Care Pathway for the Management and Referral of Urinary Incontinence in Women

HISTORY

How bothersome is the incontinence?

How frequent is the incontinence?

For how long has it been occurring?

What is the quantity of the leakage?

When does the patient leak urine?

- When performing some activity, such as coughing, lifting or exercise
- When they had the urge or feeling they needed to empty their bladder but could not get to the toilet fast enough
- Without activity or a sense of urgency
- With both activity and a sense of urgency

CLINICAL ASSESSMENT

- General health assessment
- Assess whether the patient has completed her family
- Assess quality of life and desire for treatment
- Urinary symptom assessment (including bladder diary and questionnaire)
- Physical examination: abdominal, pelvic and perineal
- Cough test to demonstrate if stress incontinence present
- Urinalysis ± urine culture -> if infected, treat and reassess if appropriate
- Assess oestrogen status and treat as appropriate
- Assess pelvic floor muscle function
- Assess post-void residual urine

"Complicated" Incontinence:

- Recurrent incontinence
- Debilitating severe incontinence
- Incontinence associated with:
  - Pain
  - Haematuria
  - Recurrent infection
  - Patients with neurological conditions
  - Patients using medications that cause an atonic bladder
  - Voiding dysfunction
  - Pelvic irradiation
  - Radical pelvic surgery
  - Suspected fistula
- Incontinence with
  - Significant post void residual OR
  - Significant pelvic organ prolapse OR
  - Pelvic mass
- Primary nocturnal incontinence
- Nocturnal enuresis
- Continuous incontinence

PROVISIONAL DIAGNOSIS

STRESS URINARY INCONTINENCE (SUI)
(incontinence when performing activity)

MIXED URINARY INCONTINENCE (MUI)
(both incontinence types present - treat most bothersome symptom first)

URGE INCONTINENCE / OVERACTIVE BLADDER (OAB)
(need to empty bladder but could not get to the toilet fast enough)

FIRST LINE MANAGEMENT

- Consider continence products for temporary support during treatment
- Lifestyle interventions include weight loss and avoiding chronic straining (lifting, coughing or constipation) for all patients
- Supervised pelvic floor muscle therapy with nurse continence advisors and/or physiotherapists with a special interest in the pelvic floor
- Vaginal devices such as cones, weights, urethral support devices
- Bladder irritants such as caffeine and alcohol should be minimised for urge incontinence / OAB
- Bladder retraining for urge incontinence / OAB
- Pharmacological treatments such as anticholinergics or beta-adrenergic agonists for urge incontinence / OAB

REVIEW OF MANAGEMENT

SPECIALIST MANAGEMENT

This may include care by gynaecologists, urogynaecologists, urologists with a special interest in pelvic floor and geriatricians

No treatment

Non-surgical treatments

Patient assessed as requiring operative management

MULTIDISCIPLINARY APPROACH

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE