# URINARY INCONTINENCE

## Definition

1- Stress urinary incontinence- Involuntary leakage of urine related to urethral sphincter failure when abdominal pressure increases eg cough, sneeze, laugh.
2- Urge urinary incontinence- Involuntary leakage of urine immediately preceded by or accompanied by urgency
3- Mixed incontinence- a combination of stress and urge incontinence

## RISK FACTORS

- Pregnancy
- Pelvic floor trauma after vaginal delivery
- Menopause
- Post Hysterectomy/Gynae surgery
- Life style factors eg. Obesity/Manual Job
- UTI
- Chronic cough
- Constipation
- Functional/cognitive impairment.
- Neurological Conditions

## INDICATIONS FOR REFERRAL TO SPECIALIST SERVICE

- persisting bladder or urethral pain
- palpable bladder on bimanual or abdominal examination after voiding
- clinically benign pelvic masses
- associated faecal incontinence
- suspected neurological disease
- symptoms of voiding difficulty
- suspected urogenital fistulae
- previous continence surgery
- previous pelvic cancer surgery
- previous pelvic radiation therapy.

## ASSESSMENT AND INVESTIGATIONS

**Assessment:**

Categorise the woman's urinary incontinence as stress urinary incontinence, mixed urinary incontinence or urgency urinary incontinence/overactive bladder based on symptoms. Start initial treatment on this basis. In mixed urinary incontinence, direct treatment towards the predominant symptom.

If urinary incontinence has associated faecal incontinence, suspect urogenital fistula, tearing in labour/delivery, previous continence surgery, previous pelvic cancer surgery or previous pelvic radiation therapy.

**Examination**:

Undertake routine digital assessment to confirm pelvic floor muscle contraction before the use of supervised pelvic floor muscle training for the treatment of urinary incontinence. Prompt PF squeeze by stating 'squeeze and lift around my finger'/'pretend you're holding in urine/bowel movement' etc.

**Investigations and initial management:**

Complete urine dipstick for all women presenting with urinary incontinence to rule out UTI and haematuria.

If women have symptoms of urinary tract infection (UTI) and their urine tests positive for both leucocytes and nitrites, send a midstream urine specimen for culture and analysis of antibiotic sensitivities. Prescribe an appropriate course of antibiotic treatment pending culture results.

If women have symptoms of UTI and their urine tests negative for either leucocytes or nitrites, send a midstream urine specimen for culture and analysis of antibiotic sensitivities. Consider the prescription of antibiotics pending culture results.

If women do not have symptoms of UTI, but their urine tests positive for both leucocytes and nitrites, do not offer antibiotics without the results of midstream urine culture.

If women have recurrent UTIs and are of menopausal age – consider prescription of vaginal oestrogen to reduce rate of infection

## FURTHER TESTING

**Special Tests:**

If urge, OAB or mixed incontinence to keep a bladder diary for at least 3 days this should cover working/non-working and leisure days, do not have to be consecutive. Input output chart.pdf (baus.org.uk) (English), you can also advise to down load the 'squeezy' app which has a bladder diary in the app but also reminders and information re. pelvic floor exercises Home Page - Squeezy (squeezyapp.com)

Inform:

Help women with pelvic floor dysfunction to understand their condition by giving clear and concise information. This should include:

- the anatomy of the pelvic floor and pelvic organs (using visual aids when helpful)
- possible causes of their symptoms
- management options and possible outcomes
- an explanation that interventions will be focused on their symptoms, rather than on pelvic floor dysfunction in general
- other medical conditions and treatments that can cause or exacerbate their symptoms (see risk factors for pelvic floor dysfunction).

Information should be adapted to age, level of understanding and circumstances.

Lifestyle recommendations:

Recommend a trial of caffeine reduction to women with overactive bladder.

Consider advising women with urinary incontinence or overactive bladder and a high or low fluid intake to modify their fluid intake. Aim for 1.5 – 2L a day.

Advise women with urinary incontinence or overactive bladder and a BMI greater than 30 to lose weight explaining link between increased pressure on bladder and pelvic floor and incontinence.

Physiotherapy

Offer trial of pelvic floor muscle training (minimum 3 month commitment from patient) to women with stress or mixed urinary incontinence.

Specialist Pelvic Health Physiotherapists (PHP) will complete internal assessment to grade the muscle power and teach the patient how to contract their pelvic floor muscle. PHP will then set an individualised programme to improve symptoms dependent on findings. Patients can be referred into to pelvic health team via ERS.

Patient information leaflet: Physio and continence

Continence Team

Bladder training lasting for a minimum of 6 weeks as first-line treatment to women with urgency or mixed urinary incontinence.

If women do not achieve satisfactory benefit from bladder training programmes, the combination of an overactive bladder medicine with bladder training should be considered if frequency is a troublesome symptom.

Referrals can be made via SPA to community continence team (please note no Pelvic Health Physiotherapy in this team)

**MEDICAL MANAGEMENT**

- Anticholigernic medication : eg tolterodine, oxybutynin, solifenacin to review and change to a different anticholinergic if no improvement or side effect after 4 weeks
- To change or add mirabegron after trying 2-3 anticholinergics

# PROLAPSE

**Definition:**

The descent of one or more of the anterior vaginal wall, posterior vaginal wall, the uterus (cervix), or the apex of the vagina (vaginal vault or cuff scar post hysterectomy). The presence of any such sign should be correlated with relevant POP symptoms. More commonly, this correlation would occur at the level of the hymen or beyond. (ICS/IUGA joint report (Haylen 2016)).

**Diagnosis:**

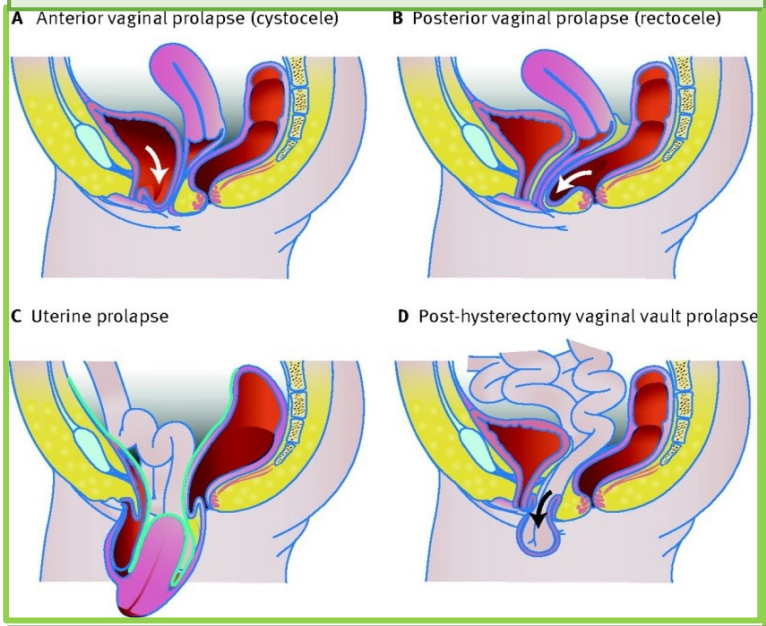
Diagnosis through use of the Pelvic Organ Prolapse Quantification (POP-Q) system

A pelvic organ prolapse is marked as symptomatic when the foremost border of the prolapse is level or past the level of the hymen (>/= stage 2 POP-Q). This needs to be considered when prescribing a patient's treatment. Physiotherapy aims to manage and maintain a stage 2. However, stage 3 and 4 likely require further management.

**Severity**

- **Stage 0**: No prolapse is observed
- **Stage 1 (mild)**: cervix visible when the perineum is depressed - prolapse is contained within the vagina.
- **Stage 2 (moderate)**: cervix prolapsed through the introitus with the fundus remaining in the pelvis.
- **Stage 3(severe)**: prolapse extends more than 1cm beneath the hymen but no further than 2 cm
- **Stage 4 (complete):** vaginal eversion has taken place

**Type**




**Risk Factors**

- Pregnancy and childbirth (increased with vaginal delivery, increased again with assisted delivery eg. Forceps/P.Floor injury eg avulsion injury)
- Obesity
- Heavy lifting / Prolonged standing
- Family history
- Age
- Menopausal changes
- Constipation
- Chronic cough
- Previous pelvic surgery

**Assessment**

Assess to rule out pelvic mass or other pathology and to document the presence of prolapse. Discuss the woman's treatment preferences with her (as below), and refer on if needed.

There is no expectation for GP to diagnose grade or type of prolapse but to be able to advise patient that this is what they are referring into specialist service for.

Notice should also be taken of patients skin quality, vaginal dryness/irritation as a result of menopause can limit options for patient in specialist care, if dry/itching/symptoms of vaginal atrophy consider starting vaginal oestrogen prior to referral.

## MANAGEMENT

**Inform:**

Help women with pelvic floor dysfunction to understand their condition by giving clear and concise information. This should include:

- the anatomy of the pelvic floor and pelvic organs (using visual aids when helpful)
- possible causes of their symptoms
- management options and possible outcomes
- an explanation that interventions will be focused on their symptoms, rather than on pelvic floor dysfunction in general
- advise on other conditions which can impact POP eg. Constipation/straining on the toilet

Information should be adapted to age, level of understanding and circumstances.

https://www.rcog.org.uk/for-the-public/browse-our-patient-information/pelvic-organ-prolapse-patient-information-leaflet/

Lifestyle recommendations:

Advise women with POP and a BMI greater than 30 to lose weight explaining link between increased pressure pelvic floor and exacerbation of symptoms

Advise on bowel care and importance of drinking fluid/maintaining healthy diet to reduce pressure on pelvic floor/ reduce need to strain on the toilet. Discuss perineal splinting/placing perineal pressure with defecation to reduce need to straining on toilet when passing bowels. Bowel management leaflet

Physiotherapy

Specialist Pelvic Health Physiotherapists (PHP) will complete internal assessment to grade the prolapse, pelvic flor muscle power and teach the patient how to contract their pelvic floor muscle. PHP will then set an individualised programme to improve symptoms dependent on findings. They will educate patient re. bladder and bowel management , PFMT and lifting/exercise considerations. Dependent on progression within therapy PHP may also recommend pessaries for patient, they will contact GP for prescription of vaginal moisturiser (+/- oestrogen) prior to trialling pessary as needed. Patients can be referred into to pelvic health team via ERS. Patients with a Prolapse distending past vaginal interoitus should be referred to gynae not PHP.

Patient information leaflet: POP and Physio leaflet

Pessaries

Consider a vaginal pessary for women with symptomatic pelvic organ prolapse, alone or in conjunction with supervised pelvic floor muscle training.

Refer women who have chosen a pessary to a urogynaecology service if pessary care is not available locally.

Before starting pessary treatment:

- consider treating vaginal atrophy with topical oestrogen
- explain that more than 1 pessary fitting may be needed to find a suitable pessary
- discuss the effect of different types of pessary on sexual intercourse
- describe complications including vaginal discharge, bleeding, difficulty removing pessary and pessary expulsion
- explain that the pessary should be removed at least once every 6 months to prevent serious pessary complications.

## WHEN TO REFER TO HOSPITAL URO-GYNAECOLOGY?

- Pelvic Organ Prolapse  stage 3-4
- Failure to respond to treatment for surgical consideration