No. 248, September 2017 (Replaces No. 74, July 1998)

This guideline was peer reviewed by the SOGC's Uroynaecology Committee* and/or principal author(s) in January 2015, and has been reaffirmed for continued use until further notice

No. 248-Guidelines for the Evaluation and Treatment of Recurrent Urinary Incontinence Following Pelvic Floor Surgery

This clinical practice guideline has been prepared by the Urogynaecology Committee and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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Key Words: Urinary incontinence, recurrent, surgery

J Obstet Gynaecol Can 2017;39(9):e309−e314

https://doi.org/10.1016/j.jogc.2017.06.009

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Abstract

Objective: To provide general gynaecologists and urogynaecologists with clinical guidelines for the management of recurrent urinary incontinence after pelvic floor surgery.

Options: Evaluation includes history and physical examination, multichannel urodynamics, and possibly cystourethroscopy. Management includes conservative, pharmacological, and surgical interventions.

Outcomes: These guidelines provide a comprehensive approach to the complicated issue of recurrent incontinence that is based on the underlying pathophysiological mechanisms.

Evidence: Published opinions of experts, and evidence from clinical trials where available.

Values: The quality of the evidence is rated using the criteria described by the Canadian Task Force on Preventive Health Care (Table).

Recommendations

1. Thorough evaluation of each patient should be performed to determine the underlying etiology of recurrent urinary incontinence and to guide management (II-3B).
2. Conservative management options should be used as the first line of therapy (III-C).
3. Patients with a hypermobile urethra, without evidence of intrinsic sphincter deficiency, may be managed with a retropubic urethropexy (e.g., Burch procedure) or a sling procedure (e.g., mid-urethral sling, pubovaginal sling) (II-2B).
4. Patients with evidence of intrinsic sphincter deficiency may be managed with a sling procedure (e.g., mid-urethral sling, pubovaginal sling) (II-3B).

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Women have the right and responsibility to make informed decisions about their care in partnership with their health care providers. In order to facilitate informed choice women should be provided with information and support that is evidence based, culturally appropriate and tailored to their needs. The values, beliefs and individual needs of each woman and her family should be sought and the final decision about the care and treatment options chosen by the woman should be respected.

Table. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment[a]	Classification of recommendations[b]
I: Evidence obtained from at least one properly randomized controlled trial.	A. There is good evidence to recommend the clinical preventive action.
II-1: Evidence from well-designed controlled trials without randomization.	B. There is fair evidence to recommend the clinical preventive action.
II-2: Evidence from well−designed cohort (prospective or retrospective) or case−control studies, preferably from more than one centre or research group.	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.	D. There is fair evidence to recommend against the clinical preventive action.
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.	E. There is good evidence to recommend against the clinical preventive action.L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

[a]The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.[20]

[b]Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the The Canadian Task Force on Preventive Health Care.[20]

5. In cases of surgical treatment of intrinsic sphincter deficiency, retropubic tension-free vaginal tape should be considered rather than transobturator tape (I-B).
6. Patients with significantly decreased urethral mobility may be managed with periurethral bulking injections, a retropubic sling procedure, use of an artificial sphincter, urinary diversion, or chronic catheterization (III-C).
7. Overactive bladder should be treated using medical and/or behavioural therapy (II-2B).
8. Urinary frequency with moderate elevation of post-void residual volume may be managed with conservative measures such as drugs to relax the urethral sphincter, timed toileting, and double voiding. Intermittent self-catheterization may also be used (III-C).
9. Complete inability to void with or without overflow incontinence may be managed by intermittent self-catheterization or urethrolysis (III-C).
10. Fistulae should be managed by an experienced physician (III-C).

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