**Pathway for female urinary incontinence**

**At the first visit:**

Take a thorough history of the urinary incontinence (UI).

Give 3 day bladder diary, instruction sheet and symptom profile.

Provide a universal pot for urinalysis at next contact.

**Useful tips:**

***Simple treatments to try:***

***Stress Urinary Incontinence (SUI):***

* **Pelvic floor muscle exercises** (**PFME):** refer to local physiotherapist for supervised pelvic floor muscle training and review in 3 months following physio report.

***Overactive bladder (OAB):***

* **Lifestyle modifications -** caffeine reduction, modification of fluid intake,

body mass index greater than 30 should be advised to lose weight.

* **Bladder training** – 6 weeks and review.
* **Trial of** - anticholingeric (oxybutynin IR\*) or antimuscarininc (tolterodine IR or darifenacin OD) first line for women with OAB or mixed UI (at least 2 types) and review.

***Check for:***

* UTI
* Medication effect
* Constipation
* Atrophic vaginitis
* Obesity
* fluid intake
* Chronic cough

Note: If voiding dysfunction (hesitancy; straining; feeling of incomplete emptying; urgency; frequency; nocturia) or recurrent UTI’s – **arrange local bladder scan**

**Things not to do**

Don’t offer absorbent products/pads as treatment for UI.

Don’t refer for urodynamic investigations unless:

* treatment (described above) has been tried and failed
* diagnosis is in doubt
* the patient wants surgery

Don’t refer to secondary care until conservative measures have been tried

**When to refer on**

If any **Red Flags** – refer direct and urgent to appropriate consultant in secondary care for:

* Micro (50yrs+) & macro haematuria; refer to haematuria pathway
* Recurrent UTI with haematuria (40yrs+); refer to haematuria pathway
* Suspected mass arising from urogenital organs

\*Not to frail older women

IR

In women with UI, further indications for **consideration for referral** to a appropriate specialist service include:

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

**Refer to Uro-Gynae Subspecialist for Urinaryincontinence (after initial assessment): for MDT review**

* Urgency / overactive symptoms not effectively treated by bladder retraining, fluid advice and after trying 2 different first line medications
* Persistent bothersome stress urinary incontinence after a surgical procedure (TVT/TOT/Colposuspension)
* Complex symptoms as proven by urodynamics (Voiding dysfunction along with stress incontinence/detrusor over-activity)

Stress incontinence in patients unsuitable for midurethral tape (TVT/TOT) e.g family not complete, raised BMI.

**Refer to General Gynaecology clinic**

* Persistent bothersome stress urinary incontinence after conservative management
* Mixed urinary incontinence after conservative management