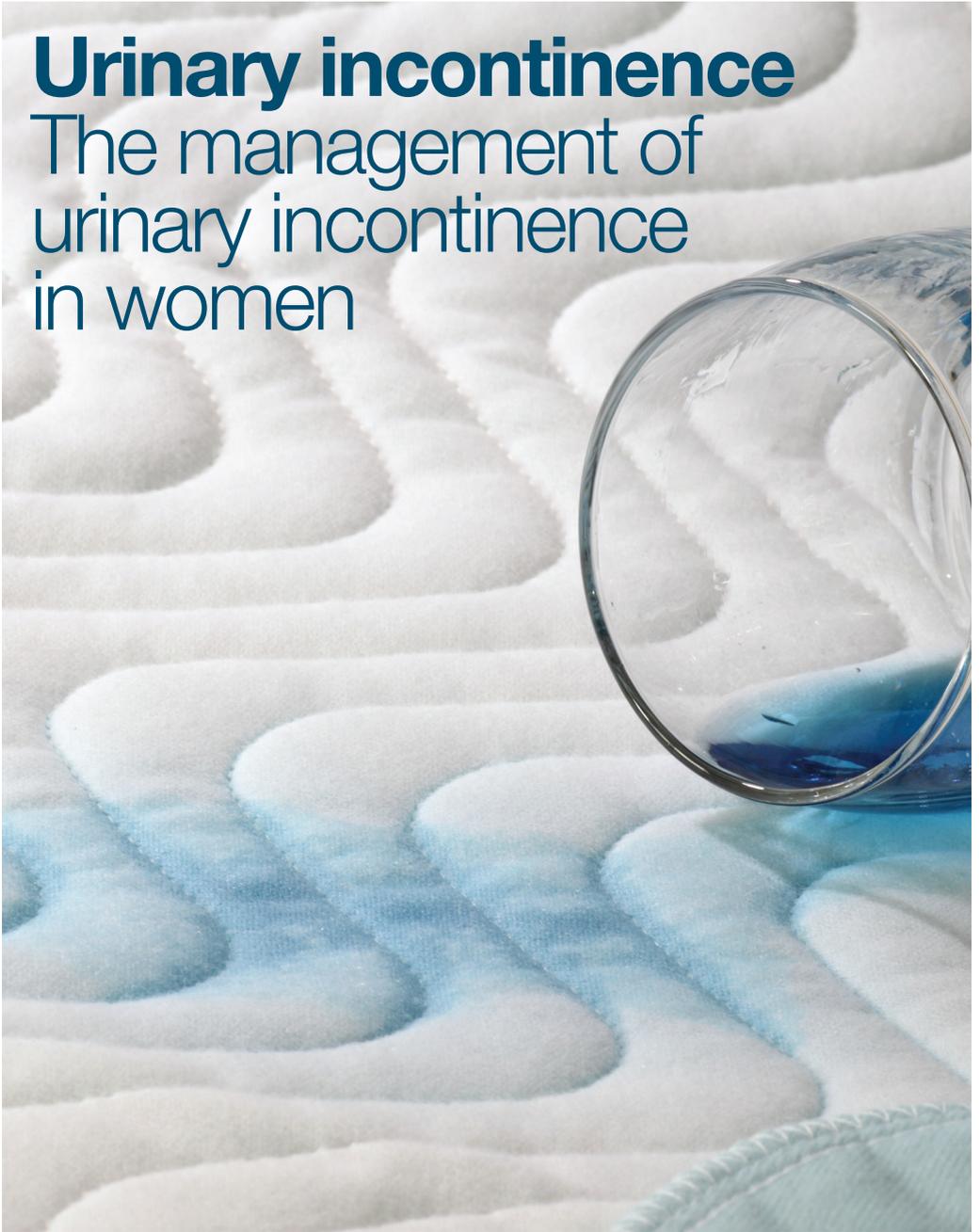


Urinary incontinence

The management of urinary incontinence in women



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Nursing
IN PRACTICE

Welcome

NICE issued an updated clinical guideline on urinary incontinence in September 2013. This clinical guideline updates 'Urinary incontinence: The management of urinary incontinence in women' (NICE clinical guideline 40). It offers evidence-based advice on the care and treatment of women with urinary incontinence.

Nursing
IN PRACTICE

Clinical guideline

Urinary incontinence (UI) is a common symptom that can affect women of all ages, with a wide range of severity and nature. While rarely life-threatening,

incontinence may seriously influence the physical, psychological and social wellbeing of affected individuals. The impact on the families and carers of women with UI may be profound, and the resource implications for the health service considerable.

UI is defined by the International Continence Society as 'the complaint of any involuntary leakage of urine'. UI may occur as a result of a number of abnormalities of function of the lower urinary tract or as a result of other illnesses, which tend to cause leakage in different situations.

- Stress UI is involuntary urine leakage on effort or exertion or on sneezing or coughing.
- Urgency UI is involuntary urine leakage accompanied or immediately preceded by urgency (a sudden compelling desire to urinate that is difficult to delay).
- Mixed UI is involuntary urine leakage associated with both urgency and exertion, effort, sneezing or coughing.
- Overactive bladder (OAB) is defined as urgency that occurs with or without urgency UI and usually with frequency and nocturia. OAB that occurs with incon-

tinence is known as 'OAB wet'. OAB that occurs without incontinence is known as 'OAB dry'. These combinations of symptoms are suggestive of the urodynamic finding of detrusor overactivity, but can be the result of other forms of urethrovaginal dysfunction.

Since the publication of the 2006 NICE guideline, new methods of managing urinary incontinence have become available on the NHS. Botulinum toxin A and sacral nerve stimulation are also now more commonly used for treating OAB symptoms. Synthetic tape procedures have become increasingly popular for the treatment of stress urinary incontinence, and there have been reported improvements in the effectiveness and advances in the types of procedure offered since 2006.

KEY RECOMMENDATIONS FOR NURSES

History-taking and physical examination

At the initial clinical assessment, the women's urinary incontinence (UI) should be categorised as either stress UI (SUI), mixed UI, or urgency UI/overactive bladder (OAB) and initial treatments should be started on this basis. In mixed UI, treatment should be directed towards the predominant symptom.

If stress incontinence is the predominant symptom in mixed UI, discuss with the woman the benefit of conservative management including OAB drugs before



offering surgery. During the clinical assessment seek to identify relevant predisposing and precipitating factors and other diagnoses that may require referral for additional investigation and treatment.

Assessment of pelvic floor muscles

Undertake routine digital assessment to confirm pelvic floor muscle contraction before the use of supervised pelvic floor muscle training for the treatment of UI.

Refer women with UI who have symptomatic prolapse that is visible at or below the vaginal introitus to a specialist.

URINE TESTING

Nurses should give a urine dipstick test to

those presenting with UI to detect the presence of blood, glucose, protein, leucocytes and nitrites in the urine.

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. 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.

ASSESSMENT OF RESIDUAL URINE

Nurses should measure post-void residual volume by bladder scan or catheterisation in women with symptoms suggestive of voiding dysfunction or recurrent UTI. Use a bladder scan in preference to catheterisation on the grounds of acceptability and lower incidence of adverse events. Refer women who are found to have a palpable bladder on bimanual or abdominal examination after voiding to a specialist.

Bladder diaries

Nurses should ask women with UI or OAB to use bladder diaries in the initial assessment. Encourage women to complete a minimum of 3 days of the diary covering variations in their usual activities, such as both working and leisure days.

Do not use pad tests in the routine assessment of women with UI.

ABSORBENT PRODUCTS, URINALS AND TOILETING AIDS

Absorbent products, hand held urinals and toileting aids should not be considered as a treatment for UI. Use them only as a coping strategy pending definitive treatment, an adjunct to ongoing therapy or a long-term management of UI only after treatment options have been explored.

REFERRAL

Urgently refer women with UI who have any of the following :

- microscopic haematuria in women aged 50 years and older

- visible haematuria
- recurrent or persisting UTI associated with haematuria in women aged 40 years and older
- suspected malignant mass arising from the urinary tract.

In women with UI, further indications for consideration for referral to a specialist service include:

- persisting bladder or urethral pain
- 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 .

NEW METHODS OF MANAGING URINARY INCONTINENCE

Since the publication of the 2006 guideline, new methods of managing urinary incontinence have become available on the NHS. Botulinum toxin A and sacral nerve stimulation are also now more commonly used for treating OAB symptoms. Synthetic tape procedures have become increasingly popular for the treatment of stress urinary incontinence, and there have been reported improvements in the effectiveness and advances in the types of procedure offered since 2006. Updated guidance is needed to reflect these changes.

Key updated recommendations include:

- Drug treatments – offer women with overactive bladder syndrome or mixed urinary incontinence the choice of using the antimuscarinic drugs, oxybutynin or tolterodine (immediate release) or

darifenacin (once daily) as a first line treatment. If the first treatment is not effective or well tolerated another drug with the lowest acquisition cost should be offered

- Invasive procedures for OAB – where women with proven overactive bladder syndrome have not responded to conservative management, healthcare professionals should offer bladder wall injections with Botulinum toxin A after discussing the risks and benefits.
- Surgical procedures for Stress Urinary Incontinence – if conservative treatment has failed women should be offered a procedure using a synthetic mid-urethral tape.
- Treatment review – women suffering from OAB should be offered a face-to-face or telephone review four weeks after the start of each new drug treatment.

Invasive treatment options should only be offered as a treatment option after a multi-disciplinary team review and with the woman's preference taken into account.

The MDT for urinary incontinence should include:

- a urogynaecologist
- a urologist with a sub-specialist interest in female urology
- a specialist nurse
- a specialist physiotherapist
- a colorectal surgeon with a sub-specialist interest in functional bowel problems, for women with coexisting bowel problems
- a member of the care of the elderly team and/or occupational therapist, for women with functional impairment.

SUPPORT TOOLS AND PATIENT INFORMATION

NICE has published a range of support tools to help healthcare professionals use the clinical guideline. Healthcare professionals can access the NICE psoriasis pathway by visiting <http://pathways.nice.org.uk/pathways/urinary-incontinence-in-women> this is a fast easy summary view of the NICE guidance on urinary incontinence in women

CONCLUSION

The NICE clinical guideline offers practical evidence-based advice for healthcare professionals on the management and treatment of urinary incontinence in women.

To access the full recommendations, support tools and patient information, please visit: www.nice.org.uk/CG171.



500 450
400 350
300 250
200 150
100 90
80 70
60 50
40 30
25 20
15 10

Estimated cc volume

2000ml Emptying Bag



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ABENA CONTINENCE CARE SOLUTIONS

Exclusive sponsors to the NICE guidelines
for urinary incontinence in women.

Approximately 35% of women (around 1 in 3) experience urinary continence problems at some point in their life, therefore a full bladder, bowel and continence assessment should be performed by a medical professional to establish an accurate diagnosis.

The Abena product range consists of a wide variety of products in varying sizes and absorbencies giving you confidence and security in everyday life. All of Abena's premium products have a fully breathable back sheet that offers superior comfort and helps to maintain healthier skin.

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