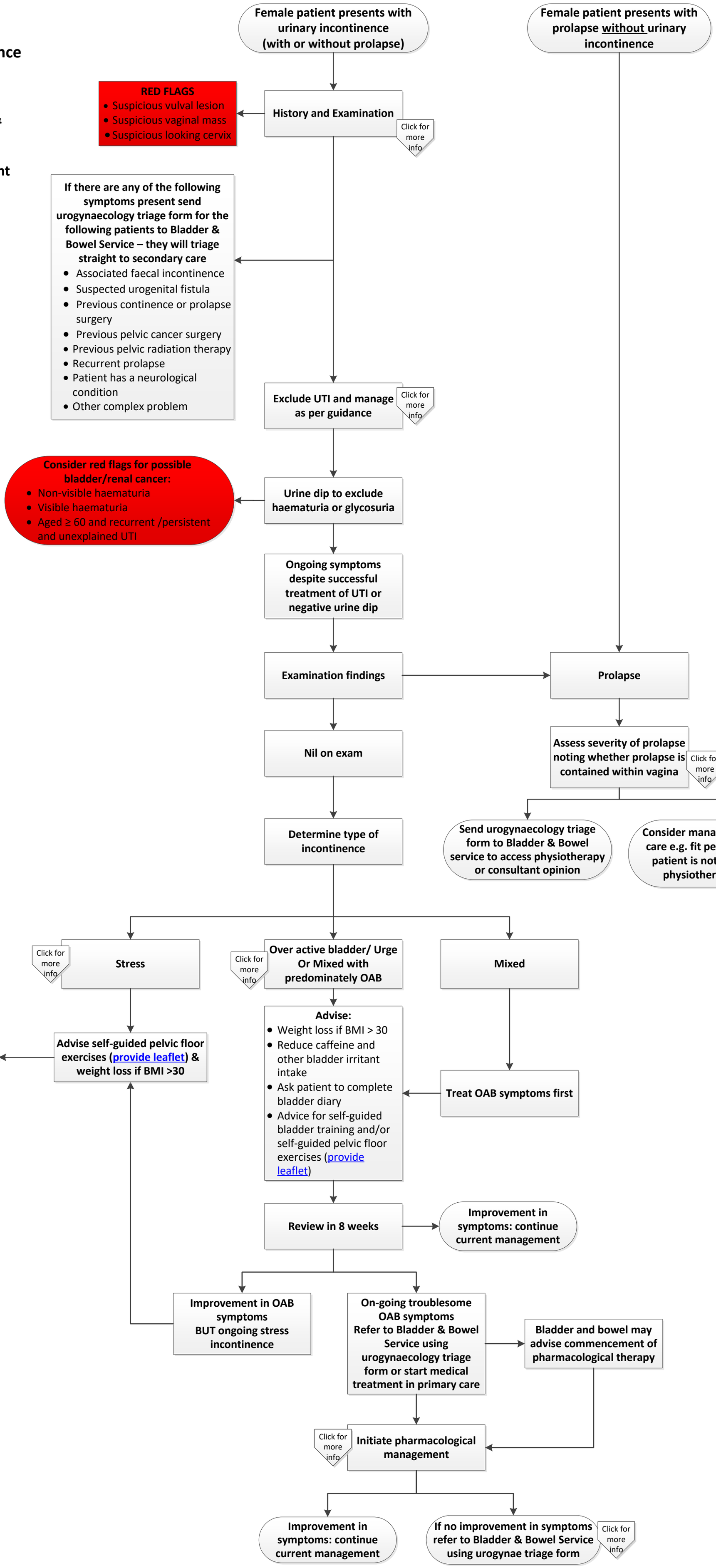
GP Pathway for the Management of Adult Female Urinary Incontinence and Prolapse

NB: All referrals (excluding 2WW) should go to Bladder & Bowel Service for triage to appropriate service (after investigation and management as described in the pathway)



Back to pathway

History and Examination

The focus is to elicit the type of incontinence (Urgency (OAB), Stress or Mixed) and rule out readily reversible causes.

History should include:

- Gynae and obstetric history
- Frequency of events
- Precipitating factors
- Effect on quality of life
- Products used
- Caffeine intake

Exam to include:

- **Pelvic exam for masses: see Ovarian Cancer pathway**
- **Manage other findings such as fibroids (if causing urinary outflow obstruction) and urinary retention before continuing on this pathway**

Back top pathway

Exclude UTI and manage as per guidance

If asymptomatic no need for further investigation.
If symptomatic:

- <65 perform urine dip
- >65 perform MSU

https://clinical-pathways.org.uk/clinical-pathways/urinary-tract-infections-utis-female

Back to pathway

If no improvement in symptoms send urogynae triage form

If inadequate improvement – send urogynae triage form

Also refer to urogynaecology (via urogynae triage form) or urology if:

- persisting bladder or urethral pain

Also refer to urology if:

- suspected neurological disease

Back to pathway

Assess severity of prolapse noting whether prolapse is contained within vagina

Assess severity of prolapse:

- Prolapse contained within the vagina (mild)
- Prolapse contained within the vagina (moderate or severe)

- **Pessaries can be offered for prolapse but may not help incontinence**
- Advise weight loss if BMI>30

Back to pathway

Stress Incontinence

Stress incontinence is more likely if incontinence occurs when coughing, sneezing, lifting or exercising

Back to pathway

Over active bladder/ Urge Or Mixed with predominately OAB

Over active bladder is more likely if incontinence occurs with sudden urgency and if there is frequency or nocturia

Back to pathway

Initiate pharmacological management

Baseline ICIQ prior to starting

Please see local Pharmacy and Medicines optimisation guidance for advice on prescribing treatment for OAB or mixed urinary incontinence:

Hertfordshire: https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/download?cid=1438&checksum=db6ebd0566994d14a1767f14eb6fba81

Manage patient expectation of drug treatment outcome. Including:

- Modest likelihood of success
- Tachyphylaxis (rapidly diminishing response to successive doses of a drug)
- Pharmaceutical side effects
- Full benefit may take 8 weeks, so persistence beyond first few weeks is needed
- Treatment goals must be clear and objective. Use a bladder diary to assess response
- When required (PRN) use suits some patients
- The long-term effects of anticholinergic medicines for overactive bladder on cognitive function are uncertain

When offering anticholinergic medicines to treat overactive bladder, take account of woman's:

- Coexisting conditions (such as poor bladder emptying, cognitive impairment or dementia)
- Current use of other medicines that affect total anticholinergic load
- Risk of adverse effects, including cognitive impairment

- Review long term patients annually or ideally every 6 months if >75 years

- Trial 2nd line medication followed by 3rd line medication if suboptimal response to this
- One or more 3rd line choices should be tried before invasive procedures