Brighton and Sussex University Hospitals NHS Trust

Management of Patients Admitted for Urinary Incontinence Surgery

Gynaecology Protocol: GP013

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Guideline Reviewer:	Vuivun Wong
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Contents

Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol.

Scope

This guideline applies to: All women attending for urinary incontinence surgery

Responsibilities

Nursing staff & Gynaecologists

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

Management:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff
- To ensure the protocol is available to service users on request

1 Urinary Incontinence

Urinary incontinence is a major health issue.15-30% of women over the age of 65 and up to 50% of nursing home residents have urinary incontinence.

1.1 Urinary incontinence is consistently associated with adverse effects on quality of life for patients. Adverse effects include embarrassment, social isolation, loneliness and sadness. It can also lead to depression. Clinicians should be aware of and take into consideration the potentially serious adverse effect that even mild urinary incontinence has on a patient's quality of life.

1.2 Stress incontinence is involuntary urine loss associated with an increase in the intra- abdominal pressure for example, during coughing, sneezing or physical activity. Stress urinary incontinence is the Urodynamic diagnosis which was previously known as genuine stress incontinence. NICE guidelines on the management of urinary incontinence. http://publications.nice.org.uk/urinary-incontinence-cg171

1.3 Postoperative urinary retention can be a significant problem after incontinence surgery. Early recognition and management is recommended to avoid impaired bladder function, urinary tract infections, and disruption of surgical repair.

1.4 The recent minimal invasive surgical procedures for stress urinary incontinence are:-

- **Two incision sub urethral sling system**
  1- Retro pubic mid- urethral tape procedures; tension free vaginal tape (TVT)
  2- Transobturator tape procedures (TOT)

- **Autologous rectus fascial sling**

- **Urethral bulking agents (Bulkamid)**

1.5 The above surgical procedures can be done under general anaesthesia (GA), Spinal anaesthesia or local anaesthetic infiltration (LA) either with or without sedation and all of them are day case procedures.

1.6 The objective assessment of the severity and the impact of the urinary incontinence on the quality of life is essential, so, every patient should complete a validated urinary questionnaire (ICIQ-UI) before the surgery.

1.7 Six weeks after the surgery this should be repeated, together with a patient satisfaction questionnaire as a part of ongoing prospective audit.

1.8 This guideline should be read in conjunction with other guidelines relating to the management of patients admitted for operative procedures, such as thromboprophylaxis and consent guidelines.

1.9 These guidelines are applicable to patients admitted to gynaecology ward or those fulfilling the criteria for day surgery unit (DSU) admission.

2 Pre-Operative Management

2.1 All cases admitted for TOT, TVT, autologous sling or Bulkamid do not require Rectal Enema or Perineal Shaving.

2.2 All cases admitted for these operations need to be fasted from midnight.

2.3 The patient will have the routine observation, routine checks and the routine enhanced recovery programme (ERP) whether she is on gynaecology ward or on the day surgery unit.

2.4 Enhanced Recovery Programme. http://nww.bsuh.nhs.uk/the-trust/safety-and-quality/safety/initiatives/enhanced-recovery-programme/

2.5 The patient will be seen by the consultant for preoperative counselling and consenting

3 Post-Operative Bladder Care

3.1 Most of the vaginal mid urethral sling operations do not have a Foley's catheter or a vaginal pack inserted unless stated clearly in the post-operative care plan.

3.2 Ensure patient passes urine before discharge

3.3 Assess for symptoms of urinary retention or incomplete bladder emptying

- Urinary frequency
- Slow stream
- Pain
- Incomplete emptying
- Incontinence
- Inability to void

3.4 All women after urinary incontinence surgery or after removal of self-retaining catheter should be encouraged to void within 4 hours and reviewed at 4 hours to ensure complete bladder emptying.

3.5 Fluid balance chart is essential with measured voids

3.6 All women require assessment of post void residual (PVR) by 4 hours of return from theatre the PVR should be measured within 10–15 minutes of the void, in order to ensure accuracy

4 Management of PVR/TWOC :

4.1 Passing >200ml and having a residual volume <100ml twice should be considered normal. The residual volume <100ml twice should ebe considered normal. The residual urine is better checked after each void, to avoid missing high residual volume. If the residual volume is high >400mls it is better to empty the bladder with an in/out cathertre once to avoid over-distention. Otherwise a self-retaining catheter should be inserted.

4.2 If voided volumes are not increasing and residuals more than voided / If unable to pass urine OR residuals > 150 mL 4 -6 hours post operatively; insert self-retaining foleys catheter (with flip flow valve preferably). Record amount of urine drained and plan discharge with catheter.

4.3 Evaluate signs of urinary tract infection, check urine dipstick and start of antibiotics if warranted after a failed TWOC.

4.4 These patients should be seen either on the gynaecology Ward or VLH, according to the patient' preference, to try passing urine without a catheter (TWC) 48 hours later. Follow same guidelines for TWOC as above.

4.5 If the voiding difficulty continues after 48 hours, then the catheter with valve should be left in for another week.

4.6 Alternatively, the patient could be taught intermittent clean self-catheterisation (ICSC) by the urologynaecology specialist nurse at BSUH and will follow up patients.

4.7 Keep the surgeon informed.

5 Post-Operative Prescription and Follow-Up

5.1 Those patients who had TOT, TVTs or Bulkamid can eat & drink once they are fully conscious and well enough either on gynaecology ward or DSU.

5.2 It is acceptable for the patients to have a mild blood loss following the procedure (similar to what would be expected at the end of a period) as vaginal pack was not used.

5.3 The patient can go home once she passes urine and feels well enough to go home. If the patient is on gynaecology ward and there is an indication to keep her overnight, inform the surgeon please.

5.4 Regular analgesia for 48 hours then PRN for 5 days.

5.5 Follow up in Urogynecology clinic as planned at the time of surgery

6 References

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