A summary of prescribing recommendations from NICE guidance

**Urinary incontinence in women**

*NICE CG171: 2013*

This guideline covers the management of urinary incontinence in women and replaces NICE CG40.

**Definition of Terms**

- **UI** urinary incontinence
- **Stress UI** involuntary urine leakage on effort/exertion or on sneezing/coughing
- **Urgency UI** involuntary urine leakage accompanied or immediately preceded by urgency
- **Mixed UI** involuntary urine leakage associated with both urgency and exertion, effort, sneezing or coughing
- **OAB** overactive bladder: urgency that occurs with/without urgency UI and usually with frequency and nocturia
- **MDT** multidisciplinary team

See NICE Pathway: Urinary incontinence

**Assessment and investigation**

- At initial clinical assessment:
  - categorise UI and start treatment on this basis,
  - seek to identify relevant predisposing and precipitating factors and other diagnoses that may require referral.
- In mixed UI direct treatment towards the predominant symptom:
  - if stress UI is the predominant symptom discuss the benefit of conservative management including drug treatment before offering surgery.
- Use bladder diaries in initial assessment. Encourage women to complete a minimum of 3 days of the diary covering variations in usual activities.
- Undertake routine digital assessment to confirm pelvic floor muscle contraction before the use of supervised pelvic floor muscle training.

See NICE Pathway for the following: Urine testing and assessment of residual urine; Symptom scoring and quality-of-life assessment; Urodynamic testing

**Referral**

- Urgently refer women with any of the following:
  - microscopic haematuria in women aged ≥50 years,
  - visible haematuria,
  - recurrent or persisting UTI associated with haematuria in women aged ≥40 years,
  - suspected malignant mass arising from the urinary tract.
- For further indications for referral - see NICE Pathway

**Treatment and management**

- **Do NOT** use absorbent products, hand held urinals and toileting aids as a treatment for UI. Use only as:
  - a coping strategy pending definitive treatment,
  - an adjunct to ongoing therapy,
  - long-term management only after other treatment options have been explored.
- **Do NOT** use intravaginal and intracutaneous devices for the routine management of UI in women. **Do NOT** advise women to consider such devices other than for occasional use when necessary to prevent leakage e.g. during physical exercise.

**Defining nocturia, vaginal atrophy and urinary retention**

- Consider use of desmopressin® for nocturia in women with UI or OAB who find it a troublesome symptom. Avoid in women >65 years with cardiovascular disease or hypertension. Use with caution in those with cystic fibrosis.
- Give intravaginal oestrogens for the treatment of OAB symptoms in postmenopausal women with vaginal atrophy.
- Consider bladder catheterisation (intermittent or indwelling urethral or suprapubic) for women in whom persistent urinary retention is causing incontinence, symptomatic infections or renal dysfunction, and this cannot otherwise be corrected. Explain to women, that the use of indwelling catheters in urgency UI may not result in continence – see NICE Pathway.

**Lifestyle interventions**

- **Caffeine**: recommend a trial of caffeine reduction to women with OAB.
- **Fluid intake**: consider advising modification of high or low fluid intake.
- **Weight**: advise women with BMI >30 to lose weight.

**Stress or mixed UI**

**Pelvic floor muscle training**

- **First-line**: offer a trial of supervised pelvic floor muscle training of at least 3 months duration.
  - Pelvic floor muscle training programmes should comprise at least 8 contractions performed 3 times per day.
  - **Do NOT** use perineometry or pelvic floor electromyography as biofeedback as a routine part of pelvic floor muscle training.
  - Continue an exercise programme if pelvic floor muscle training is beneficial.
  - Offer pelvic floor muscle training to women in their first pregnancy as a preventive strategy for UI.
  - **Do NOT** use duloxetine as first-line treatment for women with predominant stress UI. **Do NOT** routinely offer duloxetine as second-line treatment for stress UI. Only offer if drug treatment is preferred, or surgery is not suitable. Counsel women about adverse effects.

**Surgical procedures** – see NICE Pathway

**Overactive bladder**

**Behavioural therapies**

- **First-line**: offer bladder training for a minimum of 6 weeks to women with urgency or mixed UI.
- If women do not achieve satisfactory benefit from bladder training programmes consider combination of drug treatment with bladder training if frequency is a troublesome symptom.

**Pharmacological treatment**

- When offering antimuscarinic drugs to treat OAB always take account of:
  - coexisting conditions e.g. poor bladder emptying,
  - concurrent drug treatments with antimuscarinic effects,
  - risk of adverse effects.

*See Summary of Product Characteristics for full prescribing information

U unlicensed indication. Obtain and document informed consent
Before starting drug treatment, discuss:
- the likelihood of success and common adverse effects,
- the frequency and route of administration,
- that some adverse effects such as dry mouth and constipation indicate that treatment is starting to work,
- that the full benefits may not be seen until they have been taking the treatment for 4 weeks.
- Prescribe the lowest recommended dose when starting a new drug treatment.

**First-line:** give one of the following to women with OAB or mixed UI:

- oxybutynin* (immediate release), OR
tolerodine* (immediate release), OR
darifenacin* (once daily preparation).

**Second-line:** if the first treatment is ineffective/not tolerated offer an alternative drug with the lowest acquisition cost.

- Give a transdermal preparation to women unable to tolerate adverse effects of oral medication.

**Mirabegron**
- Mirabegron* is recommended as an option for treating OAB only if antimuscarinic drugs are contraindicated or ineffective, or have unacceptable adverse effects.
- Women currently receiving mirabegron that is not recommended as above should continue treatment until they and their clinician consider it appropriate to stop. See NICE TA290; Mirabegron for OAB.

- Do NOT use flavoxate, propantheline or imipramine for the treatment of UI or OAB in women.
- Do NOT offer oxybutynin (immediate release) to frail older women.

**Offering invasive therapy**
- Inform any woman wishing to consider surgical treatment for UI about:
  - the benefits and risks of surgical and non-surgical options,
  - their provisional treatment plan.
- Include consideration of the woman's child-bearing wishes in the counselling.
- Offer invasive therapy for OAB and/or stress UI symptoms only after an MDT review.
- When recommending optimal management the MDT should take into account:
  - the woman's preference,
  - past management,
  - comorbidities,
  - treatment options (including further conservative management such as drug therapy).
- Inform the woman of the outcome of the MDT review if it alters the provisional treatment plan.
- If a woman chooses not to have further treatment for urinary incontinence:
  - offer her advice about managing urinary symptoms, and
  - explain that if she changes her mind at a later date she can book a review appointment to discuss past tests and interventions and reconsider her treatment options.

**Women with urinary incontinence and detrusor overactivity**

**Botulinum toxin**
- After an MDT review, offer bladder wall injection with botulinum toxin A* to women with OAB caused by proven detrusor overactivity that has not responded to conservative management (including drug therapy).
- Discuss risks and benefits of treatment before seeking informed consent, including the:
  - likelihood of being symptom-free or having a large reduction in symptoms,
  - risk of clean intermittent catheterisation and the potential for it to be needed for variable lengths of time after the effect of the injections have worn off,
  - absence of evidence on duration of effect between treatments and the long-term efficacy and risks,
  - risk of adverse effects, including an increased risk of urinary tract infection.
- Start treatment only if the woman has been trained in clean intermittent catheterisation, has performed the technique successfully, and is willing to perform clean intermittent catheterisation on a regular basis for as long as needed.
- Give 200 units of botulinum toxin A or consider 100 units for women who would prefer a dose with a lower chance of catheterisation and accept a reduced chance of success.
- If the first botulinum toxin A treatment has no effect, discuss with the MDT.
- If botulinum toxin A treatment is effective, offer follow-up at 6 months, or sooner if symptoms return, for repeat treatment without an MDT referral.
- Tell women how to self-refer for prompt specialist review if symptoms return following a botulinum toxin A procedure.
- Offer repeat treatment as necessary.
- Do NOT offer botulinum toxin B to women with proven detrusor overactivity.

See NICE Pathway for information on: Percutaneous sacral nerve stimulation; Augmentation cystoplasty; Urinary diversion
α BOTOX preparations (Allergan Ltd) are licensed for bladder dysfunctions* however, most botulinum toxin A preparations are unlicensed for this indication; obtain and document informed consent.

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TREATMENT REVIEW

- If drug treatment is effective and well-tolerated, do not change the dose or drug.
- Offer a face-to-face or telephone review 4 weeks after the start of each new drug treatment. Ask the woman if she is satisfied with the therapy:
  - if improvement is optimal, continue treatment,
  - if there is no/suboptimal improvement or intolerable adverse effects change the dose, or try an alternative OAB drug, and review again 4 weeks later.
- Offer review before 4 weeks if adverse events are intolerable.
- Offer a further face-to-face or telephone review if a woman's condition stops responding optimally to treatment after an initial successful 4-week review.
- Refer to secondary care if the woman does not want to try another drug, but would like to consider further treatment.
- Review women who remain on long-term drug treatment for UI or OAB annually in primary care (or every 6 months for women >75 years).
- Refer to secondary care if drug treatment is not successful.
- If the woman wishes to discuss options for further management (non-therapeutic interventions and invasive therapy) refer to the MDT and arrange urodynamics investigation:
  - if detrusor overactivity is present and responsible for the OAB symptoms offer invasive therapy,
  - if detrusor overactivity is not present refer back to the MDT for further discussion concerning future management.

*See Summary of Product Characteristics for full prescribing information

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This bulletin summarises key prescribing points from NICE guidance. Please refer to the full guidance at www.nice.org.uk for further detail.
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