Management of Female Incontinence, adapted from NICE clinical guideline 40

The management of mixed incontinence should take into account the predominance of features and consider management from both stress and urge pathways as described overleaf.
# Initial Assessment of Urinary Incontinence in the Community

- Categorise urinary incontinence as urge (overactive bladder), stress or mixed incontinence
- Offer lifestyle advice - modify high/low fluid intake
  - Lose weight if BMI <30
  - For mild cases, consider simple incontinence pads
- Identify factors that may require referral
  
  **Urgent referrals:**
  - Microscopic haematuria in those aged 50+
  - Visible haematuria
  - Recurrent of persisting UTI association with haematuria in those aged 40+
  - Suspected pelvic mass arising from urinary tract

  **Refer:**
  - Symptomatic prolapse visible at or below vaginal introitus
  - Palpable bladder on bimanual or physical examination after voiding

  **Consider referring:**
  - Persisting bladder or urethral pain
  - Clinically benign pelvic masses
  - Associated faecal incontinence
  - Suspected neurological disease
  - Voiding difficulty
  - Suspected urogenital fistula
  - Previous continence surgery, previous pelvic cancer surgery and previous pelvic radiation therapy

- Ask the woman to complete bladder diary for at least 3 days, covering variations in usual days (e.g. working and leisure days)
- Urine dipstick
  - Positive and symptomatic: send MSU, prescribe antibiotics
  - Positive and asymptomatic: send MSU, prescribe antibiotics only IF culture positive
  - Negative and symptomatic: send MSU, consider antibiotics
  - Negative and asymptomatic: don’t send MSU or prescribe antibiotics

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**Overactive bladder/ urge incontinence**

- Recommend caffeine reduction
- Bladder training for at least 6 weeks with specialist physiotherapist
- In post menopausal women with vaginal atrophy, offer intravaginal oestrogens
- If cognitive impairment consider prompted and timed toileting programmes
- Consider Propiverine for frequency of urination

  If bladder training ineffective prescribe oxybutynin

  - If oxybutynin not tolerated consider other antimuscarinics
  - Early treatment review after any drug changes

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**Stress urinary incontinence**

- Pelvic floor muscle training for at least 3 months with specialist physiotherapist

  Refer if treatment not effective after 3-6 months
Surgery for stress incontinence

Surgery for stress incontinence will only be funded for patients with stress incontinence in the following circumstances:

Patient has undergone a trial of supervised pelvic floor muscle training with a physiotherapist with an interest in pelvic floor dysfunction for a minimum of 3 months. This should be supported by a physiotherapists report.
OR:
The community continence team assessed the patient and found her not suitable for supervised pelvic floor exercises.
OR:
Combined with pelvic organ prolapse surgery, when stress incontinence is likely to develop or worsen following vaginal reconstruction.

The following procedures will be funded:

- Retropubic mid-urethral tape procedures using a ‘bottom-up’ approach with macroporous (type 1) polypropylene meshes
- Open colposuspension
- Autologous rectus fascial sling

Only if the above procedures are unsuitable will the following be considered for funding on a case-by-case basis:

- synthetic slings using a retropubic ‘top-down’ or a transobturator foramen approach. Explain the lack of longterm outcome data
- intramural bulking agents (glutaraldehyde crosslinked collagen, silicone, carbon-coated zirconium beads, hyaluronic acid/dextran co-polymer)
- an artificial urinary sphincter if previous surgery has failed.

The following procedures will not be funded

- Routine use of laparoscopic colposuspension
- Synthetic slings using materials other than polypropylene that are not of a macroporous (type 1) construction
- Anterior colporrhaphy
- Needle suspensions
- Paravaginal defect repair
- Marshall–Marchetti–Krantz procedure
- Autologous fat and polytetrafluoroethylene as intramural bulking agents

Surgery for Symptomatic Female Pelvic Organ Prolapse

Surgery for Female Pelvic Organ prolapsed will only be funded in the following circumstances:

Failure of pessary in women with bothersome prolapse

OR

Women with prolapse that is interfering with daily functioning who want to have definitive treatment and decline a long term ring or shelf pessary use.

OR

In the presence of coexisting stress urinary incontinence, where surgery for both prolapse and incontinence is considered appropriate.
Vaginal Operations to support outlet of female bladder:

M53.3 Introduction of tension-free vaginal tape
M53.6 Introduction of transobturator tape
M53.8 Other specified operations to support outlet of female bladder
M53.9 Unspecified specified operations to support outlet of female bladder

P22 Repair of prolapsed of vagina and amputation of cervix uteri

P22.1 Anterior and posterior colporrhaphy and amputation of cervix uteri
P22.2 Anterior colporrhaphy and amputation of cervix uteri NEC
P22.3 Posterior colporrhaphy and amputation of cervix uteri NEC
P22.8 Other specified repair of prolapse of vagina and amputation of cervix uteri
P22.9 Unspecified repair of prolapsed of vagina and amputation of cervix uteri (includes Colporrhaphy and amputation of cervix uteri NEC)

P23 Other repair of prolapse of vagina

P23.1 Anterior and posterior colporrhaphy NEC
P23.2 Anterior colporrhaphy NEC
P23.3 Posterior colporrhaphy NEC
P23.4 Repair of enterocoele NEC
P23.5 Paravaginal repair
P23.6 Anterior colporrhaphy with mesh reinforcement
P23.7 Posterior colporrhaphy with mesh reinforcement
P23.8 Other specified repair of prolapse of vagina
P23.9 Unspecified repair of prolapse

P24 Repair of vault of vagina

P24.1 Repair of vault of vagina using combined abdominal and vaginal approach
P24.2 Sacrocolpopexy
P24.3 Repair of vault of vagina using abdominal approach NEC
P24.4 Repair of vault of vagina using vaginal approach NEC
P24.5 Repair of vault of vagina with mesh using abdominal approach
P24.6 Repair of vault of vagina with mesh using vaginal approach
P24.7 Sacrospinous fixation of vagina
P24.8 Other specified repair of vault of vagina
P24.9 Unspecified repair of vault of vagina (includes suspension of vagina NEC)