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Decision aid for women experiencing stress urinary incontinence

NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

About this decision aid

This information is for women with stress urinary incontinence. This occurs when you have accidental and uncontrollable leakage of urine (wee) with movement.

This decision aid is intended to:

- support conversations with your doctor and/or continence health professional
- help you to think about what is important to you
- inform you about ways to manage leakage, including potential benefits and harms
- allow you to compare options and make a personal choice
- help you to easily revisit the options in the future.

How was this decision aid developed?

This document was developed and funded by the NSW Agency for Clinical Innovation (ACI).

This work was undertaken to support NSW Health efforts to address recommendations of the Commonwealth of Australia Community Affairs References Committee report into the number of women in Australia who have had transvaginal mesh implants and related procedures.

The decision aid was produced by a multidisciplinary working group (see page 15). The authors did not disclose any conflicts of interest and do not stand to gain or lose anything from the stress urinary incontinence management choices people make after using this decision aid.

Information about the literature search method and information sources is on page 14.

About stress urinary incontinence

What causes stress urinary incontinence?

Urine can leak when the muscles and other tissues that support the bladder (pelvic floor) and control the flow of urine (urinary sphincter) are damaged or become weak.

This can be caused by pregnancy, childbirth (particularly if forceps were used), weight gain, constipation, some types of excessive exercising, chronic straining and coughing.

Stress urinary incontinence is more common as you age and after menopause.

When can urine leak?

Pressure on your tummy can cause urine to leak. This can be caused by movements or activities such as:

- coughing
- sneezing
- laughing
- standing up
- getting out of the car
- lifting something heavy
- exercising, and
- having sex.

You may have a little leakage or a lot – the amount depends on several factors and can change over time.

Other types of urinary incontinence

Urinary incontinence is a broad term that refers to a lack of bladder control. Other types of urinary incontinence include:

- urgency incontinence (also called overactive bladder) – the strong or urgent urge to urinate and having to go frequently
- mixed urinary incontinence – having both urgency incontinence and stress urinary incontinence.

This decision aid has been developed for women experiencing stress urinary incontinence. It may be helpful for women with mixed incontinence, but it is usually recommended to treat the urgency incontinence first.

Treatments for urgency incontinence are generally conservative and can include bladder training or medication. This may make it easier to see how much leakage is caused by stress urinary incontinence.

Talk to a continence health professional about your situation.

This decision aid has been developed for women experiencing stress urinary incontinence. It may be helpful for women with mixed incontinence, but it is usually recommended to treat the urgency incontinence first.

Finding an approach that works for you

Visit a health professional

Speak with your doctor about:

- when you have leakage and how much
- if you are already doing anything to manage leakage.

You may have some tests to check your bladder, and to see if the incontinence has been caused by another problem, such as an infection.

Continence health professionals can also provide advice and support. They include women's health physiotherapists, continence specialists, advisors and nurses.

Think about what is important to you

Take some time to reflect on how stress urinary incontinence is affecting you.

Do your symptoms interfere with daily life, such as work, hobbies/leisure, exercise or social activities? For some women, the leakage is only bothersome sometimes; for others, it is limiting and causes them to change routine.

How does it make you feel?

Some women feel embarrassed or have found it has an impact on their relationships. Other women see it as a manageable part of life.

It is important to share your feelings with your doctor or continence health professional and consider them when making a decision.

Consider and choose management options

It is helpful to understand all of the options available. This decision aid has information, and a health professional can provide more details.

The approaches outlined in this decision aid can be used separately or together.

Reconsider at any time

See how things go, and keep talking with your doctor or continence health professional about it. If your leakage changes or something is not working, you can try another approach.

Management options for stress urinary incontinence

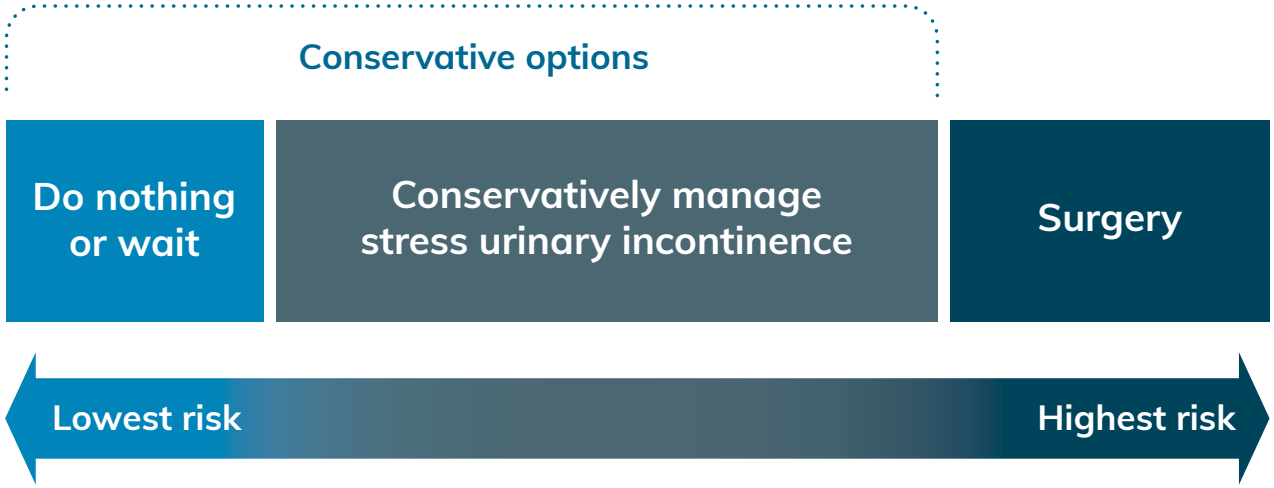
There are different ways to manage stress urinary incontinence. Everyone is different, so you can find what works best for you.

Conservative management options are low risk and do not involve surgery. These are usually tried first for some time, before surgery is considered.

Conservative management options:

- are relatively safe
- can be combined
- can be attempted over and over again
- can be continued as long as you like.

Surgery has serious risks and possible complications.



Management options not included in this decision aid

You may have heard of other options for managing stress urinary incontinence:

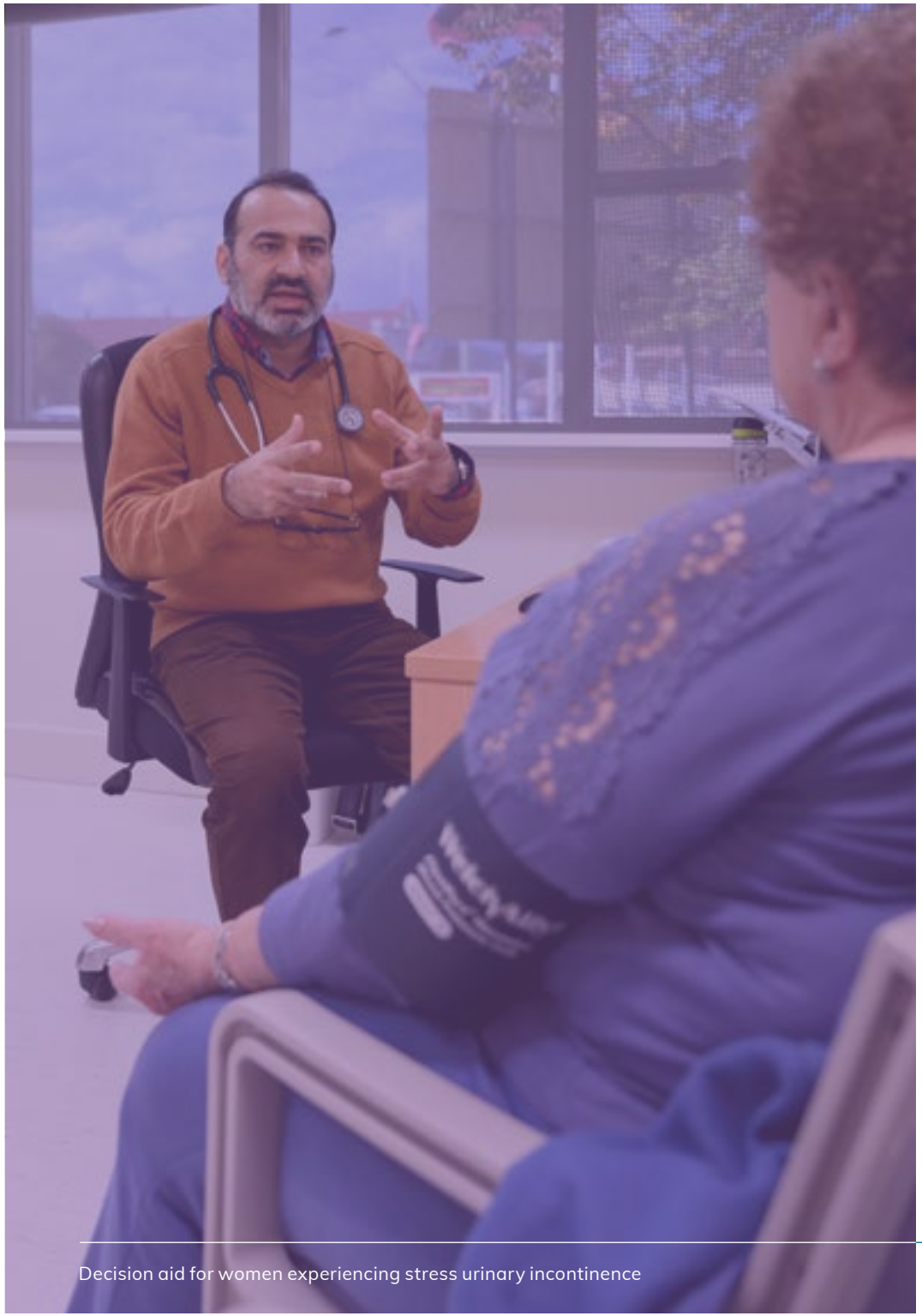
Pessaries – A pessary is a silicone support that is inserted like a tampon. It may be an effective treatment for some women who have pelvic organ prolapse at the same time as stress urinary incontinence.[1]

Pessaries are not covered in detail in this decision aid. Speak to your doctor or a continence health professional for more information.

Medication – While it is used to treat urgency incontinence, medication is not approved in Australia to treat stress urinary incontinence on its own. If you have mixed incontinence, speak with a continence health professional to discuss if medication is suitable for you.

The following options are also not included in this decision aid because they have not been appropriately studied in Australia:

- laser treatment (also called vaginal rejuvenation)
- magnetic chair therapy (also called wave chair therapy).



Conservative management options

Conservative management options are recommended before surgical options are considered because they:

- are proven to be effective in stopping or reducing leakage[2]
- are low risk
- can be used together.

The table on page 9 provides an overview of the options.

Your doctor or continence health professional can provide more detail.

Overview of conservative management options

	DO NOTHING OR WAIT	LIFESTYLE CHANGES	PELVIC FLOOR EXERCISES	CONTINENCE AIDS
What is it?	Not doing anything (or delaying doing something) to manage your incontinence.	Changing your habits or making different choices, such as: • losing weight and maintaining a healthy body weight • avoiding heavy lifting • doing lower impact activities • reducing coughing by quitting smoking or getting treatment • avoiding things that irritate the bladder (such as caffeine) • practising good bladder and bowel habits (such as avoiding constipation).	Exercising the muscles around your vagina, urethra and anus (front and back passage) to strengthen the pelvic floor. Talk to a women's health physiotherapist or continence specialist who will teach you the correct methods, so you get the best possible result.[2]	Using products, such as pads or specially designed underwear, to absorb leakage.
Will it reduce leakage?	No, however there may be natural changes in your incontinence over time.	It depends on what changes are made and other factors – talk to a health professional about your situation.	Half of women (5 out of 10) said their incontinence was cured[3,4] and most women (7 out of 10) said it improved[2].	There is no change in the incontinence, but you may feel more comfortable.
What are some other potential benefits?	You may not feel ready to make a decision about another management approach. You can change your mind any time (at any age).	Overweight and obese women who lose 5-10% of their body weight can expect the incontinence to significantly improve.[3]	Exercises can improve symptoms by helping to increase bladder control.	Using aids may help you feel more confident and be more active.
What are the risks or side effects?	There is a risk that urine leakage may irritate your skin. It is possible for incontinence to worsen as you get older, but this won't make it harder to treat.	It depends on what changes are made and other factors – talk to a health professional about your situation.	Exercises are low risk. In rare cases, they cause pain or discomfort, and if you overdo it, they can make leakage worse temporarily.[4]	An allergic reaction to the aid is possible but rare.
What are the costs?	None.	There may be costs associated with some lifestyle changes, for example with weight loss or quitting smoking.	There may be appointment fees to see specialists. Sometimes this is subsidised or free if in a continence clinic or part of a GP management plan.	It depends on what aids are used and how often. You may be eligible for a subsidy.

Surgical management options

Choosing to have surgery

The decision to have surgery is a serious one.

Discuss your options – including the risks and possible complications – with a surgeon who is experienced in managing urinary incontinence.

You can ask to be referred to a surgeon who specialises in a certain type of operation and performs it regularly. You can also request an 'open referral' that is not addressed to a specific surgeon and to choose where to present the referral.

Risks and possible complications

All types of operations have risks.

There is limited evidence about some complications. The likelihood (statistical chance) of a particular risk or complication is an estimate, based on evidence from research studies. It is not possible to predict what will happen for any individual.

General complications of surgery include bleeding, blood clots and side effects from anaesthesia. Other possible complications of surgery for stress urinary incontinence include:

- **Difficulty urinating after surgery** – Not being able to fully empty the bladder. You may need to insert a tube (catheter) into your bladder to urinate (self-catheterise). This could be temporary or permanent.
- **Urgency incontinence** – Needing to urinate more often or urgently. It may not be severe, and can be managed with bladder retraining, physiotherapy, and/or medication.
- **Damage to tissue (such as the bladder, uterus or bowel)** – This is usually repaired at the time of the operation.
- **Chronic pain (lasting longer than six months after surgery)** – Pain may start immediately or years later. This can be difficult to treat.
- **Infection** – Can be treated with antibiotics. Less than 1 in 100 women have repeated urinary tract infections (UTIs).

Overview of surgical management options

	COLPOSUSPENSION	PUBOFASCIAL/ PUBOVAGINAL SLING	MID-URETHRAL SLING (ALSO KNOWN AS PELVIC MESH TAPE)	PERI-URETHRAL BULKING INJECTIONS
Description	The tissues between the bladder and urethra are lifted and stitched into place. The stitches will remain in the body. This can be an open procedure (through a cut in the lower abdomen) or done through several small cuts (laparoscopic 'keyhole' surgery).[5]	Through a cut in the lower abdomen, a strip of your own tissue is placed under the urethra. The tissue is usually from the thigh or tummy area (there will be a wound where it is removed). Each end is stitched to the abdominal wall tissue. This creates a 'sling', providing support to the urethra and bladder. The stitch will remain in the body.	Through a cut in the vagina, mesh tape is placed under the urethra. Scar tissue forms to keep the mesh in place. This creates a 'sling', providing support to the urethra and bladder. The mesh is designed to stay in the body permanently. The name of the procedure describes how the surgeon inserts the mesh. This can be either behind the pubic bone (retropubic) or into muscles in the upper leg and groin (transobturator).	A water or silicone-based gel is injected around the urethra. This procedure creates an artificial cushion and helps close the urethra.
How long do I stay in hospital?	For open procedures: 3–5 days For laparoscopic procedures: 1–2 days	3–5 days	Overnight or 1 day	1 day
How long does it take to recover?	4–6 weeks	6+ weeks	1 week	1 day
What type of anaesthesia is used?	General anaesthesia (you are unconscious (asleep and numb) during the procedure)	General anaesthesia (you are unconscious (asleep and numb) during the procedure)	General anaesthesia is usually used, but local anaesthesia, which numbs only the area affected by surgery, may be used in some cases.	General anaesthesia (you are unconscious (asleep and numb) during the procedure)
Does it improve SUI* in the short-to medium-term (up to 5 years)?	Improvement in 8 out of 10 women.[5]	Improvement in 8 out of 10 women.[6]	Improvement in 8 out of 10 women.[7]	Results vary. 3–7 women out of 10 see improvement in their continence. More research is needed.
Does it improve SUI* in the long-term (5+ years)?	Improvement in 6 out of 10 women after 5 years.[7]	Improvement in 6 out of 10 women on average.[8]	Improvement in 6 out of 10 women on average.[7,8]	No. Another injection is needed for most women (7–8 out of 10 women) within 2 years.[8]
What are some of the complication rates?[5–12]	1–10 women out of 100 – difficulty urinating; urgency incontinence; tissue damage, pain 1–30 women out of 100 – infection Less than 1 woman out of 100 – Vaginal prolapse – there is a risk that the nearby organs drop into the vagina. This may require later treatment	1–10 women out of 100 – difficulty urinating; urgency incontinence; tissue damage, pain 1–30 women out of 100 – infection	1–10 women out of 100 – difficulty urinating; urgency incontinence; tissue damage, pain, mesh damage 6–10 women out of 100 – chronic leg/groin or abdominal pain (more common with the transobturator approach) 1–30 women out of 100 – infection 1–10 women out of 100 – the mesh can cause damage to other organs (erosion), or may become exposed in the vagina (extrusion)[7]	Complications are unlikely. However, there is an increased risk of urinary tract infection (UTI). Less than 1 woman out of 100 – long term pain, difficulty urinating
Can it be reversed (undone)?	Yes, but it is difficult and must be done by a highly trained surgeon.	Yes, but it is difficult and must be done by a highly trained surgeon.	Yes, but it is difficult and must be done by a highly trained surgeon.	No
What is the cost?	Medicare covers most costs for public patients. If you have surgery as a private patient, the out-of-pocket costs depend on your private insurance cover and doctors' charges.			

Further information

If you would like more information, speak to your continence health professional or refer to the following organisations:

- Continence Foundation of Australia
- Australian Commission on Safety and Quality in Health Care: Shared Decision Making
- Urology Care Foundation (USA)
- Therapeutic Good Administration Mesh Hub
- Department of Human Services (Medicare) – referrals for specialist treatment
- Patient support groups, such as the NSW Pelvic Mesh Support Group on Facebook
- Mesh Injured Australia – for people injured by surgical mesh

Worksheet: What is important to me

Writing down your thoughts and questions can help you focus on what is important to you. You can fill in all or part of this table before you talk to a health professional, or you can complete it together.

You do not need to make a decision urgently.

You might want time to reflect or to discuss the decision with someone close to you.

You can change your mind at any time, including combining, revisiting or trying new approaches.

	IS THIS SOMETHING I WOULD CONSIDER?	QUESTIONS FOR MY DOCTOR OR CONTINENCE HEALTH PROFESSIONAL	WHAT I LIKE ABOUT THIS OPTION	WHAT I DISLIKE ABOUT THIS OPTION
Do nothing or wait Not using continence aids or changing what you do.				
Lifestyle changes Making some changes to daily habits.				
Pelvic floor exercises Exercising the muscles around your internal organs to strengthen the pelvic floor				
Continence aids Using absorbent products, such as pads or underwear.				
Surgery If you have already tried another approach without success, you may consider having an operation.				

Other thoughts and considerations (impact on lifestyle, emotions, etc.)

References

1. Al-Shaikh G, Syed S, Osman S, Bogis A, Al-Badr A. Pessary use in stress urinary incontinence: a review of advantages, complications, patient satisfaction, and quality of life. International journal of women's health. 2018;10:195-201.
2. Dumoulin C, Hay-Smith EJ, Mac Habee-Seguin G. Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women. The Cochrane database of systematic reviews. 2014(5):Cd005654.
3. Lavelle ES, Zyczynski HM. Stress Urinary Incontinence: Comparative Efficacy Trials. Obstetrics and gynecology clinics of North America. 2016;43(1):45-57.
4. Shamliyan T, Wyman J, Kane RL. AHRQ Comparative Effectiveness Reviews. Nonsurgical Treatments for Urinary Incontinence in Adult Women: Diagnosis and Comparative Effectiveness. Rockville (MD): Agency for Healthcare Research and Quality (US); 2012.
5. Lapitan MCM, Cody JD, Mashayekhi A. Open retropubic colposuspension for urinary incontinence in women. The Cochrane database of systematic reviews. 2017;7:Cd002912.
6. Rehman H, Bezerra CA, Bruschini H, Cody JD, Aluko P. Traditional suburethral sling operations for urinary incontinence in women. The Cochrane database of systematic reviews. 2017;7:Cd001754.
7. Ford AA, Rogerson L, Cody JD, Aluko P, Ogah JA. Mid-urethral sling operations for stress urinary incontinence in women. The Cochrane database of systematic reviews. 2017;7:Cd006375.
8. The National Institute for Health and Care Excellence (NICE). Urinary incontinence and pelvic organ prolapse in women: management [E] Evidence reviews for surgical and physical management of stress urinary incontinence 2019.
9. Kirchin V, Page T, Keegan PE, Atiemo KO, Cody JD, McClinton S, et al. Urethral injection therapy for urinary incontinence in women. The Cochrane database of systematic reviews. 2017;7:Cd003881.
10. Fusco F, Abdel-Fattah M, Chapple CR, Creta M, La Falce S, Waltregny D, et al. Updated Systematic Review and Meta-analysis of the Comparative Data on Colposuspensions, Pubovaginal Slings, and Midurethral Tapes in the Surgical Treatment of Female Stress Urinary Incontinence. European urology. 2017;72(4):567-91.
11. Siddiqui ZA, Abboudi H, Crawford R, Shah S. Intraurethral bulking agents for the management of female stress urinary incontinence: a systematic review. International urogynecology journal. 2017;28(9):1275-84.
12. Gurol-Urganci I, Geary RS, Mamza JB, Duckett J, El-Hamamsy D, Dolan L, et al. Long-term Rate of Mesh Sling Removal Following Midurethral Mesh Sling Insertion Among Women With Stress Urinary Incontinence. Jama. 2018;320(16):1659-69.

Literature search method

A search for existing systematic literature reviews published within the last five years was conducted, to identify appropriate literature to support planning and development of this decision aid. Data from the systematic reviews were appraised in collaboration with clinical, consumer and research subject matter experts to collate information appropriate for the NSW health environment and in line with contemporary clinical practice.

Information sources

Systematic reviews were sourced from multiple databases, including the Cochrane Library, MEDLINE, Embase, and the National Institute for Health and Care Excellence (NICE). These resources were supplemented with recent and emerging literature identified by authors with subject matter expertise in instances where no systematic reviews were available.

Authors of this decision aid

We acknowledge the members of the working group that developed this decision aid:

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The authors did not disclose any conflicts of interest and do not stand to gain or lose anything from the stress urinary incontinence management choices people make after using this decision aid.

The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care. We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

The ACI's clinical networks, institutes and taskforces are chaired by senior clinicians and consumers who have a keen interest and track record in innovative clinical care. The ACI strives for innovations that are person-centred, clinically-led, evidence-based and value-driven.

The ACI also works closely with the Ministry of Health and the four other pillars of NSW Health to pilot, scale and spread solutions to healthcare system-wide challenges. We seek to improve the care and outcomes for patients by re-designing and transforming the NSW public health system.

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Our vision is to create the future of healthcare, and healthier futures for the people of NSW.