PATIENT INFORMATION GUIDE

Waitematā District Health Board

Best Care for Everyone

Treatment Options for Stress Urinary Incontinence

Female Pelvic Medicine and Reconstructive Surgery

PATIENT INFORMATION GUIDE

Treatment Options for Stress Urinary Incontinence

Assessment and treatment for stress urinary incontinence should only be done by a doctor who is credentialed by the hospital where the surgery will be performed, and who is experienced in the procedure. Waitematā DHB has a robust process to credential our health professionals. You can ask your doctor to confirm that they or the surgeon performing your surgery are credentialed.

This guide is designed to help you discuss the treatment options for stress urinary incontinence with your health professional, and to share decisions about your care.

This guide will cover the following:

	PAGE
Understanding the risks and benefits of treatment	4
Your Treatment Journey	5
What is stress urinary incontinence?	6
What are the types of incontinence?	6
What are my treatment options?	8
Symptom management	11
Non-surgical treatment options	12
Surgical treatment options	15
A special note about transvaginal mesh	21
My Personal Plan	22
Questions to consider asking your doctor	24
Post-surgery information	26
Further information and resources	26
Explanation of terms	27

Understanding the risks and benefits of treatment

Be informed

Before making a decision about your health care, it is important that you fully understand the risks and benefits of any medical test, treatment and procedure recommended to you by your doctor.

Asking your doctor or other health care provider questions about your tests and treatment options will help you make better decisions together. These discussions also support the consent process.

You can discuss the different treatment options with your doctor to better consider how these options may apply in your case.

Second opinions

You may consider getting more than one opinion on surgical treatments if you feel this would be of assistance. You can request your doctor to refer you to another specialist.

Your rights

You have a right to be informed about services, treatment options and costs in a clear and open way and be included in decisions and choices about your care.

Support person

You may find it helpful to take a family member or friend for support when discussing your options and the next steps with your doctor.

Pre-surgery Tests

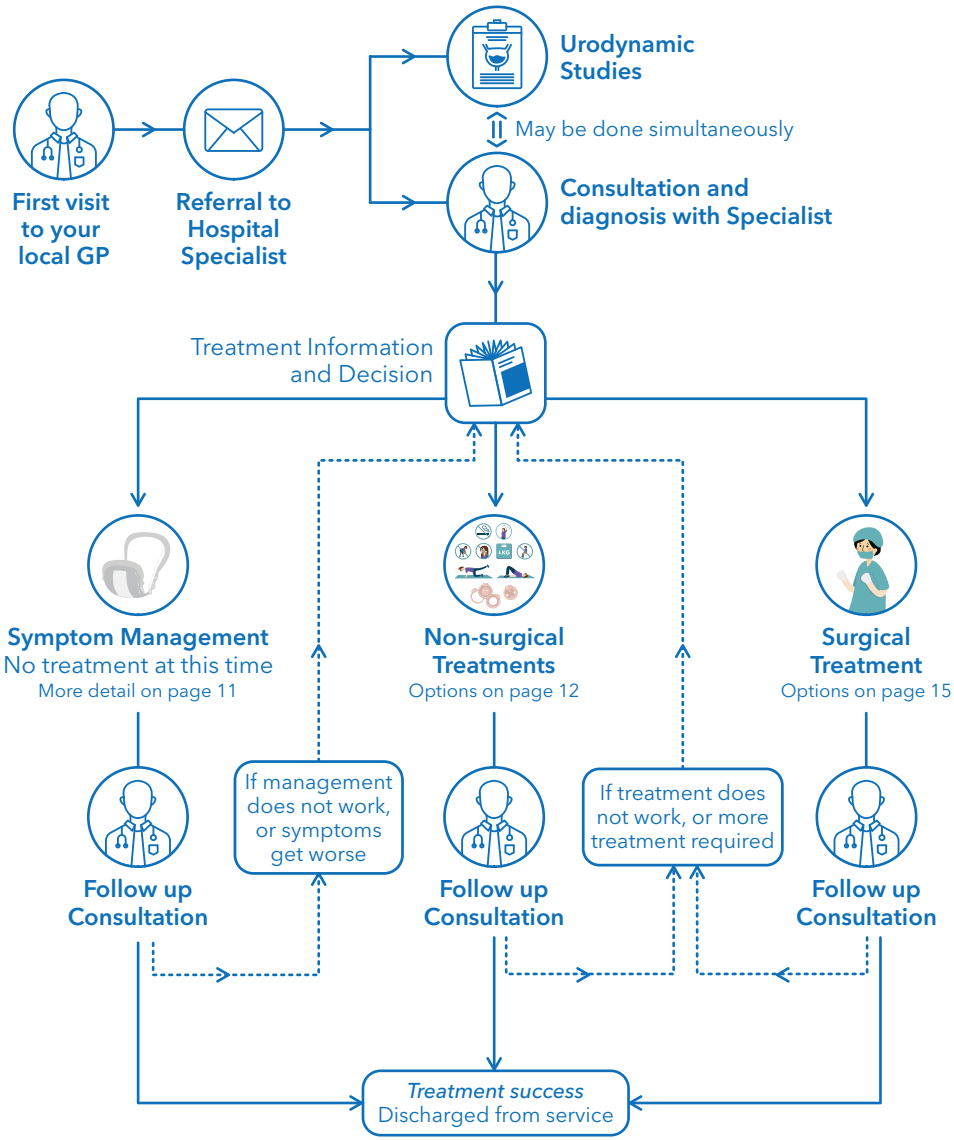
Prior to any surgery you may require urodynamic or other specialised tests. This helps your surgeon determine if you are suitable for continence surgery and the most appropriate surgery, if any, for your symptoms.

Further questions

Some questions you may wish to ask your doctor are contained on page 24 of this patient information guide.

The content of this resource has been informed by Treatment Options for Stress Urinary Incontinence developed by the Australian Commission on Safety and Quality in Health Care. Sydney: ACSQHC; 2018

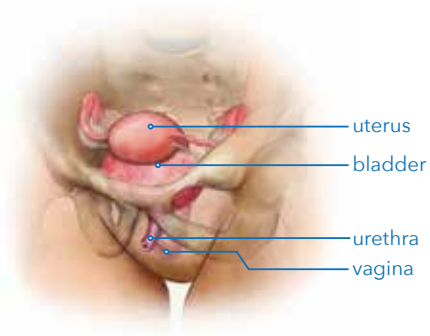
Your Treatment Journey



What is Stress Urinary Incontinence?

Stress urinary incontinence is the accidental or involuntary leaking of urine from the bladder during activities that increase pressure inside the abdomen and push down on the bladder, such as coughing, sneezing, running, or heavy lifting.

Stress urinary incontinence can occur when there is weakness or damage to the bladder neck, urethra, the supporting pevlic floor muscles, or the nerve supply to these organs.



There are several causes of stress urinary incontinence including pregnancy, childbirth (particularly where forceps were needed), weight gain, chronic straining or coughing, aging and pelvic surgery.

What are the types of incontinence?

There are different types of urinary incontinence, each with different causes and treatments. They include:

STRESS INCONTINENCE

When physical movement or activity (such as coughing, sneezing, running or heavy lifting) puts pressure (stress) on your bladder.

URGE INCONTINENCE

When you feel a sudden and strong need to urinate.

MIXED INCONTINENCE

A combination of stress and urge incontinence, where you experience leaking when coughing or sneezing but you also have the urgency to go and cannot get to the toilet in time.

INCONTINENCE ASSOCIATED WITH CHRONIC RETENTION

When the bladder is unable to empty properly and results in frequent leakage of small amounts of urine.

FUNCTIONAL INCONTINENCE

When medications or health problems make it difficult to reach the bathroom in time.

CONTINUOUS INCONTINENCE

Where your bladder cannot store any urine at all, resulting in either passing large amounts of urine constantly, or passing urine occasionally with frequent leaking.

What do I have?

Sometimes women have more than one type of incontinence. Specialised tests will help diagnose the type of incontinence you have and which treatment options are right for you.

These tests may include:

A urodynamic study
A series of tests to evaluate the function of the bladder

A bladder diary

A cystoscopy
A look inside the bladder with a telescope

What are my treatment options?

Stress urinary incontinence can be embarrassing and distressing. Your treatment will depend on how much it affects you, what you feel you can cope with, and your general health.

Non-surgical, conservative measures such as lifestyle changes and pelvic floor exercises are offered as first line treatment options. If they do not work for you, your doctor will discuss what surgical treatment options are appropriate for you. It is your decision if you wish to proceed with surgical treatment.

Your options fall into three categories:

1 Symptom Management

You can choose not to do anything ***at this time***, and manage your symptoms with continence aids such as pads.

2 Non-surgical Treatments

Non-surgical treatments include lifestyle changes, pelvic floor exercises & continence pessaries.

3 Surgical Treatments

Surgical treatments are offered if conservative treatments do not work for you. They include mid-urethral sling, pubovaginal sling, colposuspension & urethral bulking agents.

Each of these options is explained in more detail on the following pages.

The decision you make about which treatment option is best for you will depend on a number of things:

- why you are seeking treatment
- how severe or troublesome your symptoms are
- how well you understand the treatment options
- your lifestyle and values

We recommend that you consult your doctor until you are confident and fully understand your options before going ahead with treatment.

OVERVIEW OF TREATMENT OPTIONS

CONSERVATIVE OPTIONS
Pages 11–14

1 Symptom Management (No Treatment)
Page 11

Absorption Aids/Products
Page 11

2 Non-surgical Treatment
Page 12

First-line Treatment

One or a combination of...

Lifestyle Changes
Page 12

Pelvic Floor Exercises
Page 13

Continence Pessary
Page 14

3 SURGICAL INTERVENTIONS
Pages 15–20

Mid-urethral Sling
Page 16

Native Tissue Sling
Page 18

Colosuspension
Page 19

Urethral Bulking Agent
Page 20

Retropubic Mid-urethral Sling
Page 17

Transobturator Mid-urethral Sling
Page 17

"Don't be afraid to ask questions about all the treatment options, and ask them to tell you what the risks and complications are for each of those options."

– From a woman who has been through this before

"If you can take along a support person when attending appointments, a second set of ears is excellent for a sounding board when making a decision. Also they might hear something you didn't hear in the appointment."

– From a woman who has been through this before

1

Symptom Management (No Treatment)

After speaking with your doctor and considering information about stress urinary incontinence, you may choose not to have any treatment ***at this time***, particularly if your symptoms are mild or very mild.

Choosing to do nothing now, doesn't mean you can't change your decision later on if your situation changes, or you feel you would like to try one of the other treatment options.

Will my incontinence get better if I do nothing?

Your incontinence may improve with time, it may stay the same or it may get worse. Pregnancies, deliveries and menopause may make your incontinence worse.

Absorption Aids

While absorbent products will not reduce the symptoms of stress urinary incontinence, you may find that leakage of urine can be managed with pads and other absorption aids.

See the Continence New Zealand website **www.continence.org.nz/** for more information on incontinence, pelvic floor exercises and continence products.

You may be eligible for a subsidy for continence products. Ask your doctor for more information.

2

Non-surgical Treatment Options

Non-surgical treatments are recommended as the first line of treatment by the Ministry of Health. You may be able to improve some symptoms without surgery. The following treatment options are safe, and a combination of these options may give you good results. However, they may not work for everyone and you may still have symptoms that affect your quality of life.

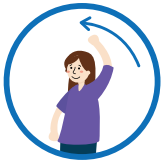
We recommend that most women try conservative treatments for 3–6 months before considering surgical intervention. It is important that you discuss what treatment option is best for you at this time. Your doctor will use page 22 to discuss your personal plan with you.

Lifestyle changes

The lifestyle changes listed to the right are all non-surgical options that should be considered. Each of these options can help increase control over your bladder and contribute to overall good health. For example, if you are overweight, 5-10% weight loss can lead to a significant improvement in stress urinary incontinence for most women.

These changes need consistent effort over the long term, as it takes time for lifestyle changes to work. Support from a health professional, such as a dietitian or your general practitioner, as well as support from family and friends may help in making these lifestyle changes.

Reduce weight


Lower impact exercises

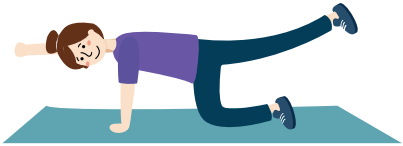

Avoid heavy lifting


Avoid constipation


Avoid chronic coughing


Stop smoking

Pelvic floor exercises



Pelvic floor exercises are intended to strengthen the pelvic floor by actively tightening and lifting the muscles at regular intervals.

Help from a health professional, such as a physiotherapist with a special interest in pelvic floor dysfunction or continence nurse, is important to give instruction and assist in improving the outcomes of these exercises.

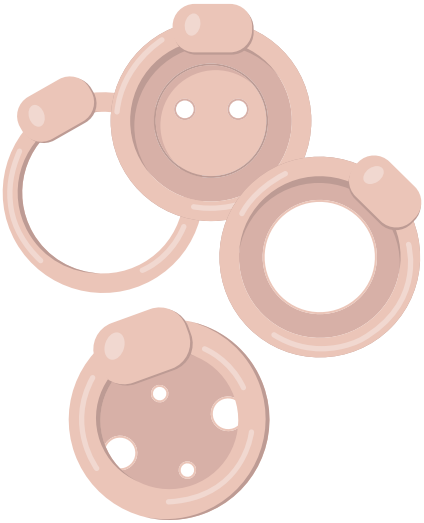
These exercises help increase control over your bladder and can reduce symptoms or the need for surgery. They need to be done correctly and consistently over time; these exercises are not a quick fix.

An internal examination and some specialised tests may be performed to assess whether you are doing the exercises correctly and whether they are helping improve your pelvic floor strength.

If muscles are very weak, there are other additional treatments that may help to improve pelvic floor function. A physiotherapist with a special interest in pelvic floor dysfunction may suggest biofeedback or electrical stimulation. Up to 75% of women show improvement with a pelvic floor exercise program supervised by a pelvic health physiotherapist.

Continence pessary

Your doctor or a physiotherapist with a special interest in pelvic floor dysfunction can fit you with a removable device called a pessary.



This is a soft device inserted into your vagina to compress your urethra against your pubic bone and lift the neck of your bladder.

Pessaries are made from a variety of materials including vinyl, silicone and latex. You may need to try a few types and sizes of pessaries to find what works for you. The material that the pessary is made of may cause a reaction in some women – for example, if you have a latex allergy.

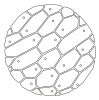
Almost half of women fitted with a pessary find it an acceptable and satisfactory long-term therapy for stress urinary incontinence (ATLAS, 2010).

3
Surgical Treatment Options

If non-surgical treatments do not work for you, and your symptoms are severe and continue to disrupt your life, you might consider surgery. Surgery is intended to improve support of the urethra and bladder so that loss of urine is minimised.

Stress incontinence surgical procedures ***are not*** designed to help with urinary frequency or urgency (rushing to the toilet or flooding before you get there, not being able to hold on). Sometimes they help these symptoms and sometimes they make these symptoms worse.

If you choose to have surgery, the next decision is whether to have a repair using:


your own tissue (native tissue)


synthetic mesh


urethral bulking agents

Surgery for stress urinary incontinence can be performed through either the vagina or abdomen, or both. Your surgeon will work with you to determine the best approach for you.

All surgery has risks including not fixing your stress urinary incontinence, damage to nearby organs, infection and life-threatening bleeding.

There are five surgical treatment options as listed below. Each option is outlined in more detail on the following pages. They are ordered by the most common option we offer at this hospital:

- Mid-Urethral Mesh Sling (two options) – page 16
- Native Tissue Sling – page 18
- Colposuspension – page 19
- Urethral Bulking Agents – page 20

Some surgical options use transvaginal mesh in a mid-urethral sling. The Ministry of Health recommends mid-urethral sling surgery for stress urinary incontinence in routine cases.

Mid-urethral Mesh Sling

Treatment Procedure

On average this is a 30 minute operation* with placement of transvaginal mesh. There are two different approaches for placement of this mesh which are outlined on page 17.

How long will this treatment last?

Success Rate 80–90%

or 8 to 9-in-10 women

Risks / Complications

For 2 to 5 in every 100 women:

- Vaginal exposure of mesh

For 1 in every 100 women:

- Chronic pain from retropubic slings
- Injury to the bladder (no long term complications if recognised during surgery)
- Being unable to urinate

For less than 1 in every 100 women:

- Urethra injury – sling not able to be placed at that time
- Injury to a major blood vessel or the bowel

* Additional 30 minutes required for prep and post surgery.

Recovery Time

Day case or overnight stay in hospital

4 weeks recovery at home with the following milestones

- Driving (2 wks)
- Work (2 wks)
- Normal exercise (4 wks)
- Sexual intercourse (6 wks)

Considerations

This treatment may not be right for you if you have the following history. Please discuss this with your doctor.

- History of radiation
- Previous mesh problems
- History of chronic pelvic pain
- History of autoimmune disease

Comparison of different mesh sling placement approaches:

Retropubic mid-urethral sling

A mesh sling is inserted through an incision in the vagina using a trocar, a needle-like instrument about as wide as a pencil. The mesh is positioned in a U shape under and around the urethra; its ends are guided up between the bladder and the pubic bone (the retropubic space) and out through tiny incisions in the abdomen above the pubic bone.

Transobturator mid-urethral sling

Mesh is inserted through the vagina and the ends are brought out through tiny incisions between the labia and the creases of the thighs.

Special note for mid-urethral slings

Occasionally mid-urethral slings require adjustments, especially if the women is experiencing difficulty passing urine. Adjustment is usually carried out within a week of insertion. It is important that if passing urine becomes difficult that you contact the hospital and inform your surgeon.

Source: Reproduced with permission from Treatment Options for Stress Urinary Incontinence, developed by the Australian Commission on Safety and Quality in Health Care. Sydney: ACSQHC; 2018

Native Tissue Sling

Treatment Procedure

On average this is a 75 minute operation.* This procedure uses your own tissue from your abdomen as as sling. The procedure involves both vaginal and abdominal surgery. Only specialised surgeons can perform this type of surgery.

How long will this treatment last?

Success Rate 80–90%

or 8 to 9-in-10 women

Risks / Complications

For 15 in every 100 women:

- Risk of hernia or haematoma or infection at site of muscle harvest (lower abdomen)

For 8 in every 100 women:

- Difficulty urinating after four weeks – you may need to catheterise yourself temporarily

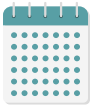
For 5 in every 100 women:

- Ongoing difficulties passing urine that may require surgery

* Additional 30 minutes required for prep and post surgery.

Recovery Time

1-2 night stay in hospital



6 weeks recovery at home with the following milestones

- Driving (2 wks)
- Work (3 wks)
- Normal exercise (6 wks)
- Sexual intercourse (6 wks)

Considerations

This treatment may not be right for you if you have the following history. Please discuss this with your doctor.

- History of underactive bladder

Colposuspension

Treatment Procedure

On average this is a 60-90 minute operation.* This procedure uses your own tissue and sutures (stitches) to re-support the bladder outlet and suspend the vagina from ligaments on the pubic bone. This procedure can be performed by either abdominal or laparoscopic surgery.

How long will this treatment last?

Success Rate 70%

Risks / Complications

Other risks:

- Permanent sutures can cause bone irritation and pain
- Damage to bladder and/or surrounding structures
- Wound infection
- Difficulty emptying bladder requiring self-catheterisation or re-operation and might be difficult to correct
- Increased risk of vaginal prolapse in the future

* Additional 30 minutes required for prep and post surgery.

Recovery Time

1-2 night stay in hospital

4–6 weeks recovery at home with the following milestones

- Driving (3–4 wks)
- Work (3–4 wks)
- Normal exercise (6 wks)
- Sexual intercourse (6 wks)

Considerations

This treatment may not be right for you if you have the following history. Please discuss this with your doctor.

- Extensive previous abdominal surgery

Urethral Bulking Agent

Urethral bulking is usually not a first-line treatment for stress urinary incontinence. It is most commonly used in women where other procedures have not worked and the urethra is fixed or severely scarred. It is a useful option for women who wish to delay considering other types of surgery or who do not wish to have a bigger procedure.

Treatment Procedure
On average this is a 15 minute operation.* This procedure uses an injection of a water-based or silicone gel into the lining of urethra. This is to help strengthen the muscles/walls of the urethra.

How long will this treatment last?

Success Rate 50–60%

or 5 to 6-in-10 women

Risks / Complications

For 24 in every 100 women:

- Incontinence does not always improve and repeat injections may be needed

For less than 1 in every 100 women:

- Temporary urinary retention

In rare cases:

- A localised infection (abscess) can form in the urethral wall where the bulking agent was injected

* Additional 30 minutes required for prep and post surgery.

Recovery Time

Day case in hospital

You can return to your normal routine straight away

Considerations

This treatment may not be right for you if you have the following history. Please discuss this with your doctor.

- History of underactive bladder

A special note about transvaginal mesh

The Ministry of Health has reviewed evidence on the use of transvaginal mesh for stress urinary incontinence. The Ministry has decided that scientific evidence supports using mid-urethral slings for stress urinary incontinence. Mid-urethral slings are different devices to single incision mini-slings. Single incision mid-urethral slings are not used in New Zealand.

Information about these changes can be found on the Ministry of Health's website – https://www.health.govt.nz/our-work/hospitals-and-specialist-care/surgical-mesh

The Ministry of Health has developed information for patients on surgical treatment of stress urinary incontinence with mesh which includes an explanation of levels of risk for those surgical procedures that you may find useful.

My Personal Plan:

Your doctor will use this page to discuss your personal plan with you.

Questions to consider asking your doctor

- What are the chances that my incontinence will get worse if I don't do anything?
- Are you credentialed by the hospital where my surgery will be done to use mesh for treatment of stress urinary incontinence?
- Do you receive payments or other benefits from the manufacture, distribution or implanting of synthetic mesh products?
- If I develop a complication, will you be able to treat me, or will you refer me to another specialist?
- What can I expect to feel after surgery? What specific symptoms should I report to you after the surgery?
- Based on your experience, how long will I have pain after surgery?
- Could I please have a copy of the synthetic mesh product information and the product number at the time of the surgery? This will help in any future treatment of your incontinence.
- Who will perform all, or parts, of my surgery?
- Will there be any people from the mesh company in the operating theatre during my procedure?
- If I develop a complication a long time after the surgery, what should I do?

It can be helpful to take a support person with you when you talk to your doctor. You may wish to ask the doctor to explain some answers again.

A space for your notes, thoughts or questions...

A special note for women following surgery

In addition to the discharge information about post-operative care, here's what you can do if you have any new symptoms.

If you experience an onset of new symptoms that do not improve with rest or simple pain relief within a day, please see:

- Your GP in the first instance
- The Emergency Department (ED) at your local hospital if you feel you require immediate treatment

You should expect the following after your surgery:

Pain should gradually improve over 6 weeks

You can urinate properly (emptying and normal flow) by 1 week

Further Information

The following websites contain helpful information, on occassion websites may change the location of information which can affect the links supplied below. To make sure you have the latest link, you can access them on our Waitematā DHB website here: **www.waitematadhb.govt.nz/healthyliving/fph/resources**

Information and documents from the Ministry of Health on surgical mesh
www.health.govt.nz/our-work/hospitals-and-specialist-care/surgical-mesh

Useful resources for mesh
www.ranzcog.edu.au/Mesh-Resources

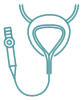
Urogynaecological-related information
www.ugsa.org.au/pages/patient-information.html

Australian Commission on Safety and Quality in Health Care www.safetyandquality.gov.au/our-work/transvaginal-mesh/consumer-forums-to-discuss-transvaginal-mesh

Top Tips for Safe Health Care to help consumers, their families, carers and other support people get the most out of their health care. www.safetyandquality.gov.au/publications/top-tips-for-safer-health-care

Explanation of Terms

Credentialing
A process used by health service organisations to verify the qualifications and experience of a medical practitioner or other clinician to determine their ability to provide safe, high quality health care services within a specific health care setting and role.



Cystoscopy
A look inside the bladder with a telescope.

Fascia
Tissue from the abdomen from which a sling can be made.

Native tissue
Tissue from your own body.

Pelvic floor
The muscles and ligaments at the base of your pelvis that support your womb (uterus), bladder, bladder opening (urethra) and bowel.

Pessary
A removable device that is placed in the vagina to compress your urethra against your pubic bone and lift the neck of your bladder so urine doesn't leak.

Synthetic mesh
Synthetic mesh is a man-made, net-like product that is placed in and attached to your pelvis. Mesh is most commonly made of polypropylene. Other terms used for mesh include tape, ribbon, sling and hammock. Sometimes the term 'mesh kit' is used to refer to packages prepared by manufacturers that include pieces of mesh and anchors.

Urethra
The urine tube from the bladder to the outside of the body.

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