONTINENCE presumed due to sphincteric incompetence
MIXED INCONTINENCE Treat most bothersome symptom first
URGENCY INCONTINENCE presumed due to detrusor overactivity
Urethral milking (B)
Pelvic floor muscle contraction (B)
DISCUSS TREATMENT OPTIONS WITH THE PATIENT
Lifestyle interventions
Pelvic floor muscle training ± biofeedback (B)
Scheduled voiding/bladder training in OAB (C)
Antimuscarinics/beta 3 agonist for OAB ± urgency incontinence (B)
α-adrenergic antagonists (if suspected bladder outlet obstruction)
Failure
SPECIALISED MANAGEMENT
* Consider CONTINENCE PRODUCTS for temporary support during treatment

II. URINARY INCONTINENCE IN MEN

B. SPECIALISED MANAGEMENT

The specialist may first **reinstitute initial management** if it is felt that previous therapy had been inadequate.

1. ASSESSMENT

- Patients with **"complicated" incontinence** referred directly to specialised management, are likely to require **additional testing**, such as cytology, cystourethoscopy and urinary tract imaging.

If additional testing is normal then those individuals can be treated for incontinence by the initial or specialised management options as appropriate.

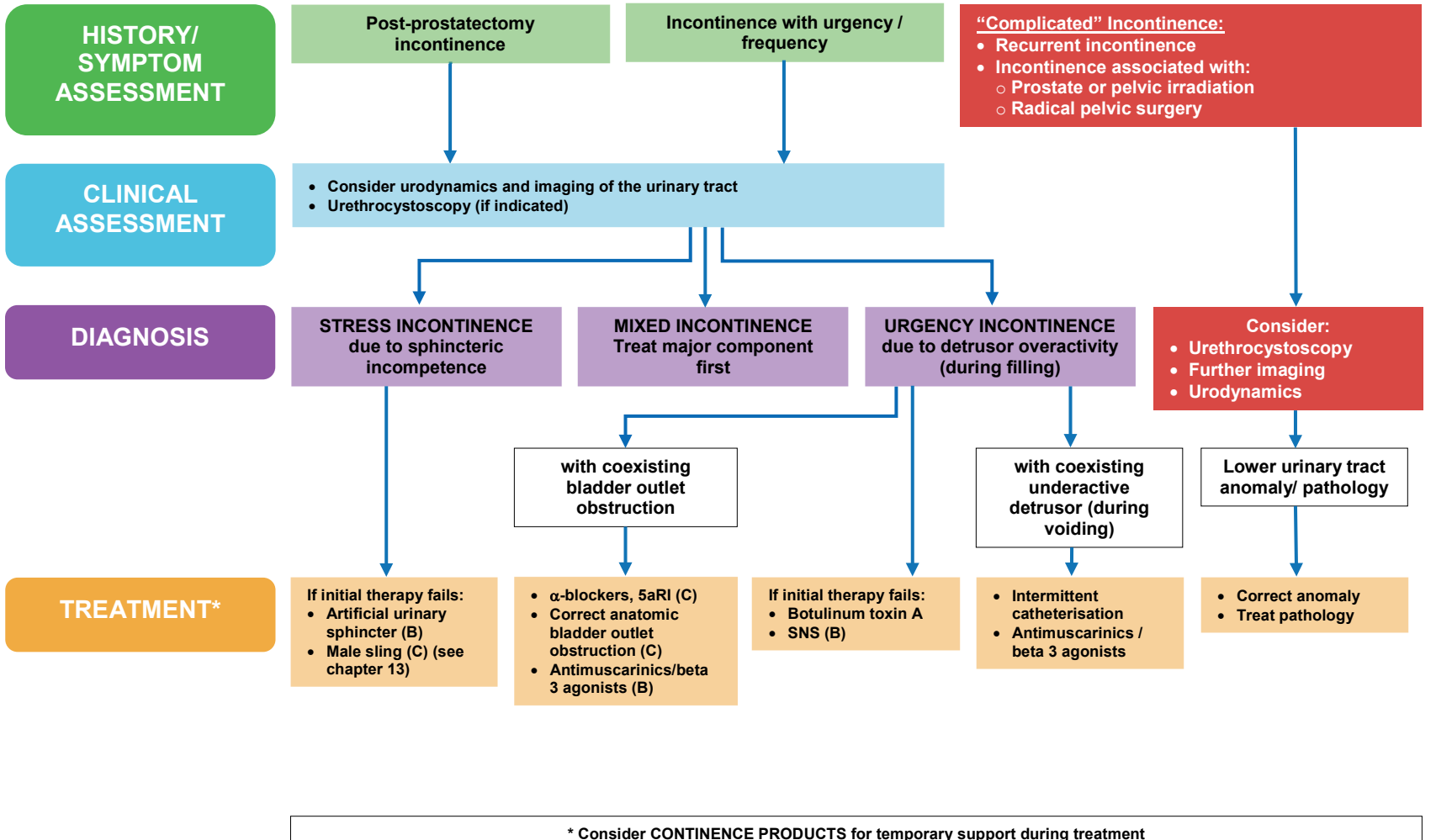
If symptoms suggestive of detrusor overactivity, or of sphincter incompetence **persist**, then **urodynamic** studies are advisable in order to arrive at a precise diagnosis, prior to invasive treatment.

2. TREATMENT

When basic management has been unsuccessful and if the patient's incontinence markedly disrupts his quality of life then **invasive therapies** should be considered.

- **For sphincter incompetence** the recommended option is the artificial urinary sphincter (GoR B). Other options, such as a male sling, may be considered (GoR C).
- **For refractory idiopathic detrusor overactivity**, (with intractable overactive bladder symptoms) the recommended therapies are: Botulinum toxin A (GoR B), and SNS (GoR C),
- When incontinence has been shown to be associated with **poor bladder emptying** due to **detrusor underactivity**, it is recommended that effective means are used to ensure bladder emptying, for example, intermittent catheterisation (GoR B/C).
- If incontinence is associated with bladder outlet obstruction, then consideration should be given to surgical treatment to relieve obstruction (GoR B). α-blockers and/or 5α- reductase inhibitors would be an optional treatment (GoR C).
- There is increased evidence for the safety of antimuscarinics for overactive bladder symptoms in men, chiefly in combination with an α-blocker (GoR B).

SPECIALISED MANAGEMENT OF URINARY INCONTINENCE IN MEN



* Consider CONTINENCE PRODUCTS for temporary support during treatment