



**PROPOSED REVIEW OF SIGN GUIDELINE  
CONSULTATION FORM**

Title of guideline	SIGN 79: Management of urinary incontinence in primary care
Date of publication	December 2005
SIGN scoping search – sources	<p>MeSH headings for the condition specified and any common variations as free text, plus terms for the interventions and care processes discussed in the guideline</p> <p>Sources: <b>Guidelines:</b> NICE; National Library for Health guidelines finder; National Guidelines Clearinghouse; GIN Web site. <b>Technology appraisals:</b> NICE; UK HTA database (Southampton); INAHTA database. <b>Cochrane reviews:</b> Cochrane Library. <b>Other good quality systematic reviews:</b> UK HTA database (Southampton); DARE.</p>
SIGN scoping search - summary	<p><b>Guidelines – 7</b>  <b>HTAs – 4</b>  <b>Cochrane reviews – 19</b>  <b>Other good quality systematic reviews – 7</b></p>
Other guidelines/HTAs	<p><b>American College of Obstetricians and Gynecologists (ACOG).</b> Urinary incontinence in women. 2005.</p> <p><b>Dowling-Castronovo A, Bradway C.</b> Urinary incontinence (UI) in older adults admitted to acute care. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008</p> <p><b>European Association of Urology.</b> Guidelines on neurogenic lower urinary tract dysfunction. 2008</p> <p><b>Finnish Medical Society Duodecim.</b> Urinary incontinence in women. 2008.</p> <p><b>NICE.</b> Urinary incontinence: the management of urinary incontinence in women. 2006.</p> <p><b>Registered Nurses Association of Ontario (RNAO).</b> Promoting continence using prompted voiding. 2005</p> <p><b>Society of Obstetricians and Gynaecologists of Canada.</b> Conservative management of urinary incontinence. 2006</p> <hr/> <p><b>Canadian Coordinating Office for Health Technology Assessment.</b> Duloxetine for major depressive disorder and stress urinary incontinence. Ottawa: Canadian Coordinating Office for Health Technology Assessment (CCOHTA) 2004</p> <p><b>Fader M, Cottenden A, Getliffe K, Gage H, Clarke-O'Neill S, Jamieson K, et al.</b> Absorbent products for urinary/faecal incontinence: a comparative evaluation of key product designs. <i>Health Technol Assess</i> 2008;<b>12</b>(29).</p> <p><b>Martin JL, Williams KS, Abrams KR, Turner DA, Sutton AJ, Chapple C, et al.</b> Systematic review and evaluation of methods of assessing urinary incontinence. <i>Health Technol Assess</i> 2006;<b>10</b>(6).</p> <p><b>Shamliyan T, Wyman J, Bliss D Z, Kane R L, Wilt T J.</b> Prevention of urinary and fecal incontinence in adults. Rockville, MD, USA: Agency for Healthcare Research and Quality. Evidence Report/Technology Assessment; 161. 2007</p>

	<p>Systematic review and economic modelling of the effectiveness and efficiency of non-surgical treatments for women with stress urinary incontinence (SUI). Vale L. D. <b>(due for publication Feb 2010)</b></p>
<p>Main conclusions from new evidence</p>	<p>Anticholinergics (antimuscarinics)</p> <ul style="list-style-type: none"> <li>▪ There was more symptomatic improvement when (a) anticholinergics were compared with bladder training alone, and (b) anticholinergics combined with bladder training were compared with each modality alone.</li> <li>▪ The review found that there are several anticholinergic drugs prescribed for adults with overactive bladder symptoms. Oxybutynin and tolterodine have similar effects, but on average those taking oxybutynin were more likely to withdraw from the studies because of adverse effects, mainly dry mouth.</li> <li>▪ It is not clear whether any benefits are sustained during long-term treatment or after treatment stops. <i>SIGN (A) recommendation for trial of antimuscarinics.</i></li> </ul> <p>Duloxetine</p> <ul style="list-style-type: none"> <li>▪ Evidence suggests that duloxetine treatment can significantly improve the quality of life of patients with stress urinary incontinence, but it is unclear whether or not benefits are sustainable. Adverse effects are common but not serious. <i>Duloxetine is recommended for female patients with moderate to severe stress incontinence on a four week trial. Patients should be reviewed again after 12 weeks (A).</i></li> </ul> <p>Pelvic floor muscle training</p> <ul style="list-style-type: none"> <li>▪ Evidence supports the widespread recommendation that PFMT be included in first-line conservative management programmes for women with stress, urge, or mixed, urinary incontinence. Statistical heterogeneity reflecting variation in incontinence type, training, and outcome measurement made interpretation difficult. The treatment effect might be greater in younger women (in their 40's and 50's) with stress urinary incontinence alone, who participate in a supervised PFMT programme for at least three months, but these and other uncertainties require testing in further trials. <i>PFMT currently recommended by SIGN for stress(A), mixed (A) and urge (D)</i></li> </ul> <p>Bladder retraining</p> <ul style="list-style-type: none"> <li>▪ The evidence is too limited to judge whether or not there are improvements in continence that would make investment in habit-retraining programmes worthwhile. The limited evidence available suggests that bladder training may be helpful for the treatment of urinary incontinence, but this conclusion can only be tentative as the trials were of variable quality and of small size with wide confidence intervals around the point estimates of effect. There was also not enough evidence to determine whether bladder training was useful as a supplement to another therapy. Definitive research has yet to be conducted. <i>SIGN says weak evidence and that it should be offered (C) Retraining programmes are discussed in information for discussion with patients and carers, but not supported by an evidence base.</i></li> </ul> <p>Botulinum</p> <ul style="list-style-type: none"> <li>▪ Practitioners should be aware that at present there is little more than anecdotal evidence, in the form of case reports to support the efficacy of intravesical botulinum toxin; there is not much in the way of substantial, robust safety data. <i>Not discussed in the guideline</i></li> </ul> <p>Timed voiding</p> <ul style="list-style-type: none"> <li>▪ Data were too few and of insufficient quality to provide empirical support for or against the intervention of timed voiding. <i>Not discussed in the guideline</i></li> </ul> <p>Absorbant products</p>

	<ul style="list-style-type: none"> <li>▪ People have different preferences for absorbent product designs and using a combination (different designs for day/night, going out/staying in) may be more effective and less expensive than using one design all the time.</li> </ul> <p>Mechanical devices</p> <ul style="list-style-type: none"> <li>▪ Currently there is little evidence from controlled trials on which to judge whether their use is better than no treatment and a large well-conducted trial is required for clarification. There was also insufficient evidence in favour of one device over another and no evidence to compare mechanical devices with other forms of treatment.</li> </ul> <p>Sacral nerve stimulation</p> <ul style="list-style-type: none"> <li>▪ There is evidence indicating that SNS is effective for decreasing symptoms in patients with urge incontinence. Adverse events occurred in about half of the implanted cases and surgical revision was performed in 33%. No major irreversible complications were reported in the studies reviewed. Further research is required on the long-term effects of and quality of life in patients with SNS. <i>Not primary care intervention?</i></li> </ul>
New areas that could be added to the guideline	none
Summary of the recommendations that could be updated	none

This report has been reviewed by SIGN Senior Management who do not consider that the new evidence provides justification for updating of the guideline at this stage, and the guideline remains current. This report will be updated and reconsidered in 2011.