NICE National Institute for Health and Care Excellence

NICE Pathways

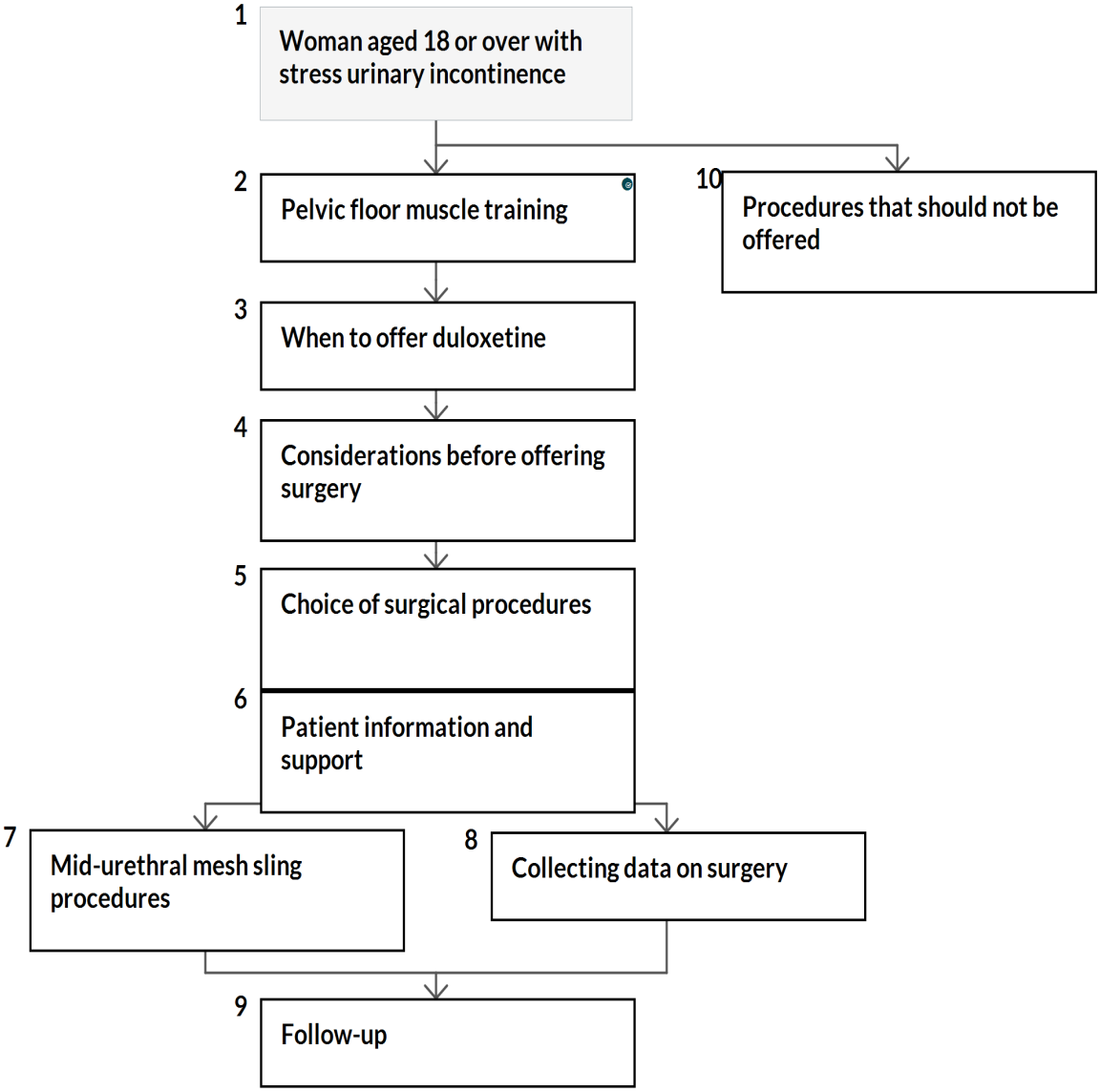
Managing stress urinary incontinence in women

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 stress urinary incontinence

No additional information

2 Pelvic floor muscle training

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

Offer a trial of supervised pelvic floor muscle training of at least 3 months' duration as first-line treatment to women with SUI or mixed UI.

Pelvic floor muscle training programmes should comprise at least 8 contractions performed 3 times per day.

Do not use perineometry or pelvic floor electromyography as biofeedback as a routine part of pelvic floor muscle training.

Continue an exercise programme if pelvic floor muscle training is beneficial.

Do not routinely use electrical stimulation in combination with pelvic floor muscle training.

Electrical stimulation and/or biofeedback should be considered in women who cannot actively contract pelvic floor muscles in order to aid motivation and adherence to therapy.

Quality standards

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

Urinary incontinence in women

4. Supervised pelvic floor muscle training

3 When to offer duloxetine

Do not use duloxetine as a first-line treatment for women with predominant SUI. Do not routinely offer duloxetine as a second-line treatment for women with SUI, although it may be offered as second-line therapy if women prefer pharmacological to surgical treatment or are not suitable

for surgical treatment. If duloxetine is prescribed, counsel women about its adverse effects.

See also review for long-term use of medicines.

4 Considerations before offering surgery

If stress incontinence is the predominant symptom in mixed UI, discuss with the woman the benefit of non-surgical management and medicines for OAB before offering surgery.

5 Choice of surgical procedures

There is public concern about the use of mesh procedures. For all of the procedures recommended in this flowchart, including mesh procedures, there is evidence of benefit, but limited evidence on long-term adverse effects. In particular, the true prevalence of long-term complications is unknown.

If non-surgical management for SUI has failed, and the woman wishes to think about a surgical procedure, offer her the choice of:

- colposuspension (open or laparoscopic) **or**
- an autologous rectus fascial sling.

Also include the option of a retropubic mid-urethral mesh sling in this choice but see the recommendations on mid-urethral mesh sling procedures [See page 6] for additional guidance on the use of mid-urethral mesh sling procedures for SUI.

See the NICE guideline to find out why we made this recommendation and how it might affect practice.

Also see surgery for stress urinary incontinence and pelvic organ prolapse in considerations before surgery for pelvic organ prolapse.

Intramural bulking agents

Consider intramural bulking agents to manage SUI if alternative surgical procedures are not suitable for or acceptable to the woman. Explain to the woman that:

- these are permanent injectable materials

- repeat injections may be needed to achieve effectiveness
- limited evidence suggests that they are less effective than the surgical procedures listed above and the effects wear off over time
- there is limited evidence on long-term effectiveness and adverse events.

If an intramural bulking agent is injected, give the woman written information about the bulking agent, including its name, manufacturer, date of injection, and the injecting surgeon's name and contact details.

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

NICE has published interventional procedures guidance on intramural urethral bulking procedures for stress urinary incontinence with **normal arrangements** for clinical governance and for audit or research.

Artificial urinary sphincters

Do not offer women an artificial urinary sphincter to manage SUI unless previous surgery has failed.

6 Patient information and support

There is public concern about the use of mesh procedures. For all of the procedures recommended in this flowchart, including mesh procedures, there is evidence of benefit, but limited evidence on long-term adverse effects. In particular, the true prevalence of long-term complications is unknown.

If a woman is thinking about a surgical procedure for SUI, use the NICE patient decision aid on surgery for SUI to promote informed preference and shared decision making. Discussion with the woman should include:

- the benefits and risks of all surgical treatment options for SUI that NICE recommends, whether or not they are available locally
- the uncertainties about the long-term adverse effects for all procedures, particularly those involving the implantation of mesh materials
- differences between procedures in the type of anaesthesia, expected length of hospital stay, surgical incisions and expected recovery period
- any social or psychological factors that may affect the woman's decision.

If the woman's chosen procedure for SUI is not available from the consulting surgeon, refer her to an alternative surgeon.

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

See also the NICE Pathway on preoperative tests.

7 Mid-urethral mesh sling procedures

When offering a retropubic mid-urethral mesh sling, advise the woman that it is a permanent implant and complete removal might not be possible.

If a retropubic mid-urethral mesh sling is inserted, give the woman written information about the implant, including its name, manufacturer, date of insertion, and the implanting surgeon's name and contact details.

When planning a retropubic mid-urethral mesh sling procedure, surgeons should:

- use a device manufactured from type 1 macroporous polypropylene mesh
- consider using a retropubic mid-urethral mesh sling coloured for high visibility, for ease of insertion and revision.

Do not offer a transobturator approach unless there are specific clinical circumstances (for example, previous pelvic procedures) in which the retropubic approach should be avoided.

Do not use the 'top-down' retropubic mid-urethral mesh sling approach or single-incision sub-urethral short mesh sling insertion except as part of a clinical trial.

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

See also assessing and managing complications associated with mesh surgery.

Interventional procedures

NICE has published guidance on single-incision short sling mesh insertion for stress urinary incontinence in women with **special arrangements** for clinical governance, consent, and audit or research.

8 Collecting data on surgery

Providers must ensure that data on surgical procedures for SUI are recorded in the national registry.

Ask women having surgery for SUI or POP, or who have experienced complications related to these types of surgery, for their consent to enter the data listed below into a national registry. Give each woman a copy of her data.

Providers must ensure that the following data are collected in a national registry of surgery for UI and POP:

- the woman's NHS number
- hospital and consultant identifiers
- date and details of the procedure
- for procedures involving mesh, the mesh material, manufacturer, product unique identification code and type of sutures used
- for procedures involving colposuspension, the type of sutures used
- for procedures involving bulking agent, the bulking material, manufacturer and product unique identification code
- date and details of any investigation for complications
- date and details of any surgical or non-surgical intervention for complications.

The national registry of surgery for UI or POP in women must ensure that follow-up data are collected on key short- and long-term (at least 5 years) outcomes, including:

- validated relevant outcome measures
- adverse events including pain
- suspected and confirmed mesh-related complications.

The national registry of surgery for urinary incontinence and pelvic organ prolapse in women should report annually and be quality assured.

Rationale and impact

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

9 Follow-up

Offer a follow-up appointment within 6 months to all women who have had a surgical procedure to treat SUI.

For women who have had retropubic mid-urethral mesh sling surgery, the follow-up appointment should include a vaginal examination to check for exposure or extrusion of the mesh sling.

Providers should ensure that women who have had surgery for SUI have access to further referral if they have recurrent symptoms or suspected complications. See also assessing and managing complications associated with mesh surgery.

For women whose primary surgical procedure for SUI has failed (including women whose symptoms have returned):

- seek advice on assessment and management from a regional MDT that deals with complex pelvic floor dysfunction **or**
- offer the woman advice about managing urinary symptoms if she does not wish to have another surgical procedure, and explain that she can ask for a referral if she changes her mind.

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

Artificial urinary sphincters

For women who have an artificial urethral sphincter:

- offer postoperative follow-up **and**
- ensure access to review if needed.

10 Procedures that should not be offered

Do not offer women the following procedures to treat stress urinary incontinence:

- anterior colporrhaphy
- needle suspension
- paravaginal defect repair
- porcine dermis sling
- the Marshall–Marchetti–Krantz procedure.

See the NICE guideline to find out why we made this recommendation and how it might affect practice.

Interventional procedures

NICE has published guidance on the following with **special arrangements** for clinical governance, consent, and audit or research:

- extraurethral (non-circumferential) retropubic adjustable compression devices for stress urinary incontinence in women
- bone-anchored cystourethropexy.

Glossary

Autologous rectus fascial sling

(a type of sling used to treat stress urinary incontinence: it is made out of tissue from the woman's abdomen; the sling supports the tube that carries urine out of the body (the urethra))

Colposuspension

(a type of surgery used to treat stress urinary incontinence; the neck of the bladder is lifted up and stitched in this position)

Intramural bulking agents

(materials used to treat stress urinary incontinence: they are injected into the sides of the tube that carries urine out of the body (the urethra); this helps it remain closed so that urine is less likely to leak out)

MDT

multidisciplinary team

OAB

overactive bladder

SUI

stress urinary incontinence

UI

urinary incontinence

Sources

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

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.