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Update

# What's new in guidance? Urinary incontinence and pelvic organ prolapse (NICE guideline NG 123)

The third version of the National Institute for Health and Care Excellence (NICE) guideline on the management of urinary incontinence (UI) was published in April 2019.[1] It was fast tracked for publication because of the mesh pause implemented in July 2018. This was the first time that NICE made recommendations for the management of pelvic organ prolapse (POP) as well as urinary incontinence. The previous NICE guidelines published in October 2006 and September 2013 focused exclusively on urinary incontinence.

This guideline makes recommendations for the NHS but more importantly for clinicians about the treatment and care of women with pelvic floor problems, both UI and POP. It incorporates the assessment and management of women with pelvic floor dysfunction and also covers complications associated with mesh surgery. The guideline makes proposals for the organisation of specialist services and highlights the importance of working in local, regional and mesh multidisciplinary teams to ensure best care for patients. It also emphasises the importance of collecting data on surgery and surgical complications. The guideline recommends conservative management in the first instance for both UI and POP before consideration of surgery.

For UI, the guideline advises making an assessment and distinguishing between urgency and stress incontinence based on history and examination. Initial conservative treatment should be directed to managing the most bothersome symptoms. Baselines tests such as bladder diaries, assessing residual urine, ruling out infections and symptom scoring using validated questionnaires should all precede any invasive investigations such as urodynamic studies. Though the guideline does not explicitly state this, the initial consultation should be an opportunity for clinicians to educate women about their condition and options going forwards. Providing information leaflets and using visual aids facilitates this process. This is also an opportunity to consider lifestyle modifications including weight loss in addition to fluid and diet advice, treating genitourinary syndrome of the menopause, and emphasising the role of pelvic floor muscle training (PFMT) in the management of urinary incontinence.[2] Failing this, the use of medicines and devices can be considered in specific circumstances, and urodynamic investigations considered when the diagnosis is not clear cut. Only then should women be offered the range of surgical treatment, including the option of doing nothing, making allowance for the fact that urethral bulking may have a lower success rate but may be more acceptable to patients due to lower risk profile. The synthetic sling remains on pause except in exceptional circumstances; colposuspension and fascial slings have risks that are different to the synthetic sling but these risks are not insignificant.

For POP, the initial consultation is directed to assessment of symptoms in the four domains of pelvic floor function including vaginal, urinary, bowel and sexual. In addition, examination to determine the compartment affected by prolapse, assessment of atrophy, examination of pelvic floor strength and ruling out pelvic masses should be undertaken. Women with pain, urinary symptoms and obstructive defecation may need further investigation before being offered treatment options for their POP. As with UI, lifestyle modifications including weight loss, and treating constipation and atrophy should be considered. The options are based on women's preferences, age and desire for childbearing as well as comorbidities and previous surgery. For early stage prolapse, PFMT should be offered, though the evidence of benefit is far less compelling.[3] All women should be offered pessaries if symptomatic and advised that more than one fitting may be required as well as discussing the effects on sexual function, the complications including vaginal discharge bleeding and difficulty removing the pessary as well as the need to remove them every 6 months to prevent serious complications. If considering surgery, the benefits and risks of all surgical options, realistic expectations of what can be achieved from surgery, lack of long-term data on outcomes and the impact on sexual function should all be considered. The possibility of worsening of both incontinence and sexual function should be discussed as well as the role of intraoperative prolapse assessment in deciding the most appropriate surgical procedure when this is uncertain. The guideline highlights that when the patients chosen surgical procedure is not available with the treating clinician, consideration should be given to referring the

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patient to an alternative surgeon/unit where this can be offered.

When mesh is being used as part of a surgical procedure it should be ensured that the patient is informed of the permanency of mesh and risks unique to the use of mesh. The details of mesh usage are to be entered into a registry and the patient should be given details of the name of manufacturer and date of insertion of the mesh.

Studies have shown that women will trade a higher risk of complications for lower success of surgery when choosing the type of surgery they opt for, hence a detailed discussion of the pros and cons of all surgical procedures should take place to ensure Montgomery compliance when consenting patients.

Another addition to NG123 not seen in previous versions of the guideline was the linkage to patient decision aids (PDA) to assist patients when making difficult decisions in choosing procedures where one of the options could involve the use of mesh. Three PDA were launched with NG123 which considered in detail the options for uterine prolapse, vaginal vault prolapse and stress urinary incontinence. PDA have been shown in other areas of medicine to be beneficial in reducing decisional conflict.[4-6] Clinicians need to follow the advice provided by NICE on how to use these PDA in a clinical setting.

In the past, a guideline was seen as just that, a piece of advice which suggests how to treat a condition. However, in this ever-increasing era of litigation, the goalposts have changed. Rightly or wrongly, any variation in practice from the guidance is viewed as substandard care. It is therefore imperative that clinicians practicing in this area of gynaecology are familiar with the guidelines and follow this.

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