



## **Managing Urinary Incontinence against NICE Guidelines (Wrexham Maelor Hospital)**

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## Introduction

Managing urinary incontinence becomes a challenge due to

- . Time
- . Resources

Financial implications

- It is essential to make an integrated pathway to deliver Up-to-date evidence-based care to the patients
- Providing the best cost-effective care NICE clinical guideline standards
- Offer expectant management techniques
  - Pelvic floor exercises (3 months) for stress C mixed incontinence - 100%
  - Bladder training for (6 weeks) urge C mixed incontinence- 100%
  - Lifestyle modification
    - Caffeine reduction for urge C mixed incontinence – 100%
    - Fluid intake modification for urinary incontinence – 100%
    - Weight reduction for urinary incontinence – 100%
- Prescribing anticholinergics, before attending the clinic from primary care (for predominant urge in mixed C pure urge incontinence) - 100%
- Offer frequency volume chart (3 days) – 100%
- Offer urodynamics, urge C mixed incontinence not responding to expectant management with prior explanation and given PIL to the patient– 100%
- Offer urine dipstick before urodynamics – 100%
- Offer the patient NICE shared decision tool- 100%
- Agreement for the procedure - 100%
- Discussion in MDT- 100%
- Data-input (BSUG database)-100%

## The aim of the audit

- To evaluate the management of urinary incontinence against NICE clinical guideline 123, Issued in April 2019.
- This guideline replaces CG171(September2013), NICE guideline CG40(October2016) and Interventional procedure guidance154

- Close the loop of the audit of the same topic that was done in 2015.

**Method**

- This is a retrospective audit
- Data collected from medical case notes using audit pro-forma.
- 50 case notes of the patients who attended the continence clinic in Wrexham Maelor Hospital, UK, from 01.10.2023 to 01.10.2024, were reviewed.
- Data was analyzed using an Excel spreadsheet.

**Results**

- Age ranges from 33 years to 73 years.

31-40 (8%)

41-50 (26%)

51-60 (22%)

61-70 (22%)

71-80 (8%)

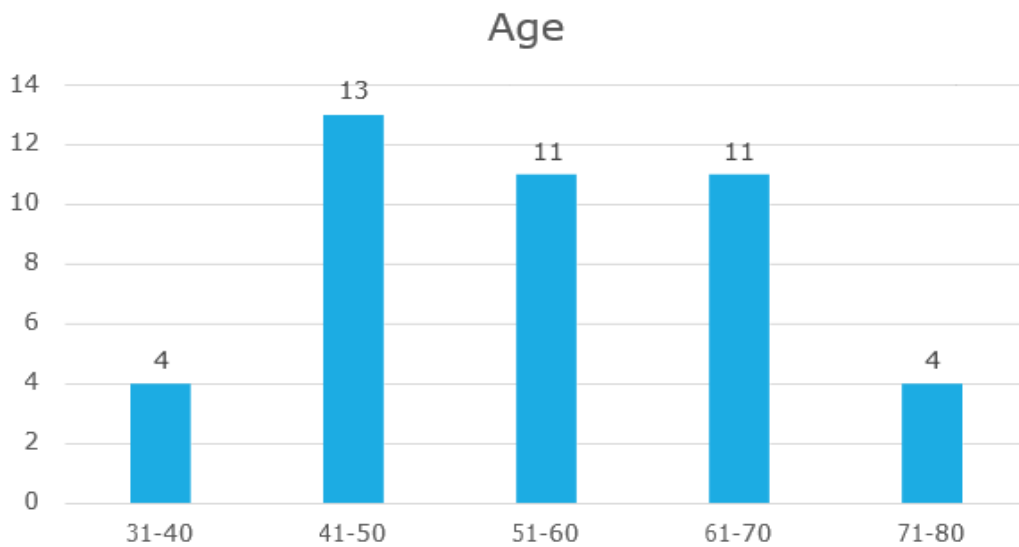


Fig 1

BMI ranges between 19 and 40

<20 2%

20-25 (14%)

26-30 (30%)

31-35 (22%)

36-40 (18%)

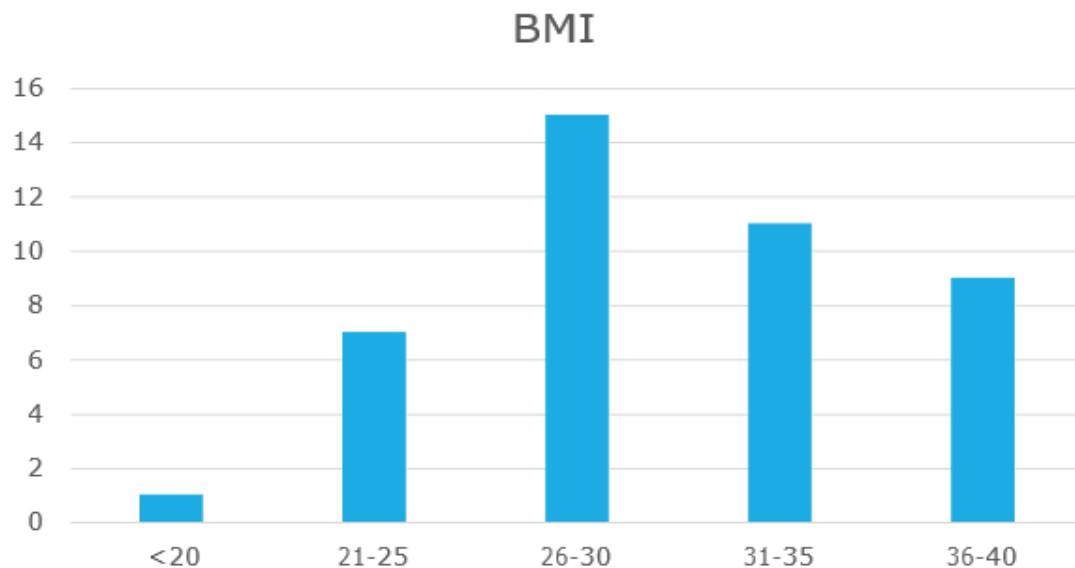


Fig 2

Presenting complaint

62% (31/50) presented with mixed incontinence, 20% (10/50) presented with urge incontinence

C 18% (9/50) presented with stress incontinence

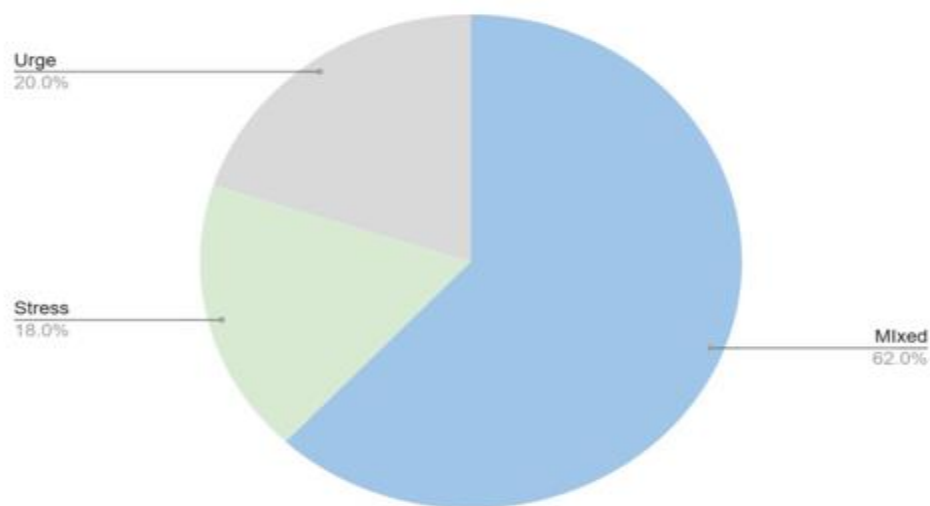


Fig 3

**Assessment and investigations**

Urine dipstick offered to n=48 (96%)

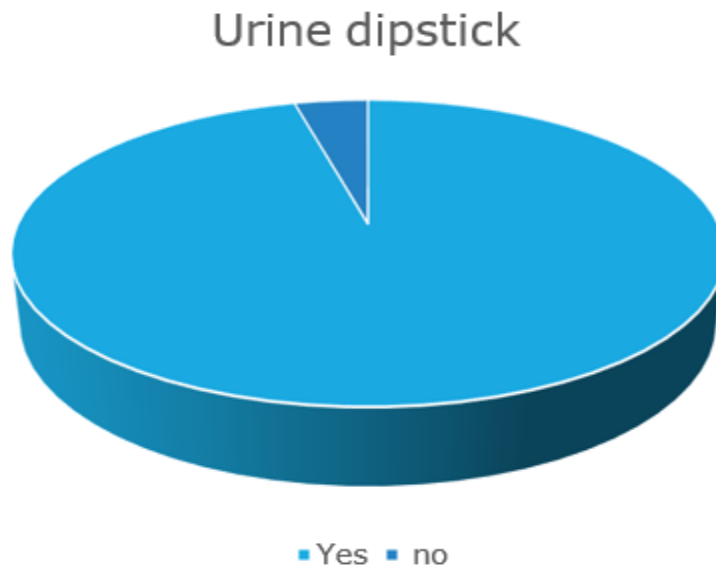


Fig 4

Conservative measures PFME 82%

Bladder training 75%

Lifestyle modification 58%

Fluid intake modification 80% Avoidance of caffeine 78%

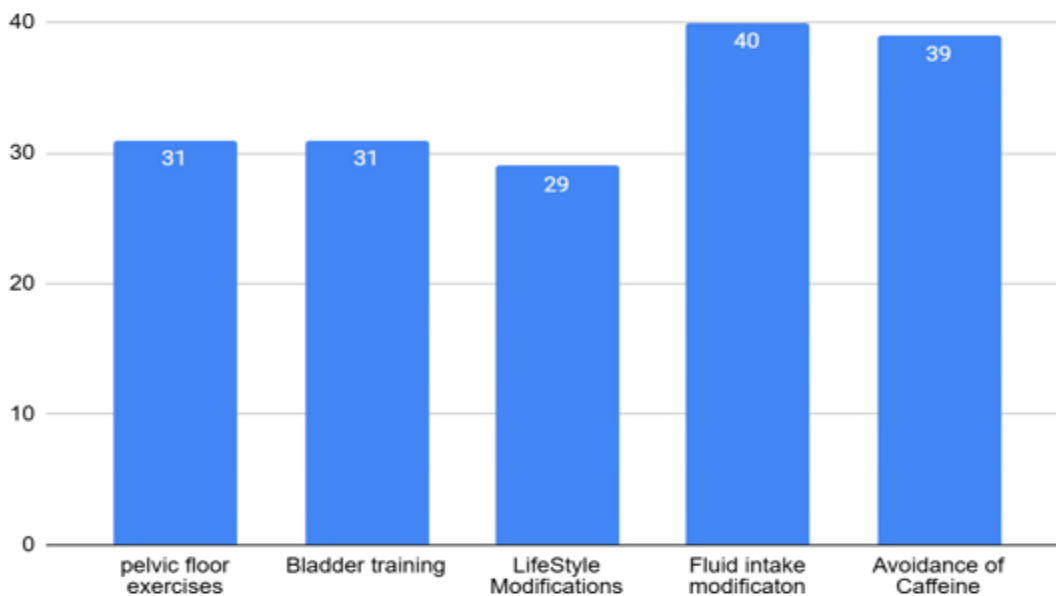


Fig 5

Prescribing anticholinergics, before attending the clinic from primary care (predominant urge in mixed C pure urge) n=31

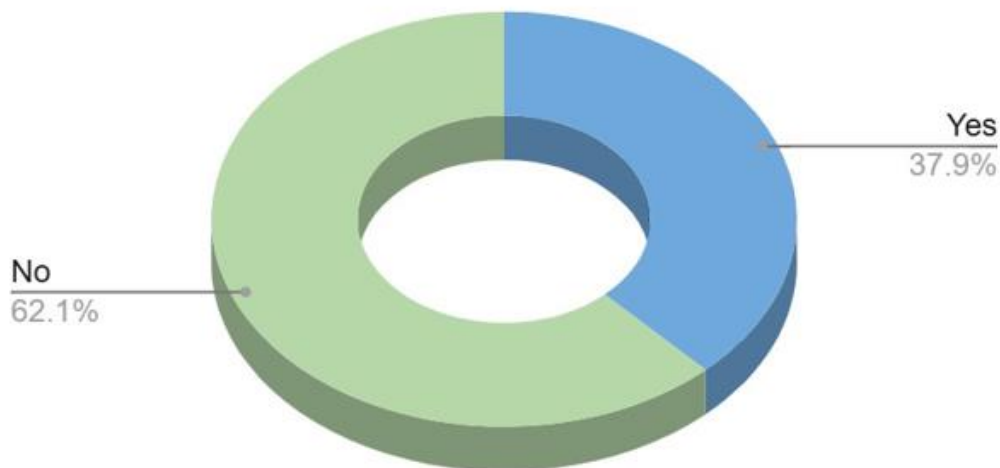


Fig 6

Urodynamic studies n=41

Prior explanation of the procedure 98%

### PRIOR EXPLANATION OF THE PROCEDURE

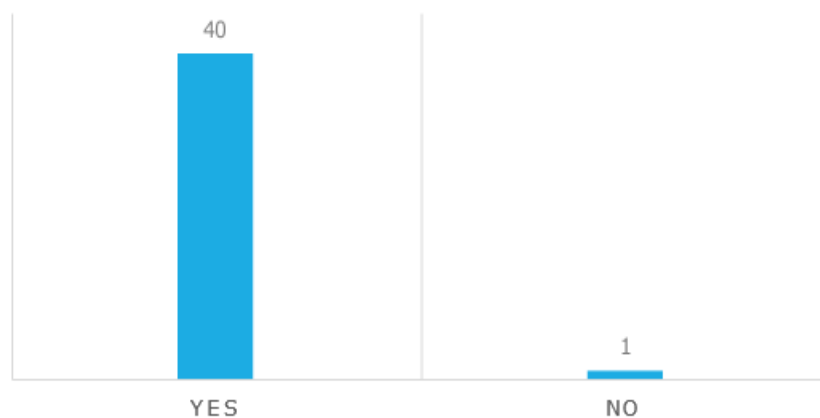


FIG 7

Patient information leaflet of urodynamic study given to 85%

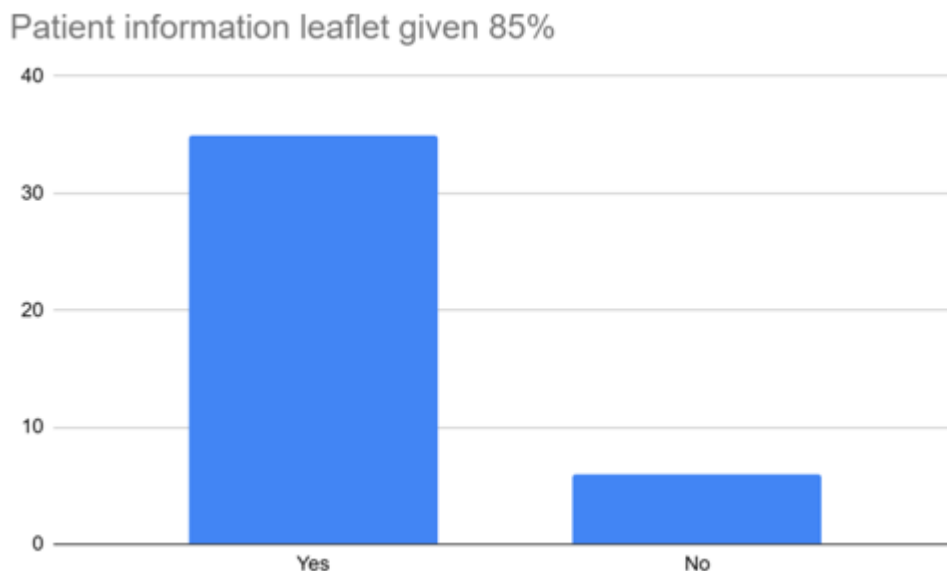


Fig 8

### Results of Urodynamic Studies

Urodynamic studies were done for urge C mixed incontinence not responding to expectant management n=41 (82%)

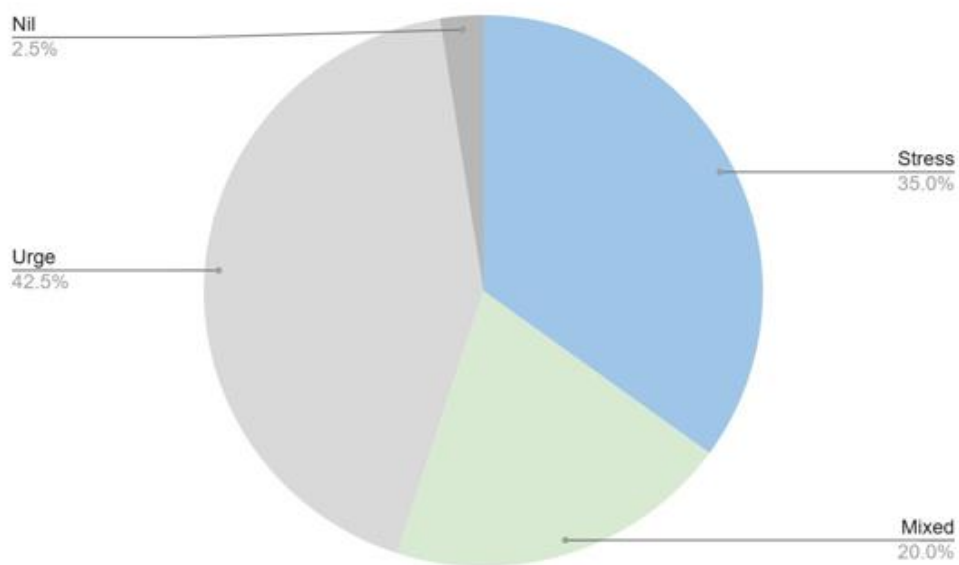


Fig 9

ICIQ (International Consultation on Incontinence Questionnaire) offered to n=45

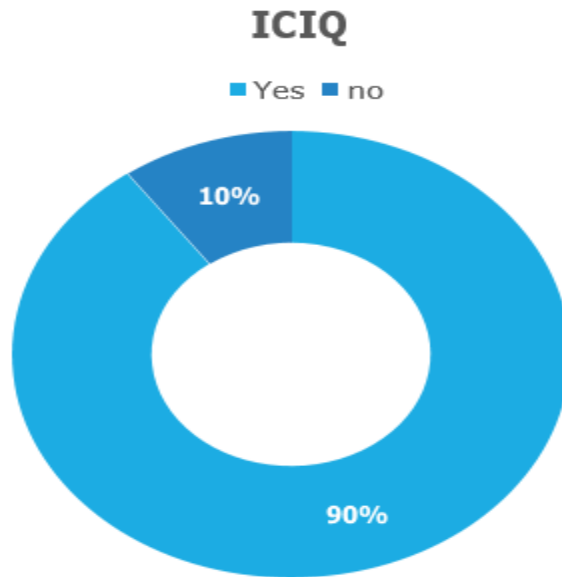


Fig 10

82% Offered shared decision tools

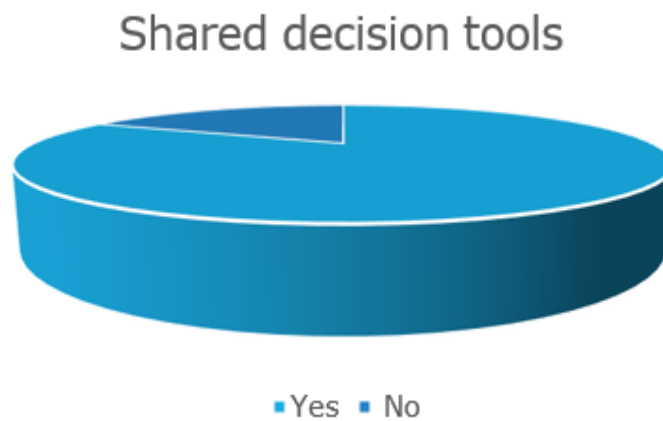


Fig 11

Among the patients who were diagnosed as having urodynamic stress incontinence n=14

- (4/14) 28% underwent Rectus Fascial Sling surgery
- (1/14) 7% underwent Retropubic TVT



- (6/14) 42% underwent Bulkamid Injection
- (1/14) 7% relieved their symptoms with the conservative approach
- (2/14) 14% on the waiting list for Bulkamid injection
- Among the patients who were diagnosed with urge incontinence 16 underwent Botox and 1 PTNS
- C 7 on the WL for Botox

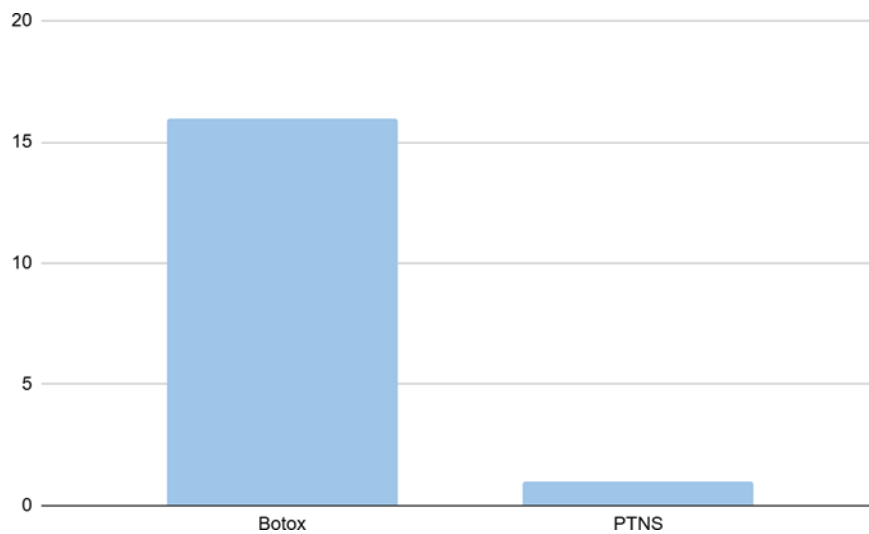


Fig 12

Comparing current results in 2024 with the results that were done in 2015

Standard	2015	2024
Offer urine dipstick for urinary incontinence	98%	96%
Pelvic floor exercises (3 months) for stress & mixed incontinence	82%	82%
Bladder training for (6 weeks) urge & mixed incontinence	10%	75%
Caffeine reduction for urge & mixed incontinence	58%	78%
Fluid intake modification for urinary incontinence	58%	80%
Weight reduction for urinary incontinence	36%	58%
Prescribing anticholinergics, before attending the clinic from primary care (for mixed & urge incontinence)	10%	37%
Offer frequency volume chart (3 days)	26%	78%
Prior explanation of the procedure	94%	98%
Offer urodynamics, urge & mixed incontinence not responding to expectant management	88%	82%
Patient information leaflet given for UDS	86%	85%
Offer urine dipstick before urodynamics	98%	100%
Offer the patient NICE shared decision tool		82%
ICIQ score		90%
Agreement for the procedure		100%
Discussion in MDT		96%
Data-input (BSUG database)		80%

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Fig 13

### **Recommendations**

- BCUHB recommends referral protocol in the management of overactive bladder syndrome in adults in primary care in accordance with NICE NG 123, NICE TA 290 and NICE CG 97 published Feb 2022 which should be followed referral to secondary care.
- This includes categorisation of predominant symptoms (stress urinary incontinence, urge urinary incontinence or mixed), assessment of pelvic floor muscles, urine dipstick +/- mid stream urine specimen, bladder diary, caffeine restriction, fluid management, weight loss if body mass index >30 and bladder training for minimum of 6 weeks.
- Re-audit in 12 months.



Medtronic