Hertfordshire Guidelines for the Management of Urinary Incontinence

These guidelines have been based on [http://guidance.nice.org.uk/CG171](http://guidance.nice.org.uk/CG171)

**SUMMARY OF KEY POINTS FOR PRIMARY CARE CLINICIANS:**

**INITIAL ASSESSMENT**
- Take history and dipstick test urine
- Urgently refer patients with certain symptoms (table)

<table>
<thead>
<tr>
<th>URGENTLY refer</th>
<th>Refer</th>
<th>Consider referring</th>
</tr>
</thead>
<tbody>
<tr>
<td>- microscopic haematuria if ≥ 50 years</td>
<td>- symptomatic prolapse visible at or below the vaginal introitus</td>
<td>- persistsing bladder/urethral pain</td>
</tr>
<tr>
<td>- visible haematuria</td>
<td>- palpable bladder on bimanual or physical examination after voiding</td>
<td>- associated faecal incontinence</td>
</tr>
<tr>
<td>- recurrent or persisting UTI associated with haematuria if ≥ 40 years</td>
<td>- clinically benign pelvic masses</td>
<td>- previous pelvic radiation therapy</td>
</tr>
<tr>
<td>- suspected pelvic mass arising from the urinary tract</td>
<td>- suspected neurological disease</td>
<td>- patient education on self-management of condition</td>
</tr>
</tbody>
</table>

- Score symptoms and assess quality of life
- Categorise Urinary Incontinence (UI)

**Stress UI**
- Pelvic floor muscle training
- Lifestyle changes and patient education

**Mixed UI**
- Pelvic floor muscle training
- Bladder training
- Lifestyle advice and patient education

**OAB with or without Urge UI**
- Bladder training
- Lifestyle changes and patient education

- **Direct treatment to predominant symptom** Treat nocturia (desmopressin), vaginal atrophy (intraginal oestrogens) or urinary retention
- Consider a referral for more complex patients (e.g. significant stress UI or patient with cognitive impairment) to [HCT Adult Bladder and Bowel Service](http://hct.nhs.uk) for assessment and management.

**1st LINE TREATMENT** - non-pharmacological conservative management:
- **Bladder diary** (minimum 3 days)
- **Lifestyle interventions** (reduce caffeine intake, fluid modification, reduce weight if BMI>30)
- **Pelvic floor muscle training** (minimum 3 months) for stress or mixed UI
- **Bladder training** (minimum 6 weeks) for OAB or mixed UI
- **Patient education** on self-management of condition

If no improvement in 6-8 weeks, and symptoms are bothering the individual, a referral can be made to the [HCT Adult Bladder and Bowel Service](http://hct.nhs.uk) for further assessment, treatment, advice and support.
DRUG TREATMENT (OAB & MIXED UI) – Conservative measures should be tried before drug treatment.

- OAB drugs only provide modest benefit and there are significant adverse effects (e.g. dry mouth, constipation, falls)

- Manage patient expectation of drug treatment outcome. Including:
  - modest likelihood of success
  - tachyphylaxis to side effects.
  - Full benefit may take 8 weeks, so persistence beyond first few weeks is needed.
  - Treatment goals must be clear and objective. Use a bladder diary to assess response.
  - When required (PRN) use suits some patients

- **Dose**: Start on low doses; take account of total anticholinergic burden (other drugs with antimuscarinic side-effects) and co-existing conditions (e.g. poor bladder emptying)

- Risk benefit assessment is required in frail older people with multiple co-morbidities, functional impairments (walking/dressing difficulties) or cognitive impairment.

- ACUTE prescriptions only for new lines of drug treatment. Do not put on REPEAT until reviewed 4-8 weeks after starting. Do not change drug or dose if therapy is beneficial.

- Review long term patients annually or ideally every 6 months if >75 years.
  - At review only continue drug treatment if benefit maintained, PRN use suits some patients.
  - If drug still needed, always review choice of drug is the most appropriate one and working

- There is no difference in the clinical efficacy between OAB drugs. No evidence that one treatment is better than another. The lowest cost drug should be used and the best choice is effectiveness - balanced against side effects.

- We no longer recommend oxybutynin because the side effects are worse than others.
  - 1st line = tolterodine 2mg twice daily
  - 2nd line = Branded tolterodine XL as Neditol XL 4mg (half the price of the generic XL)
  - 3rd line = mirabegron or trospium or fesoterodine
    The 3rd line antimuscarinic should NOT be solifenacin or oxybutynin M/R (as both are high cost) but one or more 3rd line choices should be tried before invasive procedures.

- Patients currently on OAB drug choices not within the guidelines may remain on treatment whilst benefit is still maintained.

- If all OAB drugs are not effective, consider referral to HCT Adult Bladder & Bowel service

- Do not prescribe UI/OAB drugs for stress UI. Duloxetine may be used for stress UI (specialist initiation only) when primary stress UI procedures have failed.

*MHRA Drug Safety Update Oct 2015*: Mirabegron may raise the BP. It is contraindicated in patients with severe uncontrolled hypertension i.e. systolic BP ≥180mm Hg or diastolic BP ≥110 mm Hg. Monitor regularly.
**Consider:**

- Intravaginal oestrogen in postmenopausal women with vaginal atrophy.

**REFERRAL TO SECONDARY CARE**

Specialist may consider 4th line treatments, before offering invasive treatment.
Choice is based on the drug of next lowest acquisition cost (NOT solifenacin or oxybutynin MR) For costs see appendix 1.
Specialist to provide rationale for the drug if requesting ongoing GP prescribing.
Secondary care options include:

Further Assessment & Urodynamic Testing (Secondary Care)

For the few patients with pure stress, UI multi-channel cystometry is not routinely necessary before primary surgery.

Use multi-channel filling and voiding cystometry before surgery for UI if there are OAB symptoms and clinical suspicion of detrusor overactivity OR there are symptoms of voiding dysfunction or anterior compartment prolapse OR there has been previous surgery for stress UI.

Surgical/Invasive Management (Secondary Care)

Primary Stress UI

Discuss the risks and benefits of surgical and nonsurgical options.

Use NICE information to facilitate discussion: NICE_CG171

Consider the woman’s childbearing wishes during the discussion.

If conservative treatments have failed, Discuss at an MDT & consider:

- Synthetic mid-urethral tape
- Injectable bulking agent (e.g. Bulkmomed)
- Open colposuspension
- Autologous rectus fascial sling
- Intramural bulking agents (e.g. silicone)
- Artificial urinary sphincter if previous surgery has failed.

Offer follow-up review 6-8 weeks following surgery

Secondary Stress UI procedures

Where primary SUI surgical procedure has failed/symptoms return:

Refer to specialist care for further assessment.

Consider duloxetine (specialist initiation only)

Or if woman does not want continued invasive stress UI procedures, offer advice on managing symptoms with option for review appointment and further treatment if she changes her mind.

OAB with or without Urge UI

Discuss the risks and benefits of surgical and non-surgical options. Consider the woman’s child-bearing wishes during the discussion.

The following choices are listed in the order they are usually offered:

1. Botulinum toxin type A – consider for idiopathic detrusor or neurogenic detrusor overactivity in those willing and able to self catheterise.
   - must also fit local eligibility criteria for treatment
2. Percutaneous tibial nerve stimulation (PTNS).
3. Percutaneous sacral nerve stimulation (PSNS): if unable to self catheterise
4. Augmentation cystoplasty – restrict to those willing & able to self catheterise; explain complications and the small risk of bladder malignancy
5. Urinary diversion
**Alternative Conservative Management**

- **Catheters:** Consider when persistent urinary retention causes incontinence, symptomatic infections, or renal dysfunction which cannot be corrected. Inform patient that use of indwelling catheters in urgency UI may NOT result in continence.

- **Absorbent products, urinals and toileting aids:** Not to be considered as treatment. Only to be used as a coping strategy pending definitive treatment; as an adjunct to ongoing therapy or long-term management of UI only after other treatment options have been explored.

- **Products to prevent leakage (intravaginal and intrarectal devices):** Do not use for routine management of UI in women. Do not advise use of devices other than for occasional use when necessary to prevent leakage (example during physical exercise).

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**Useful Contact Details and Resource Materials – Patient QOL Questionnaires/Leaflets/Information**

- **Hertfordshire Community Trust Adult Bladder and Bowel Care Service** [http://www.hct.nhs.uk/our-services/bladder-and-bowel-care](http://www.hct.nhs.uk/our-services/bladder-and-bowel-care) includes:
  - Information for Healthcare Professionals
  - Service Information
  - Patient Information
  - Referral Information

- **Patient Information on Urinary Incontinence and Further Reading:**
  - Bladder & Bowel Foundation: [https://www.bladderandbowelfoundation.org/](https://www.bladderandbowelfoundation.org/)

- **Patient Information on Overactive Bladder (OAB):**
  - Patient UK: [http://www.patient.co.uk/health/overactive-bladder-syndrome](http://www.patient.co.uk/health/overactive-bladder-syndrome)
  - Bladder & Bowel Community: [https://www.bladderandbowel.org/](https://www.bladderandbowel.org/)

- **Patient Incontinence-Specific QoL & symptom scoring questionnaires:** The following scoring questionnaires are used locally:
  - International Consultation on Incontinence Questionnaire (ICIQ) – permission required: [http://www.iciq.net/structure.html](http://www.iciq.net/structure.html)


- **Bladder Training:** [http://www.patient.co.uk/health/overactive-bladder-syndrome](http://www.patient.co.uk/health/overactive-bladder-syndrome)

- **Lifestyle Interventions:** [http://www.nhs.uk/Conditions/Incontinence-urinary/Pages/Treatment.aspx](http://www.nhs.uk/Conditions/Incontinence-urinary/Pages/Treatment.aspx)

- **Pelvic Floor Exercises**
  - Bladder and Bowel Foundation Fact Sheet for women and men: [https://www.bladderandbowelfoundation.org/resources/factsheet-examples/](https://www.bladderandbowelfoundation.org/resources/factsheet-examples/)

- **Patient Information on OAB drugs:** [http://www.nhs.uk/Conditions/Incontinence-urinary/Pages/Treatment.aspx](http://www.nhs.uk/Conditions/Incontinence-urinary/Pages/Treatment.aspx)


- **Hertfordshire Medicines Management Committee (HMMC) Decisions:**
  - Mirabegron for OAB: HVCCG
    - ENHCCG
  - Botulinum toxin type A for OAB: HVCCG
    - ENHCCG

- **Further information**
  - **The Bladder & Bowel Foundation** - a charitable organisation providing information and support for patients, carers and healthcare professionals: [https://www.bladderandbowelfoundation.org/](https://www.bladderandbowelfoundation.org/)
  - **Promocon (Bladder and Bowel UK)** - An organisation promoting awareness and providing information and advice to patients and health professionals, particularly useful for product information and aids to daily: [Link](https://www.bladderandbowelfoundation.org/)
  - **NHS choices** Information and conditions, treatments, local services and healthy living: [www.nhs.uk](http://www.nhs.uk)
Appendix 1 - Drug costs in primary care of medicines used in OAB

The cost of the maximum doses licensed for adults of different medications for treatment of urinary incontinence

<table>
<thead>
<tr>
<th>Medication</th>
<th>Cost when prescribed as Neditol XL</th>
<th>Cost of treatment for 28 days</th>
</tr>
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<tbody>
<tr>
<td>Flavoxate 200mg TDS</td>
<td>£10.89</td>
<td></td>
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<tr>
<td>Darifenacin MR 15mg tablet OD</td>
<td></td>
<td>£25.48</td>
</tr>
<tr>
<td>Tolterodine IR 2mg BD</td>
<td>£2.17</td>
<td>£25.78</td>
</tr>
<tr>
<td>Oxybutynin IR 5mg QDS</td>
<td>£2.64</td>
<td></td>
</tr>
<tr>
<td>Trospium chloride IR 20mg BD</td>
<td></td>
<td>£7.78</td>
</tr>
<tr>
<td>Trospium chloride MR 60mg OD</td>
<td></td>
<td>£23.05</td>
</tr>
<tr>
<td>Oxybutynin MR 20mg OD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fesoterodine MR 8mg OD</td>
<td>£12.89</td>
<td>£25.78</td>
</tr>
<tr>
<td>Tolterodine MR 4mg OD</td>
<td>£10.89</td>
<td>£25.78</td>
</tr>
<tr>
<td>Mirabegron (Betmiga) MR 50mg...</td>
<td></td>
<td>£27.07</td>
</tr>
<tr>
<td>Oxybutynin 3.9mg/24 hours...</td>
<td></td>
<td>£27.20</td>
</tr>
<tr>
<td>Solifenacin 10mg OD</td>
<td></td>
<td>£33.52</td>
</tr>
</tbody>
</table>

Cost when prescribed as Neditol XL

Cost of treatment for 28 days

Version 3.1
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