**Management of urinary incontinence in primary care**

**Quick Reference Guide**

Scottish Intercollegiate Guidelines Network

December 2004

Copies of all SIGN guidelines are available by calling 0131 247 3664 or online at www.sign.ac.uk

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**Sample care pathway**

**Male patients with urinary incontinence**

Male patients with urinary incontinence may seek help from a general practitioner, continence adviser, specialist physiotherapist or community nurse (district nurse, practice nurse, health visitor)

**Initial Assessment**

Clinical history and physical examination • Validated quality of life and incontinence severity questionnaire • Urinalysis • Frequency volume chart • Post void residual volume • Estimation of flow rate • Digital rectal examination

- Post void residual > 100 mls and/or reduced flow rate.
- Post void residual < 100 mls and no evidence of reduced flow rate.

• Refer to secondary care

**Conservative Treatment +/- Containment**

- Stress Incontinence
  - Pelvic floor muscle re-education
  - YES
  - Complete treatment course / maintain
  - NO
  - Containment
  - Refer to secondary care

- Urge Incontinence
  - Review caffeine intake • bladder retraining • antimuscarinics
  - YES
  - Treatment Success
  - NO
  - Containment
  - Refer to secondary care

- Mixed Incontinence
  - Review caffeine intake • bladder retraining • pelvic floor muscle re-education • antimuscarinics
  - YES
  - Treatment Success
  - NO
  - Refer to secondary care

**Sample care pathway**

**Female patients with urinary incontinence**

Female patients with urinary incontinence may seek help from a general practitioner, continence adviser, specialist physiotherapist or community nurse (district nurse, practice nurse, health visitor)

**Initial Assessment**

Clinical history and physical examination • Validated quality of life and incontinence severity questionnaire • Urinalysis • Frequency volume chart

- Presence of voiding dysfunction or symptomatic pelvic organ prolapse.
- NO
- Refer to secondary care

**Conservative Treatment +/- Containment**

- Urge Incontinence
  - Review caffeine intake • bladder retraining • antimuscarinics
  - YES
  - Treatment Success
  - NO
  - Containment
  - Refer to secondary care

- Stress Incontinence
  - Pelvic floor muscle re-education • Consider supplementing with duloxetine
  - YES
  - Treatment Success
  - NO
  - Refer to secondary care

- Mixed Incontinence
  - Review caffeine intake • bladder retraining • pelvic floor muscle re-education • antimuscarinics
  - YES
  - Treatment Success
  - NO
  - Refer to secondary care
Quick Reference Guide
Management of urinary incontinence in primary care

This Quick Reference Guide provides a summary of the main recommendations in the SIGN guideline on the Management of urinary incontinence in primary care.

Recommendations are graded [A B C D] to indicate the strength of the supporting evidence.

Good practice points [ ] are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: www.sign.ac.uk

### QUALITY OF LIFE

**Clinicians should be aware of and take into consideration the potentially serious adverse effects that even mild urinary incontinence has on a patient's quality of life.**

**Healthcare practitioners should consider using a validated quality of life and incontinence severity questionnaire to evaluate the impact of urinary symptoms and to audit the effectiveness of any management strategy.**

### INFORMATION AND HEALTH PROMOTION

**Patients with urinary incontinence should be offered information and advice on the treatment options available to them in both primary and secondary care.**

**Patients with urinary incontinence should have access to trained healthcare professionals who have the relevant knowledge and skills to offer appropriate advice and information.**

**Patients with urinary incontinence should be made aware that they are able to access specially trained staff in primary care without GP referral.**

**Strategies using a number of different approaches and delivery media should be employed to raise awareness of urinary continence and promote incontinence services to a range of target audiences.**

### PHYSICAL THERAPIES

**Pelvic floor muscle exercises should be the first choice of treatment offered to patients suffering from stress or mixed incontinence. Exercise programmes should be tailored to be achievable by the individual patient.**

**Digital assessment of pelvic floor muscle function should be undertaken prior to initiating any pelvic floor muscle exercise treatment.**

**Digital assessment of pelvic floor muscle function should only be carried out by an appropriately trained clinician.**

**Pelvic floor muscle exercise treatment should be considered for patients following radical prostate surgery.**

### SOURCES OF INFORMATION

**Bladder and Bowel Foundation**
SATRA Innovation Park, Rockingham Rd, Kettering, NN16 9JH
Helpline: 0845 345 0165 Tel: 01536 533 255
www.bladderandbowelfoundation.org
Email: information.officer@bladderandbowelfoundation.org

**Scottish Continence Resource Centre**
Southern General Hospital, Govan Road, Glasgow G51 4OF
Tel: 0141 201 1861
Email: mary.ballentyne@sgh.scot.nhs.uk

### PHARMACOTHERAPY

**Duloxetine should be used only as part of an overall management strategy in addition to pelvic floor muscle exercises and not in isolation. A 4 week trial of duloxetine is recommended for female patients with moderate to severe stress incontinence. Patients should be reviewed again after 12 weeks of therapy to assess progress and determine whether it is appropriate to continue treatment.**

**A trial of oxybutynin, propiverine, tolterodine, or trospium should be given to patients with significant urgency with or without urge incontinence. The dose should be titrated to combat adverse effects (see British National Formulary for dose ranges).**

**Antimuscarinic therapy should be tried for a period of six weeks to enable an assessment of the benefits and side effects. Treatment should be reviewed after six months to ascertain continuing need.**

### CONTAINMENT

**All patients should undergo a continence assessment before product issue. Issue of products should not take the place of therapeutic interventions.**

### REFERRAL

**Patients should be referred to secondary care if previous surgical or non-surgical treatments for urinary incontinence have failed or if surgical treatments are being considered.**

**Female patients with symptomatic pelvic organ prolapse or suspected voiding dysfunction should be referred to secondary care.**

**Male patients with reduced urinary flow rates or elevated post void residual volumes should be referred to secondary care.**

### RISK FACTORS AND ASSESSMENT

**Health professionals should be vigilant and adopt a proactive approach in consultations with patients who are at greatest risk of developing urinary incontinence through factors including age, the menopause, pregnancy and childbirth, high BMI and experience of continence problems in childhood.**

**Initial assessment of a male patient with urinary incontinence should include completion of a voiding diary, urinalysis, estimation of post void residual volume and digital rectal examination.**

**Initial assessment of a female patient with urinary incontinence should include completion of a voiding diary, urinalysis and, where symptoms of voiding dysfunction or repeated UTIs are present, estimation of post void residual volume.**

**Health professionals should recognise the difficulty that some patients have in raising concerns about continence and should be proactive in questioning patients about continence during consultations.**

**Health professionals should have a positive attitude to continence problems.**

**Assessment, treatment and referral, as appropriate, should be offered to all patients with urinary continence problems.**

**Patients undergoing radical prostatectomy should be referred to secondary care if previous pelvic floor muscle exercises and other therapies have failed or if surgical treatments are being considered.**

**Pelvic floor muscle retraining should be offered to patients with urge urinary incontinence.**

**Patients should be referred to secondary care if previous pelvic floor muscle exercises and other therapies have failed or if surgical treatments are being considered.**

**Pelvic floor muscle exercise treatment should be considered for patients following radical prostate surgery.**

**Bladder retraining should be offered to patients with urge urinary incontinence.**

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This page contains excerpts from a document that outlines recommendations and guidance on the management of urinary incontinence, including details on risk factors, assessment, treatment, and referral processes. The document emphasizes the importance of recognizing the impact of incontinence on quality of life and promotes strategies for health promotion and education. It also highlights the need for careful assessment and the consideration of pharmacotherapies and physical therapies, with specific recommendations for grading and evaluation of interventions. For further details, including evidence supporting these recommendations, readers are directed to the full SIGN guideline available online.