

# Surgery for stress urinary incontinence

## Patient decision aid: user guide and data sources

### **Background**

The NICE guideline on [urinary incontinence and pelvic organ prolapse in women](#) says:

1.5.1 If a woman is thinking about a surgical procedure for stress urinary incontinence, use the NICE patient decision aid on surgery for stress urinary incontinence to promote informed preference and shared decision making.

Discussion with the woman should include:

- the benefits and risks of all surgical treatment options for stress urinary incontinence that NICE recommends, whether or not they are available locally
- the uncertainties about the long-term adverse effects for all procedures, particularly those involving the implantation of mesh materials
- differences between procedures in the type of anaesthesia, expected length of hospital stay, surgical incisions and expected recovery period
- any social or psychological factors that may affect the woman's decision.

1.5.2 If non-surgical management for stress urinary incontinence has failed, and the woman wishes to think about a surgical procedure, offer her the choice of:

- colposuspension (open or laparoscopic) **or**
- an autologous rectus fascial sling.

Also include the option of a retropubic mid-urethral mesh sling in this choice but see [recommendations 1.5.7 to 1.5.11](#) for additional guidance on the use of mid-urethral mesh sling procedures for stress urinary incontinence.

1.5.3 Consider intramural bulking agents to manage stress urinary incontinence if alternative surgical procedures are not suitable for or acceptable to the woman. Explain to the woman that:

- these are permanent injectable materials
- repeat injections may be needed to achieve effectiveness
- limited evidence suggests that they are less effective than the surgical procedures listed in recommendation 1.5.2 and the effects wear off over time
- there is limited evidence on long-term effectiveness and adverse events.

The NICE patient decision aid on surgery for stress urinary incontinence describes the potential benefits and harms of surgery, with diagrams to show the numerical data. The woman making the decision about whether to have surgery, and her family members or carers (as appropriate), can review the written information before deciding. The decision aid is intended to be worked through with the woman and healthcare professional together. It should support discussions, not replace them.

### ***Developing and reviewing the patient decision aid***

The patient decision aid was developed by the NICE Medicines and Technologies Programme and a project group drawn from the guideline committee including urogynaecologists, other health professionals and lay members, according to the [NICE process guide](#) and in association with NHS England. Stakeholders who responded to the guideline consultation, and the Royal College of Obstetricians and Gynaecologists' Women's Network and Women's Voices Involvement Panel, all commented on a draft of the patient decision aid.

The Royal College of Obstetricians and Gynaecologists, the British Association of Urological Surgeons and the British Society of Urogynaecology agreed to co-badge the patient decision aid.

NICE patient decision aids are reviewed as part of the surveillance process for the related guidance. If the relevant recommendations are changed, the patient decision aid is updated.

### ***Sources of data***

The patient decision aid is based on the evidence review for the NICE guideline ([evidence review E: surgical and physical management of stress urinary incontinence](#)). All quantitative data on the likely effectiveness of the types of surgery

and the risks of complications are taken from GRADE tables 20 (colposuspension versus synthetic mesh sling), 21 (autologous rectus fascial sling versus synthetic mesh sling) and 27 (fascial sling versus colposuspension). Information relating to bulking agents was also informed by NICE interventional procedures guidance on [intramural urethral bulking procedures for stress urinary incontinence in women](#).

Other content is based on the patient decision aid project group's expertise. This includes information about what the different types of surgery involve, the likely length of hospital stay, and possible complications not included in the GRADE tables, including possible complications of mesh surgery.

To reflect the limited evidence, quantitative data are either expressed as an order of magnitude (for example, 1 to 10 women per 100) or rounded to the nearest 5% to avoid giving an unwarranted impression of accuracy. If the clinical evidence statements in the evidence review indicate no clinically important difference in a particular outcome across the different types of surgery, this is expressed in the patient decision aid as 'It isn't possible to say for sure whether this is more likely to happen with one of these types of operation than either of the other two' or similar wording. This reflects the fact that the clinical evidence statements indicate an absence of evidence for a clinically important difference rather than evidence of no difference.