Pelvic organ prolapse and bladder health Guideline

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Target Audience:

People who need to know about this document in detail	All health care professionals working within Gynaecology
People who need to have a broad understanding of this document	Womens health directorate team. Board Members, Management Board. Senior Leaders. Board Committees.)
People who need to know that this document exists	All staff involved in the development of Health Board Policies.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:21/9/2026**
	Outcome:
Welsh Language Standard	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
Date of approval by Equality Team:	21/9/2026
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care



Disclaimer:

COMPONENTS:

A policy must contain the following components and must also be written to include the values and behaviours of the organisation wherever relevant:

It is accepted that for Clinical Policies and or other Written Control Documents (Procedures, Guidance etc.) the policy components below may not all be relevant.

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non Clinical Policy Development please contact:

CTM_Corporate_Governance@wales.nhs.uk

Or visit the Policy Author Page on SharePoint:

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Background

Guideline Definition

Clinical guidelines are systematically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions. They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Purpose

The aim of the document is to provide standards evidence-based approach for both primary and secondary care in regarding to the management of pelvic organ prolapse and bladder health problems

Scope

For all staff, medical, nursing and clerical, to provide uniformity in the management and treatment of Urogynaecology conditions

Roles and Responsibilities

In seeking further advice on any uncertainties contained in this document, or if you feel that there is new or more updated advice it is your responsibility to contact the guideline author or Approval Group manager so that any amendments can be made.

The guideline Approval Group is responsible for disseminating this guideline to all appropriate staff. The guideline author or a named alternative is responsible for updating the guideline with any amendments that they become aware of or are highlighted to them.

All health professionals are responsible to ensure that the guideline is utilised effectively, and to ensure that they are competent and compassionate in the implementation of it.

Training Requirements

There is no mandatory training associated with this guideline.

Monitoring of Compliance

- The Governance Department will collate any complaints and distribute to the relevant individuals for comments, and share any learning points.
- The Service Lead will oversee any governance issues, make relevant recommendations to the directorate, and advise the Clinical Director or the directorate of any matters that require implementation.
- The Health Board reserves the right, without notice, to amend any monitoring requirements in order to meet any statutory obligations or the needs of the organisation

Complaints

All complaints should try to be resolved with the patient during any contact to avoid escalation. There concerns should be listened to and documented. If it is not possible to address any concerns at the time, or if the complaint is of a serious nature, the patient's complaint should be discussed with the consultant in charge for the day, or the patient should be given details of how to raise a formal complaint via the local governance department.

Definition and Background

The Urogynaecology unit provides a holistic service for the management of all pelvic health related conditions including pelvic organ prolapse and bladder health conditions. The Urogynaecology team provides an evidence-based approach in managing patient's conditions and maintains patient's safety through providing a systematic approach and treatments according to national guidance such as Royal college of Obstetricians and Gynaecologists guidelines

Bladder health and related conditions

Management of women with suspected UTI without visible haematuria (not catheterised or pregnant)

Initial management

- Offer women with suspected UTI self-care advice as per Nice Guidance. Advise people with lower UTI about drinking enough fluids to avoid dehydration. Be aware that no evidence was found on cranberry products or urine alkalinising agents to treat lower UTI.
- https://www.nice.org.uk/guidance/ng109/resources/urinary-tract-infection-lower-antimicrobial%20prescribing-pdf-66141546350533
- Offer symptomatic relief with paracetamol. If the response is insufficient, offer a nonsteroidal anti-inflammatory drug (NSAID) in addition, such as ibuprofen or naproxen, unless not tolerated or contraindicated
- Consider antibiotic to all women with a suspected urinary tract infection (UTI) — for a woman with mild symptoms who has normal immunity, normal renal function, and a normal renal tract, treatment can be delayed following shared decision making to see if symptoms will resolve without treatment, especially if the urine dipstick test is negative for nitrites and leucocyte esterase (indicating a low probability of a UTI). For all other women start treatment without delay.
- If treatment is indicated, please refer to the CTM antimicrobial guidelines.
- Consider offering a prescription for a 'stand-by' antibiotic to be used for future episodes, please see CTM antimicrobial guidelines.

When to send urine for culture

Send urine for culture from women with a first presentation of a urinary tract infection (UTI) if they have any of the following:

- Impaired renal function.
- An abnormal urinary tract (for example renal calculus, vesicoureteric reflux, reflux nephropathy, neurogenic bladder, urinary obstruction, or recent instrumentation).
- Immunosuppression (for example because they have poorly controlled diabetes mellitus or are receiving immunosuppressive treatment).
- >65 years, risk factors for resistance*, recurrent UTI, atypical symptoms, symptoms that resolve or recur within 2-4 weeks following treatment
- Do not routinely send urine for culture in women with an uncomplicated urinary tract infection.
- Ensure that the urine is collected and stored properly
- Please refer to the CTM antimicrobial guidelines

Risk factors for resistance

- Care home resident
- Recurrent UTI
- Hospitalisation >7days in the last 6 months
- Unresolving urinary symptoms
- Recent travel to areas of high antimicrobial resistance (outside northern Europe & Australasia)
- Previous resistant UTI

Follow up

- Advise all women to seek medical attention if they develop fever, loin pain, or do not respond to treatment with the first-choice antibiotic. Follow up if loin pain or fever develops
- For choice of antibiotics in different clinical situations related to UTI, please refer to the CTM antimicrobial guidelines

Managing treatment failure

- If symptoms of a UTI persist following treatment, send urine for culture and sensitivity and adjust treatment as necessary when the results become available.
- Seek specialist advice if a multi-resistant organism is cultured.
- If there is no bacterial growth after culturing the urine, consider an alternative cause for symptoms.

Management of Women with suspected UTI with visible or non-visible haematuria

- Send urine for culture and sensitivity from all women with a suspected urinary tract infection associated with visible or non-visible haematuria.

- Offer symptomatic relief with paracetamol. If the response is insufficient, offer a nonsteroidal anti-inflammatory drug (NSAID) in addition, such as ibuprofen or naproxen, unless not tolerated or contraindicated.

- For women with haematuria who are not pregnant please refer to the CTM antimicrobial guidelines

Follow up/referral

- Advise all women to seek medical attention if they develop fever, loin pain, or do not respond to treatment.
- Arrange follow up when the results of culture and sensitivity are available.
- Adjust antibiotic treatment according to sensitivities, if there are persistent symptoms of a urinary tract infection following initial treatment
- For pregnant women, please refer to the CTM antimicrobial guidelines
- In pregnant women, send urine culture on presentation and repeat the urine culture seven days after finishing antibiotic treatment.
- In pregnant women, if a group B streptococcus is isolated, inform the antenatal care service, as prophylactic antibiotics will be offered during labour and delivery. Please note that NSAIDs are not advised in pregnancy https://www.medicinesinpregnancy.org/Medicine--pregnancy/Ibuprofen/

For all women with visible or non-visible haematuria

- If infection has been confirmed re-test the urine for blood with a dipstick after completing treatment with an appropriate antibiotic, to detect persistent haematuria. Persistence is defined as two out of three dipsticks positive for blood on separate occasions.
- Arrange an urgent 2-week wait referral if a urological or Gynaecological cancer is suspected.
- If non-visible haematuria persists after infection has been successfully treated in a person less than 60 years of age, test the urine for proteinuria (albumin/creatinine ratio [ACR] equal to or higher than 30 mg/mmol, or protein/creatinine ratio [PCR] equal to or higher than 50 mg/mmol), and measure serum estimated glomerular filtration rate (eGFR) levels.

Management of women with recurrent UTI — (no visible haematuria, not pregnant or catheterised)

- Send urine for culture and sensitivity from all women with recurrent urinary tract infections

- Offer symptomatic relief with paracetamol. If the response is insufficient, offer a nonsteroidal anti-inflammatory drug (NSAID) in addition, such as ibuprofen or naproxen, unless not tolerated or contraindicated.

- Offer an antibiotic to all women with recurrent urinary tract infections (UTIs).
- Initiate treatment:

    - For a woman with mild symptoms who has normal immunity, normal renal function, and a normal renal tract, treatment can be delayed following shared decision making to see if symptoms will resolve without treatment, especially if the probability of a UTI is low (indicated by a negative urine dipstick test for nitrites, and leucocyte esterase).

    - For all other women start treatment without delay.

    - Please refer to the CTM antimicrobial guidelines

Discuss behavioural and personal hygiene measures, advise the woman to:

- Avoid douching and occlusive underwear.

- Wipe from front to back after defaecation.

- Avoid delay of habitual and post-coital urination.

- Maintain adequate hydration.

- Please review the antimicrobial guidelines https://viewer.rx-guidelines.com/POWH/Abx#content,hoapiJJegi

In postmenopausal women consider prescribing vaginal oestrogen (please refer to BNF for dosing information) if underlying cause has been investigated and behavioural/hygiene measures alone are ineffective or inappropriate.

- The lowest effective dose should be prescribed.

- Discuss the risks and benefits of treatment including adverse effects of tenderness and vaginal bleeding (which may require investigation), and the uncertainty of endometrial safety with long-term or repeated use.

- Review treatment within 12 months.

- Do not offer oral oestrogens (hormone replacement therapy) specifically to reduce the risk of recurrent UTI.

For more information, https://cks.nice.org.uk/topics/urinary-tract-infection-lower-women/management/recurrent-uti-no-haematuria-not-pregnant-or-catheterized/

Consider antibiotic prophylaxis if underlying cause has been investigated and behavioural/personal hygiene measures and vaginal oestrogen (in postmenopausal women) are ineffective or inappropriate. Please see CTM antimicrobial guidelines.

Take account of severity and frequency of symptoms, risk of complications, previous urine culture and susceptibility results, previous antibiotic use and the woman's preference.

Discuss the risks of long-term antibiotics including resistance and possible adverse effects.

Ensure that any current UTI has been adequately treated and consider single-dose antibiotic prophylaxis (off-label) for use in non-pregnant women when exposed to an identifiable trigger:

First choice - Nitrofurantoin (if eGFR ≥45ml/ minute) 100mg single dose when exposed to a trigger or Trimethoprim 200mg single dose when exposed to a trigger. Or

Second choice – Amoxicillin 500mg single dose when exposed to a trigger (only if recent culture results available and susceptible) or Cefalexin 500mg single dose when exposed to a trigger (only if recent culture results available and susceptible).

If there is no improvement after single-dose antibiotic prophylaxis or no identifiable triggers, ensure that any current UTI has been adequately treated then consider a trial of daily antibiotic prophylaxis. Please see CTM antimicrobial guidelines.

Arrange follow-up within 3–6 months and advise the woman to seek urgent review if symptoms of acute UTI develop — different antibiotics should be used for prophylaxis and treatment of acute UTI. At follow-up:

- Check effectiveness of prophylaxis.
- Discuss discontinuation or changing to an alternative (including risk of antimicrobial resistance and adverse effects).
- Reinforce behavioural and personal hygiene measures

Advise all women with recurrent cystitis that:

- Cranberry juice and products are no longer recommended for the prevention of recurrent cystitis.
- If cystitis is related to sexual intercourse, they should consider using a different contraceptive method

If a diaphragm is being used.

- There is no evidence that voiding before or after intercourse, hydration or changes to diet help prevent recurrent urinary tract infections

Hiprex (Methenamine Hippurate) in Urinary Tract Infection

Indication

Prevention of recurrent urinary tract infections in adults and adolescents. For use particularly when:

- Non-antibiotic strategies have failed.
- Antibiotic prophylaxis is undesirable (e.g., antimicrobial stewardship).
- The organism is sensitive to urine acidification–based suppression

Mechanism of Action

- Methenamine converts to formaldehyde in acidic urine (pH < 6).
- Formaldehyde provides non-specific antibacterial activity, preventing bacterial growth.
- Does not promote antimicrobial resistance

Dosage

- 1 g twice daily (morning and evening).

Administration notes

- Should be taken with water.
- Urine pH must remain acidic for efficacy. Consider ascorbic acid (Vitamin C) if urine is not adequately acidic.

Monitoring

- Review efficacy after 3–6 months.
- Monitor:
    - Symptom recurrence.
    - Urine pH (aim <6).
    - Renal function baseline if prolonged use.

Contraindications

- Renal impairment (severe).
- Severe hepatic impairment.
- Dehydration.
- Concomitant sulfonamides (risk of crystalluria).

Precautions

- Ensure adequate hydration.
- Avoid in patients with catheter-associated UTI prophylaxis unless specialist-directed.
- Not suitable for active UTI treatment—prophylaxis only

Role in UTI Prevention Pathway

1. Behavioural modifications (hydration, timed voiding, sexual-trigger measures).
2. Vaginal oestrogen in post-menopausal women (if appropriate).
3. D-mannose (optional).
4. Hiprex as non-antibiotic prophylaxis.
5. Antibiotic prophylaxis only if above options fail.

Advantages

- Non-antibiotic.
- Low resistance risk.
- Suitable for long-term use.

Limitations

- Ineffective in alkaline urine.
- Limited role if structural abnormalities or chronic catheterisation.
- Evidence strongest for recurrent uncomplicated cystitis, less so for complicated UTI

Follow up

- Advise women to seek medical attention if they develop fever, loin pain, or do not respond to treatment.
- If loin pain or fever develops in association with a urinary tract infection (UTI)
- If symptoms of a UTI persist following treatment:
    - Adjust treatment, if necessary, when the results of urine culture and sensitivity testing become available.
    - If there is no bacterial growth after culturing the urine, consider an alternative cause for symptoms.
    - Do not recommend cranberry products or urine alkalinizing agents.

Urological Referral

- Arrange urgent 2-week wait referral if a urological cancer is suspected, unexplained visible haematuria without urinary tract infection or visible haematuria that persists or recurs after successful treatment of urinary tract infection.
- Consider non-urgent referral for bladder cancer in women aged 60 and over with recurrent or persistent unexplained urinary tract infection.
- Consider routine referral for women with recurrent UTIs (women presenting with two or more episodes of UTI in 6 months period or 3 or more episodes in 12 months' period):
- A past history of urinary tract surgery or trauma.
- A past history of bladder or renal calculi.
- Obstructive symptoms such as straining, hesitancy, poor stream.
- Urea splitting bacteria on culture of the urine such as Proteus or Yersinia.
- Persistent bacteriuria despite appropriate antibiotic treatment.
- A past history of abdominal or pelvic malignancy.
- Symptoms of a fistula such as pneumaturia.
- Known immunocompromised or has diabetes.
- Known abnormality of their renal tract who might benefit from surgical correction, such as cystocele, vesicoureteric reflux, or bladder outlet obstruction.
- No response to preventive treatments

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Urinary Incontinence Pathway

"Appointments will not be offered unless the relevant pathway has been followed"

GP responsibilities

Initial assessment, identification of predisposing factors and treatment of any precipitating factor

OAB SYMPTOMS	SI SYMPTOMS	MIXED INCONTINENCE
Referral to BBHT for Bladder retraining/drills & lifestyle advice. Review of a bladder diary Trial of at least two anticholinergic and a trial of mirabegron	Referral to Physio for PFMT, Bladder retraining/drills & lifestyle advice. Review of a bladder diary	Referral to Physio for PFMT Referral to BBHT for Bladder retraining/drills & lifestyle advice. Review of a bladder diary Trial of at least two anticholinergic and a trial of mirabegron

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

- Significant urogenital prolapse
- 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

Urogynaecology responsibilities:

- Full reassessment in clinic, including history and examination (Using the new patient assessment proforma; appendix A)
- Bladder diary and quality of life questionnaire to be sent before the clinic appointment
- Urine analysis (Refer to UTI protocol)
- Post voiding residual urine (Bladder scan)
- Review of bladder diary (3 days)
- Review outcome of conservative management

OAB SYMPTOMS	PURE SI SYMPTOMS	MIXED INCONTINENCE
Trial of mirabegron (in case of failure or contraindications of anti-cholinergic drugs) with Virtual clinic follow-up by Clinical Nurse Specialist If patient not responding, for UDS then review by the urogynaecology consultant with possible MDT discussion Options 1. PTNS (PTNS pathway) 2. Botulinium A Toxin 3. Sacral nerve stimulation (referral to tertiary centre)	Uroflow/PVR = If urinary retention demonstrated or reduced flow rate below 10mls/sec = ISC (Discuss in MDT) Normal PVR and Uroflowmetry:(Discuss in MDT) • Colposuspention • Uretheral bulking • Autologous sling • MUS	Treat the predominant complaint first as per OAB & SI symptoms.

Urinary Incontinence Facts

Lifestyle interventions

- Recommend a trial of caffeine reduction to women with OAB
- Consider advising modification of high or low fluid intake in women
- Advise women with UI or OAB who have a BMI greater than 30kg/m2 to lose weight.
- Refer to smoking cessation services if indicated
- Pelvic floor muscle training and bladder drills

Medical treatment

- Anti-cholinergic drugs

When offering anticholinergic drugs to treat OAB always take account of:

- The woman's coexisting conditions (for example, poor bladder emptying)
- Use of other existing medication affecting the total anticholinergic load
- Risk of adverse effects.

Before OAB drug treatment starts, discuss with women:

- the likelihood of success and associated common adverse effects, long term effects and
- the frequency and route of administration, and that some adverse effects such as dry mouth and constipation may indicate that treatment is starting to have an effect
- that they may not see the full benefits until they have been taking the treatment for 4 weeks

Drug choice and dosage

Offer one of the following choices first to women with OAB or mixed UI:

- Tolterodine (immediate release), (1st line treatment) or
- Solifenacin (1st line treatment)
- Trospium chloride (2nd line treatment)or
- Oxybutynin (immediate release),(1st line treatment but avoid in old frail women)
- Prescribe the lowest recommended dose when starting a new OAB drug treatment.
- Offer a transdermal anti muscarinic drug to women unable to tolerate oral medication.
- Offer intravaginal oestrogens for the treatment of OAB symptoms in postmenopausal women with vaginal atrophy.
- Consider drug interactions when prescribing antimuscarinic medications. https://bnf.nice.org.uk/
- Do not use flavoxate, propantheline and imipramine for the treatment of UI or OAB in women.

Contraindications of anticholinergic drugs https://bnf.nice.org.uk/

- Gastro-intestinal obstruction
- Intestinal atony
- Myasthenia gravis (but some antimuscarinics may be used to decrease muscarinic side-effects of
- anticholinesterases)
- Paralytic ileus
- Pyloric stenosis
- Severe ulcerative colitis
- Significant bladder outflow obstruction
- Toxic megacolon
- Urinary retention
- Angle closure glaucoma

Cautions with anticholinergic drugs https://bnf.nice.org.uk/

- Acute myocardial infarction (in adults)
- Arrhythmias (may be worsened)
- Autonomic neuropathy
- Cardiac insufficiency (due to association with tachycardia)
- Cardiac surgery (due to association with tachycardia)
- Conditions characterized by tachycardia
- Congestive heart failure (may be worsened)
- Coronary artery disease (may be worsened)
- Diarrhoea
- Elderly (especially if frail) (in adults)
- Gastro-oesophageal reflux disease; hiatus hernia with reflux oesophagitis
- Hypertension
- Hyperthyroidism (due to association with tachycardia)

- Individuals susceptible to angle-closure glaucoma
- Pyrexia
- Ulcerative colitis

NB: Link to the anticholinergic burden calculator for more frail patients - link below for info ACB Calculator

Mirabegron

- Mirabegron is recommended as an option for treating the symptoms of overactive bladder only for people in whom antimuscarinic drugs are contraindicated or clinically ineffective, or have unacceptable side effects.
- People currently receiving Mirabegron that is not recommended for them as above should be able to continue treatment until they and their clinician consider it appropriate to stop
- On prescribing mirabegron, consider drug interactions, advise on side-effect profile and monitoring of BP https://bnf.nice.org.uk/

Contraindications

- Severe uncontrolled hypertension (systolic blood pressure ≥180 mmHg or diastolic blood pressure ≥110 mmHg),

Cautions

- History of QT-interval prolongation; stage 2 hypertension

Follow up

If a woman's OAB drug treatment is effective and well-tolerated, do not change the dose or drug.

Offer a telephone review 4 weeks after the start of each new OAB drug treatment. Ask the woman if she is satisfied with the therapy:

- If improvement is optimal, continue treatment.
- If there is no or 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 the adverse events of OAB drug treatment 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.

Review women who remain on long-term drug treatment for OAB annually in primary care (or every 6 months for women over 75).(To be highlighted in the letter sent to the GP upon discharge)

In case of refractory OAB:

- Repeat full assessment (History, Examination, Drug interaction, MSU morning sample)
- Ultrasound assessment to exclude pelvic mass (If not already done)
- Consider post voiding residual urine
- Arrange UDS

Arrange urodynamic investigation to determine whether detrusor overactivity is present and responsible for her OAB symptoms:

- If detrusor overactivity is present and responsible for the OAB symptoms offer invasive therapy.
- If detrusor overactivity is present but the woman does not wish to have invasive therapy, offer advice as described.
- If detrusor overactivity is not present refer back to the MDT for further discussion concerning future management
- Please note: if patient requires containment devices and incontinence pads, this should be referred to BBHT

Botulinum toxin A (Botox®)

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 and medical management (including OAB drug therapy).

Discuss the risks and benefits of treatment with botulinum toxin A with women before seeking informed consent, covering:

- The likelihood of being symptom free or having a large reduction in symptoms
- Women should be counselled about the potential risk of clean intermittent catheterisation and the potential for it to be needed for variable lengths of time after the effect of the injections has worn off
- The absence of evidence on duration of effect between treatments and the long-term efficacy and risks
- The risk of adverse effects, including an increased risk of urinary tract infection.

Use 100 units when offering botulinum toxin A (Botox®)

Consider 100 units of botulinum toxin A (Botox®) for women who would prefer a dose with a lower chance of catheterisation and accept a reduced chance of success.
https://www.medicines.org.uk/emc/

If the first botulinum toxin A (Botox®)treatment has no effect discuss with the MDT.

If botulinum toxin A (Botox®)treatment is effective, offer follow-up at 6 months or sooner if symptoms return for repeat treatment without an MDT referral.

PTNS

Refer to PTNS pathway

Sacral nerve stimulation

Patient should be informed that referral to tertiary unit may be required

Other lines of treatment

- Augmentation cystoplasty
- Urinary diversion

Stress Urinary Incontinence Pathway

"Appointments will not be offered unless the relevant protocol has been followed"

GP responsibilities

Initial assessment, identification of predisposing factors and treatment of any precipitating factor

- Referral to Physiotherapy for Pelvic floor muscle training exercise, bladder retraining/drills
- Lifestyle advice.
- Review of a bladder diary

Urogynaecology responsibilities

Full reassessment in clinic, including history and examination (Using the new patient assessment proforma; appendix 1)

- Quality of life questionnaire
- Urine analysis (Refer to UTI protocol)
- Post voiding residual urine (Bladder scan)
- Review of bladder diary (3 days)
- Review outcome of conservative management and drug therapy
- Offer urodynamic investigations
- All patients with stress urinary incontinence should be discussed in MDT before surgical treatment
- All patients should be given all the relevant surgical options, leaflets should be given

Stress Urinary Incontinence Fact

Lifestyle interventions

- Reduce weight if BMI more than 30kg/m2
- Reduce caffeine, alcohol and other fizzy drinks
- Healthy bladder diet advice
- Smoking cessation advice and refer to stop smoking services

Pelvic floor muscle training

- Refer to physiotherapy for supervised pelvic floor muscle training for 3 months

Surgical approaches for stress urinary incontinence

- All patients should have UDS before surgical treatment
- All patients with SUI should be discussed in MDT before booking for surgical treatment
- Patients should be counselled about the different surgical options taking into considerations the risks and benefits of each option
- Patients should be offered all the options irrespective of its availability in Cwm Taf Morgannwg University Health Board. If patient choose an option which is not feasible in the hospital, this should be highlighted in the MDT and referral form should be sent to tertiary centre

Surgical options for management of stress urinary incontinence (Options not in order)

Women should be offered all the relevant options for her care, NICE decision aid, counselled about the risks and benefits of each option and offered the relevant patients' information leaflets

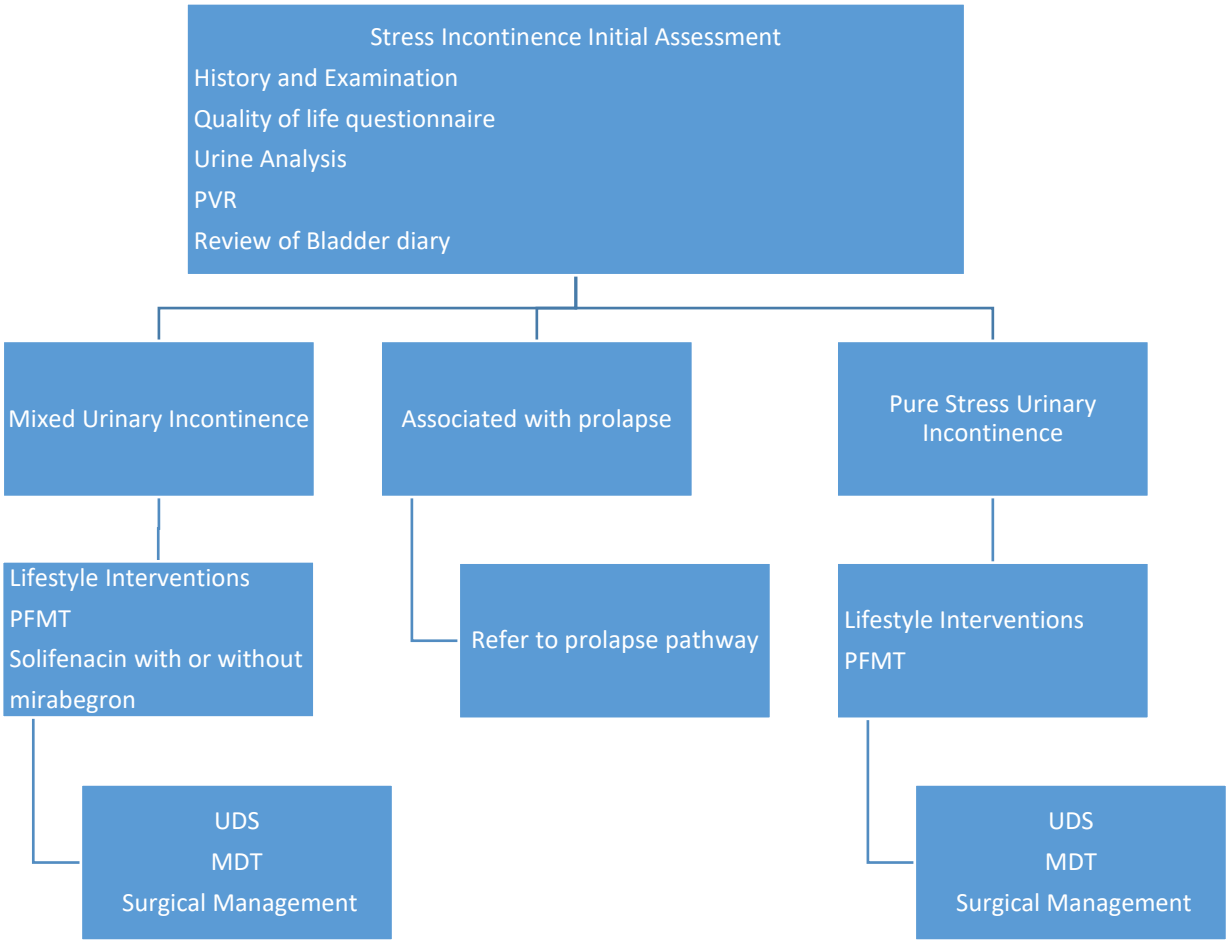
- Colposuspension
- Synthetic tapes (refer to tertiary centre)
- Autologous sling
- Intramural bulking agents
- Artificial urinary sphincters (refer to tertiary centre)

Notes for guidance:

- Laparoscopic colposuspension shouldn't be offered as a routine procedure for the treatment of stress UI in women. Only an experienced laparoscopic surgeon working in an MDT with expertise in the assessment and treatment of UI should perform the procedure
- When offering TVT or TOT; Patients should be counselled about the use of synthetic mesh with the risk of erosion, infection and bladder injury and patients should be offered a follow up appointment (including vaginal examination to exclude erosion) within 6 months to all women who have had continence surgery. (Suspended until further notice)
- When offering Bulkamid (medical device) as treatment of SUI, Patients should be counselled about the possible need for repeated injections and that efficacy may decrease over time
- In view of the associated morbidity, the use of an artificial urinary sphincter should be considered for the management of stress UI in women only if previous surgery has failed. Lifelong follow up is recommended.
- Referral to tertiary centre should be considered in case of failure of surgical treatment or recurrence of symptoms

PATHWAYS

Stress Incontinence



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Refractory OAB Pathway (Overactive Bladder)

Initial Assessment

1. History
2. Examination
3. Urine analysis
4. Bladder diary
5. Quality of life questionnaire (using ICIQ-OAB form)

Diagnosis of OAB

- Lifestyle modification
- Behavioural therapy
- Anti-cholinergic drugs
- Mirabegron

No improvement or intolerance to side effects

Refer to MDT ± URODYNAMICS

PTNS

Contraindications for PTNS

- Pacemaker or implantation defibrillator
- Bleeding disorders
- Neuropathy
- Pregnant or planning for pregnancy during duration of treatment

Counselling for side effects

- Minor bleeding
- Bruising
- Mild pain
- Tingling
- Skin Inflammation

Refer to PTNS Clinic

12 outpatient sessions lasting 30 minutes each, typically a week apart.

Before each session, assessment of side effects and any contraindications

Further sessions are generally needed for longer-term relief

Botulinum Toxin A

- Risk of clean intermittent self-catheterisation and
- the potential for it to be needed for variable
- lengths of time
- Absence of evidence on duration of effect between treatments and the long-term efficacy and risks
- Increased risk of urinary tract infection

Start treatment with botulinum toxin only if women:

- Have been trained in clean intermittent catheterisation and have performed the technique successfully, and
- Able and willing to perform clean intermittent catheterisation on a regular basis for as long as needed

Percutaneous tibial nerve stimulation for overactive bladder syndrome

Percutaneous tibial nerve stimulation (PTNS), also referred to as posterior tibial nerve stimulation, is the least invasive form of neuromodulation used to treat overactive bladder (OAB) and the associated symptoms of urinary urgency, urinary frequency and urge incontinence.

Procedure

A fine-gauge needle is inserted percutaneously just above the ankle, next to the tibial nerve, and a surface electrode is placed on the foot. The needle and electrode are connected to a low-voltage stimulator.

Stimulation of the posterior tibial nerve produces a typical motor (plantar flexion or fanning of the toes) and sensory (tingling in the ankle, foot or toes) response. Initial treatment usually consists of 12 outpatient sessions lasting 30 minutes each, typically a week apart. Further sessions are generally needed for longer term relief.

Potential Harms

PTNS is generally considered low risk. The most common side effects are local and related to placement of the electrode. They include minor bleeding and bruising, mild pain, tingling and inflammation of the skin.

Contraindications

Patients with pacemakers or implantable defibrillators, patients prone to excessive bleeding, patients with nerve damage that could impact either percutaneous tibial nerve or pelvic floor function and patients who are pregnant or planning to become pregnant during the duration of the treatment.

Do not offer percutaneous posterior tibial nerve stimulation for OAB unless:

- Multidisciplinary team (MDT) review, and
- Conservative management including OAB drug treatment has not worked adequately, and
- The woman does not want botulinum toxin A or percutaneous sacral nerve stimulation, and
- They are unable to perform clean intermittent catheterisation

Positive Aspects of Percutaneous Tibial Nerve Stimulation (PTNS)

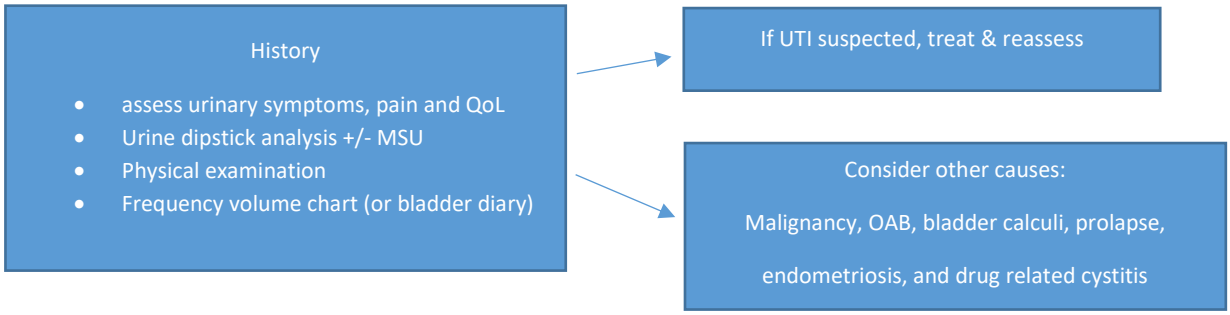
PTNS is non-surgical and a low-risk option. It does not require an implant or have lingering side-effects.

This therapy is perceived as relatively painless. Patients typically describe the sensation as a “tingling” or a “pulsing” in the foot or ankle.

Bladder pain pathway

Symptoms of bladder pain syndrome or interstitial cystitis include: Pain/pressure/discomfort in the pelvis/bladder, associated with urinary symptoms (frequency, urgency, nocturia, bladder filling pain) lasting at least 6weeks, with no identifiable cause.

Initial assessment should be carried out by the GP which will include:



First Line recommendations:

- Over the counter pain relief, stress relief, dietary modification, pelvic floor exercises, and support groups
- If treatment fails, refer to secondary care specialist

Second Line Treatments:

- Amitriptyline +/- cimetidine (cimetidine use for bladder pain is unlicensed)
- Intravesical treatment with chondroitin sulphate or hyaluronic acid
- If treatment fails, refer to Pain Team MDT

Third Line Treatments:

- Cystoscopy and hydrodistension, with or without bladder biopsy
- If treatment fails, refer to Continence MDT for posterior tibial nerve stimulation, referral to urology or specialist centre

Pelvic Organ Prolapse Pathway

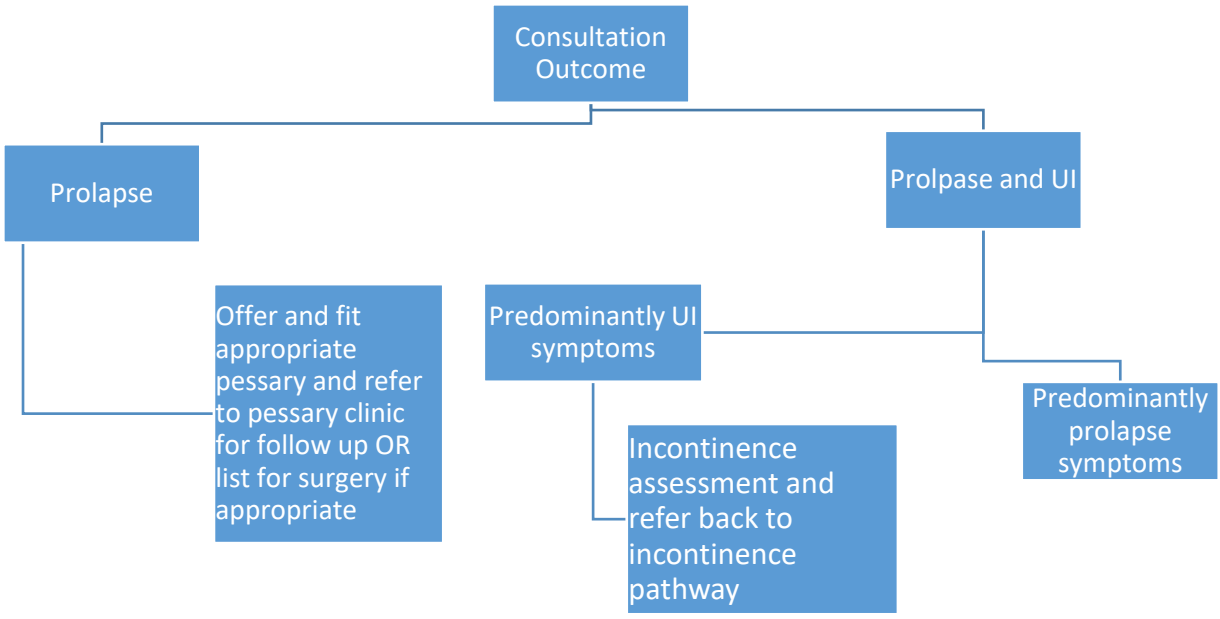
Assessments: (using the new patient assessment proforma; Appendix B)

- History (correct any predisposing factor)
- Predominant complaint
- Examination (BMI, general, chest and abdominal examination
- Pelvic Organ Prolapse Quantification System
- Other assessment tools: Quality of life questionnaire

Investigations:

- Urinalysis
- Bladder Diary/Fluid volume chart (If LUTS is present)
- Uroflow /PVR (in voiding difficulty)

Physician consultation



Please refer to Management of Pelvic Floor Organ Prolapse Facts

Standardised classification systems should be used for the assessment and documentation of pelvic organ prolapse (POP), including vault prolapse

Relevant patient information leaflet should be offered to patients for proposed operation as well as alternative treatment (BSUG patient information leaflets The British Society of Urogynaecology (BSUG)

Management of pelvic organ prolapse Facts

Lines of treatment

Conservative management to be started in primary care before accepting the referral

- Correction of any predisposing factor (chest infection, constipation)
- Weight loss If BMI >30kg/m2
- Healthy diet
- Stop smoking
- Avoiding heavy lifting
- Avoiding certain physical activity such as trampoline or high-impact exercise.
- Pelvic floor exercises. All patients with prolapse should be referred and seen by physiotherapy before being accepted in secondary care as per community health pathway

Pelvic floor muscle training (PFMT) is an effective treatment option for women with stage I–II vaginal prolapse, including PHVP

Oestrogen replacement therapy (ERT)

- Preventing/treating constipation

Pessary (Refer to pessary pathway)

- Vaginal pessaries are an alternative treatment option for women with stage II–IV post hysterectomy vault prolapse (PHVP)
- Pessary should be removed or replaced every 4-6 months
- If contraindicated or cannot be tolerated by the patient, consider referral for surgery

Surgical management: (according to type of prolapse)

Preoperative assessment

- Correction of any predisposing factor
- Treatment of any decubitus ulcers (ERT)

Postoperative care:

- Vaginal pack and urinary catheter to be removed after 24- 48 hours
- Check volume of 1st void urine after catheter removal
- If urine retention: consider TWOC after 5- 7 days by Urogynaecology nurse specialist
- 3-6 months follow up appointment in Advanced nurse practitioner clinic with quality of life questionnaire

All cases booked for prolapse surgery and cases of recurrent prolapse cases should be discussed in Pelvic floor MDT

Further Reading, Consultation and Glossary

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref No	Document Title	Document Location
1	Urinary incontinence and pelvic organ prolapse in women: management. NICE guideline [NG123]Published: 02 April 2019 Last updated: 24 June 2019	https://www.nice.org.uk/guidance/ng123/
2	NICE guidelines; Urinary tract infection (lower) – women. July 2015	https://www.nice.org.uk/guidance/ng109/resources/urinary-tract-infection-lower-antimicrobial-prescribing-pdf-66141546350533
3	Post-Hysterectomy Vaginal Vault Prolapse (Green-top Guideline No. 46), Published: 24/07/2015	http://www.rcog.org.uk/
4	Guidance follows the RCOG Green-top Guideline No. 70 as published in 2016 by Royal College of Obstetricians and Gynaecologists	http://www.rcog.org.uk/
5	CTM UHB antimicrobial guideline	https://viewer.rx-guidelines.com/POWH/Abx#content,eMe5xfW7Vq
6	Andersson, KE, Chapple, CR, Cardozo L; et al. (2009). "Pharmacological treatment of overactive bladder: report from the International Consulation on Incontinence". Current Opinion in Urology. 19: 380–394.	Current Opinion in Urology

The following terms and acronyms are used within the document:

BSUG	British society of Urogynaecology
BBHT	Bladder and Bowel Health Team
GFR	Glomerular filtration rate
ERT	Oestrogen replacement therapy
ISC	Intermittent Self Catheterisation
LUTS	Lower urinary tract symptoms
MDT	Multidisciplinary team
MI	Muscarinic inhibitors
MSU	Midstream urine
MUS	Mid Urethral sling
NHS	National Health Service
NSAID	Nonsteroidal anti-inflammatory drugs
OAB	Overactive bladder
PFMT	Pelvic floor muscle training
PHVP	Post hysterectomy vault prolapse
PTNS	Percutaneous tibial nerve stimulation
PVR	Post voiding residual urine
SI	Stress incontinence
SUI	Stress urinary incontinence
TOT	Transobturator tape
TVT	Tension Free Vaginal tape
TWOC	Trial without a catheter
UDS	Urodynamic studies
UI	Urinary incontinence
UTI	Urinary tract infection

Appendices

Appendix A – New Patient Assessment Proforma

Date/time:
Age:
Presenting Complaint:

ADDRESSOGRAPH

Bladder:

Storage Symptoms:

☐ Stress incontinence ☐ Frequency ☐ Urgency ☐ Urge incontinence ☐ Nocturia
☐ Nocturnal enuresis

Voiding Symptoms:

☐ Hesitancy ☐ Interrupted flow ☐ Difficult voiding ☐ Incomplete voiding ☐ Dysuria
☐ Haematuria ☐ Double voiding ☐ Post void dripping

Red Flags:

☐ Haematuria Micro / Macro ☐ Recurrent UTI 2/ 6 months or 3/ 12 months ☐ Pain suprapubic / loin

Prolapse:

☐ Pressure sensation ☐ Pain ☐ Mass protruding from the vulva

Bowels:

☐ Constipation ☐ straining ☐ Incontinence Faeces ☐ Incontinence Flatus ☐ Faecal urgency

Red Flags:

☐ Bleeding per rectum ☐ New bowel symptoms over 50 years of age ☐ Excessive weight loss

Sexual Function:
Obstetric History: G P Mode of Delivery: Previous 3rd/4th degree tear: if yes; outcome:
Menstrual History:
LMP: D/C: Smear: Contraception:
Bleeding: ☐ inter-menstrual ☐ PCB ☐ PMB ☐ Dyspareunia

Previous surgery:
Previous treatment of the current complaint:
Please specify:
Medical History:
Medication: **Allergies**:

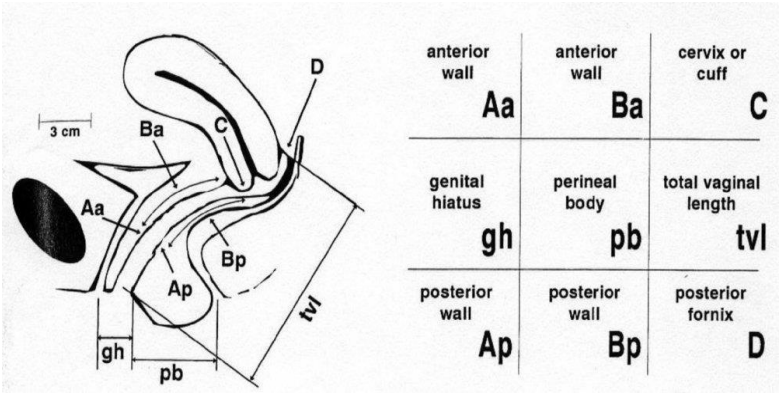
Family History: ☐ DVT ☐ diabetes ☐ hypertension ☐ related cancer ☐ other
Social History: ☐ smoker ☐ alcohol ☐ tea/coffee ☐ carbonated drinks

Examination:

Abdominal examination:

Vaginal assessment: (Chaperone and verbal consent) Speculum:

Simms:



Active Diagnosis:

Urinalysis: MSU ☐

Weight: Height: BMI:

Treatment/Management:

Physiotherapy referral Yes ☐ NO☐ NA☐

Bladder and bowel team referral Yes ☐ NO☐ NA☐

Conservative management with vaginal pessary Yes ☐ NO☐ NA☐

NICE decision aid Yes ☐ NO☐ NA☐

Anticholinergic drug prescribed: Yes ☐ NO☐ NA☐

If yes; Name: Duration of treatment: 4 weeks virtual follow up arranged:

Candidate for corrective surgery?

Primary surgery ☐ Repeated surgery☐ (please refer to MDT) Proposed surgical management:

Up to date leaflets given? Paper (in-clinic) / Electronic **Source**: BSUG RCOG EIDO Other……

MDT referral: UroGynaecology☐ Pelvic floor ☐

Signed: Designation:

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Appendix B: Urodynamics referral form Referral date……

Consultant……

Requested by……

Patient's tel no……

Patient's addressograph

Indication for referral: (please tick as appropriate)

Lower urinary tract symptoms

Stress incontinence ☐ Urge incontinence ☐ Recurrent UTIs

Frequency ☐ Urgency ☐ Incomplete emptying ☐

Poor stream ☐ Nocturia ☐ Dysuria/pain ☐

Associated symptoms

Faecal incontinence yes ☐ no ☐ Vaginal prolapse yes ☐ no ☐

If yes what type of prolapse / ring pessary…… BMI

Previous treatment

Previous Continence or Pelvic Floor Surgery: yes ☐ no ☐ Please mention……

OAB treatment yes ☐ no ☐ Name of medication ……

What is the UroDynamics question? ……

Patient mobile yes ☐ no ☐ Hoist required yes ☐ no ☐

Latex Allergy yes ☐ no ☐ Iodine allergy yes ☐ no ☐

Urine dipstick - nitrates yes ☐ / no ☐ MSU yes ☐ no ☐

Please check and tick box before UDS referral	
1. Completion of Physiotherapy for 3 months	
2. Review by Bladder and Bowel health team	
3. BMI > 30 – Weight loss advice / referral to dieticians	
4. Trial of at least two Anticholinergic / Mirabegron medication for OAB	
5. Trial of vaginal Oestrogen if not contraindicated	
6. Patient counselled and willing to go ahead with surgery if appropriate	
7. Patient willing to learn ISC	
8. Indication of referral is in line with the NICE guideline for management of female urinary incontinence	

Please do not complete this part

Uroflow & PVRV ☐ UDS ☐ Video UDS ☐

Patient to stop Anticholinergics / Mirabegron one week before Yes ☐ No ☐

Please circle site **RGH** **PCH** **POW** and send referral to Gynaecology department

Appendix C Urogynaecology MDT form

Patient Addressograph			Age
			Consultant
Date Of MDT			
CLINICAL HISTORY			
Presenting Problems/Symptoms			
C0-Morbidity (incl. Obstetric History)			
Medications			
Relevant Surgical History			
EXAMINATION			
Abdomen			
Pelvis			
BMI			
CONSERVATIVE/MEDICAL TREATMENT			
Conservative/Physio			
Medical			
Other			
	PRE CYSTOMETRY	POST	
Maximum Flow			
Average Flow			
Residual Volume			
Voided Volume			
URODYNAMIC DIAGNOSIS			
DO			
USI			
Other			
PROPOSED SURGICAL INTERVENTION			
MDT DECISION AND FOLLOW-UP ARRANGEMENTS			
		PREOPERATIVE CISC	
		YES	NO

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Bladder Diary

Please complete all 3 days and bring to your appointment with you

Name: …… Date: ……..

	Day 1					Day 2					Day 3				
TIME	Fluid in (millilitres)	Drink Type	Leakage	Urgency 0-3	Fluid out (millilitres)	Fluid in (millilitres)	Drink Type	Leakage	Urgency 0-3	Fluid out (millilitres)	Fluid in (millilitres)	Drink Type	Leakage	Urgency 0-3	Fluid out (millilitres)
6 am															
7am															
8 am															
9 am															
10 am															
11 am															
12 pm															
1 pm															
2 pm															
3 pm															
4 pm															
5 pm															
6 pm															
7 pm															
8 pm															
9 pm															
10 pm															

11 pm															
12 am															
1 am															
2 am															
3 am															
4 am															
5 am															
TOTAL															

Average freq.		**Average Intake**		**Average Output**		**Min void**		**Max void**	

Please complete this form as accurately and honestly as possible over three different days.
It gives us a considerable amount of important information about your bladder in order to plan your treatment effectively and therefore needs to be fully completed and brought to your assessment appointment.

You will need to use a litre jug

Fluid in
Measure and record the amount you drink (in millilitres) next to the nearest hour

Drink type
Record the type of drink next to the nearest hour.
You can use your own key such as T for tea, C for coffee, W for water

Ref:
Policy Title: Pelvic organ prolapse and bladder health Guideline
Page Number: 35

Leakage

Every time you leak record the extent i.e.

D = Damp
W = Wet
S = Soaked

And what you were doing at the time you leaked e.g. Coughing, sneezing, running getting out of the car, next to the nearest hour

Urgency

Please score how much of an urge you felt each time you passed urine

0 = No urge (i.e. went to the loo 'just in case')
1 = Slight urge
2 = Desperate rush
3 = Leaked on the way

Fluid out

When you pass urine, measure the amount that you pass (in millilitres) using a measuring jug and record the amount in the appropriate column next to the nearest hour. If you pass urine twice in an hour, put both measurements in the same box