

The quality of evidence is rated, and recommendations are made using the criteria described by the Canadian Task Force on Preventive Health Care.

Clinical Practice Guidelines:

The Evaluation of Stress Incontinence Prior to Primary Surgery

J Obstet Gynaecol Can 2003; 25(4):313–8.

Comprehensive evaluation of women considering surgery to treat urinary incontinence is essential to rule out causes of incontinence that may not be amenable to surgical treatment. Simplifying the evaluation minimizes the discomfort and embarrassment potentially experienced by women.

Recommendations:

1. Thorough evaluation of each woman is essential to determine the underlying etiology of the urinary incontinence and to guide management. (II-3B)
2. Preoperative pelvic examination should be performed to identify pelvic masses that may provoke lower urinary tract symptoms (e.g., a large fibroid uterus impinging on the bladder), concomitant pelvic organ prolapse, and to rule out latent stress incontinence. All of these findings may necessitate a modification of the surgical approach. (III-C)
3. Hypermobility of the urethra should be confirmed preoperatively, as women with fixed, well-supported bladder necks are less likely to experience a cure following standard anti-incontinence procedures. (II-2B)
4. Stress incontinence should be objectively demonstrated prior to anti-incontinence surgery. (III-B)
5. The volume of post void residual urine should be measured prior to anti-incontinence surgery. Elevated post void residual volumes are uncommon and should signal the need for further evaluation of the voiding mechanism. (III-C)
6. Urinary tract infection should be identified and treated prior to initiating further investigation or therapeutic intervention for urinary incontinence. (II-2B)
7. In women presenting with pure stress incontinence that can be objectively demonstrated during examination, preoperative urodynamic testing is not necessary (II-3B). For women with other lower urinary tract symptoms and/or mixed urinary incontinence, the clinician's judgment must guide the use of preoperative urodynamic testing (II-3B).

Clinical Practice Guidelines cont'd:

Choice of Surgery for Stress Incontinence

J Obstet Gynaecol Can 2005;27(10):964–971

Careful consideration of the surgical options available will result in informed choice, which is essential to the process of determining the most appropriate surgery for a woman. Use of a range of surgeries that have the highest proven efficacy is most likely to result in long-term patient satisfaction.

Recommendations:

1. When considering a primary surgical correction of stress urinary incontinence women should be informed that, according to current available evidence, a retropubic procedure provides the best assurance of a durable cure (I-A).
2. Some surgeons offer laparoscopic Burch as an alternative to the open Burch. Currently available short-term evidence does not clearly demonstrate an advantage or disadvantage over the open Burch (I-A).
3. The tension-free vaginal tape procedure (TVT) has demonstrated short-term equivalency to retropubic procedures and may be offered as a primary surgery with the proviso that it has not been rigorously tested for long-term equivalency. There is insufficient evidence to permit informed recommendations concerning other sling procedures (I-A).
4. Anterior colporrhaphy should generally not be offered to women as a treatment for isolated primary stress urinary incontinence because of higher failure rates (I-A).
5. Needle suspensions should generally not be offered to women as a treatment for isolated primary stress urinary incontinence because of higher failure rates (I-A).
6. Periurethral injection of bulking agents should generally not be offered to women for the treatment of primary stress urinary incontinence because of anticipated high failure rates (III-C).

Clinical Practice Guidelines cont'd:

Conservative Management of Urinary Incontinence

J Obstet Gynaecol Can 2006;28(12):1113–1118

Evidence for the efficacy of conservative management options for urinary incontinence is strong. These options can be advocated as primary interventions with minimal or no harm to women.

Recommendations:

1. Pelvic floor retraining (Kegel) exercises should be recommended for women presenting with stress incontinence. (I-A)
2. Proper performance of Kegel exercises should be confirmed by digital vaginal examination or biofeedback. (I-A)
3. Follow-up should be arranged for women using pelvic floor retraining, since cure rates are low and other treatments may be indicated. (III-C)
4. Kegel exercises may be offered as an adjunct to other treatments for overactive bladder (OAB) syndrome, but they should not be the only treatment offered for these symptoms. (I-B)
5. Although functional electrical stimulation (FES) has not been studied as an independent modality, it may be used as an adjunct to pelvic floor retraining, especially in patients who have difficulty identifying and contracting the pelvic muscles. (III-C)
6. FES should be offered as an effective option for the management of OAB. (I-A)
7. Vaginal cones may be recommended as a form of pelvic floor retraining for women with stress incontinence. (I-A)
8. Continence pessaries should be offered to women as an effective, low-risk treatment for both stress and mixed incontinence. (II-B)
9. Bladder training (bladder drill) should be recommended for symptoms of OAB, since it has no adverse effects (III-C), and it is as effective as pharmacotherapy. (I-B)
10. Behavioural management protocols using lifestyle changes in combination with bladder training and pelvic muscle exercises are highly effective and should be used to treat urinary incontinence. (I-A)

Technical Updates:

Tension-Free Vaginal Tape (TVT) Procedure

J Obstet Gynaecol Can 2003; 25(8):692–4.

Recommendations:

1. The Burch procedure should be offered as the gold standard. The TVT procedure is promising but currently under evaluation in trials that will establish its efficacy and safety (II-3A).
2. Proper training is recommended prior to performing TVT procedures.
3. Long-term trial results are needed before the TVT procedure can be offered to patients as an equal alternative to the Burch procedure.

Midurethral Minimally Invasive Sling Procedures for Stress Urinary Incontinence

J Obstet Gynaecol Can 2008;30(8):728–733

Recommendations:

1. Tension-free vaginal tape can be offered as an alternative of equal efficacy to the Burch procedure for the surgical management of stress urinary incontinence. (I-A)
2. Transobturator tape can be offered as an alternative to tension-free vaginal tape that eliminates the risks of intra-abdominal organ injury. It should be offered with the proviso that its long-term effectiveness and safety relative to tension-free vaginal tape remain to be determined. (II-B)
3. Midurethral sling procedures performed through a single suburethral incision should be used only in the setting of a clinical trial until their effectiveness and safety are proven. (III-C)
4. Despite the suggested simplicity of pre-packaged surgical kits for midurethral procedures, specific training is recommended prior to performing any of these surgical procedures. (III-C)

Committee Opinion:

Urodynamics Testing

J Obstet Gynaecol Can 2008;30(8):717–721

Urinary incontinence is a pervasive problem that can be treated effectively once properly diagnosed.

Summary Statements and Recommendations

1. Urodynamic testing is an objective tool that helps to clarify confusing or complex urinary tract symptoms.
2. Urodynamic testing is not recommended prior to (a) conservative management of urinary incontinence. (III-C) (b) primary surgery for stress incontinence when the diagnosis is clear. (III-C)
3. Urodynamic testing is recommended (a) when the diagnosis remains uncertain after an initial history and physical examination. (III-C) (b) when patient symptoms do not correlate with objective physical findings. (III-C) (c) if the patient fails to improve with treatment. (III-C) (d) in a clinical trial setting. (III-C)
4. Significant controversy exists about the use of urodynamics in the clinical setting. A Cochrane review found no evidence that urodynamic testing prior to treatment affected outcomes and recommended larger prospective trials.