Urinary Incontinence in Females

Obstetrics and Gynaecology > Gynaecology > Urinary Incontinence in Females

1. Care map information

In scope:

- assessment and management of urinary incontinence (UI) in adult females
- includes UI in pregnancy and post partum period

Out of scope:

- UI in children under age 16
- UI in men
- UI caused by neurological disease

Definition:

UI is defined by the International Continence Society as 'the complaint of any involuntary leakage of urine' UI may occur as a result of a number of abnormalities of function of the lower urinary tract or as the result of other illnesses, which tend to cause leakage in different situations [1].

UI:

- is a common symptom that can affect women of all ages, with a wide range of severity and nature
- while rarely life-threatening, UI may seriously influence the physical, psychological and social wellbeing of affected individuals
- impact on the families and carers of women with UI may be profound
- resource implications for the health service is considerable

Types of UI include [1]:

- stress UI; involuntary urine leakage on effort, exertion, coughing or sneezing
- urgency UI; involuntary urine leakage accompanied or immediately preceded by urgency (a sudden compelling desire to urinate that is difficult to defer)
- mixed UI; involuntary leakage associated with both urgency, exertion, effort, sneezing or coughing

Women may also experience:

- voiding dysfunction
- overactive bladder syndrome (OAB):
  - defined as urgency that occurs with or without urge UI and usually with frequency and nocturia

See Provenance Certificate for full list of references.

2. Information resources for patients

Information resources for patients:

- information on incontinence
- where to purchase continence products
- pelvic floor exercises
- bladder diary
- bladder training
- overactive bladder
- stress incontinence
- constipation

- vaginal estrogen treatment
- urinary tract infection
- Coping with Incontinence (Alzheimers New Zealand)

Te Ara Whānau Ora Brochure:

- Te Ara Whānau Ora Brochure

3. Resources for providers

Information resources for providers:

- Where to purchase continence products

Te Ara Whānau Ora Brochure:

- Te Ara Whānau Ora Brochure

4. Updates to this care map

Date of publication: DATE.

5. Hauora Māori

Māori are a diverse people and whilst there is no single Māori identity, it is vital practitioners offer culturally appropriate care when working with Māori whānau. It is important for practitioners to have a baseline understanding of the issues surrounding Māori health.

This knowledge can be actualised by (not in any order of priority):

- acknowledging Te Whare Tapa Wha (Māori model of health) when working with Māori whānau
- asking Māori clients if they would like their whānau or significant others to be involved in assessment and treatment
- asking Māori clients about any particular cultural beliefs they or their whānau have that might impact on assessment and treatment of the particular health issue (Cultural issues)
- consider the importance of whānaungatanga (making meaningful connections) with their Māori client / whānau
- knowledge of Whānau Ora, Te Ara Whānau Ora and referring to Whānau Ora Navigators where appropriate
- having a historical overview of legislation that has impacted on Māori well-being

For further information:

- Hauora Māori

6. Pasifika

Pacific Cultural Guidelines (Central PHO) 6MB file

Our Pasifika community:

- is a diverse and dynamic population:
  - more than 22 nations represented in New Zealand
  - each with their own unique culture, language, history, and health status
  - share many similarities which we have shared with you here in order to help you work with Pasifika patients more effectively

The main Pacific nations in New Zealand are:

- Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau and Tuvalu

Acknowledging *The FonoFale Model (pasifika model of health)* when working with Pasifika peoples and families.

Acknowledging general pacific guidelines when working with Pasifika peoples and families:

- Cultural protocols and greetings
- Building relationships with your pasifika patients
- Involving family support, involving religion, during assessments and in the hospital
- Home visits
- Contact information

Pasifika Health Service - Better Health for Pasifika Communities:

- the Pasifika Health Service is a service provided free of charge for:
  - all Pasifika people living in Manawatu, Horowhenua, Tararua and Otaki who have long term conditions
  - all Pasifika mothers and children aged 0-5 years
- an appointment can be made by the patient, doctor or nurse
- the Pasifika Health Service contact details are:
  - Palmerston North Office - 06 354 9107
  - Horowhenua Office - 06 367 6433
- Better Health for Pasifika Communities brochure

Additional resources:

- Ala Mo'ui - Pathways to Pacific Health and Wellbeing 2014-2018
- Primary care for pacific people: a pacific health systems approach
- Tupu Ola Moui: The Pacific Health Chart Book 2004
- Pacific Health resources
- Central PHO Pasifika Health Service

7. Female urinary incontinence clinical presentation

Urinary incontinence (UI) is any involuntary leakage of urine.

The woman may present with symptoms of different types of UI, such as:

- stress UI:
  - urinary loss when coughing or sneezing
  - urinary loss on exertion or effort
  - more common in the 10-15 years following childbirth
- urge UI:
  - urinary loss accompanied or proceeded by urgency (sudden desire to urinate that is difficult to defer)
  - likely to be caused by overactivity of the detrusor muscle
  - increases with age
- mixed UI:
  - urinary loss associated with urgency and effort, exertion, coughing, or sneezing
  - incidence increases with age, especially after the menopause

Woman may present with symptoms suggesting overactive bladder syndrome (OAB):

- presents as urgency that occurs with urge UI (OAB wet) or without urge UI (OAB dry)

- usually occurs with frequency and nocturia

UI is highly prevalent in the population but is often not reported by women:

- women are often embarrassed about incontinence problems and may be reluctant to raise the issue
- clinicians should be aware of this and be proactive in raising the issue during consultations if appropriate
- ensure the woman's privacy and dignity are maintained at all times

8. History

Take an accurate history in order to:

- determine the type and severity of urinary incontinence (UI)
- identify predisposing factors
- identify a need for urgent referral
- determine the impact on the woman's quality of life
- understand and discuss the woman's aims and expectations of treatment
- exclude serious differential diagnoses

Ask the woman about:

- **onset, duration and severity of symptoms of UI** such as:
  - frequency and timing of incontinence
  - symptoms of urgency
  - volume of leakage
  - precipitating factors, e.g:
    - coughing
    - sneezing
    - exercise or exertion
    - sound of running water
    - caffeine
    - alcohol
    - giggling
    - sexual intercourse
- voiding frequency (day and night)
- use of pads and changing of clothes
- **symptoms of voiding dysfunction**, such as:
  - hesitancy
  - straining to void
  - poor or intermittent urinary stream
  - sensation of incomplete emptying and post micturition dribbling
- **symptoms of urinary tract infection** (UTI) including:
  - dysuria (pain or discomfort on passing urine)
  - frequency, including nocturia
  - urgency
  - visible haematuria
  - suprapubic tenderness, abdominal, or back pain
  - cloudy or offensive-smelling urine
  - fever and generally feeling unwell
- **features of pelvic organ prolapse**, including:

- sensation of a lump
- visible prolapse (with or without speculum examination)
- palpable prolapse
- pelvic pressure
- dragging sensation
- difficulty in passing stools

- **previous medical/surgical investigations or treatments**, such as:
  - abdominal or pelvic surgery, including hysterectomy or surgeries for malignancies
  - previous pelvic floor or vaginal repair
  - previous surgery for UI or pelvic organ prolapse
  - genital mutilation and any surgery to correct this
- constipation
- ano-rectal problems
- urinary tract disorders
- co-morbid conditions
- use of medications:
  - diuretics
  - antipsychotics-can promote urinary retention
  - antidepressants promote urinary retention
  - alpha-blockers- can relax bladder and cause stress incontinence
- symptoms suggesting the presence of neurological disease
- obstetric history
- impact of UI on sexual function - for those with sexual dysfunction consider referral to Sex Therapy NZ (not funded but WINZ will cover for those on a benefit)
- lifestyle factors such as:
  - obesity
  - smoking
  - fluid, alcohol, and caffeine intake
  - exercise
- issues with social, cultural or physical environment

9. Examination

Conduct an examination of the woman including:

- examination of the abdomen to detect:
  - enlarged or palpable bladder
  - other abdominal/pelvic mass
  - tenderness
  - organomegaly
  - renal angle mass or pain
  - signs of constipation
  - relevant surgical scars
- if bladder is palpable:
  - consider chronic retention with or without incontinence (overflow incontinence)
  - ask the woman to pass urine and see if the bladder is still palpable
- perform an external genitalia examination to assess:
  - oestrogen status
  - genitourinary prolapse

- signs of irritation
- tissue quality and sensation

- conduct a vaginal examination for:
  - pelvic floor contraction
  - urogenital atrophy
  - irritation, inflammation or discharge
  - pelvic organ prolapse
  - enlarged uterus
  - vaginal, cervical or pelvic mass
- conduct a 'stress test' (cough and strain to detect urinary leakage)
- calculate body mass index

10. Dipstick urinalysis

Perform dipstick urinalysis to detect:

- leukocytes - possible urinary tract infection (UTI)
- nitrites - possible UTI
- blood - malignancy or infection
- glucose - diabetes mellitus
- protein - infection or renal disease

Urinary tract infections:

If symptoms of urinary tract infection (UTI) present or dipstick test indicates positive nitrite or leukocyte esterase see UTI in Females Pathway and provide patient with UTI patient information handout.

If symptoms of urinary incontinence (UI) persist after treatment of UTI then return to UI pathway. Haematuria:

If haematuria present see Haematuria Pathway.

11. Management options

Management options include:

- other indications for specialist referral
- pelvic mass detected
- symptomatic pelvic organ prolapse
- normal abdominal and genital examination

12. Other indications for specialist referral

Refer to specialist those women with urinary incontinence who have [1]:

- persisting bladder or urethral pain
- associated faecal incontinence
- suspected neurological disease
- symptoms of voiding difficulty
- suspected urogenital fistulae
- previous continence surgery
- previous pelvic cancer surgery
- previous pelvic radiation therapy

13. Pelvic mass detected

If suspected pelvic mass detected refer for **urgent** pelvic ultrasound to confirm mass.

14. Symptomatic pelvic organ prolapse

Symptomatic pelvic organ prolapse go to pelvic organ prolapse Pathway.

16. Bladder diary

Ask person to keep bladder diary:

- for a minimum of 3 days
- across both work and leisure days
- noting the following:
  - amount and types of fluid drunk
  - individual voided volume
  - frequency of voiding
  - episodes of urgency and incontinence
  - pads and clothing changes

Bladder diaries are useful in quantifying symptoms such as:

- frequency
- urgency
- stress incontinence episodes
- voided volume
- 24 hour or nocturnal total volume

17. Refer to appropriate specialist

Refer to gynaecology clinic or urology clinic as appropriate.

18. Pelvic ultrasound results

Result of pelvic ultrasound:

- if mass present refer to appropriate specialist
- if absent continue on incontinence pathway and go to "bladder diary" box

19. Exclude residual urine and constipation

If clinical examination suggests a large residual urine greater than 100mls then refer for bladder scan or ultrasound for confirmation.

If clinical history or examination suggests constipation then treat as appropriate.

Additional information on constipation

20. Ultrasound or bladder scan

If ultrasound or bladder scan confirms that a large residual urine is:

- ***present:***
  - refer to appropriate specialist
- ***absent:***
  - continue on incontinence pathway

21. Refer to appropriate specialist

Refer to gynaecology clinic or urology clinic as appropriate.

22. Refer to appropriate specialist

Refer to gynaecology clinic or urology clinic as appropriate.

23. Categorise type of incontinence

Types of Urinary Incontinence (UI) include [1]:

- stress UI:
  - involuntary urine leakage on effort, exertion, coughing or sneezing
- urgency UI:
  - involuntary urine leakage accompanied or immediately preceded by urgency (a sudden compelling desire to urinate that is difficult to defer)
- mixed UI:
  - is involuntary leakage associated with both urgency, exertion, effort, sneezing or coughing

Women may also experience:

- voiding dysfunction
- overactive bladder syndrome (OAB):
  - defined as urgency that occurs with or without urge UI and usually with frequency and nocturia Where to purchase continence products

24. Pelvic floor rehab is too complex for primary care

If physical, cognitive or intellectual impairment (e.g. dementia, post stroke, intellectual disability) suggests an inability to follow instructions - consider referral to continence service for consideration of product provision.

Alzheimers New Zealand Information Coping with Incontinence

26. Treatment of stress incontinence

Stress incontinence:

- trial of supervised pelvic floor exercises for at least 3 months
- advise on modifying fluid intake:
  - limit volume of fluid to less than 3 litres in 24 hours

- avoid drinking before bedtime
- avoid too much caffeine, carbonated drinks and alcohol

- advise on weight loss if BMI >30:
  - consider referral to PHO dietician or physical activity educator
- review medications:
  - consider modifying medications e.g. diuretics (conduct medicines review)
- Where to purchase continence products

27. Treatment of mixed incontinence

Mixed incontinence

Treat urge incontinence first.

Urge/overactive bladder incontinence:

- overactive bladder syndrome
- bladder retraining for at least 3 months. ***If little improvement:***
  - consider adding oxybutynin and ***if no improvement*** try solifenacin (review in 4 weeks or sooner if any issues)
- consider vaginal estrogens if post-menopausal
- advise on modifying fluid intake:
  - limit volume of fluid to less than 3 litres in 24 hours
  - avoid drinking before bedtime
  - avoid too much caffeine, carbonated drinks and alcohol
- advise on weight loss if BMI >30:
  - consider referral to PHO dietician or physical activity educator
- review medications:
  - consider modifying medications e.g. diuretics (conduct medicines review)

Stress incontinence:

- trial of supervised pelvic floor exercises for at least 3 months
- Where to purchase continence products

28. Treatment of urge/overactive bladder incontinence

Urge/overactive bladder incontinence:

- overactive bladder syndrome
- bladder retraining for at least 6 weeks. ***If little improvement***, consider adding oxybutynin and ***if no improvement*** try solifenacin (review in 4 weeks or sooner if any issues)
- consider vaginal estrogens if post-menopausal (vaginal estrogen patient information)
- advise on modifying fluid intake:
  - limit volume of fluid to less than 3 litres in 24 hours
  - avoid drinking before bedtime
  - avoid too much caffeine, carbonated drinks and alcohol
- advise on weight loss if BMI >30:
  - consider referral to PHO dietician or physical activity educator
- review medications:
  - consider modifying medications e.g. diuretics (conduct medicines review)

- Where to purchase continence products

29. Evaluate treatment outcome/regular review

Communicate 4-6 weekly to ascertain response to treatment.
Encourage pelvic floor exercises and /or review technique if required at about 6 weeks
Remember: pelvic floor exercises and bladder retraining take time to be effective

30. Treatment unsuccessful

If no change to symptom profile within 3 months then refer to gynaecology clinic for further assessment and management.

31. Treatment successful

If improvement in symptom profile then monitor in primary care.

32. Refer to Gynaecology Clinic

Complete the referral form and return as directed at the bottom of the form.

Please note if the referral information is incomplete or the Female Urinary Incontinence Pathway on Map of Medicine has not been followed, then the referral will likely result in being declined.

33. Monitor in primary care

Monitor by enquiring at routine visits and other opportunistic times if treatment is still effective.

Urinary Incontinence in Females

Provenance Certificate

Overview | Editorial methodology | References | Contributors | Disclaimers

Overview

This document describes the provenance of MidCentral District Health Board's **Urinary Incontinence in Females** pathway.

This localised pathway was last updated in September 2016**.**

One feature of the "Better, Sooner, More Convenient" (BSMC) Business Case, accepted by the Ministry of Health in 2010, was the development of 33 collaborative clinical pathways (CCP).

The purpose of implementing the CCP Programme in our DHB is to:

- Help meet the Better Sooner More Convenient Business Case aspirational targets, particularly the following:
    - Reduce presentations to the Emergency Department (ED) by 30%
    - Reduce avoidable hospital admissions to Medical Wards and Assessment Treatment and Rehabilitation for over-65-year-olds by 20%
    - Reduce poly-pharmacy in the over-65-year-olds by 10%
- Implement a tool to assist in planning and development of health services across the district, using evidence-based clinical pathways.
- Provide front line clinicians and other key stakeholders with a rapidly accessible check of best practice;
- Enhance partnership processes between primary and secondary health care services across the DHB.

To cite this pathway, use the following format:

Map of Medicine. Medicine. MidCentral District View. Palmerston North: Map of Medicine; 2014 (Issue 1).

Editorial methodology

This care map was based on high-quality information and known Best Practice guidelines from New Zealand and around the world including Map of medicine editorial methodology. It has been checked by individuals with front-line clinical experience (see Contributors section of this document).

Map of Medicine pathways are constantly updated in response to new evidence. Continuous evidence searching means that pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is monitored for new evidence, and feedback is collected from users year-round. The information is triaged so that important changes to the information landscape are incorporated into the pathways through the quarterly publication cycle.

References

This care map has been developed according to the Map of Medicine editorial methodology. The content of this care map is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. This localised version of the evidence-based, practice-informed care map has been peer-reviewed by stakeholder groups and the CCP Programme Clinical Lead.

1	Urinary incontinence in women BPAC guidelines http://www.bpac.org.nz/guidelines/2/docs/Urinary-incontinence-in-women.pdf
2	Urinary incontinence in adults BPJ 55 October 2013 http://www.bpac.org.nz/BPJ/2013/October/urinary-incontinence.aspx

Contributors

MidCentral DHB's Collaborative Clinical Pathway editors and facilitators worked with clinical stakeholders such as front-line clinicians and pharmacists to gather practice-based knowledge for its care maps.

The following individuals have contributed to this care map:

- Sarah Machin, Obstetrician and Gynaecologist, MidCentral Health (Secondary Care Clinical Lead)
- Alex Herbert, General Practitioner, Whakapai Hauora (Primary Care Clinical Lead)
- Mary Meendering, Clinical Nurse Specialist, Gynaecology, MidCentral Health
- Lucy Keedle, Clinical Nurse Specialist, Women's Health, MidCentral Health
- Quinten King, Urologist, MidCentral Health
- Elinor Wood, Clinical Nurse Specialist, ElderHealth, MidCentral Health
- Tania Iddon, Clinical Nurse Specialist, Urology, MidCentral Health
- Digby Ngan Kee, Gynaecologist, MidCentral Health
- Donna Mason, Nurse Practitioner Intern, City Doctors
- Liz Elliott, Clinical Advisor Health of Older People, Health Care Development, MidCentral DHB (Facilitator/Editor)

Disclaimers

Clinical Board Central PHO, MidCentral DHB

It is not the function of the Clinical Board Central PHO, MidCentral DHB to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.