National Women & Infants Health Programme

QUICK SUMMARY DOCUMENT

Assessment and Management of Stress Urinary Incontinence in Women

This Quick Summary Document (QSD) is a resource for all clinicians working in healthcare in Ireland who are involved in the care of women with Stress Urinary Incontinence (SUI).

Following a comprehensive literature review a number of evidence-based recommendations for management of SUI were agreed upon.

Key Recommendations

1. We strongly recommend taking a detailed history (to include obstetric and gynaecological history), and a clinical examination be undertaken in women presenting with suspected SUI.
2. A clinical assessment involving pelvic and vaginal examination should be undertaken in patients presenting with suspected Stress Urinary Incontinence.
3. We recommend that basic investigations to include urine dipstick/microscopy should be carried out in the first instance. Additional investigations, primarily urodynamics, should be followed up as indicated.
4. Urodynamic testing is an invasive and time-consuming investigation and there is a small risk of UTI following testing. We would therefore not recommend urodynamics be carried out before initiating conservative treatment.
5. We recommend urodynamic testing be performed prior to all surgical procedures for stress urinary incontinence.
6. We recommend that urodynamic testing is carried if the type of urinary incontinence is unclear, if there is mixed incontinence, if there is a voiding disorder or if there is a previous continence procedure.
7. Referral for additional investigations may be indicated, and we recommend that those treating women with SUI should be aware of these indications.
8. We recommend that all women should be offered non-surgical therapy as first line treatment of SUI. Lifestyle modification (fluid restriction, smoking cessation), weight loss, continence pessaries, pharmacological agents (duloxetine) and local vaginal oestrogen therapy are conservative options for SUI. Pelvic floor muscle training with a specialist physiotherapist for a minimum of three months, can be delivered in the primary care setting prior to referral to specialist.
9. We recommend that neither cystoscopy nor imaging are indicated as part of the evaluation of SUI, unless there is concern about urinary tract anomalies
10. We recommend that women should be fully informed regarding treatment options available to them, including the potential risks and benefits to enable them to decide which course of treatment they wish to proceed with.
11. In women with SUI, or stress-predominant mixed urinary incontinence, who are considering surgery, we recommend that physicians should offer the following treatment options: no further treatment, pelvic floor physiotherapy, non-surgical options (e.g., continence pessary) or surgical treatment.
12. We recommend that women undergoing surgery for SUI should be fully informed on all surgical options available to them and counselled on associated benefits and potential risks of each surgery. For women undergoing surgery with a Mid-Urethral Sling (MUS), when the choice of surgery involves a Mid-Urethral Sling (MUS), the HSE's Mid Urethral Sling Mesh Procedure for the Surgical Treatment of Stress Urinary Incontinence information and Consent should be used.

13. We recommend that details of all surgical procedures using a mesh, bulking agent or other implant for the treatment of SUI are registered with the HPRA and recorded on the National Register of Pelvic Floor Implants. Reporting of complications via HPRA is linked to the register.
14. We recommend that surgery for SUI should only be undertaken by appropriately trained surgeons who undertake such operations regularly, and who work within a Multidisciplinary Team (MDT) where all women undergoing surgery are discussed and treatment pathways are agreed by the MDT.
15. We suggest that mesh implants should only be considered after all the options for conservative and non-mesh surgery have been discussed. We suggest that single Incision Slings and TVT-O should not be used. We suggest retropubic slings should be used for uncomplicated SUI and Trans-Obturator Tapes should only be considered in women with a high risk of bowel or other injury using the retropubic route.

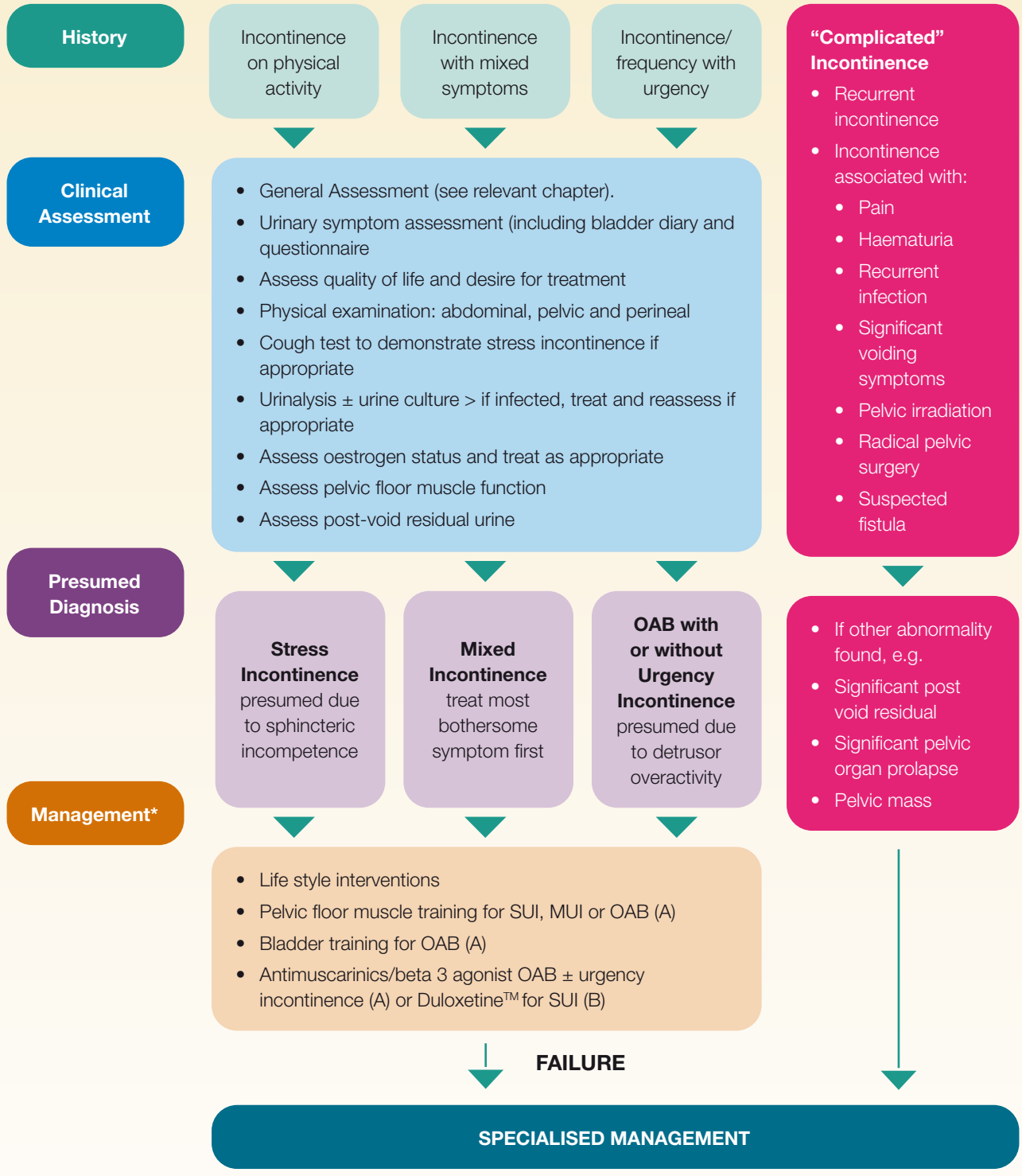
Distinguishing Incontinence Aetiology by History

Question	SI	UI
Description of incontinence episodes	Loss with cough, sneeze or activity	Sudden urgency with inability to reach toilet
Precipitating factors	Cough, physical exercise, strain	Full bladder, sensory triggers (e.g. Running water)
Urinary frequency	Normal	Often increased
Nocturia	<1	Variable
Volume of urine loss	Small amounts, pad sufficient	Large amounts, soaked clothing, runs down legs

SI: Stress Incontinence; UI: urgency incontinence

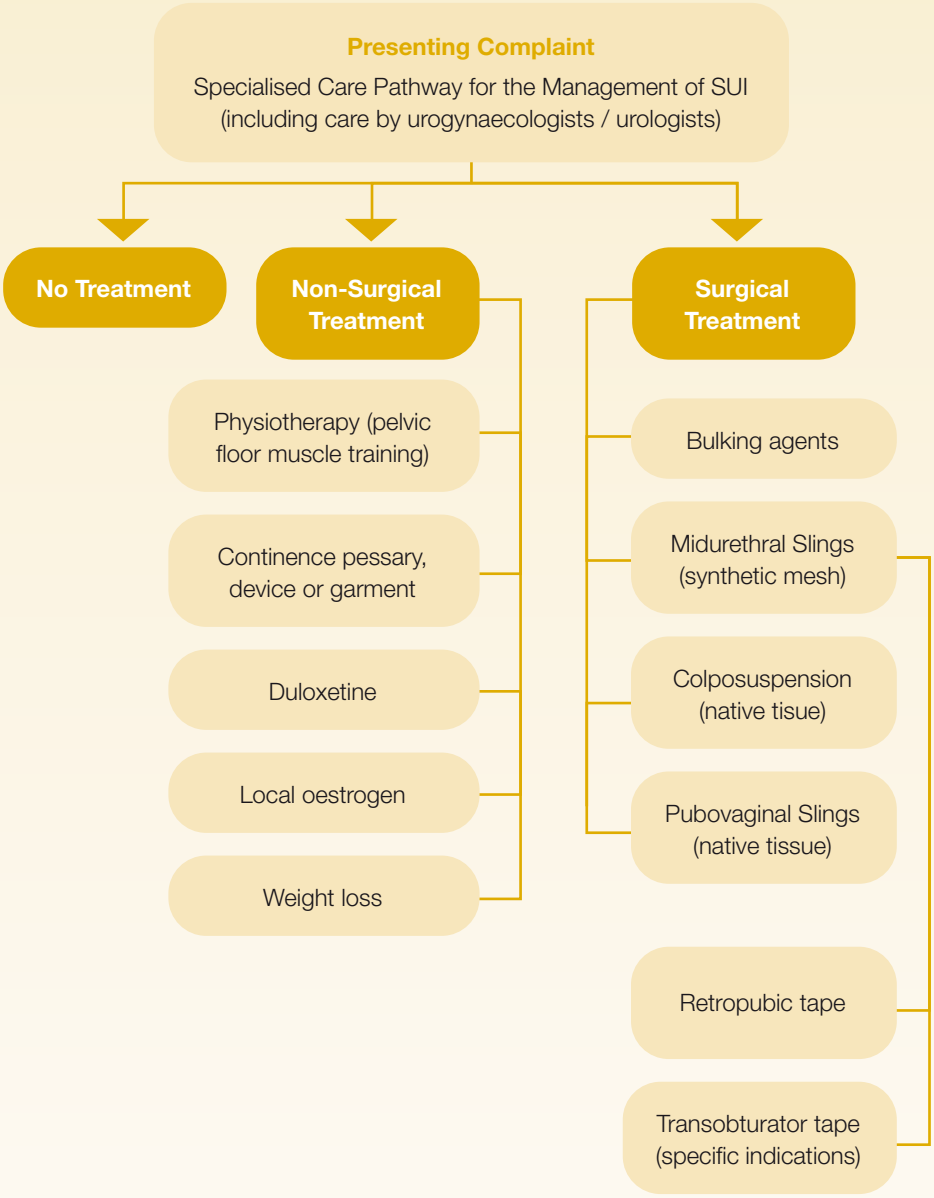
Adapted from: *Farrell, S.A., et al. The Evaluation of Stress Incontinence Prior to Primary Surgery* [1].

Algorithm 1: Initial Management of Female Urinary Incontinence



Adapted from: *ICI 2016 initial management algorithm of female UI*[2]

Algorithm 2: Specialised Care Pathway for the Management of Stress Urinary Incontinence in Women



Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary, and to provide evidence of quality improvement initiatives.

Auditable standards for this Guideline include:

1. Number of women referred to physiotherapy
2. Number of women who have successfully completed a physiotherapy programme
3. Number of women who have had a urodynamic study assessment prior to surgical intervention
4. Use of urodynamic studies in those who are not considering or being considered for surgical management
5. Completion of national consent form at time of booking and repeat consent before surgery
6. Number of women that have consented for their data to be used in National Pelvic Floor Implant Register
7. Full completion of data in National Pelvic Floor Implant Register
8. MDT discussion for all women who undergo mid-urethral sling surgery

Recommended reading:

1. HSE Nomenclature for Clinical Audit – https://www.hse.ie/eng/about/who/nqpsd/ncca/nomenclature-a-glossary-of-terms-for-clinical-audit.pdf
2. HSE National Framework for developing Policies, Procedures, Protocols and Guidelines at https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/
3. Farrell SA. No. 127-The Evaluation of Stress Incontinence Prior to Primary Surgery. Journal of Obstetrics and Gynaecology Canada. 2018;40(2). https://pubmed.ncbi.nlm.nih.gov/29447724/
4. NICE Guidance – Urinary incontinence and pelvic organ prolapse in women: management. BJU International. 2019;123(5). https://www.nice.org.uk/guidance/ng123
5. Ford AA, Rogerson L, Cody JD, Aluko P, Ogah JA. Mid-urethral sling operations for stress urinary incontinence in women. Cochrane Database of Systematic Reviews 2017. https://pubmed.ncbi.nlm.nih.gov/26130017/
6. Imran R, Kearney R. Surgical management of stress urinary incontinence. Vol. 26, Obstetrics, Gynaecology and Reproductive Medicine. 2016. https://research.manchester.ac.uk/en/publications/surgical-management-of-stress-urinary-incontinence

Authors

Craven, S., Salameh, F., O' Sullivan, S. National Clinical Practice Guideline: Assessment and Management of Stress Urinary Incontinence in women. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists. December 2022

https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/

https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/