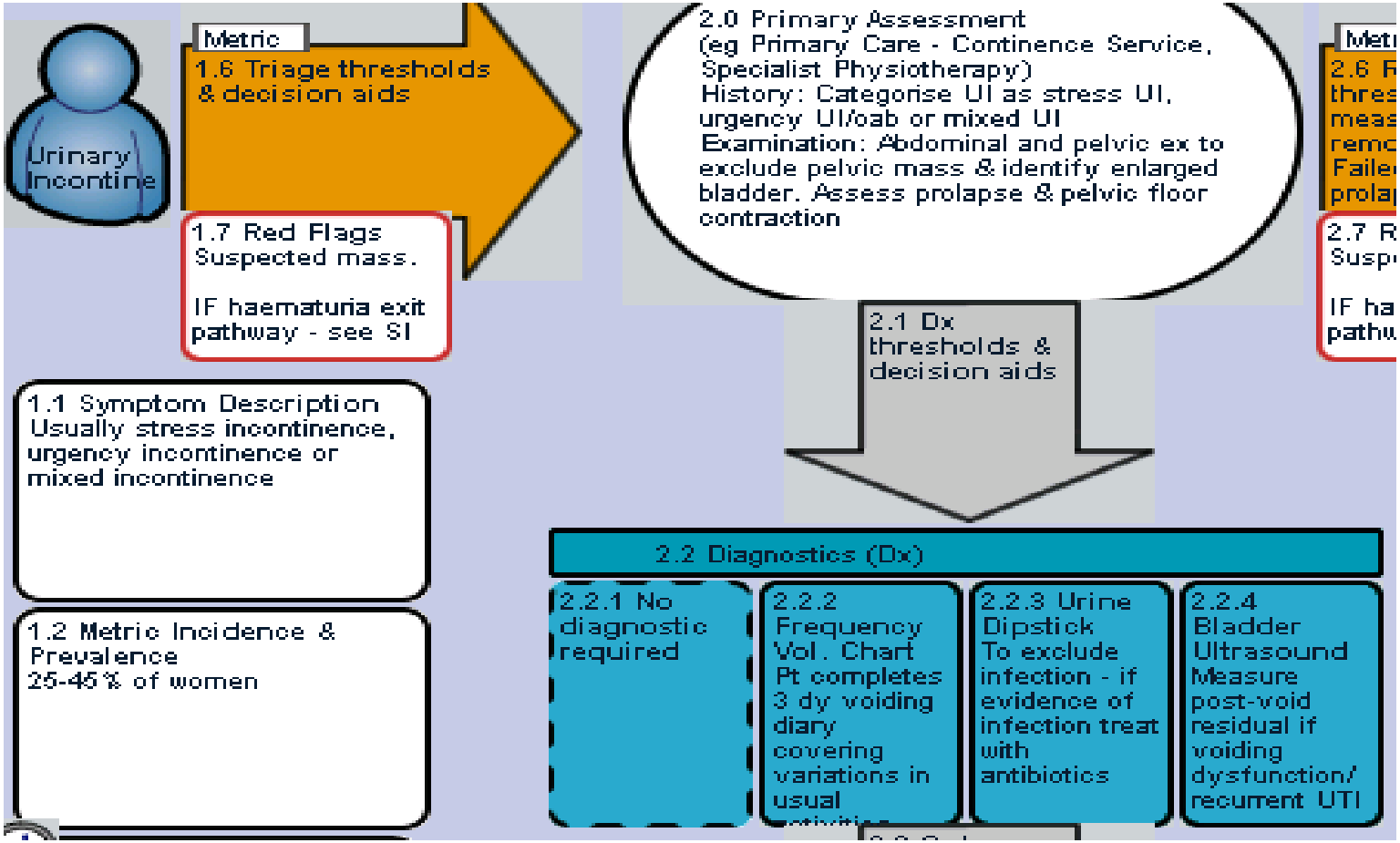
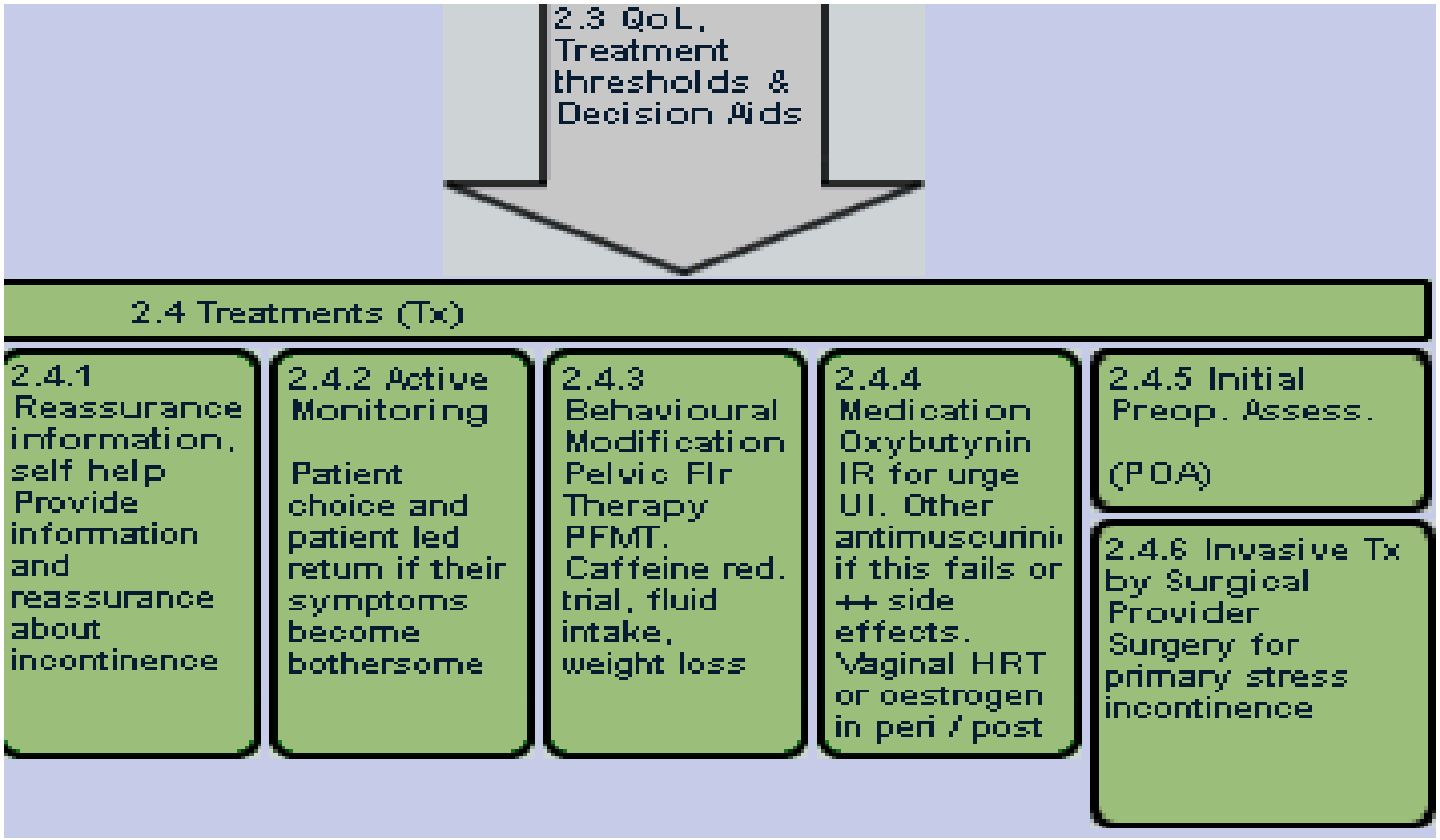
Update on Management of Stress Urinary Incontinence and Refferal Pathway

Mr Roland Morley
Consultant Urologist
Department of Urology

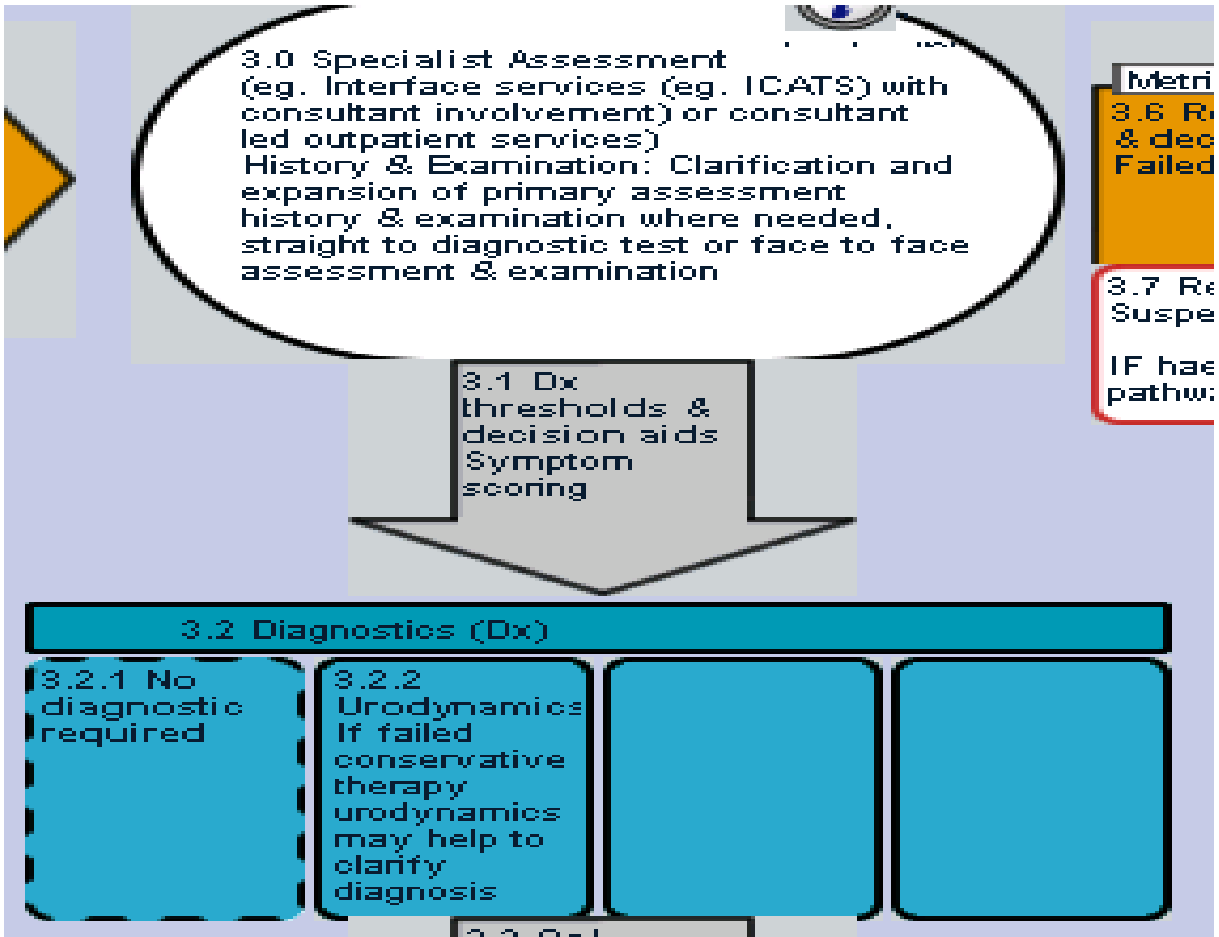
Urinary Incontinence
Primary Care Assessment



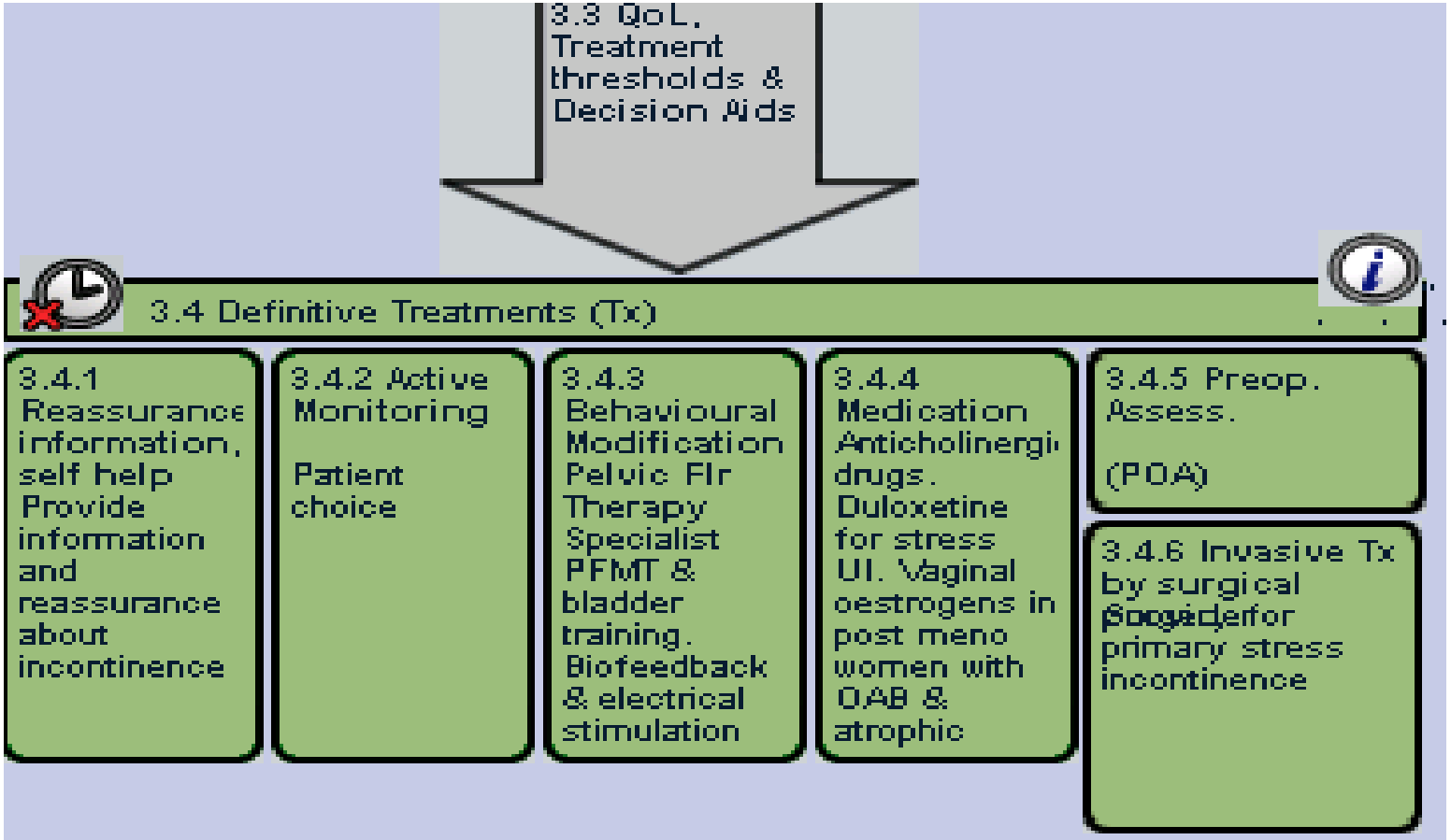
Urinary Incontinence
Primary Care Treatment



Urinary Incontinence
Specialist Assessment



Urinary Incontinence
Specialist Treatment



UI in Primary Care

9 - 47% sufferers seek professional help

25% reported ineffective ways of dealing with the problem

75% unaware that drug treatment is available

46% of UI patients suffer for 5 years or more before presenting to a GP

Further investigation or empirical treatment ?

Empirical therapy

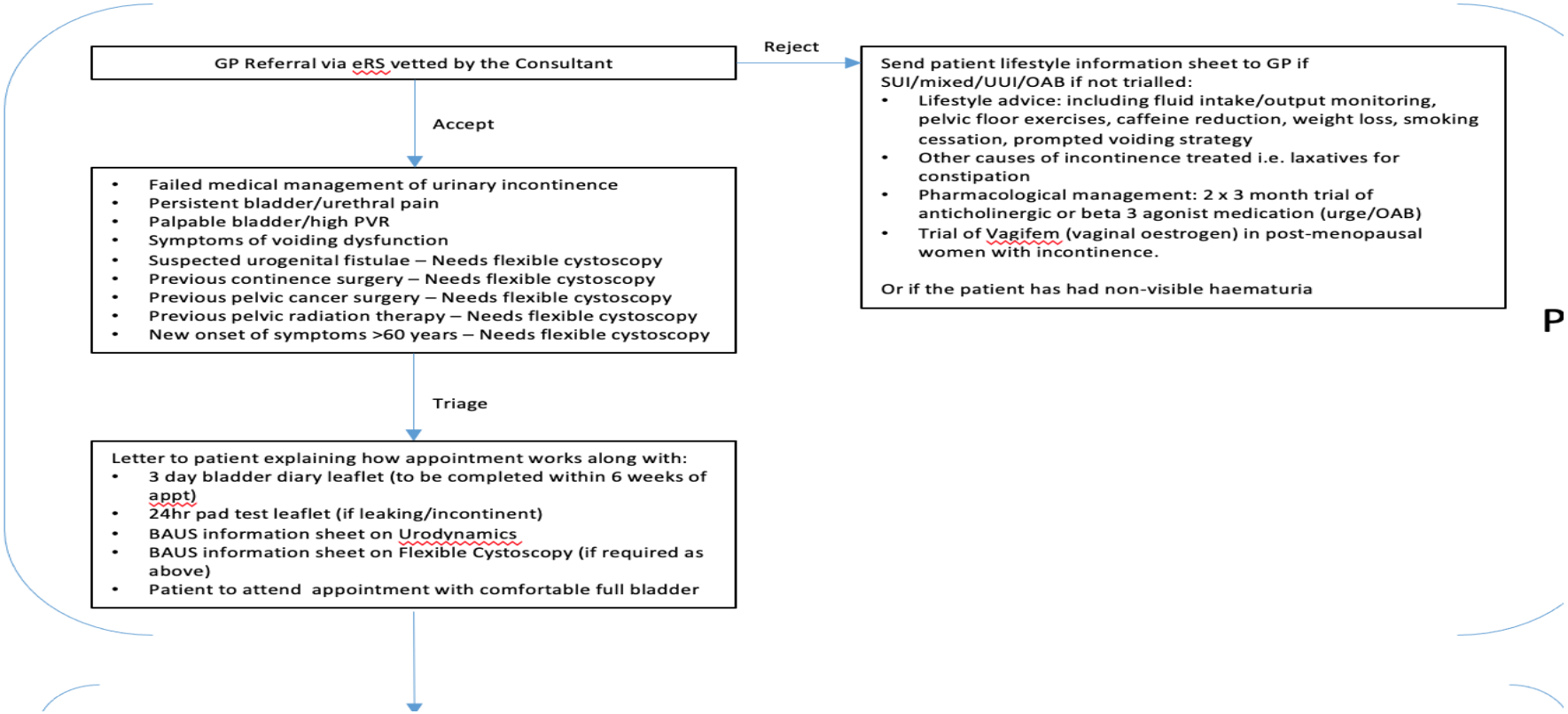
Blood, rec UTIs, suspected neuropathy must be investigate

otherwise empirical therapy is justified

If empirical therapy fails

Cystoscopy is more important than urodynamics

Imperial Pathway



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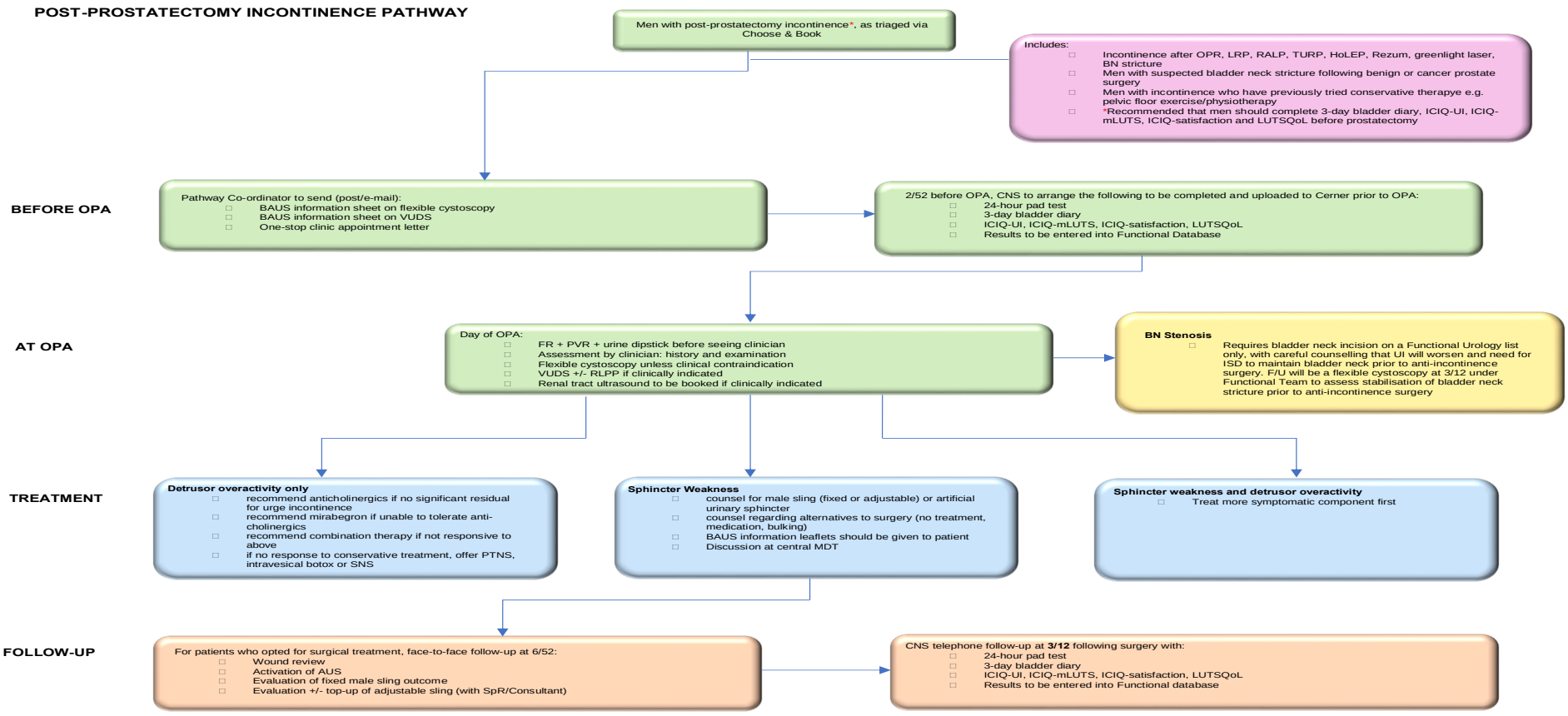
Imperial Pathway

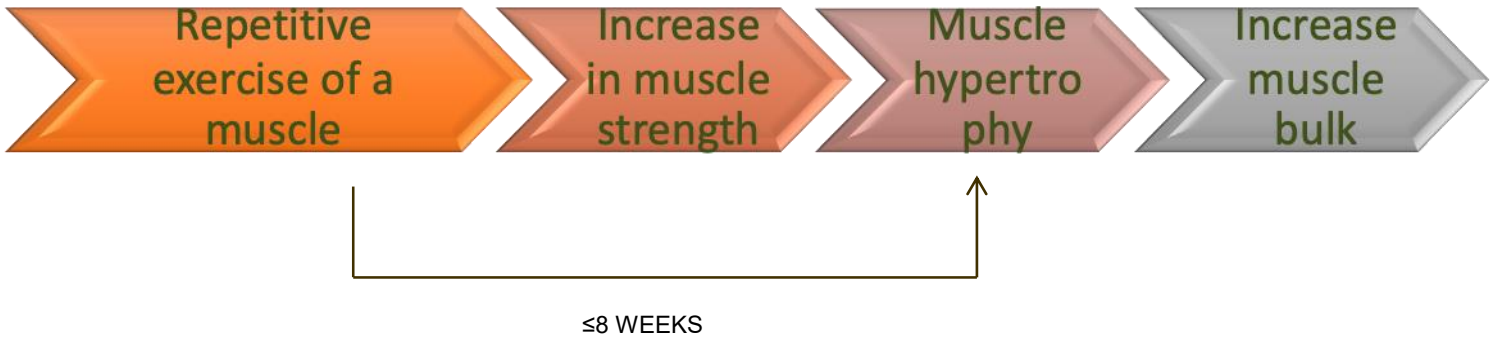


Conservative Management of SUI

SUI Treatment Options

- Medications
- Exercises
- Injection therapy
- Slings
- Retropubic suspension
- Artificial sphincter

Principles of skeletal muscle strengthening



Guidelines

ICS

For morbidly and moderately obese women weight loss is a useful treatment to reduce UI prevalence

[Grade of Recommendation: A]

NICE

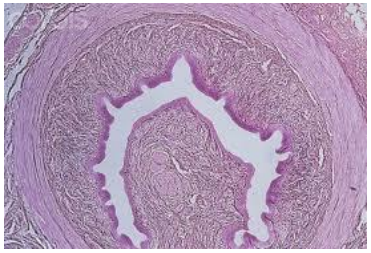
Advise women with UI who have a BMI greater than 30 to lose weight [CG171, Sept 2019]

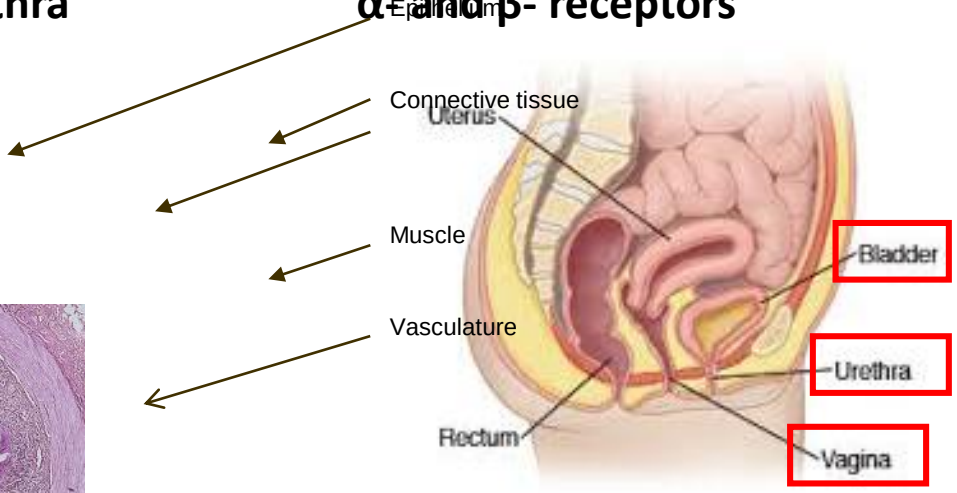
ICS:	International Continence Society
EAU:	European Association of Urology
NICE:	National Institute of Clinical Excellence

Oestrogens

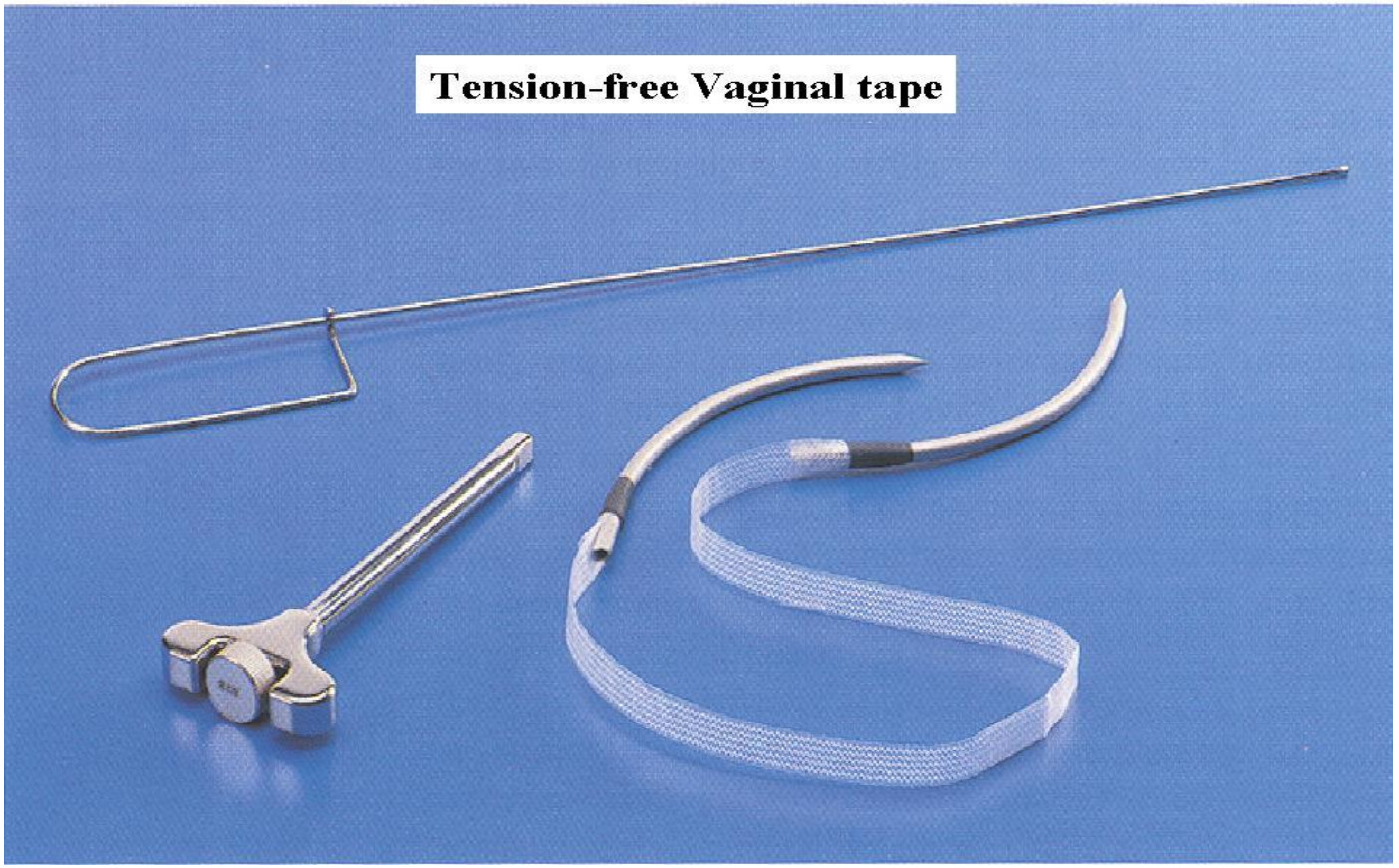
Oestrogen-sensitive urethra

α- and β- receptors





TVT



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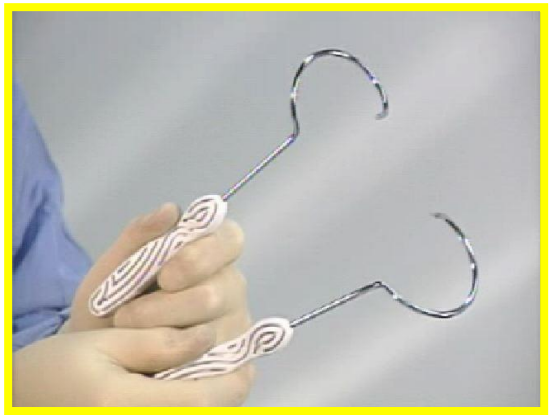
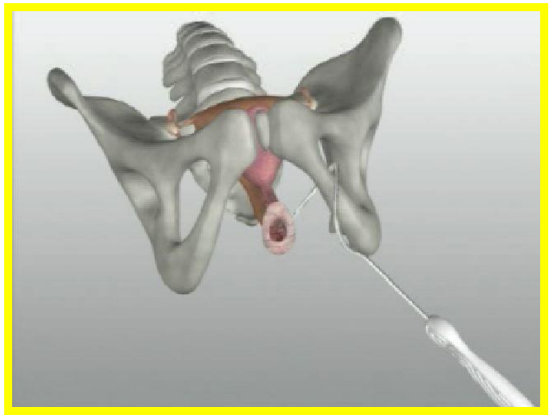
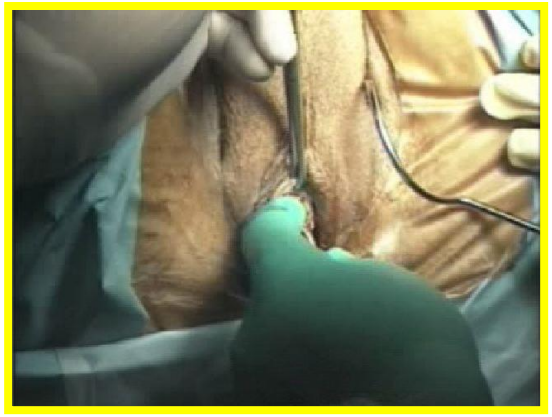
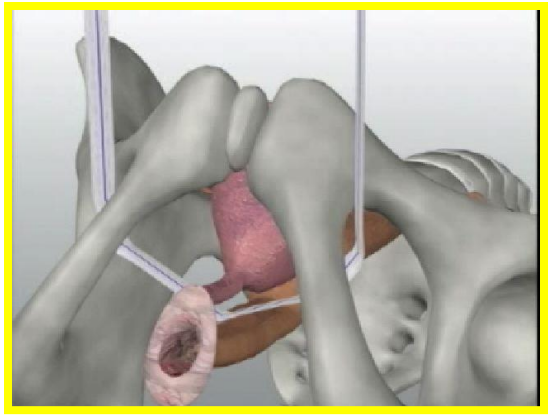
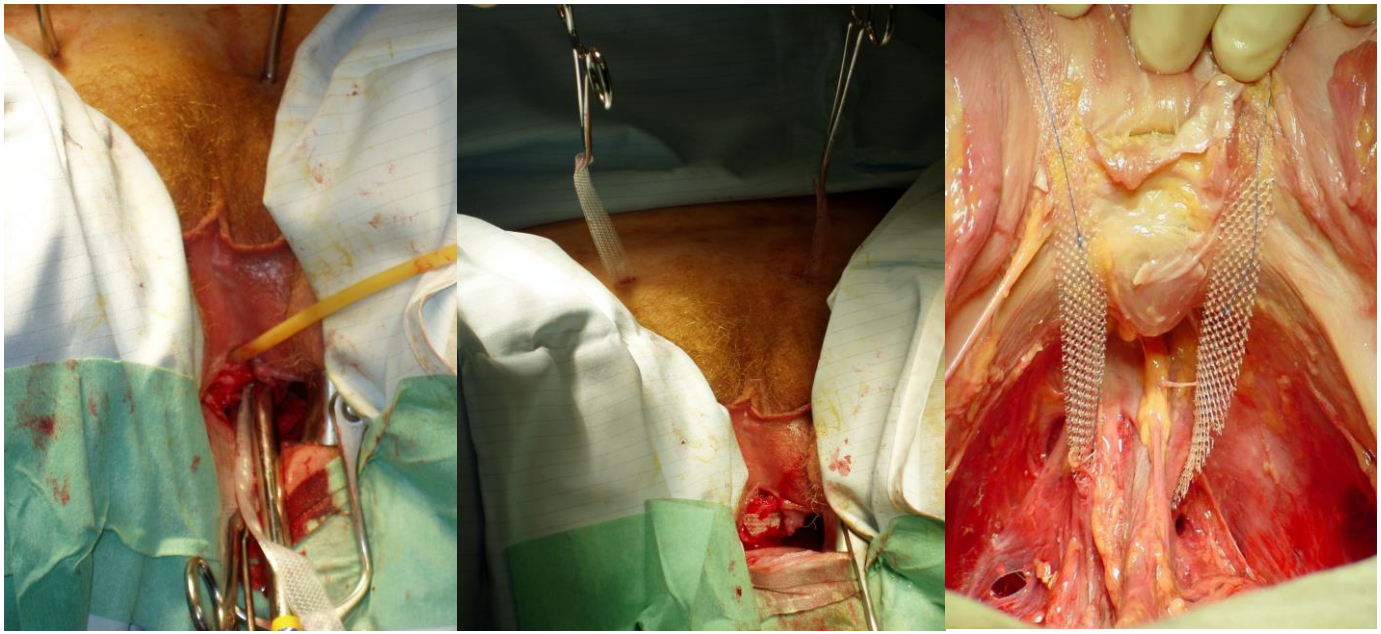




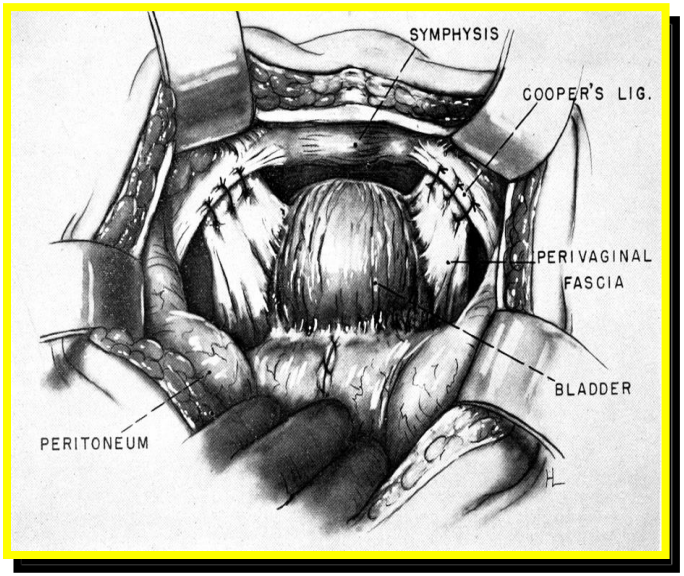


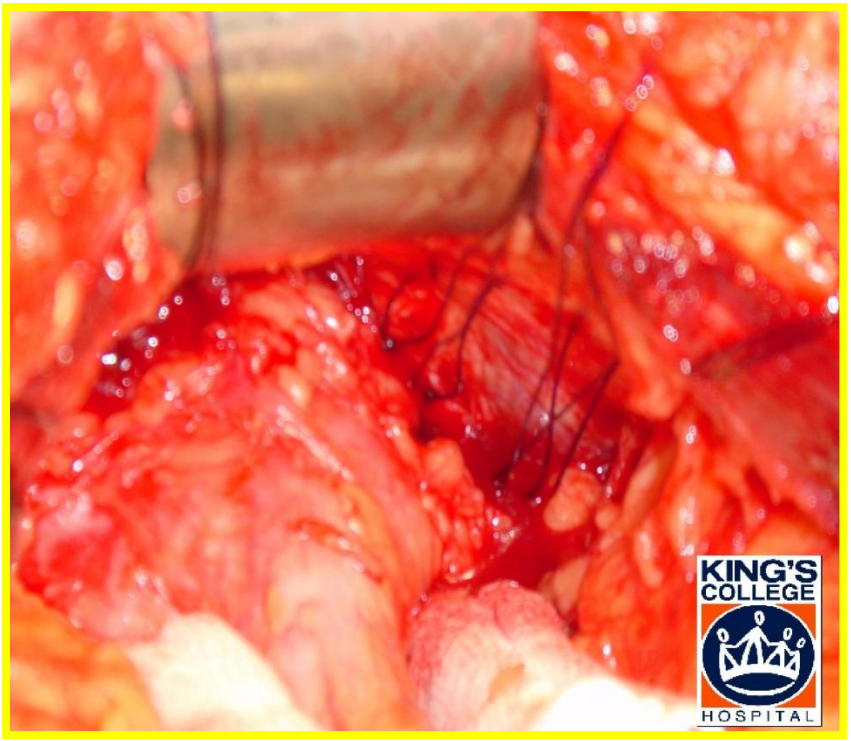


Mid Urethral Slings



Colposuspension





Pubovaginal Sling

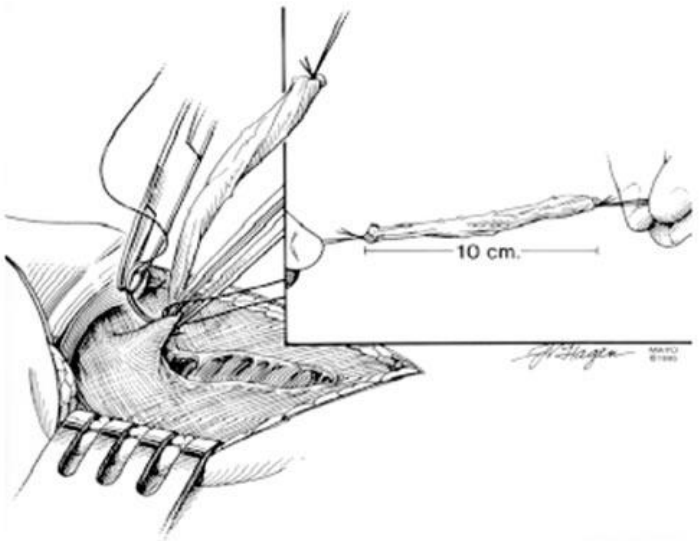
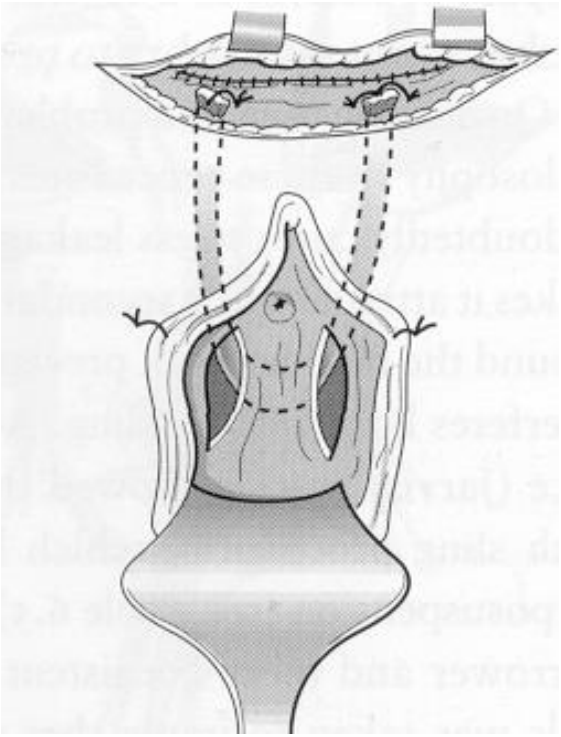


Figure 1 - *A 10 x 2-cm anterior rectus fascial strip is harvested (by permission of Mayo Foundation)*

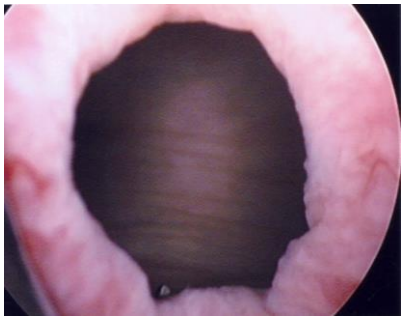


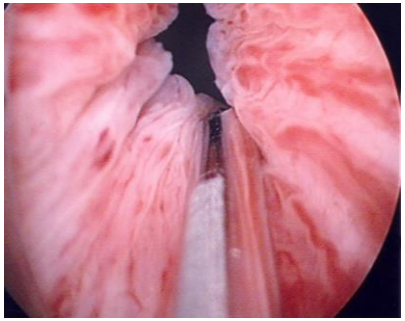
Urethral Bulking

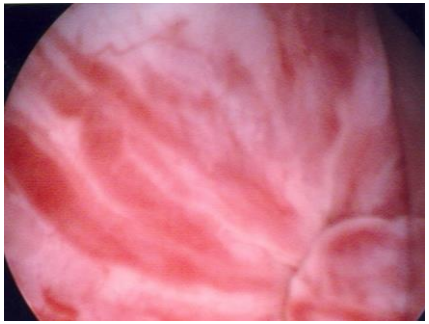
- Peri-urethral injection of bulking agent may provide short-term improvement in symptoms (3 months), but not cure, in women with SUI.

Level 2a evidence

EAU and NICE Guidelines







Cochrane Review Results

- MUS vs Colpo vs AFS similar efficacy LE1
- MUS vs Colpo vs AFS similar complications LE3

Evolution of where we are now with mesh complications!

2008

- Problems with mesh acknowledged but thought to be rare

2011

- Decision reversed and mesh complications acknowledged to be 'not rare'
- During 2005 – 2010 there were 4000 reports of complications including 4 deaths

2012

- Orders to manufacturers to conduct post market surveillance studies

2014

- FDA has proposed to reclassify vaginal mesh from a moderate risk to a high risk device

" ***we will require manufacturers to provide premarket clinical data to demonstrate reasonable assurance of safety"***

Vaginal Mesh: Scotland

- Mesh implants scandal: Legendary activist *Erin Brockovich* joins Sunday Mail campaign for NHS patients left in anguish

March, 2014

- Scottish Health Minister Calls for urgent review

May, 2014

- Shadow Heath Minister accuses the government of failing women

April, 2014

  - Use of meshes for prolapse and incontinence suspended pending review

July 2014

Daily Record

3 Mesh Reviews

European Commission (SCENIHR) - Public Consultation on the preliminary Opinion on the safety of surgical meshes used in urogynaecological surgery 2015

The Scottish Independent Review of the Use, Safety and Efficacy of Transvaginal Mesh Implants in the Treatment of Stress Urinary Incontinence and Pelvic Organ Prolapse in Women 2016

NHS England Mesh Working Group 2017

MHRA review of evidence

(September 2015) – part of Scottish Review

Cochrane Mesh review surgery

(feb 2016)

England

- Hunt review of Mesh

  22nd Feb 2018

- Baroness Cumberlege suspension of mesh

  9th July 2018

- NHS England propose high vigilance on all other procedures

- NICE UI 2019 guidelines

all pts to be offered all treatments

Treatment decision aid for all

Patient Decision Aid

NICE National Institute for Health and Care Excellence

NHS

Surgery for stress urinary incontinence

Patient decision aid

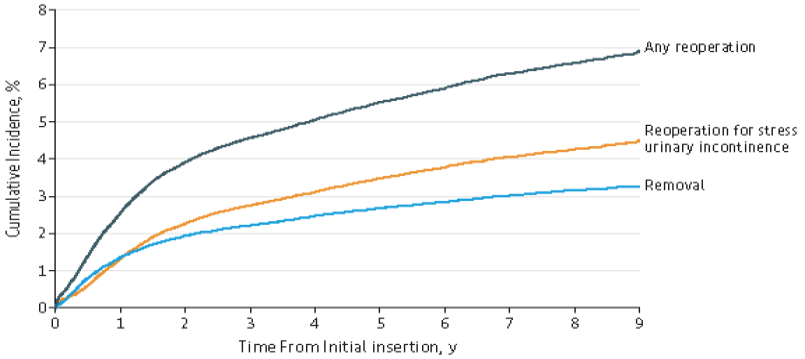
Colposuspension, rectus fascial sling and retropubic mesh sling	
What are the other possible complications? (Continued from the previous page.) The diagrams on page 4 may help make sense of the numbers.	**Wound complications.** In the studies NICE looked at, 1 to 10 in 100 women got these problems during the first year after mesh surgery (so 90 to 99 did not). A few more women than this got these problems after rectus fascial sling surgery than after mesh surgery (but most still did not). NICE didn't find evidence on how likely they are to happen after colposuspension. **Persistent pain in the abdomen or pelvis, or during sex.** Generally in the studies NICE looked at, 1 to 10 in 100 women got these problems (so 90 to 99 did not). The evidence is very limited, and in some studies more women than this got these problems. It isn't possible to say for sure whether these problems are more likely to happen with one of these types of operation than either of the other two. Painkiller medicines can help, but not always. The pain might not trouble you very much, or it might be severe. **Pelvic organ prolapse.** This includes the rectum bulging into the vagina. This might not be troublesome but it can cause discomfort and problems with opening the bowels. In the studies NICE looked at, up to 25 women in 100 got this at some time after colposuspension (so 75 or more did not), but it's not clear how many of them would have had these problems if they hadn't had surgery. Pelvic organ prolapse seems more likely after colposuspension than after mesh surgery but the evidence is very limited. It isn't possible to say for sure whether these problems are more or less likely to happen with mesh surgery compared with rectus fascial sling surgery. **Mesh complications (if you have mesh surgery).** See the next page of this decision aid.

JAMA | Original Investigation

Long-term Rate of Mesh Sling Removal Following Midurethral Mesh Sling Insertion Among Women With Stress Urinary Incontinence

Ipek Gurol-Urganci, PhD; Rebecca S. Geary, PhD; Jil B. Mamza, PhD; Jonathan Duckett, FRCOG; Dina El-Hamamsy, MRCOG; Lucia Dolan, MD; Douglas G. Tincello, MD; Jan van der Meulen, PhD

Figure 2. Mesh Sling Removal, Reoperation for Stress Urinary Incontinence, and Any Reoperation According to Time After Initial Mesh Insertion in 95 057 Women



No. at risk										
Any reoperation	95057	87800	79221	69654	59871	49499	38802	27821	16708	6428
Reoperation for stress urinary incontinence	95057	88963	80661	71050	61170	50628	39730	28535	17148	6590
Removal	95057	88940	80955	71514	61664	51207	40308	29058	17502	6741

- 10-15% chronic pelvic pain
- 10% reoperation rate
- Similar dysparunia rate
- Mesh contracture

Male SUI

The problem

- What's the true incidence of iatrogenic incontinence post surgery?

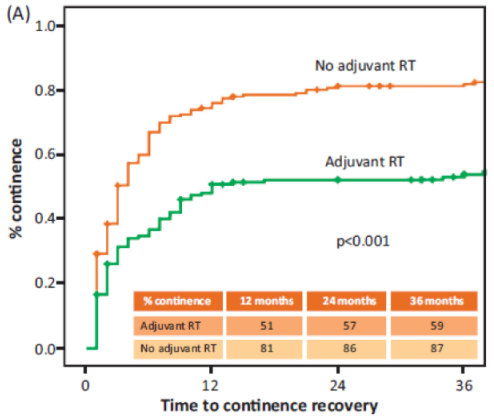
- From pt reporting
  - 88% post-RRP, 42% post-TURP at 3 weeks postop

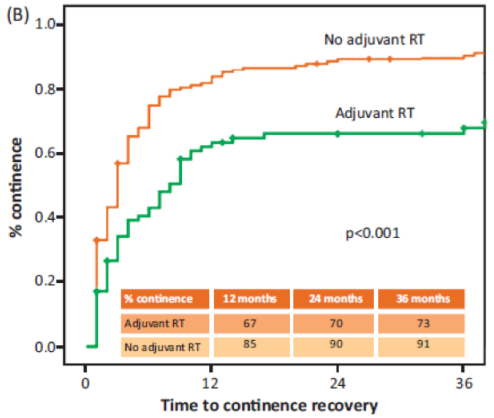
- Post-prostatectomy
  - Lack of standardised definition and reporting
  - Holm et al J Urol 2014
    - Various definitions produced different rates of MSUI
    - PROMS/ pads/ surgeon reporting

Radiotherapy effects

- Adjuvant DXT makes leakage worse
  - –Suardi et al Eur Urol 2014

- At 15 years, no significant difference in incontinence rates between DXT and ORP
  - –Resnick MJ et al NEJM 2013

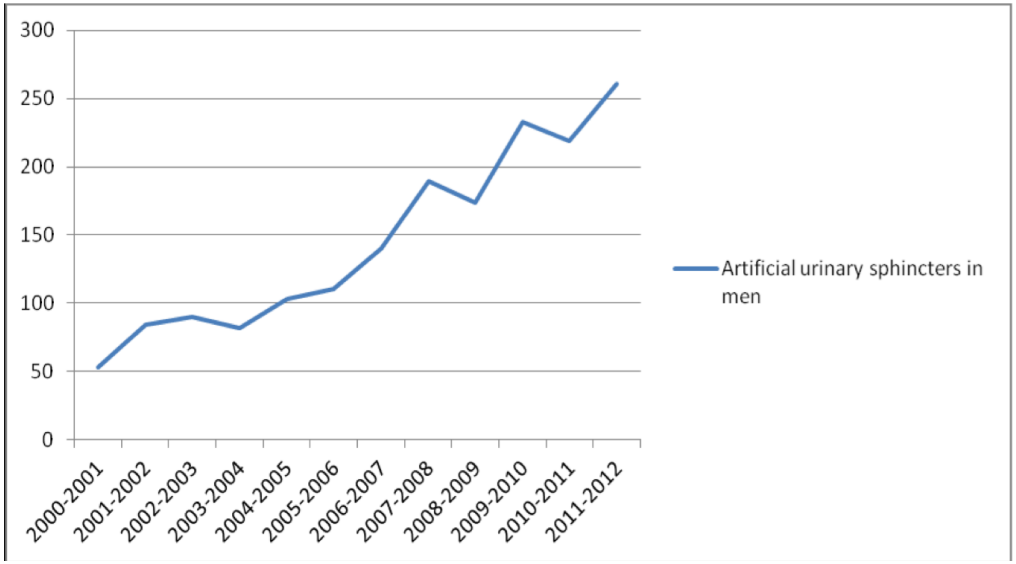




Anti MSUI surgery

- Kim et al J Urol 2013
  - SEER data
  - 6% undergoing surgery for SUI after RRP

- Withington et al BJUi 2014

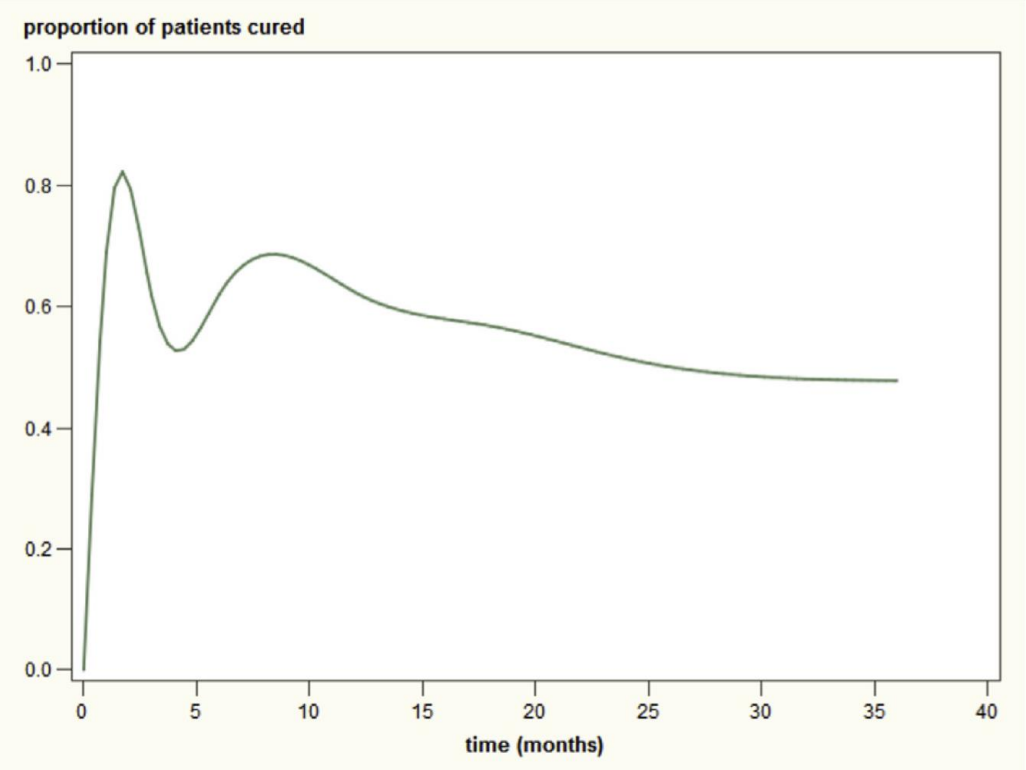


Non-invasive therapy

- Pelvic floor muscle training
  - Evidence problems
    - Definitions, use of preop PFMT, use of biofeedback, non-randomised, non-controlled studies, patient motivation and compliance
    - Preop/postop
    - With/without biofeedback
    - Within a rehabilitation program
  - Meta-analysis Hunter et al *Cochrane Database Sys Rev* 2004
    - 11 studies and 1028 men
    - Achieved continence faster with PFMT but same at one year
  - **Reduces early severity and duration of UI but does not reduce UI rates at one year**

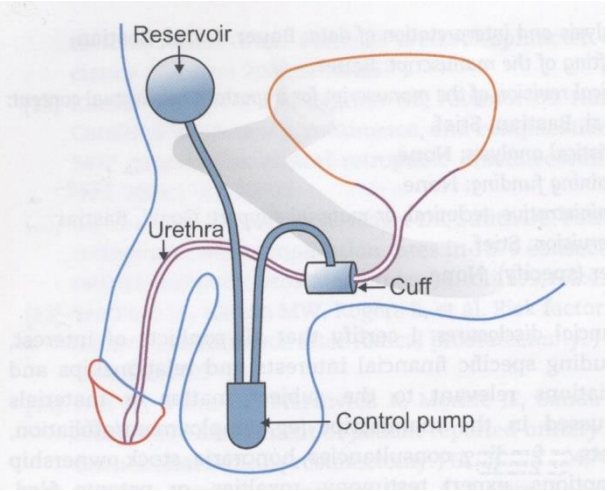
ADVANCE – 3 year f/u

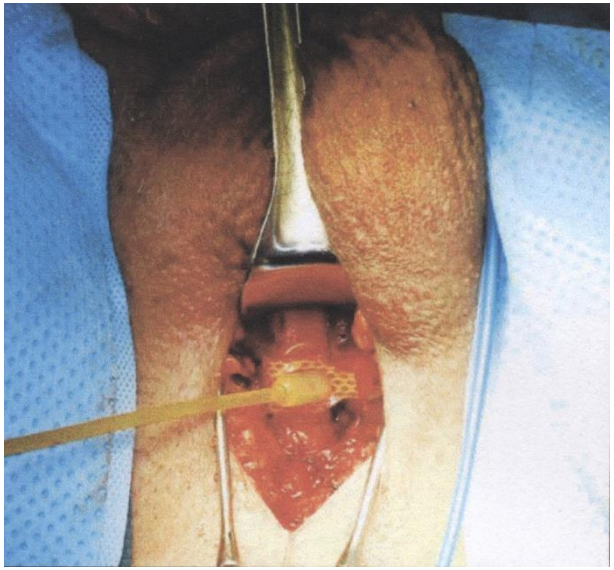
- Kowalik et al NUU epub
  - –60% cured /13% improved /27% failed
- Zuckerman et al Urology 2014
  - –62% dry
- Rehder et al Eur urol 2012
  - –53% cured /24% improved /23% failed



Artificial urinary sphincter

- Remains gold standard
  - Highest long term success rates
  - 80-90% dry
  - High pt satisfaction rates
  - 70-80% continence rates after DXT

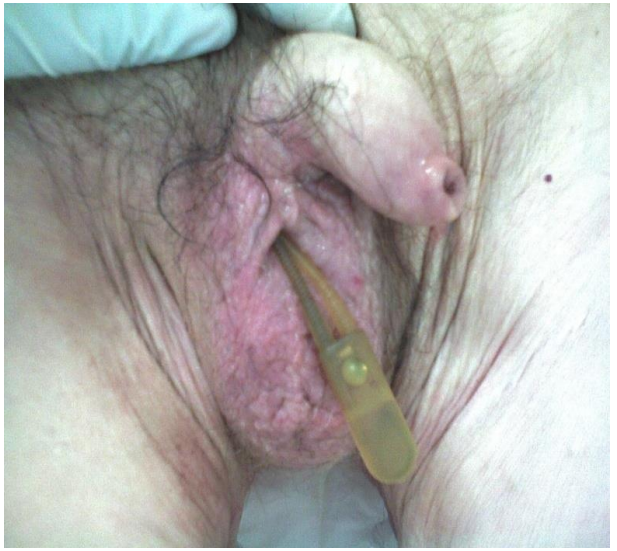


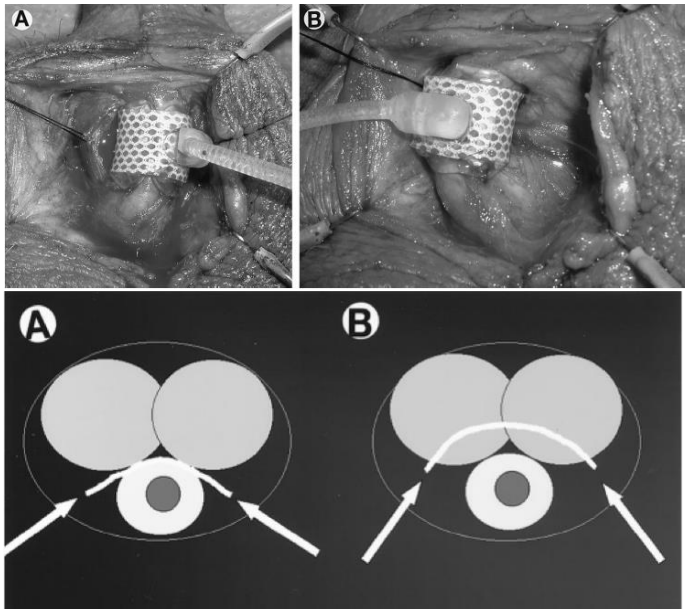


Artificial urinary sphincter

Imperial College Healthcare NHS Trust

- Probs
  - Fiddly
  - High surgical revision rate – mechanical failure, erosion, infection
  - falling with Inhibizone – 1-2% infection
  - 42% to 17% with design changes
  - 60% revision at 10 years
  - Average life span 11 years





Cambridge University Hospitals NHS
NHS Foundation Trust

MASTER
Male synthetic sling versus Artificial urinary Sphincter Trial

NHS
National Institute for Health Research

Are you considering having surgery for urine leakage after your prostate operation?

If you would consider having an operation for your leakage you may be able to take part in a research study called the **MASTER** trial.

The **MASTER** trial is about comparing two operations for urine leakage after prostate surgery in men.

To take part you will need:

- to be male
- to have bothersome urine leakage after a prostate operation
- to have had simple treatments including pelvic floor exercises
- to have persistent symptoms nevertheless

If you would like to find out more, please ask your urologist or nurse about the **MASTER** trial.

For further information and advice about taking part, contact:

Kelly Leonard, Research Nurse

Phone: **01223 348442**

Email: **kelly.leonard@addenbrookes.nhs.uk**

Nikesh Thiruchelvam, Local PI

Phone: **01223 216068**

Email: **nikesh.thiruchelvam@addenbrookes.nhs.uk**

Version 2.1, 15.11.2013

Thankyou


I CALLED THE INCONTINENCE HOTLINE...
THEY ASKED, "CAN YOU HOLD PLEASE?"