NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Primary Care Pathway: Female Predominant Stress Incontinence March 2015

Key Points:

- Stress Urinary incontinence (UI) is the involuntary leakage of urine on effort or exertion, or on sneezing or coughing. It can affect women of all ages, but the biggest risk factor is older age due to physiological changes that occur with natural ageing. •
- Consider potential drug causes (i.e. ACE inhibitors, Alpha blockers)
- Non-surgical management options include modification of lifestyle factors and bladder re-training via Community Continence Service (Uniting Care).
- Do not routinely offer absorbent pads, hand-held urinals, and toileting aids as treatments for UI.

Initial Consultation with GP

History: Symptoms predominantly of leakage with cough/sneeze/laugh/exercise. Patient may have mixed symptoms with urgency, frequency, nocturia. Consider if prolapse and faecal symptoms present.
Examination: Vaginal and abdominal examination to exclude pelvic mass. Assess for vaginal atrophy. Assess for prolapse. Cough and Valsalva for leak.
Investigation: Urine dipstick – presence of haematuria: see CCG policy, infection, glycosuria
Consultation: Give advice regarding lifestyle changes. Give patient a stress incontinence leaflet, ICIQ-SF and a bladder diary to complete.
Refer patient to CCS Physiotherapy for supervised pelvic floor exercises for 3/12 [NICE CG171]

Red Flag Exclusions- refer immediately.
Haematuria – See CCG Cystoscopy Primary Care Haematuria Assessment Policy
Pelvic Mass – refer gynaecology Rapid Access Clinic

Bladder diary normal values
Frequency <5
Nocturia <1
Average void 300ml

CCS Physiotherapy Specialist physiotherapy for at least 3 months [NICE CG171]. Expected cure rate 70% Review bladder diary.

Lifestyle measures:

Advise the patient to:

- Reduce caffeine intake
- Modify fluid intake—advise the woman to avoid drinking either excessive amounts. The recommended daily intake is six to eight glasses of water. Reduced fluid intake may worsen or cause constipation)..
- Offer weight loss advice, (if the woman's body mass index is 30kg/m^2 or greater).
- Offer smoking cessation advice.

Review Consultation with GP (2nd patient consultation): 4 months post initial consultation

Treatment successful

Treatment unsuccessful
Repeat ICIQ/bladder diary; complete referral proforma,
Give urodynamics leaflet to patient.

Secondary Care Referral

Hinchingbrooke: Choose and Book (C and B) to **uro-gynaecology** at Hinchingbrooke and peripheral clinics with referral. Uro-gynaecology working with both gynaecology and urology to cover female incontinence.
Addenbrookes and Peterborough: C and B to either urogynaecology or relevant urology clinics. One stop urodynamics if appropriate proforma complete. N. B. One stop urodynamics is not available at Doddington and is not appropriate for under 18, within a year of childbirth, frail elderly or where recurrent UTI.

Based on the Joint Huntingdon LCG and Hinchingbrooke Primary & Secondary Care Pathways for Predominant Urge Incontinence. Lead Authors Dr Helen Johnson, Consultant Hinchingbrooke Hospital, Dr Uma Balasubramaniam. In collaboration with C & P CCG Medicines Management Team

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GP or CCS Physiotherapy Secondary Care Referral
All patients should have sequential QoL scores, negative dipstick, have had 3/12 physiotherapy, any urgency and urge incontinence also managed. Proforma completed.

Initial Secondary Care visit.
One stop with urodynamics if appropriate proforma complete plus patient suitable and suitable appointments available. One stop is currently not available at Doddington.

Investigation: Urodynamics: May be part of one stop visit if appropriate. Under 18, within 1 year post-partum, frail elderly should have clinic only.

Stress incontinence not confirmed, Detrusor over-activity or both: to over-active bladder pathway

Stress incontinence not confirmed, normal test: MDT

Stress incontinence confirmed:
Offer **MDT** and surgery
Mid-Urethral Sling
Local Injectable
Colpo-suspension

Investigation: Ambulatory urodynamics and pad test

Stress incontinence not confirmed, normal test: MDT
Clinic visit to discuss

Duloxetine 40mg BD for those not suitable for or not wishing surgery.

Further physio therapy support

Treatment: cystoscopy +/- local injectable with counselling

Treatment:
Mid Urethral Sling [with pre-op] Local Injectable

Nurse led assessment of success and complications

Treatment successful
No further follow **up**

Treatment unsuccessful or complications, manage with MDT

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References:
National Institute for Health and Clinical Excellence. NICE Guidance CG171 The management of urinary incontinence in women. September 2013. Available at https://www.nice.org.uk/guidance/cg171
NICE Clinical Knowledge Summary. Incontinence- Urinary in women. Last updated February 2015. Available at http://cks.nice.org.uk/incontinence-urinary-in-women