♂ Sample care pathway male patients with urinary incontinence

Male patients with urinary incontinence may seek help from a general practitioner, continence adviser, specialist physiotherapist or community nurse (district nurse, practice nurse, health visitor)

Initial Assessment

Clinical history and physical examination • Validated quality of life and incontinence severity questionnaire • Urinalysis • Frequency volume chart • Post void residual volume • Estimation of flow rate • Digital rectal examination

- Post void residual >100 mls and/or reduced flow rate. → Refer to secondary care
- Post void residual <100 mls No evidence of reduced flow rate.

Conservative Treatment +/- Containment

- **Stress Incontinence** → Pelvic floor muscle re-education
- **Urge Incontinence** → Review caffeine intake • bladder retraining • antimuscarinics
- **Mixed Incontinence** → Review caffeine intake • bladder retraining • pelvic floor muscle re-education • antimuscarinics

Treatment Success

- YES → Complete treatment course / maintain
- NO → Containment
- NO → Refer to secondary care

♀ Sample care pathway female patients with urinary incontinence

Female patients with urinary incontinence may seek help from a general practitioner, continence adviser, specialist physiotherapist or community nurse (district nurse, practice nurse, health visitor)

Initial Assessment

Clinical history and physical examination • Validated quality of life and incontinence severity questionnaire • Urinalysis • Frequency volume chart

Presence of voiding dysfunction or symptomatic pelvic organ prolapse.

- NO
- YES → Refer to secondary care

Conservative Treatment +/- Containment

- **Urge Incontinence** → Review caffeine intake • bladder retraining • antimuscarinics
- **Stress Incontinence** → Pelvic floor muscle re-education • Consider supplementing with duloxetine
- **Mixed Incontinence** → Review caffeine intake • bladder retraining • pelvic floor muscle re-education • antimuscarinics

Treatment Success

- YES → Complete treatment course / maintain
- NO → Containment
- NO → Refer to secondary care

Scottish Intercollegiate Guidelines Network

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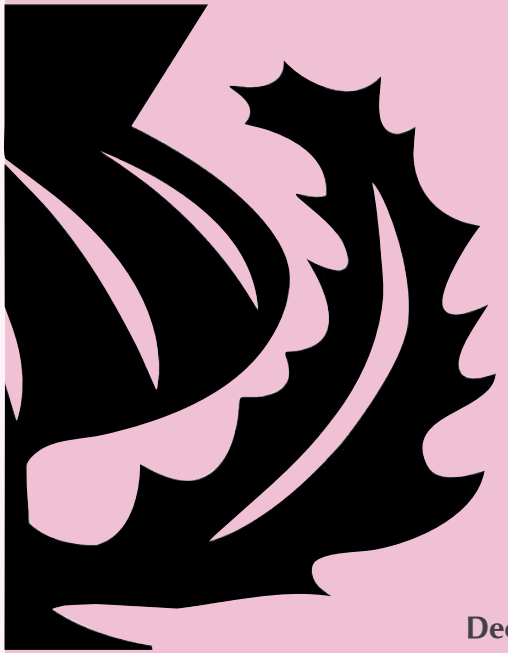
Quick Reference Guide



December 2004

Quick Reference Guide

Management of urinary incontinence in primary care

This Quick Reference Guide provides a summary of the main recommendations in the SIGN guideline on the **Management of urinary incontinence in primary care**

Recommendations are graded A B C D to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

QUALITY OF LIFE

☑ Clinicians should be aware of and take into consideration the potentially serious adverse effects that even mild urinary incontinence has on a patient's quality of life.

B **Healthcare practitioners should consider using a validated quality of life and incontinence severity questionnaire to evaluate the impact of urinary symptoms and to audit the effectiveness of any management strategy.**

INFORMATION AND HEALTH PROMOTION

D **Patients with urinary incontinence should be offered information and advice on the treatment options available to them in both primary and secondary care.**

D **Patients with urinary incontinence should have access to trained healthcare professionals who have the relevant knowledge and skills to offer appropriate advice and information.**

D **Patients with urinary incontinence should be made aware that they are able to access specially trained staff in primary care without GP referral.**

C **Strategies using a number of different approaches and delivery media should be employed to raise awareness of urinary continence and promote incontinence services to a range of target audiences.**

RISK FACTORS AND ASSESSMENT

B **Health professionals should be vigilant and adopt a proactive approach in consultations with patients who are at greatest risk of developing urinary incontinence through factors including age, the menopause, pregnancy and childbirth, high BMI and experience of continence problems in childhood.**

D **Initial assessment of a male patient with urinary incontinence should include completion of a voiding diary, urinalysis, estimation of post void residual volume and digital rectal examination.**

D **Initial assessment of a female patient with urinary incontinence should include completion of a voiding diary, urinalysis and, where symptoms of voiding dysfunction or repeated UTIs are present, estimation of post void residual volume.**

C **Health professionals should recognise the difficulty that some patients have in raising concerns about continence and should be proactive in questioning patients about continence during consultations.**

C **Health professionals should have a positive attitude to continence problems.**

B **Assessment, treatment and referral, as appropriate, should be offered to all patients with urinary continence problems.**

PHYSICAL THERAPIES

A **Pelvic floor muscle exercises should be the first choice of treatment offered to patients suffering from stress or mixed incontinence. Exercise programmes should be tailored to be achievable by the individual patient.**

D **Digital assessment of pelvic floor muscle function should be undertaken prior to initiating any pelvic floor muscle exercise treatment.**

☑ Digital assessment of pelvic floor muscle function should only be carried out by an appropriately trained clinician.

B **Pelvic floor muscle exercise treatment should be considered for patients following radical prostate surgery.**

C **Bladder retraining should be offered to patients with urge urinary incontinence.**

PHARMACOTHERAPY

A **Duloxetine should be used only as part of an overall management strategy in addition to pelvic floor muscle exercises and not in isolation. A 4 week trial of duloxetine is recommended for female patients with moderate to severe stress incontinence. Patients should be reviewed again after 12 weeks of therapy to assess progress and determine whether it is appropriate to continue treatment.**

A **A trial of oxybutynin, propiverine, tolterodine, or trospium should be given to patients with significant urgency with or without urge incontinence. The dose should be titrated to combat adverse effects** *(see British National Formulary for dose ranges).*

☑ Antimuscarinic therapy should be tried for a period of six weeks to enable an assessment of the benefits and side effects. Treatment should be reviewed after six months to ascertain continuing need.

CONTAINMENT

D **All patients should undergo a continence assessment before product issue. Issue of products should not take the place of therapeutic interventions.**

REFERRAL

D **Patients should be referred to secondary care if previous surgical or non-surgical treatments for urinary incontinence have failed or if surgical treatments are being considered.**

D **Female patients with symptomatic pelvic organ prolapse or suspected voiding dysfunction should be referred to secondary care.**

D **Male patients with reduced urinary flow rates or elevated post void residual volumes should be referred to secondary care.**

SOURCES OF INFORMATION

Continence Foundation
Tel: 0845 345 0165 (helpline Monday - Friday, 9.30am - 1pm)

Incontact Scotland
PO Box 2796, Glasgow G61 4YT
Tel: 0870 770 3248
Email: cathy@incontact.org

Scottish Continence Resource Centre
Southern General Hospital, Govan Road, Glasgow G51 4OF
Tel: 0141 201 1861
Email: mary.ballentyne@sgh.scot.nhs.uk