III. URINARY INCONTINENCE IN WOMEN

A. INITIAL MANAGEMENT

1. INITIAL ASSESSMENT SHOULD IDENTIFY:

➢ **"Complicated" incontinence group.**

Those with pain or haematuria, recurrent infections, suspected or proven voiding problems, significant pelvic organ prolapse or who have persistent incontinence or recurrent incontinence after pelvic irradiation, radical pelvic surgery, previous incontinence surgery, or who have a suspected fistula, should be referred to a specialist.

➢ **Three other main groups** of patients should be identified by initial assessment.

- Women with **stress incontinence** on physical activity
- Women with **urgency, frequency** with or without urgency incontinence: overactive bladder (OAB)
- Those women with **mixed** urgency and stress incontinence

Abdominal, pelvic and perineal examinations should be a routine part of physical examination. Women should be asked to perform a "stress test" (cough and strain to detect leakage likely to be due to sphincter incompetence). Any pelvic organ prolapse or urogenital atrophy should be assessed. Vaginal or rectal examination allows the assessment of voluntary pelvic floor muscle function, an important step prior to the teaching of pelvic floor muscle training.

2. TREATMENT

➢ For women with **stress, urgency or mixed** urinary incontinence, initial treatment should include appropriate lifestyle advice, pelvic floor muscle training, PFMT), scheduled voiding regimes, behavioural therapies and medication. In particular:

- **Advice** on caffeine reduction for OAB (GoR B) and weight reduction (GoR A).
- Supervised pelvic floor muscle training (GoR A), supervised vaginal cones training for women with stress incontinence (GoR B).
- Supervised bladder training (GoR A) for OAB.
- **If oestrogen deficiency** and/or **UTI** is found, the patient should be treated at initial assessment and then reassessed after using vaginal oestrogens for a suitable period (GoR B).
- **Antimuscarinics/beta 3 agonist** for OAB symptoms with or without urgency incontinence (GoR A); duloxetine* may be considered for stress urinary incontinence (GoR B)

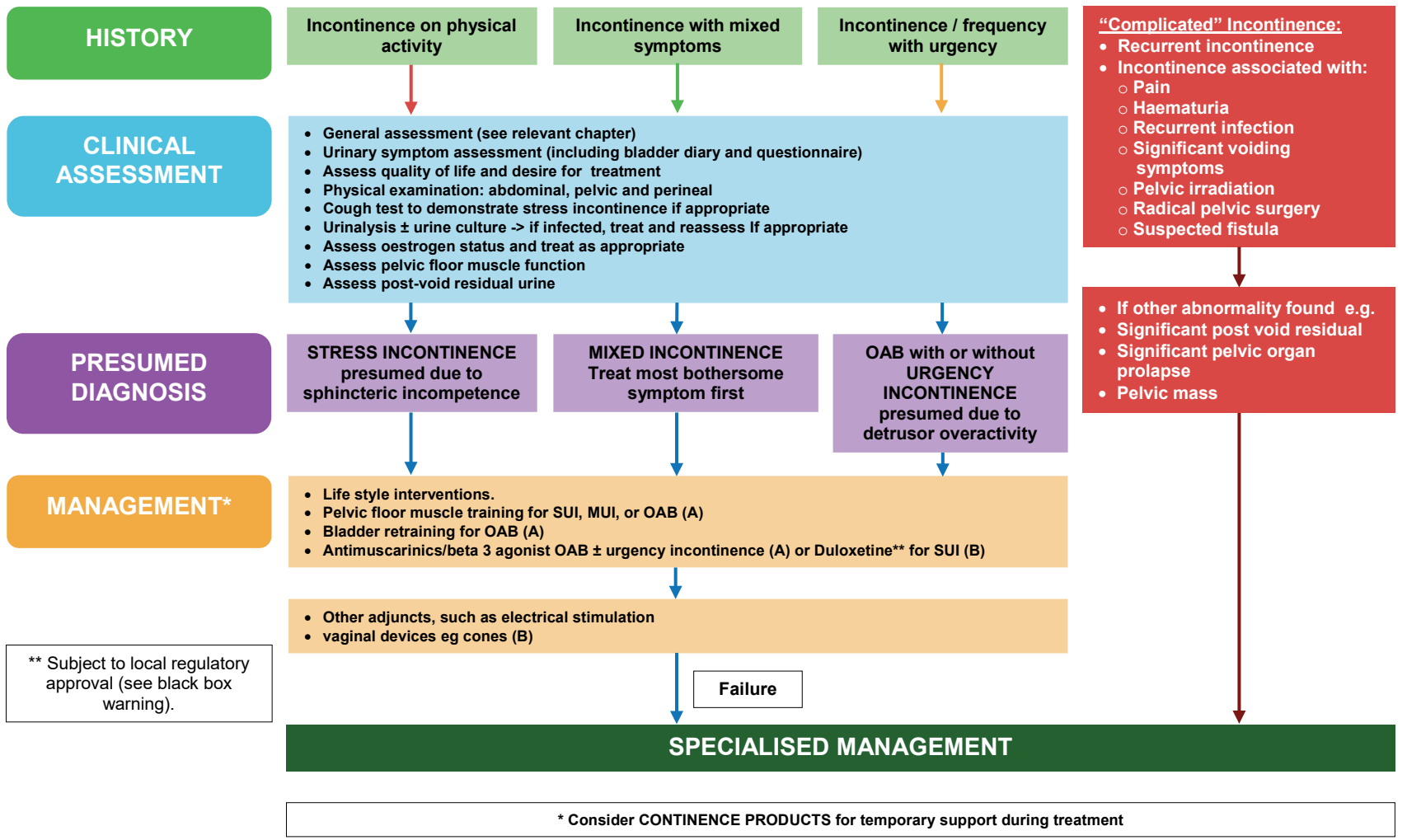
PFMT should be based on sound muscle training principles such as specificity, overload progression, correct contraction confirmed prior to training and use of "the Knack" for 12 weeks before reassessment and possible specialist referral.

Clinicians are likely to wish to treat the **most bothersome symptom first** in women with symptoms of mixed incontinence. (GoR C).

➢ Some women with significant pelvic organ prolapse can be treated by vaginal devices that treat both incontinence and prolapse (incontinence rings and dishes).

*Duloxetine is not approved for use in United States. In Europe it is approved for use in severe stress incontinence (see committee report on pharmacological management for information regarding efficacy, adverse events, and 'black box' warning by the Food and Drug Administration of the United States).

INITIAL MANAGEMENT OF URINARY INCONTINENCE IN WOMEN



III. URINARY INCONTINENCE IN WOMEN

A. SPECIALISED MANAGEMENT

1. ASSESSMENT

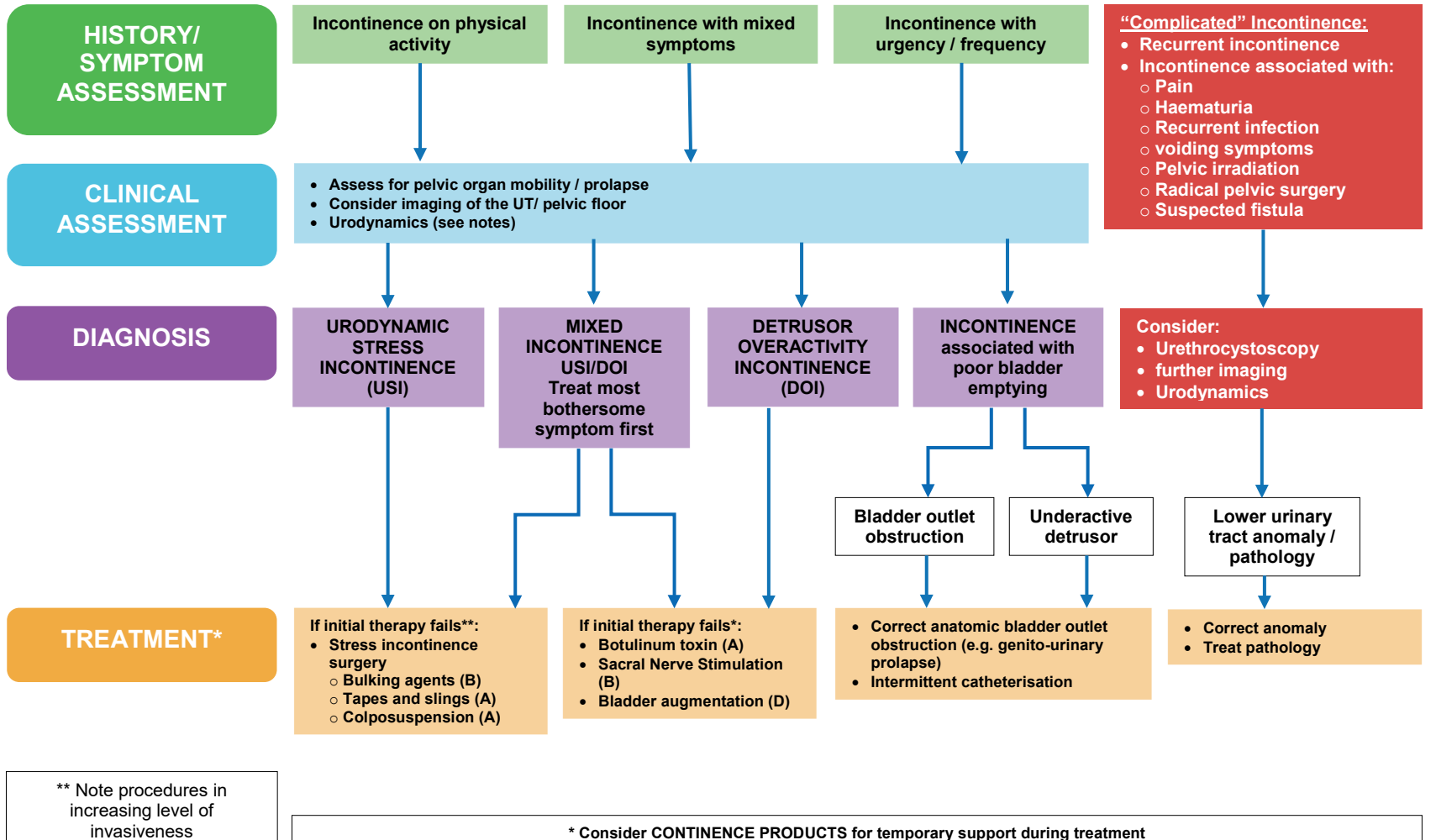
Women who have **"complicated" incontinence** (see initial algorithm) may need to have additional tests such as cytology, urodynamics, cystourethroscopy or urinary tract imaging. If these tests are normal then they should be treated for incontinence by the initial or specialised management options as appropriate.

- Those women with persistent symptoms despite **initial management** and whose quality of life is impaired are likely to request further treatment. If initial management has been given an adequate trial then **interventional therapy may be desired**. When the results of urodynamic testing may change management, we highly recommend testing prior to intervention in order to diagnose the incontinence type and, therefore, inform the management plan. Urethral function testing by urethral pressure profile or leak point pressure is optional.
- Systematic assessment for **pelvic organ prolapse** is highly recommended and the POP-Q method should be used in research studies. Women with coexisting pelvic organ prolapse should have their prolapse treated as appropriate.

2. TREATMENT

- **If stress incontinence is confirmed** then the treatment options that are recommended for patients include the full range of non-surgical treatments, as well as colposuspension procedures, (GoR A) and bladder neck/sub-urethral sling operations (GoR A). All of these procedures have potential risks and associated complications which should be discussed with the individual. **The correction of symptomatic** pelvic organ prolapse may be desirable at the same time. For selected patients injectable bulking agents (GoR B) and the artificial urinary sphincter (GoR C) can be considered.
- **Refractory urgency incontinence** (overactive bladder) secondary to idiopathic detrusor overactivity may be treated by botulinum toxin A (GoR A), sacral nerve stimulation (GoR B) or bladder augmentation/intestinal cystoplasty (GoR D).
- Those patients with **voiding dysfunction** leading to significant post-void residual urine (for example, >30% of total bladder capacity) may have bladder outlet obstruction or detrusor underactivity. Prolapse is a common reversible cause, of voiding dysfunction.

SPECIALISED MANAGEMENT OF URINARY INCONTINENCE IN WOMEN



** Note procedures in increasing level of invasiveness

* Consider CONTINENCE PRODUCTS for temporary support during treatment