

# *The trend and care pathway for management of stress urinary incontinence*



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## Urinary incontinence

- (1) stress urinary incontinence(SUI), loss of urine occurring as a result of an increase in intra-abdominal pressure due to effort or exertion or on sneezing or coughing;
- (2) urge urinary incontinence (UUI),involuntary leakage arising for no apparent reason and associated with urgency
- (3) mixed urinary incontinence (MUI), denoting the combination of both SUI and UUI.

# SUI PREVALENCE

- prevalence of each type (**SUI**,UUI,MUI) of urinary incontinence in noninstitutionalized women is 49%, 21% and 29%

S. Hunskar, K. Burgio, A. Diokno, A.R. Herzog, K. Hjälmås, M.C. Lapitan, Epidemiology and natural history of urinary incontinence in women, Urology 62 (Suppl. 1) (2003) 16–23

- Prevalence of SUI range between **10% and 40%** of the post-menopausal female population .

# Pathogenesis of SUI

- Urinary continence : synergy between the structures that constitute the pelvic floor, the sympathetic and parasympathetic nervous systems, and the motor fibres of the pudendal nerves.
- SUI Factors : age, parity (especially with vaginal delivery) and obesity, as they are associated with a **weakening of the pelvic floor support** structures, resulting in urethral hypermobility

# Guideline of guidelines: urinary incontinence in women

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*European Association of Urology (EAU) 2019*

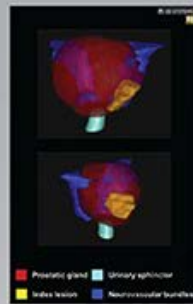


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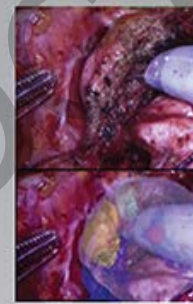
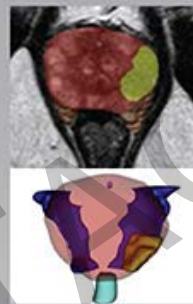
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- The STAR-CAP Prognostic System for Predicting Prostate Cancer by C. Würrschimmel et al
- OLIGOPELVIS: Salvage treatment for Prostate Cancer Relapses by S. Supiot et al
- Prevalence of Male Only Expert Panels at Urological Meetings by J. Teoh et al
- European Urology Commitment to Gender Equity and Diversity by S. Psutka
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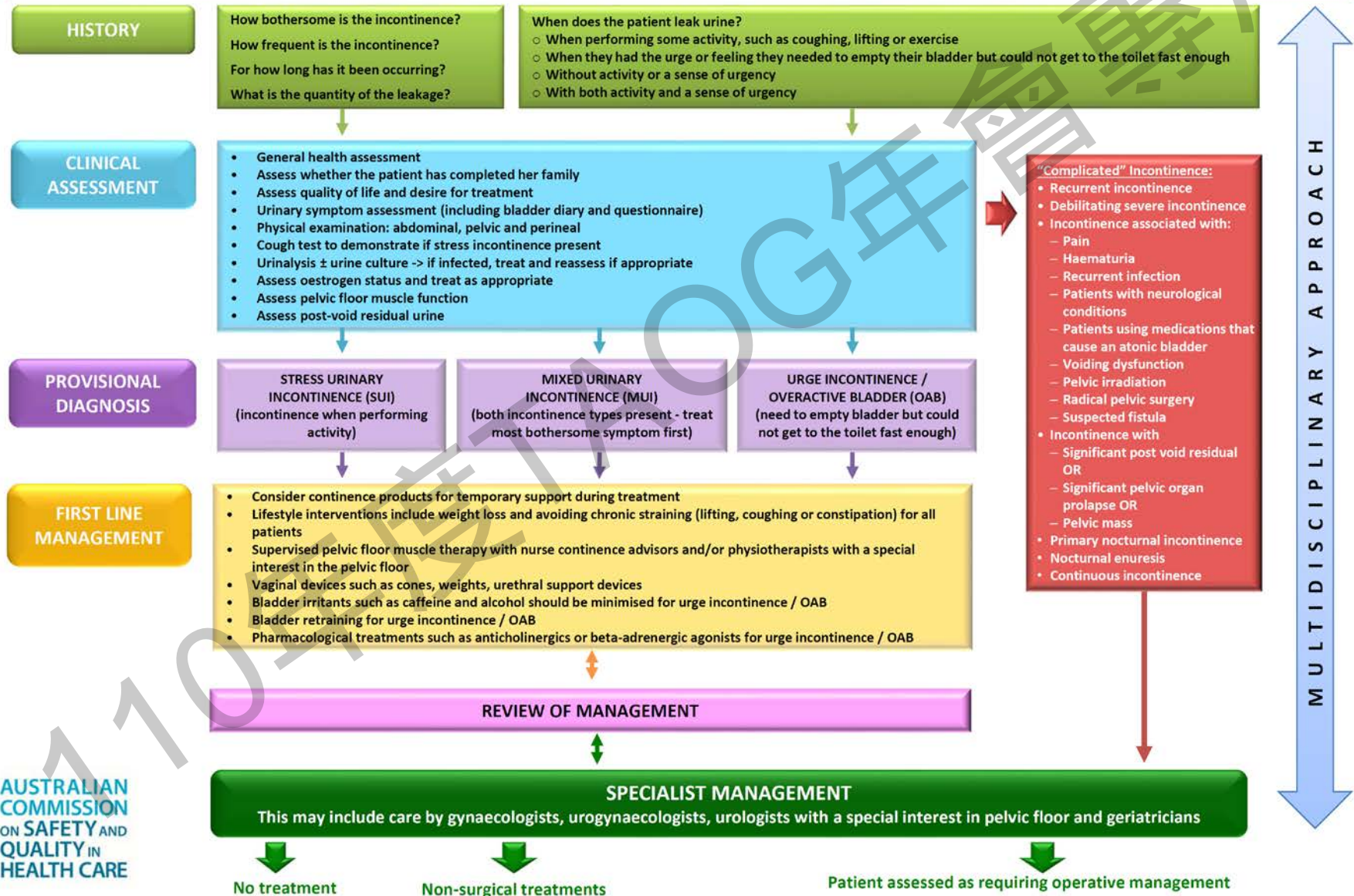
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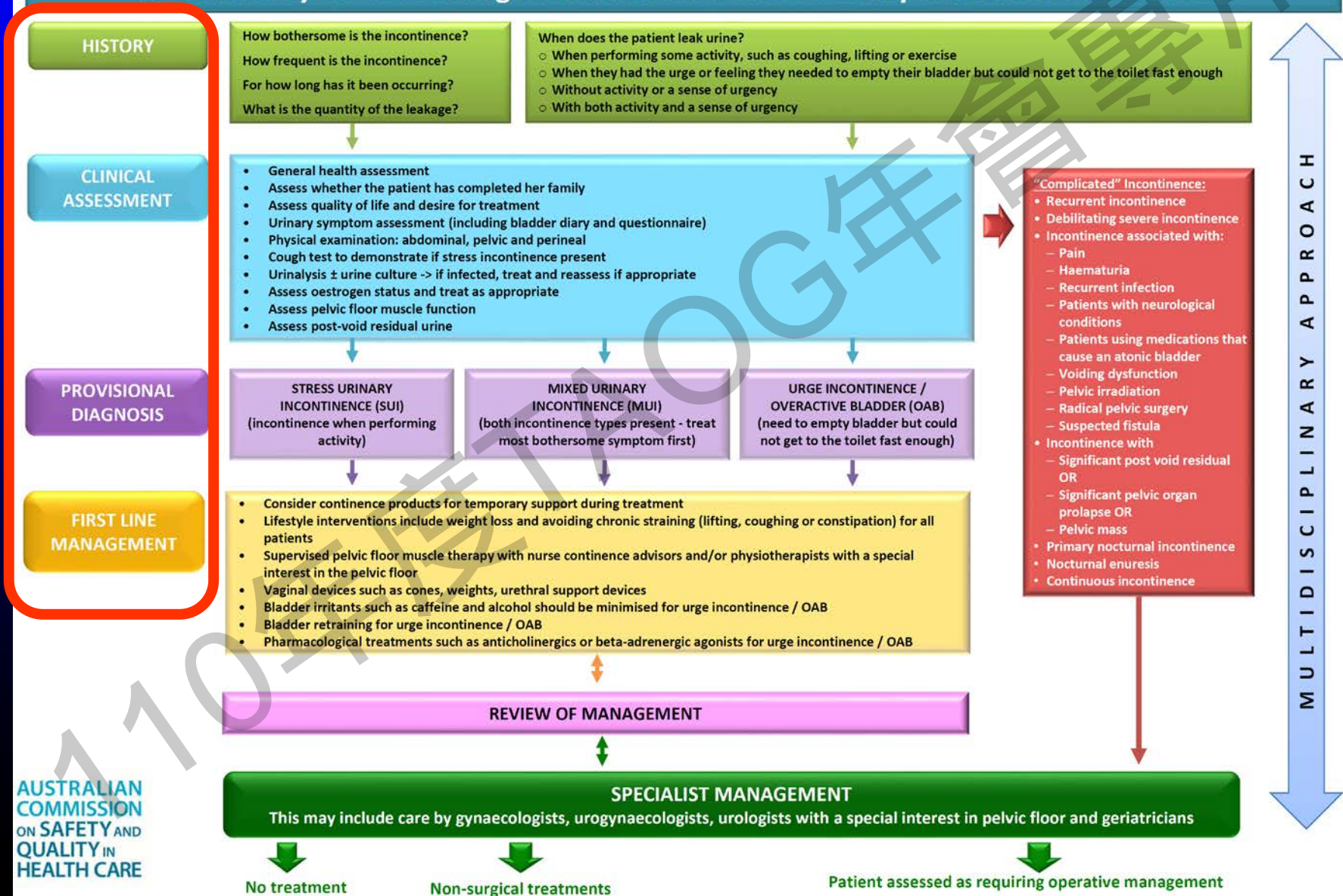
# Initial treatment of UI (EAU 2019)

## Care Pathway for the Management and Referral of Urinary Incontinence in Women



# Initial treatment of UI (EAU 2019)

## Care Pathway for the Management and Referral of Urinary Incontinence in Women





## HISTORY

How bothersome is the incontinence?

How frequent is the incontinence?

For how long has it been occurring?

What is the quantity of the leakage?

When does the patient leak urine?

- When performing some activity, such as coughing, lifting or exercise
- When they had the urge or feeling they needed to empty their bladder but could not get to the toilet fast enough
- Without activity or a sense of urgency
- With both activity and a sense of urgency

# CLINICAL ASSESSMENT

- **General health assessment**
- **Assess whether the patient has completed her family**
- **Assess quality of life and desire for treatment**
- **Urinary symptom assessment (including bladder diary and questionnaire)**
- **Physical examination: abdominal, pelvic and perineal**
- **Cough test to demonstrate if stress incontinence present**
- **Urinalysis  $\pm$  urine culture -> if infected, treat and reassess if appropriate**
- **Assess oestrogen status and treat as appropriate**
- **Assess pelvic floor muscle function**
- **Assess post-void residual urine**

# PROVISIONAL DIAGNOSIS

**STRESS URINARY  
INCONTINENCE (SUI)**  
(incontinence when performing  
activity)

**MIXED URINARY  
INCONTINENCE (MUI)**  
(both incontinence types present - treat  
most bothersome symptom first)

**URGE INCONTINENCE /  
OVERACTIVE BLADDER (OAB)**  
(need to empty bladder but could  
not get to the toilet fast enough)

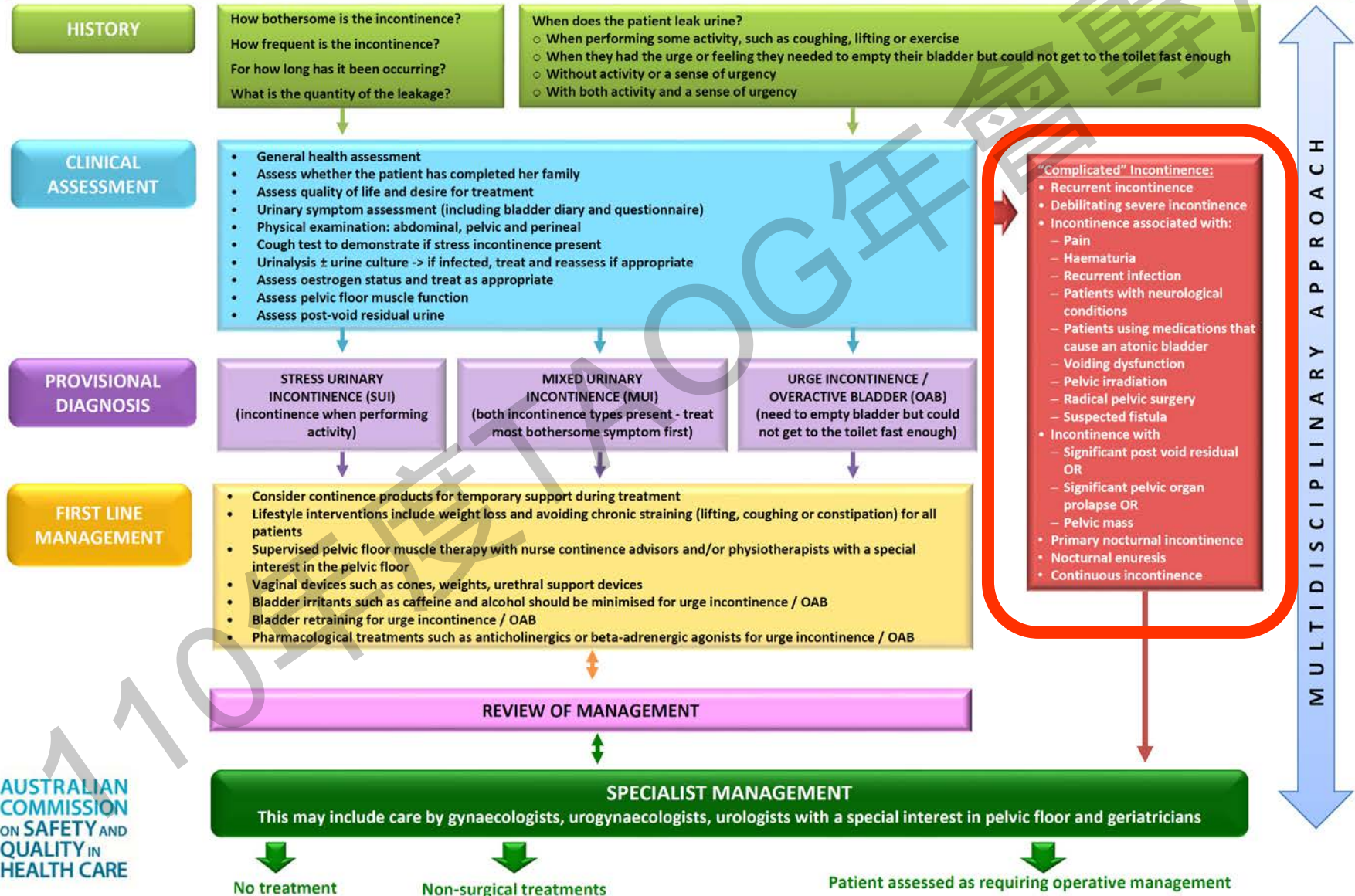
# FIRST LINE MANAGEMENT

- Consider continence products for temporary support during treatment
- Lifestyle interventions include weight loss and avoiding chronic straining (lifting, coughing or constipation) for all patients
- Supervised pelvic floor muscle therapy with nurse continence advisors and/or physiotherapists with a special interest in the pelvic floor
- Vaginal devices such as cones, weights, urethral support devices
- Bladder irritants such as caffeine and alcohol should be minimised for urge incontinence / OAB
- Bladder retraining for urge incontinence / OAB
- Pharmacological treatments such as anticholinergics or beta-adrenergic agonists for urge incontinence / OAB



# Initial treatment of SUI (EAU 2019)

## Care Pathway for the Management and Referral of Urinary Incontinence in Women



### “Complicated” Incontinence:

- Recurrent incontinence
- Debilitating severe incontinence
- Incontinence associated with:
  - Pain
  - Haematuria
  - Recurrent infection
  - Patients with neurological conditions
  - Patients using medications that cause an atonic bladder
  - Voiding dysfunction
  - Pelvic irradiation
  - Radical pelvic surgery
  - Suspected fistula
- Incontinence with
  - Significant post void residual OR
  - Significant pelvic organ prolapse OR
  - Pelvic mass
- Primary nocturnal incontinence
- Nocturnal enuresis
- Continuous incontinence

### SPECIALIST MANAGEMENT

This may include care by gynaecologists, urogynaecologists, urologists with a special interest in pelvic floor and geriatricians



No treatment



Non-surgical treatments

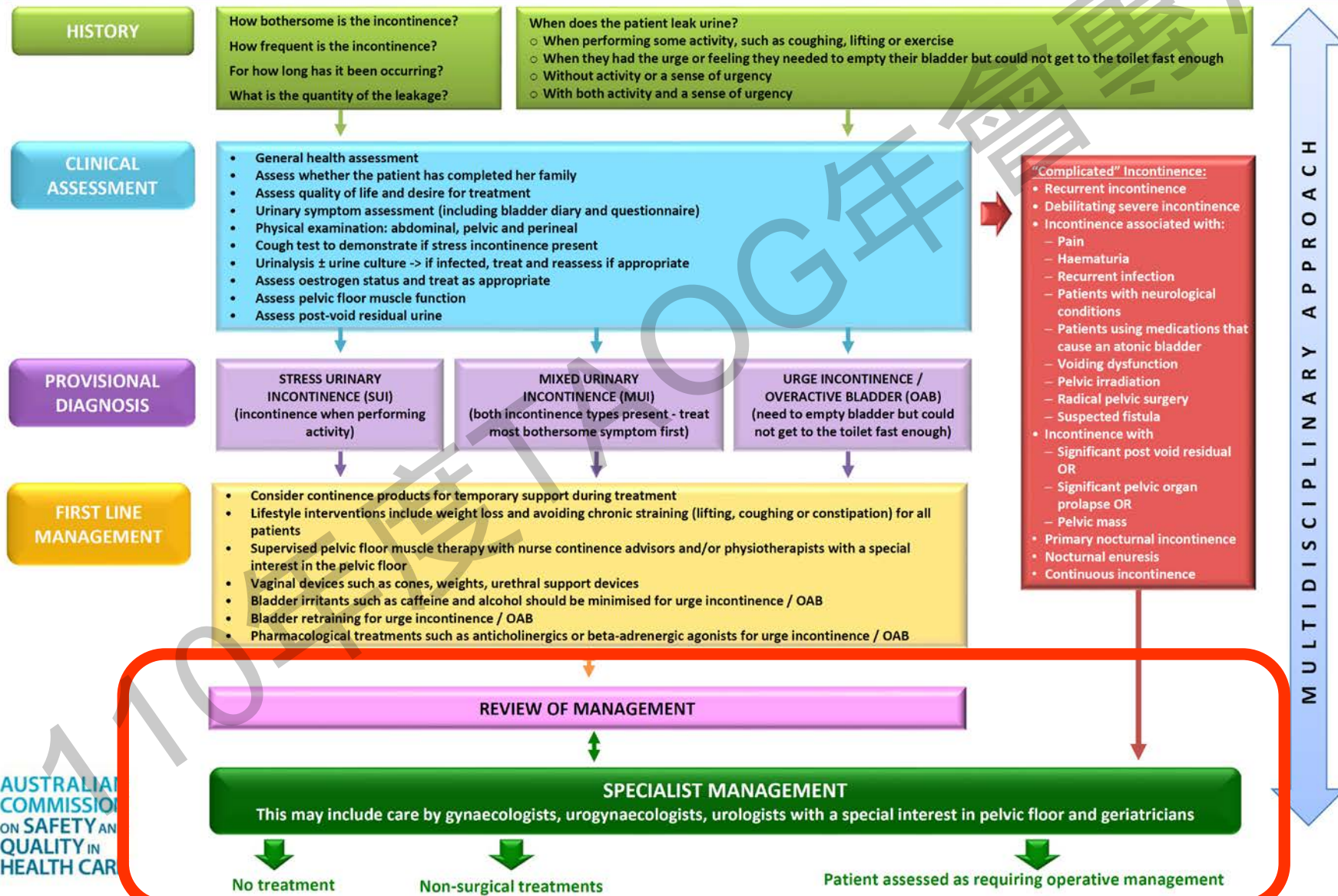


Patient assessed as requiring operative management



# Initial treatment of SUI (EAU 2019)

## Care Pathway for the Management and Referral of Urinary Incontinence in Women



# Specialized management

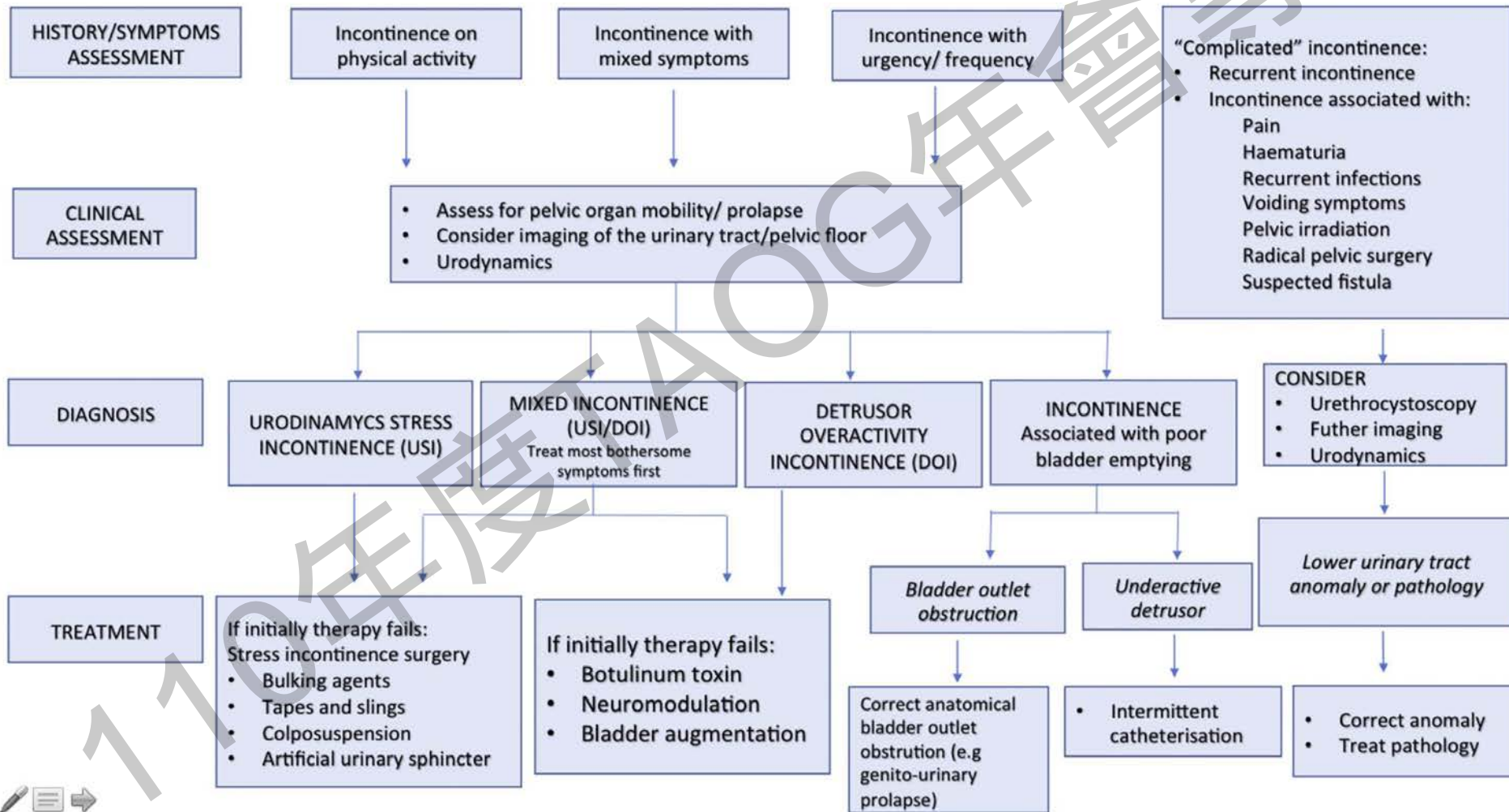


Fig. 2. Specialized management of urinary incontinence in women [5].



# Specialized management

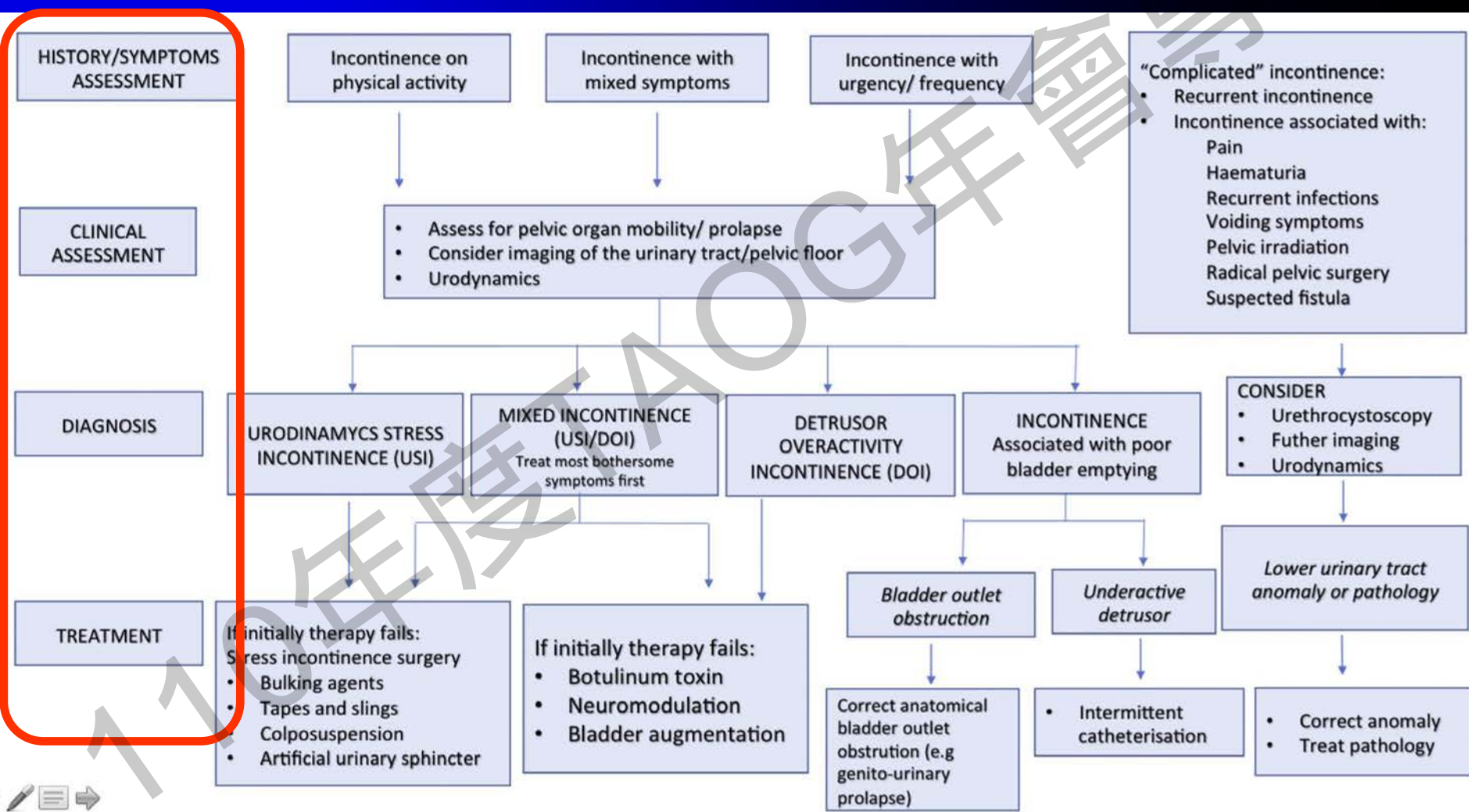


Fig. 2. Specialized management of urinary incontinence in women [5].

1.

## HISTORY/SYMPTOMS ASSESSMENT

Incontinence on  
physical activity

Incontinence with  
mixed symptoms

Incontinence with  
urgency/ frequency

## 2.

# CLINICAL ASSESSMENT

- Assess for pelvic organ mobility/ prolapse
- Consider imaging of the urinary tract/pelvic floor
- Urodynamics

3.

## DIAGNOSIS

4.

## TREATMENT

URODYNAMICS STRESS  
INCONTINENCE (USI)

MIXED INCONTINENCE  
(USI/DOI)

Treat most bothersome  
symptoms first

DETRUSOR  
OVERACTIVITY  
INCONTINENCE (DOI)

If initially therapy fails:  
Stress incontinence surgery

- Bulking agents
- Tapes and slings
- Colposuspension
- Artificial urinary sphincter

If initially therapy fails:

- Botulinum toxin
- Neuromodulation
- Bladder augmentation



3.

## DIAGNOSIS

4.

## TREATMENT

INCONTINENCE  
Associated with poor  
bladder emptying

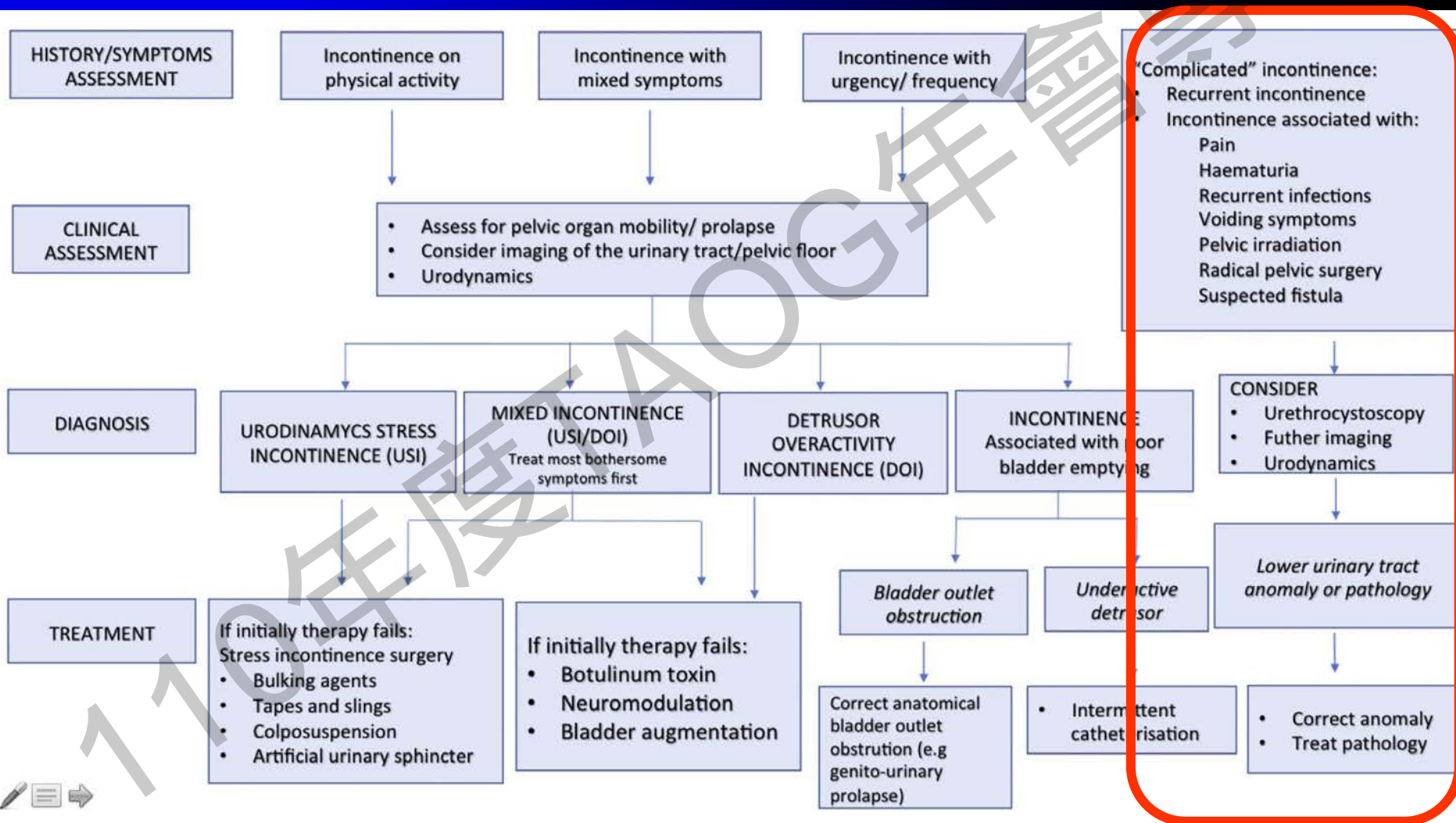
*Bladder outlet  
obstruction*

*Underactive  
detrusor*

Correct anatomical  
bladder outlet  
obstruction (e.g  
genito-urinary  
prolapse)

- Intermittent  
catheterisation

# Specialized management (EAU 2019)



**“Complicated” incontinence:**

- Recurrent incontinence
- Incontinence associated with:
  - Pain
  - Haematuria
  - Recurrent infections
  - Voiding symptoms
  - Pelvic irradiation
  - Radical pelvic surgery
  - Suspected fistula

**CONSIDER**

- Urethrocystoscopy
- Further imaging
- Urodynamics

*Lower urinary tract anomaly or pathology*

- Correct anomaly
- Treat pathology

Fig. 2. Specialized management of urinary incontinence in women [5].

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- Recurrent incontinence
- Incontinence associated with:
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**CONSIDER**

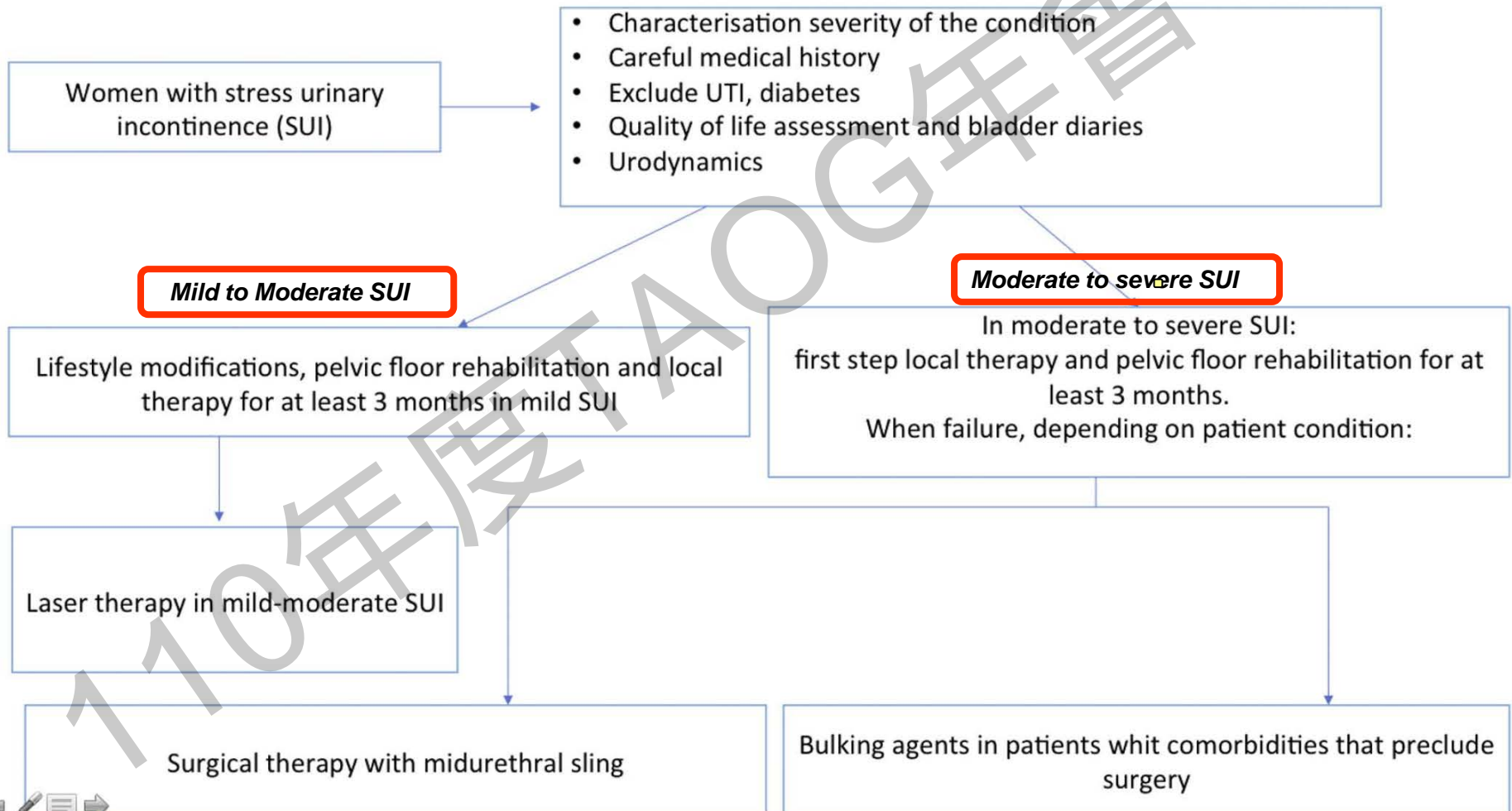
- Urethrocystoscopy
- Further imaging
- Urodynamics

*Lower urinary tract  
anomaly or pathology*

- Correct anomaly
- Treat pathology

# Care pathway of SUI (EAU 2019)

## Care pathway of female Stress Urinary Incontinence (SUI)





# Guideline of guidelines: urinary incontinence in women

Rachael D. Sussman\* , Raveen Syan<sup>†</sup> and Benjamin M. Brucker<sup>‡</sup>

\*Department of Urology, MedStar Georgetown University Hospital, Washington, DC, <sup>†</sup>Department of Urology, Stanford School of Medicine, Stanford, CA, and <sup>‡</sup>Department of Urology, New York University Medical Center, New York, NY, USA

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2. Nature Reviews Urology	14.432
3. European Urology Oncology	7.749
4. Journal of Urology	7.450
4. European Urology Focus	5.996
5. BJU International	5.588
6. Prostate Cancer and Prostatic Diseases	5.554
7. World Journal of Mens Health	5.400
8. Sexual Medicine Reviews	4.836
9. World Journal of Urology	4.226
10. Prostate	4.104

# AUA / SUFU 2017

## Female Stress Urinary Incontinence: AUA/SUFU Evaluation and Treatment Algorithm

### EVALUATION (INDICATIONS)

#### Initial evaluation

The initial evaluation of patients desiring to undergo surgical intervention should include the following components:

- History
- Physical exam
- Demonstration of SUI
- PVR assessment
- Urinalysis

#### Cystoscopy

Should not be performed unless there is a concern for lower urinary tract abnormalities

#### Urodynamics

May be omitted when SUI is clearly demonstrated

#### Additional evaluation

Additional evaluation **should** be performed in the following scenarios:

- Lack of definitive diagnosis
- Inability to demonstrate SUI
- Known/suspected NLUTD
- Abnormal urinalysis
- Urgency-predominant MUI
- Elevated PVR
- High-grade POP (if SUI not demonstrated with POP reduction)
- Evidence of significant voiding dysfunction

Additional evaluation **may** be performed in the following scenarios:

- Concomitant OAB symptoms
- Failure of prior anti-incontinence surgery
- Prior POP surgery



In patients who wish to undergo treatment, physicians should counsel regarding the availability of observation, pelvic floor muscle training, other non-surgical options, and surgical interventions. Physicians should counsel patients on potential complications specific to the treatment options.

## TREATMENT

### Non-Surgical

- Continenence pessary
- Vaginal inserts
- Pelvic floor muscle exercises

### Surgical

- Bulking agents
- Mid urethral sling (synthetic)
- Autologous fascia pubovaginal sling
- Burch colposuspension

If a mid urethral sling surgery is selected, either the retropubic or transobturator mid urethral sling may be offered. A single-incision sling may be offered to index patients if they are informed as to the immaturity of evidence regarding their efficacy and safety. Physicians must discuss the specific risks and benefits of mesh as well as alternatives to a mesh sling.

## SPECIAL CASES

### 1. Fixed immobile urethra

- Pubovaginal sling
- Retropubic midurethral sling
- Urethral bulking agents

### 2. Concomitant surgery for POP repair and SUI

Any incontinence procedure

### 3. Concomitant NLUTD

Surgical treatment following appropriate evaluation and counseling

### 4. Child-bearing, diabetes, obesity, geriatric

Surgical treatment following appropriate evaluation and counseling

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# Initial evaluation

**Table 2** Initial evaluation.

Recommendation	ACOG	AUA/SUFU SUI	AUA/SUFU OAB	EAU	ICI	NICE
Detailed history with emphasis on characterisation of UI	•	•	•	•	•	•
Detailed partum history	•			•		
Exclude other disease processes (e.g., malignancy, ectopic ureter, etc.)	•			•		
Bowel history	•	•	•		•	
Physical examination including pelvic examination and assessment of pelvic floor musculature	•	•	•	•	•	•
Neurological examination	•	•			•	
Stress test for objective demonstration of SUI	•	•				
Bladder/voiding diary				•	•	•
ICIQ for initial assessment					•	
Questionnaires when standardised assessment is needed				•		

Detailed history with emphasis on characterisation of UI  
 Detailed partum history  
 Exclude other disease processes (e.g., malignancy, ectopic ureter, etc.)  
 Bowel history  
 Physical examination including pelvic examination and assessment of pelvic floor musculature  
 Neurological examination  
 Stress test for objective demonstration of SUI  
 Bladder/voiding diary  
 ICIQ for initial assessment  
 Questionnaires when standardised assessment is needed



# History and Physical Examination

- All guidelines require a **detailed history**
- The **physical examination**: general status (mental status, obesity, mobility), an abdominal examination, and a pelvic examination with an assessment of pelvic floor muscles and evaluation for POP



# History and Physical Examination

- Referral to a specialist :  
such as associated pain, haematuria, a history of recurrent UTI, pelvic surgery or radiotherapy, constant leakage suggesting a fistula, faecal incontinence (NICE only), voiding difficulty, or suspected neurological disease

# Questions and Questionnaires

- The ICI and NICE recommend the use of a 3-day voiding diary
- The ICI gives a Grade A recommendation to the use of the ICI Questionnaire (ICIQ)
- The EAU gives a 'Strong' recommendation for the use of a validated and appropriate questionnaire.

# Diagnosis

**Table 3** Diagnostic tests.

Recommendation	ACOG	AUA/SUFU SUI	AUA/SUFU OAB	EAU	ICI	NICE
Urine analysis	•	•	•	•	•	•
PVR in all patients	•	•				
PVR in specific situations			•	•	•	•
Pad testing for quantifying UI	•	•		•		
Pad testing for monitoring change after treatment						•
Routine imaging not recommended	•	•	•	•	•	•
Cystourethroscopy not recommended in routine UI	•	•	•	•	•	•

Urine analysis

PVR in all patients

PVR in specific situations

Pad testing for quantifying UI

Pad testing for monitoring change after treatment

Routine imaging not recommended

Cystourethroscopy not recommended in routine UI



# Diagnosis

- All guidelines on UI agree upon a **urine analysis** (UA) as an initial diagnostic test.
- Most guidelines agree that post-void residual urine volume (**PVR**) should be checked.
- **Pad testing** :The EAU (Weak) and the AUA (Recommendation) support pad testing when quantification of UI is required.
- The ICI states that pad testing : routine evaluation of UI , and suggests a 24-h test.



# Diagnosis

- Routine **imaging** is **not** recommended unless there is concern for other underlying pelvic disorders.
- The cotton swab or '**Q-tip**' test has been the traditional method to assess urethral mobility
- NICE guidelines specifically recommend against the use of the Q-tip test

# UDS

ACOG	Preoperative UDS is not necessary prior to surgery in patient with uncomplicated SUI (Level A)
AUA/SUFU	
AUA/SUFU SUI	May omit UDS for the index patient desiring treatment when SUI is clearly demonstrated (Conditional Recommendation; Evidence Level: Grade B) May perform UDS in non-index patients with SUI (Expert Opinion)
AUA/SUFU UDS	Perform UDS when it is important to determine if altered compliance, DO or other urodynamic abnormalities are present (or not) when considering invasive treatment (Option; Evidence Strength: Grade C) May perform UDS in patients with evidence of SUI on physical examination if considering invasive treatment (Option; Evidence Strength: Grade C)
AUA/SUFU OAB	UDS should not be used in the evaluation of an uncomplicated patient (Clinical Principle)
EAU	Do not use for uncomplicated UDS (Strong) Use UDS if the findings may change the choice of invasive treatment (Weak)
ICI	Use UDS if results will alter treatment
NICE	Do not perform UDS in patient with uncomplicated SUI demonstrated on examination. Perform UDS prior to SUI surgery for women with urge predominant or MUI, voiding dysfunction, anterior or apical POP, or previous surgery for SUI

# UDS

- All guidelines agree that **UDS** are **not necessary** prior to treatment of uncomplicated SUI
- (RCT) that showed no difference in surgical outcomes
- For non-surgical patients, EAU : UDS may influence choice of treatment, they did do alter the clinical outcome of conservative or drug therapy

# UDS

- The ACOG and NICE guidelines do not recommend UDS for patients with uncomplicated SUI
- The AUA/SUFU UDS guideline made a statements about UDS on four disease states: SUI/POP;OAB, UUI and MUI; neurogenic bladder; and LUTS



# Conservative management

Table 5 Conservative management.

Recommendation	ACOG	AUA/SUFU SUI	AUA/SUFU OAB	EAU	ICI	NICE
Scheduled voiding	•		•	•	•	
Fluid management	•		•			•
Smoking cessation				•		
Avoidance of caffeine	•			•	•	•
Weight loss	•		•	•	•	•
Treatment of constipation	•			•		
PFMT for UUI	•		•		•	
PFMT for SUI and MUI	•	•	•	•	•	•
Offer incontinence pads and/or contaminant devices for the management of UI				•		
Counsel women with SUI on the availability of non-surgical options, e.g., continence pessary	•	•				
PTNS for UUI			•	•	•	

Scheduled voiding

Fluid management

Smoking cessation

Avoidance of caffeine

Weight loss

Treatment of constipation

PFMT for UUI

PFMT for SUI and MUI

Offer incontinence pads and/or contaminant devices for the management of UI

Counsel women with SUI on the availability of non-surgical



# Consevative management

- All guidelines recommend a trial of conservative treatment before invasive therapy
- Conservative therapies include behavioural therapy, physical therapy, and scheduled voiding
- NICE and ICI guidelines recommend a trial of **caffeine reduction** for women with OAB
- EAU, ICI, NICE, and AUGS guidelines: **weight loss** in obese patients is beneficial in improving UI

# Consevative management

- **Pelvic floor muscle therapy** (PFMT) is recommended for SUI and UUI
- The AUA :women with SUI or stress-predominant MUI should be counselled about the availability of other non-surgical options or vaginal devices (e.g., continence pessary)
- **Posterior tibial nerve simulation** (PTNS) : UUI and OAB. The EAU,AUA/SUFU OAB guidelines both recommend its use in patients who have failed antimuscarinics

# Consevative management

- **Duloxetine** inhibits the presynaptic re-uptake of neurotransmitters serotonin and norepinephrine in the sacral spinal cord, increase stimulation of the pudendal nerve and therefore tone of the urethral striated sphincter.
- EAU : recommendation to use duloxetine only in select patients with symptoms of SUI when surgery is not indicated
- ICI, EAU and NICE give recommendations to use **topical hormonal therapy** in women with UI and findings of vulvovaginal atrophy

**Table 7** Surgical treatment for SUI.

Recommendation	ACOG	AUA/SUFU SUI	EAU	ICI	NICE
Inform women that any vaginal surgery has an impact on sexual function, which is generally positive			•		
Open or laparoscopic colposuspension technique as option for women with SUI	•	•	•	•	•
Inform women undergoing colposuspension of longer operation time, hospital stay, recovery, and risk of POP and voiding dysfunction postoperatively			•		
MUS as option for treatment of uncomplicated SUI	•	•	•	•	•
TMUS and RMUS have equivalent cure rates	•		•		
Do not offer TMUS unless there are specific clinical circumstances that retropubic space should be avoided					•
Do not use 'top-down' RMUS outside of a clinical trial					•
Do not use single-incision slings outside of a clinical trial					•
Single-incision slings may be offered, but patients should be warned about lack of long-term data	•	•	•	•	•
Counsel women undergoing periurethral bulking about need for repeat injections		•		•	•
Do not recommend periurethral bulking agents to women seeking a permanent cure for SUI				•	•
May offer prophylactic anti-UI procedure at the time of POP repair after informed decision making	•	•	•		
Do not offer anti-UI procedure at the time of POP repair in continent women				•	•
AUS as an option for women with complicated SUI with warning of high complication and mechanical failure rate				•	•
Do not offer AUS to women with SUI unless prior surgery has failed					•

**Surgery**

Inform women that any vaginal surgery has an impact on sexual function, which is generally positive

Open or laparoscopic colposuspension technique as option for women with SUI

Inform women undergoing colposuspension of longer operation time, hospital stay, recovery, and risk of POP and voiding dysfunction postoperatively

MUS as option for treatment of uncomplicated SUI

TMUS and RMUS have equivalent cure rates

Do not offer TMUS unless there are specific clinical circumstances that retropubic space should be avoided

Do not use 'top-down' RMUS outside of a clinical trial

Do not use single-incision slings outside of a clinical trial

Single-incision slings may be offered, but patients should be warned about lack of long-term data

Counsel women undergoing periurethral bulking about need for repeat injections

Do not recommend periurethral bulking agents to women seeking a permanent cure for SUI

May offer prophylactic anti-UI procedure at the time of POP repair after informed decision making

Do not offer anti-UI procedure at the time of POP repair in continent women

AUS as an option for women with complicated SUI with warning of high complication and mechanical failure rate

Do not offer AUS to women with SUI unless prior surgery has failed





# Conclusions

- The initial evaluation should include a thorough **history** , **physical examination** and tools to quantify and qualify the degree of UI.
- For patients with uncomplicated SUI, invasive testing and imaging should be avoided,
- It is generally agreed upon that **MUS** is recommended for the patient with uncomplicated SUI



*Thanks !*