Hertfordshire Guidelines for the Management of Urinary Incontinence

These guidelines have been based on https://www.nice.org.uk/guidance/ng123

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>
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</thead>
</table>
| - microscopic haematuria if ≥ 50 years  
- visible haematuria  
- recurrent or persisting UTI associated with haematuria if ≥ 40 years  
- suspected pelvic mass arising from the urinary tract |
| - symptomatic prolapse visible at or below the vaginal introitus  
- palpable bladder on bimanual or physical examination after voiding |
| - persisting bladder/urethral pain  
- associated faecal incontinence  
- previous pelvic radiation therapy  
- clinically benign pelvic masses  
- suspected neurological disease  
- voiding difficulty  
- suspected urogenital fistulae  
- previous continence or pelvic cancer surgery |

- 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 – caution in patients with cystic fibrosis, avoid in those over 65 years with cardiovascular disease or hypertension), vaginal atrophy (intravaginal 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 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 overactive bladder (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 for HCT Adult Bladder and Bowel Service 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. Refer to NICE Guideline CG N97 (June 2018): Dementia: assessment, management and support for people living with dementia and their carers.

- 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 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. More expensive OAB drugs do not mean they are more effective. 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 = Solifenacin 5 to 10mg once daily or Tolterodine XL 4mg once daily (as branded Nedidol XL 4mg as less expensive than generic Tolterodine XL)
  - 3rd line = Mirabegron 50mg once daily or Oxybutynin patch if NBM
  - 4th Line = Trospium 20mg twice daily or 60mg MR once daily (if potential drug interactions)

- The guidelines do not recommend fesoterodine (for new patients), oxybutynin plain or m/r, flavoxate, propantheline or imipramine for the treatment of urinary incontinence or overactive bladder.

- 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 secondary care or HCT Adult Bladder & Bowel service if the patient is having significant bother from their symptoms.

- 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.

**Patient Assessment & Conservative Management**
should be tried before any medication

**1st Line**

**Tolterodine 2mg twice daily**
1mg dose if moderate renal or hepatic impairment

Review at 4-8 weeks for efficacy and if tolerated?

**2nd Line**

**Solifenacin 5 to 10mg once daily**
OR
**Neditol XL 4mg daily (= Tolterodine XL)**
(Prescribe by brand name)

Review at 4-8 weeks for efficacy and if tolerated?

**3rd Line**

**Mirabegron 50mg daily**;
25mg dose if moderate renal or hepatic impairment or if drug interactions. Caution MHRA alert - may raise BP
OR
IF NBM **Oxybutynin patch**
36mg twice a week
(only licensed option)

Review at 4-8 weeks for efficacy and if tolerated?

**4th Line**

**Trospium 20mg twice daily or 60mg MR daily**
(if potential drug interactions)

Review at 4-8 weeks for efficacy and if tolerated?

**REFERRAL TO SECONDARY CARE**

Patients who have failed to improve with conservative measures including medication should be referred to secondary care if they are having significant bother from their symptoms. Specialist may consider 5th line treatments, before offering invasive treatment. Choice is based on the drug of next lowest acquisition cost (NOT fesoterodine [for new patients] 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 (including mesh procedures): https://www.nice.org.uk/guidance/ng123
Consider the woman’s childbearing wishes during the discussion. If conservative treatments have failed, Discuss at an MDT & consider:
- Injectable bulking agent (e.g. Bulkmid or Macroplastique)
- Synthetic mid urethral tape
- Colposuspension
- Autologous rectus fascial sling
- 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 intraurethral 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** [https://www.hct.nhs.uk/our-services/adult-bladder-and-bowel-care/](https://www.hct.nhs.uk/our-services/adult-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 Record Chart (Diary):** [https://www.hct.nhs.uk/media/1068/bladder-record-chart.doc](https://www.hct.nhs.uk/media/1068/bladder-record-chart.doc)

- **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.bladderandbowel.org/downloads/](https://www.bladderandbowel.org/downloads/)

- **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)

- **NICE guideline NG123: Urinary incontinence and pelvic organ prolapse in women: management** [https://www.nice.org.uk/guidance/ng123](https://www.nice.org.uk/guidance/ng123)

- **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/)
  - **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/)

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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.

**Cost of Treatment for 28 days**

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolterodine IR 2mg BD</td>
<td>£1.68</td>
</tr>
<tr>
<td>Tolterodine MR 4mg OD</td>
<td>£25.78</td>
</tr>
<tr>
<td>Tolterodine MR 4mg OD (as Neditol XL)</td>
<td>£23.20</td>
</tr>
<tr>
<td>Mirabegron MR 50mg OD</td>
<td>£29.00</td>
</tr>
<tr>
<td>Trospium chloride IR 20mg BD</td>
<td>£6.47</td>
</tr>
<tr>
<td>Trospium chloride MR 60mg OD</td>
<td>£23.05</td>
</tr>
<tr>
<td>Solifenacin 5mg OD</td>
<td>£3.54</td>
</tr>
<tr>
<td>Solifenacin 10mg OD</td>
<td>£4.26</td>
</tr>
<tr>
<td>Oxybutynin Patch 3.9mg/24 hours</td>
<td>£27.20</td>
</tr>
<tr>
<td>Fesoterodine MR 8mg OD</td>
<td>£25.78</td>
</tr>
<tr>
<td>Darifenacin MR 15mg tablet OD</td>
<td>£25.48</td>
</tr>
<tr>
<td>Oxybutynin IR 5mg QDS</td>
<td>£4.94</td>
</tr>
<tr>
<td>Oxybutynin MR 20mg OD</td>
<td>£55.08</td>
</tr>
</tbody>
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**Version** 4.0

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