Care Pathway for Women with Urinary Incontinence

**Table 1**

**Indication for Referral directly to Secondary Care (rather than to Community Gynaecology):**

Urgently refer women with any of the following:

- microscopic haematuria if aged 50 years and older
- visible haematuria
- recurrent or persisting UTI associated with haematuria if \( \geq 40 \) years
- suspected pelvic mass arising from the urinary tract.

Refer women with:

- symptomatic prolapse visible at or below the vaginal introitus
- palpable bladder on bimanual or physical examination after voiding.

Consider referring women with:

- persisting bladder or urethral pain
- clinically benign pelvic masses
- associated faecal incontinence
- suspected neurological disease
- voiding difficulty
- suspected urogenital fistulae
- previous continence surgery
- previous pelvic cancer surgery
- previous pelvic radiation therapy.
Woman with Urinary Incontinence (UI) or Overactive Bladder Syndrome (OAB)

- Careful History
- Exclude UTI, Diabetes
- Identify factors that may require referral (see table 1)
- A 3-day fluid/bladder diary may be useful (App.1)

Lifestyle Intervention

- Modify high/low fluid intake
- Lose weight if BMI >30
- Caffeine reduction in OAB

Refer to Conservative Therapy Team

Stress UI
- 1st line: Pelvic Floor Muscle Training for at least 3 months.
- 2nd line: Electrical Stimulation, Bio-Feedback
  Duloxetine should not be used as 1st or 2nd line treatment, may be offered as alternative to surgical treatment

Mixed IU
- Treat dominant symptom

OAB with or without urge UI
- 1st line: bladder training for at least 6 weeks
- 2nd line: oxybutinin
- 3rd line: darifenacin, solifenacin, tolterodine, trospium, other oxybutinin formulations

Adapted from NICE CG 40

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