Her Life Her Health

PRIMARY CARE WOMEN'S HEALTH FORUM

Urinary incontinence and pelvic organ prolapse NICE update

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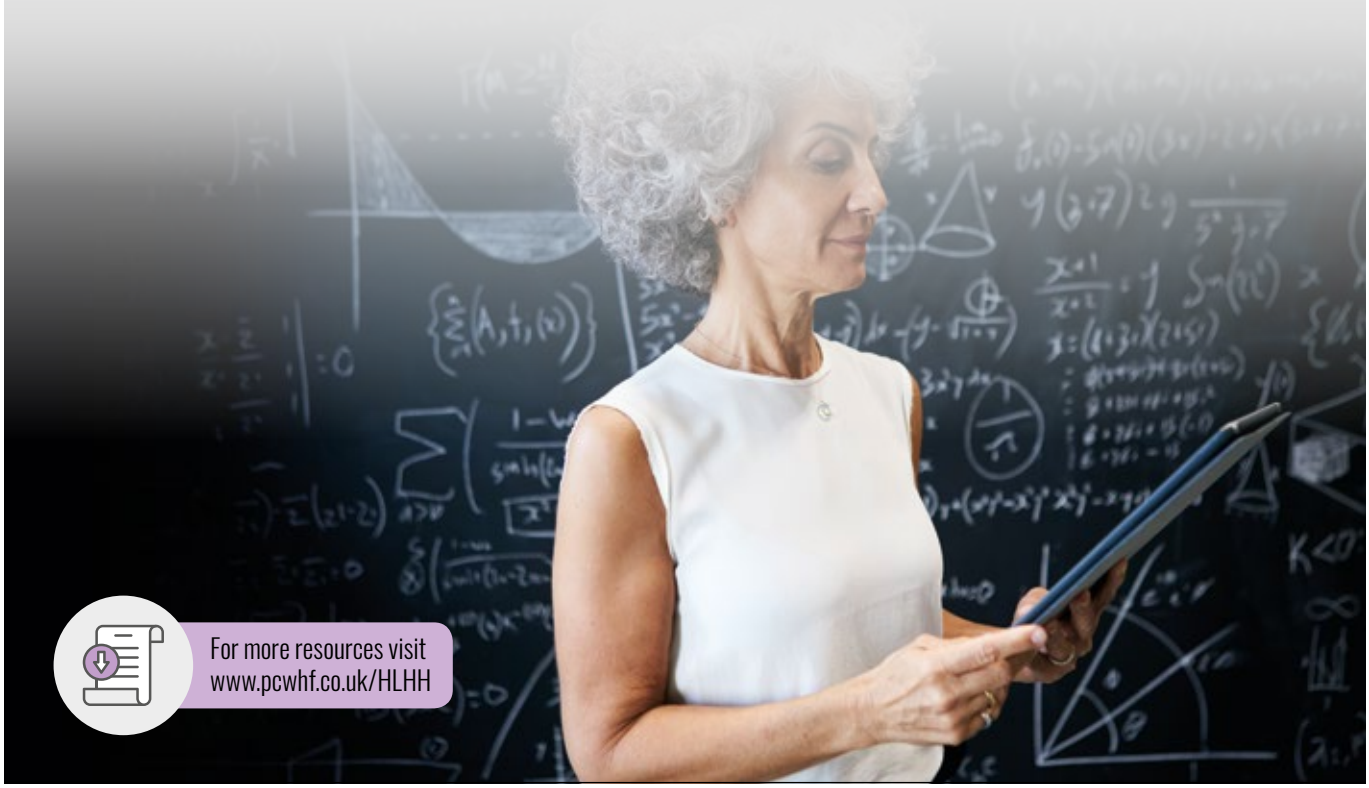

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Urinary incontinence and pelvic organ prolapse NICE update

In April 2019 NICE published its update on the management of urinary incontinence and new guidance on pelvic organ prolapse. This article summarises the recommendations.

The new guidance recommends that initial management should address the predominant symptom:

Stress incontinence

Primary care management of stress incontinence remains unchanged and comprises:

- weight loss if the woman is overweight
- exclusion of UTI
- three months of pelvic floor muscle training supervised by a physiotherapist.

If symptoms do not resolve following this, referral to secondary care is recommended.

If symptoms are purely stress incontinence and this is demonstrable on examination, surgical management may be undertaken without prior urodynamic studies (UDS).

Decision aids have been developed to help counsel women regarding the surgical options currently available:

- urethral bulking agents
- colposuspension (open or laparoscopic)
- autologous fascial sling.

NICE also found that mid-urethral slings are highly effective at treating stress incontinence. However, their use is currently 'paused' due to concerns regarding the use of mesh in vaginal surgery.

Current trends have seen increased uptake of urethral bulking agents, further potentiated by the current mesh suspension. Recent evidence suggests better efficacy of bulking agents than previously reported, probably due to different materials and administration techniques. All surgical management of stress incontinence is discussed at an MDT.

Overactive bladder

Urgency symptoms should initially be managed in primary care with lifestyle advice including:

- weight loss if overweight
- appropriate fluid intake (1.5l/day)
- caffeine avoidance
- exclusion of UTI
- six weeks of bladder retraining.

Anticholinergics remain first line medical management of urgency and urgency incontinence. To aid compliance it is important to advise of common side effects:

- dry mouth
- constipation
- dry eyes

and that it can take up to four weeks to be effective.

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If initial medical treatment is not successful, a second anticholinergic should be tried, alongside topical oestrogens if postmenopausal with vaginal atrophy.

It is also important to be aware of the potential anticholinergic burden for these patients and the long-term impact on cognition should be considered.

If treatment is successful then these patients should be reviewed annually (six monthly if aged over 75 years) as sometimes it is possible to reduce or stop treatment.

If patients are still symptomatic despite the above regimen, a referral to secondary care is recommended. Mirabegron is often started and patients may be asked to attend the GP surgery for blood pressure monitoring two to four weeks following initiation, as Mirabegron can be associated with severe hypertension. Mirabegron can also be used alongside Solifenacin as dual therapy.

Currently surgical management is only recommended for urodynamically proven detrusor overactivity, not just overactive bladder symptoms. Options include intravesical botulinum toxin (BOTOX®), which is often available as an outpatient treatment, sacral neuromodulation or percutaneous tibial nerve stimulation (weekly outpatient treatment for 12 weeks). There are currently studies evaluating the need for UDS prior to Botox.

Mixed incontinence

If mixed incontinence symptoms are present then the predominant symptom should be tackled first. If initial conservative management is unsuccessful in patients with mixed incontinence, medical management of urgency symptoms should be undertaken regardless of the more bothersome symptom rather than moving on to surgical management of stress incontinence.

Prolapse

Prolapse is common in parous women and only symptomatic prolapse requires treatment; mild incidental findings are not significant. Initial management comprises:

- weight loss if overweight
- avoidance of pressure on the pelvic floor (chronic cough/constipation)
- supervised pelvic floor muscle training.

Management with pessaries of various shapes and sizes may be successful for many patients and some are suitable in the sexually active population. To reduce pessary complications, such as erosions or adhesions, concomitant vaginal oestrogen therapy is useful. If reduced cognition prevents traditional topical treatments then the oestrogen ring may be an acceptable alternative.

If surgical management is required most primary procedures do not require mesh and patients can expect a short hospital stay of one or two nights, although isolated repairs may be done as day case procedures. It may take up to 6 weeks to get back to normal activity and we would recommend ongoing lifestyle changes to reduce the risk of recurrence. ♀

