NICE National Institute for Health and Care Excellence

NICE Pathways

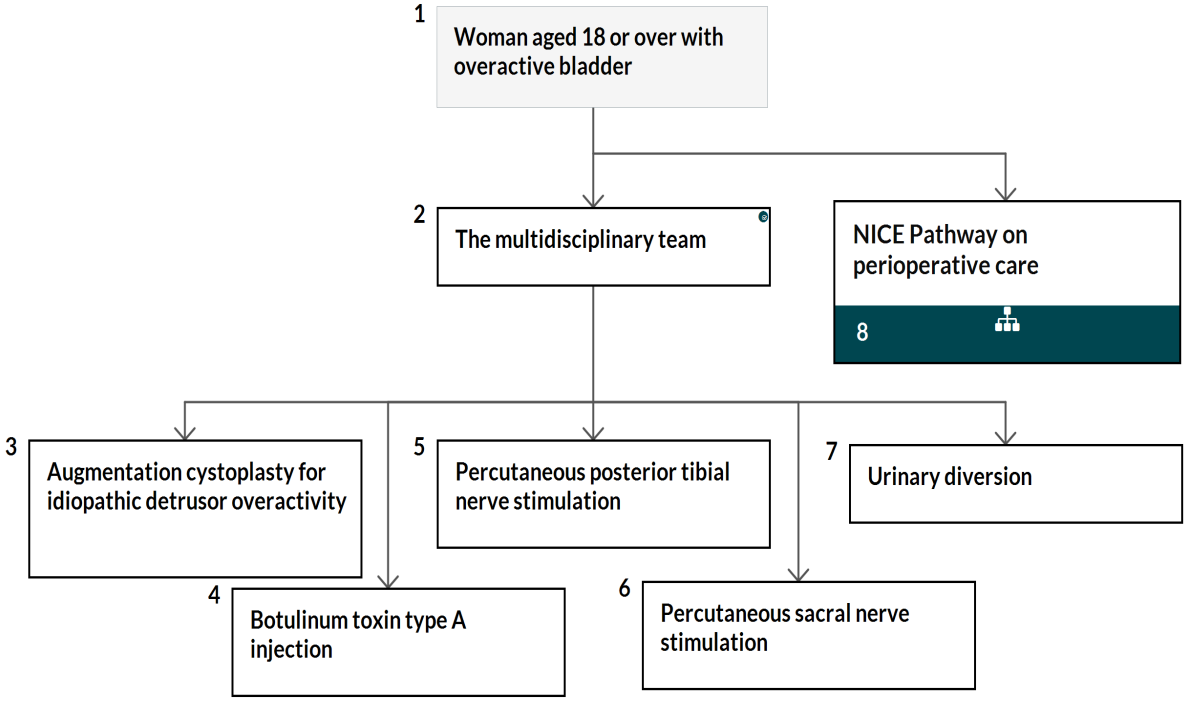
Invasive procedures for overactive bladder in women

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/urinary-incontinence-and-pelvic-organ-prolapse-in-women
NICE Pathway last updated: 03 September 2020

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Woman aged 18 or over with overactive bladder

No additional information

2 The multidisciplinary team

Local

Local MDTs for women with primary SUI, OAB or primary prolapse should:

- review the proposed treatment for all women offered invasive procedures for primary SUI, OAB or primary prolapse
- review the proposed management for women with primary SUI, OAB or primary prolapse if input from a wider range of healthcare professionals is needed
- work within an established clinical network that has access to a regional MDT. (NHS England consulted on specialised gynaecology surgery and complex urogynaecology conditions service specifications in 2018.)

Local MDTs for women with primary SUI, OAB or primary prolapse should include:

- 2 consultants with expertise in managing UI in women and/or POP
- a urogynaecology, urology or continence specialist nurse
- a pelvic floor specialist physiotherapist

and may also include:

- a member of the care of the elderly team
- an occupational therapist
- a colorectal surgeon.

Members of the local MDT should attend all local MDT meetings.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

Regional

Regional MDTs that deal with complex pelvic floor dysfunction and mesh-related problems should review the proposed treatment for women if:

- they are having repeat continence surgery
- they are having repeat, same-site prolapse surgery
- their preferred treatment option is not available in the referring hospital
- they have coexisting bowel problems that may need additional colorectal intervention
- vaginal mesh for prolapse is a treatment option for them
- they have mesh complications or unexplained symptoms after mesh surgery for UI or prolapse
- they are considering surgery and may wish to have children in the future.

Regional MDTs that deal with complex pelvic floor dysfunction and mesh-related problems should include:

- a subspecialist in urogynaecology
- a urologist with expertise in female urology
- a urogynaecology, urology or continence specialist nurse
- a pelvic floor specialist physiotherapist
- a radiologist with expertise in pelvic floor imaging
- a colorectal surgeon with expertise in pelvic floor problems
- a pain specialist with expertise in managing pelvic pain

and may also include:

- a healthcare professional trained in bowel biofeedback and trans-anal irrigation
- a clinical psychologist
- a member of the care of the elderly team
- an occupational therapist
- a surgeon skilled at operating in the obturator region
- a plastic surgeon.

Regional MDTs that deal with complex pelvic floor dysfunction and mesh-related problems should have ready access to the following services:

- psychology
- psychosexual counselling
- chronic pain management
- bowel symptom management
- neurology.

Members of the regional MDT should attend regional MDT meetings when their specific expertise is needed.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Urinary incontinence in women

7. Multidisciplinary team review before surgery or invasive treatment

3 Augmentation cystoplasty for idiopathic detrusor overactivity

Restrict augmentation cystoplasty for the management of idiopathic detrusor overactivity to women whose condition has not responded to non-surgical management and who are willing and able to self-catheterise. Preoperative counselling for the woman or her carer should include common and serious complications: bowel disturbance, metabolic acidosis, mucus production and/or retention in the bladder, UTI and urinary retention. Discuss the small risk of malignancy occurring in the augmented bladder. Provide life-long follow-up.

See also review for long-term use of absorbent containment products.

Laparoscopic augmentation cystoplasty

NICE has published interventional procedures guidance on laparoscopic augmentation cystoplasty (including clam cystoplasty) with **normal arrangements** for clinical governance, consent and audit.

4 Botulinum toxin type A injection

After a local MDT review, offer bladder wall injection with botulinum toxin type A[1] to women with OAB caused by detrusor overactivity that has not responded to non-surgical management, including pharmacological treatments.

Consider treatment with botulinum toxin type A after a local MDT review for women with

[1] At the time of publication (April 2019), only 1 preparation of botulinum toxin type A (BOTOX, Allergan) has a UK marketing authorisation for overactive bladder. The licensed dose is 100 units. Note that units of botulinum toxin type A are not interchangeable between preparations. If prescribing outside the marketing authorisation, the prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the GMC's Prescribing guidance: prescribing unlicensed medicines for further information.

symptoms of OAB in whom urodynamic investigation has not demonstrated detrusor overactivity, if the symptoms have not responded to non-surgical management and the woman does not wish to have other invasive treatments.

After a local MDT review, discuss the benefits and risks of treatment with botulinum toxin type A with the woman and explain:

- the likelihood of complete or partial symptom relief
- the process of clean intermittent catheterisation, the risks, and how long it might need to be continued
- the risk of adverse effects, including an increased risk of urinary tract infection
- that there is not much evidence about how long the injections work for, how well they work in the long term and their long-term risks.

Start treatment with botulinum toxin type A only if the woman is willing, in the event of developing significant voiding dysfunction:

- to perform clean intermittent catheterisation on a regular basis for as long as needed **or**
- to accept a temporary indwelling catheter if she is unable to perform clean intermittent catheterisation.

Use 100 units as the initial dose of botulinum toxin type A to treat OAB in women.

Offer a face-to-face or telephone review within 12 weeks of the first treatment with botulinum toxin type A to assess the response to treatment and adverse effects, and

- if there is good symptom relief, tell the woman how to self-refer for prompt specialist review if symptoms return, and offer repeat treatment as necessary
- if there is inadequate symptom relief, consider increasing subsequent doses of botulinum toxin type A to 200 units[1] and review within 12 weeks
- if there was no effect, discuss with the local MDT.

If symptom relief has been adequate after injection of 100 units of botulinum toxin type A but has lasted for less than 6 months, consider increasing subsequent doses of botulinum toxin type A to 200 units and review within 12 weeks.

Do not offer botulinum toxin type B to women with OAB.

See the NICE guideline to find out why we made these recommendations and how they might affect practice.

[1] At the time of publication (April 2019), 1 preparation of botulinum toxin type A (BOTOX, Allergan) has a UK

marketing authorisation for use at a dose of 200 units, for treating neurogenic detrusor overactivity with urinary incontinence due to subcervical spinal cord injury (traumatic or non-traumatic) or multiple sclerosis. Note that units of botulinum toxin type A are not interchangeable between preparations. If prescribing outside the marketing authorisation, the prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the GMC's Prescribing guidance: prescribing unlicensed medicines for further information

See also review for long-term use of absorbent containment products.

5 Percutaneous posterior tibial nerve stimulation

Do not offer percutaneous posterior tibial nerve stimulation (needles inserted close to the posterior tibial nerve) for OAB unless:

- there has been a local MDT review **and**
- non-surgical management including OAB medicine treatment has not worked adequately **and**
- the woman does not want botulinum toxin type A[1] or percutaneous sacral nerve stimulation.

See also review for long-term use of absorbent containment products.

NICE has published interventional procedures guidance on percutaneous posterior tibial nerve stimulation for overactive bladder syndrome with **normal arrangements** for clinical governance, consent and audit.

6 Percutaneous sacral nerve stimulation

Offer percutaneous sacral nerve stimulation to women after local or regional MDT review if their OAB has not responded to non-surgical management including medicines and:

- their symptoms have not responded to botulinum toxin type A **or**
- they are not prepared to accept the risks of needing catheterisation associated with botulinum toxin type A.

Discuss the long-term implications of percutaneous sacral nerve stimulation with women including:

- the need for test stimulation and probability of the test's success
- the risk of failure
- the long-term commitment
- the need for surgical revision
- the adverse effects.

Tell women how to self-refer for prompt specialist review if symptoms return following a percutaneous sacral nerve stimulation procedure.

[1] At the time of publication (April 2019), most botulinum toxin type A preparations did not have a UK marketing authorisation for this indication. Evidence was only available for the licensed botulinum toxin type A preparation (BOTOX, Allergan).

See also review for long-term use of absorbent containment products.

Axonics sacral neuromodulation system for treating refractory overactive bladder

The following recommendations are from NICE medical technologies guidance on Axonics sacral neuromodulation system for treating refractory overactive bladder.

Evidence supports the case for adopting Axonics SNM system for treating refractory overactive bladder in the NHS. Axonics SNM system improves symptoms and quality of life. It also has a longer battery life than the non-rechargeable system used in NHS clinical practice.

Axonics SNM system should be considered as an option for people with refractory overactive bladder, that is, when conservative treatment or treatment with medicine has not worked, in line with the NICE Pathway on lower urinary tract symptoms in men and the recommendations in this NICE Pathway. Axonics SNM system is small and does not need to be removed for most types of MRI scans, so it may be useful for people with a low BMI or when an MRI is likely.

Cost modelling estimates that, over 15 years, Axonics SNM system is cost saving compared with the non-rechargeable system by about £6,025 per person. Cost savings are estimated to begin 6 years after implant. This is because the device needs to be replaced less frequently than the non-rechargeable system, assuming Axonics has a life span of at least 15 years. For more details, see the NICE resource impact statement.

Interventional procedures

NICE has published interventional procedures guidance on sacral nerve stimulation for urge incontinence and urgency-frequency with **normal arrangements** for consent, audit and clinical governance.

7 Urinary diversion

Urinary diversion should be considered for a woman with OAB only when non-surgical management has failed, and if botulinum toxin A[1], percutaneous sacral nerve stimulation and augmentation cystoplasty are not appropriate or are unacceptable to her. Provide life-long follow-up.

See also review for long-term use of absorbent containment products.

[1] At the time of publication (April 2019), most botulinum toxin type A preparations did not have a UK marketing

8 NICE Pathway on perioperative care

See perioperative care

authorisation for this indication. Evidence was only available for the licensed Botulinum toxin A preparation (BOTOX, Allergan).

Glossary

Augmentation cystoplasty

(a procedure to treat overactive bladder; the bladder is made larger by adding a piece of tissue from the intestines to the bladder wall)

BMI

Body mass index

Botulinum toxin type A

(a treatment used for overactive bladder; it is injected into the wall of the bladder)

Detrusor overactivity

(involuntary bladder contractions seen during a cystometry test; they can be the cause of overactive bladder symptoms)

MDT

multidisciplinary team

OAB

overactive bladder

Percutaneous posterior tibial nerve stimulation

(a procedure used to treat overactive bladder: a mild electric current is passed through a fine needle to stimulate a nerve in the leg; this nerve controls bladder function)

Percutaneous sacral nerve stimulation

(a procedure used to treat overactive bladder: a device is implanted in the back to stimulate the nerves at the base of the spine; these nerves affect the bladder and surrounding muscles)

SNM

sacral neuromodulation

Urinary diversion

(a type of surgery used to treat stress urinary incontinence; it causes urine to flow through an opening in the abdomen into an external bag, instead of into the bladder)

UTI

urinary tract infection

Sources

Urinary incontinence and pelvic organ prolapse in women: management (2019) NICE guideline NG123

Axonics sacral neuromodulation system for treating refractory overactive bladder (2020) NICE medical technologies guidance 50

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services,

and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to

make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.