Diagnosis And Testing For Female Urinary Incontinence

Talking To Your Doctor

Your diagnosis will start with a discussion of your symptoms. Your doctor will ask you questions about your symptoms and medical history, which may include: – How often your urinary incontinence occurs

- If there is a pattern to when it occurs, such as when you cough, laugh or exercise
- How frequently you need to urinate during the day and night
- If you have any difficulty urinating, or feel unable to fully empty your bladder – Whether you are taking any medication
- Whether you have given birth, and if so, details of the pregnancy and delivery
- How much fluid, alcohol or caffeine you consume
- This is to helps your doctor to:
- Build a picture of how your symptoms affect you
- Determine what type of urinary incontinence you are experiencing – Identify

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Potential Risk Factors And/Or Causes Associated With Your Lifestyle And Medical History

Rule out or identify other conditions that may cause or be associated with incontinence, such as:

- Urinary tract infections
- Prolapse
- Bladder stones
- Bladder cancer
- Bladder Diary

To gather more information about the pattern of your symptoms, your doctor may ask you to keep a bladder diary for several days. This involves recording information relating to your fluid intake and incontinence, such as:

- How much fluid you drink, and what type
- How often you need to urinate
- How much you urine you pass (you may be asked to measure this) – The colour of your urine (you may be given a urine colour chart to help with this) – How often you experience urine leaks
- How often you experience a strong and/or sudden urge to urinate
- Physical Examination

Your doctor may need to do a physical examination of your lower abdomen and pelvis. This may involve:

- Feeling your abdomen for a distended bladder, which can indicate difficulty with emptying your bladder fully
- Asking you to cough or laugh to see if any urine leaks – this helps identify stress incontinence

- Your doctor placing a finger inside your vagina and asking you to squeeze your pelvic floor muscles, to assess how well you can contract them
- Your doctor placing a finger inside your vagina to feel for any pelvic organ prolapse (link to page)

This usually involves undressing from the waist down. You do not have to have a physical examination if you are not comfortable with it, but it does help your doctor with diagnosis and treatment planning.

Tests

There are several tests that your doctor may need to perform, dependent on your symptoms. These may include:

Urine sampling

A sample of your urine may be tested. Tests can show whether you have a urinary tract infection. They can also show if you have blood. protein or glucose (sugar) in your urine, which may indicate other conditions such as kidney stones or diabetes.

Bladder scan

An ultrasound scan of your bladder can be used to see how much urine is in your bladder after you urinate. This is known as a 'residual urine test'. It can be used to diagnose or exclude overflow incontinence.

Cystoscopy

A cystoscopy is a procedure in which a thin tube with a camera attached is inserted into your urethra to look at your bladder and urinary tract. It can be used to identify any abnormalities which may be causing your incontinence.

Urodynamic testing

Urodynamic tests are a series of tests to further check your bladder function. This can include urinating into a machine that measures your flow of urine, as well as measuring the pressure in your bladder and abdomen using small catheters (tubes) which are inserted through the urethra and back passage (rectum). Urodynamic testing is usually only required in cases of severe urinary incontinence, when a diagnosis is unclear, or when surgical treatments are being considered.

To find out how urinary incontinence is treated, see 'Non-surgical treatments for female urinary incontinence' and 'Surgery and procedures for female urinary incontinence'.

Non-Surgical Treatments For Female Urinary Incontinence

There are a range of non-surgical and surgical treatments to treat different types of urinary incontinence. Unless there is a clear underlying condition which requires medicine or surgery, non-surgical treatments (also known as 'conservative treatments' are tried first.

Non-Surgical Treatments

Pelvic floor muscle training

Your doctor may help with or refer you to a specialist such as a physiotherapist for pelvic floor muscle training. This usually involves assessing your ability to contract (squeeze) your pelvic floor muscles, and then providing you with an exercise programme that improves the strength of these muscles by performing 'squeezes' (contractions) several times daily.

Bladder training

Bladder training is a combination of techniques used to increase the length of time between initially feeling the need to urinate and going to the toilet. Over time, this increases your ability to 'hold on' and reduces the frequency of toilet visits. Lifestyle changes

Since many lifestyle factors can contribute to urinary incontinence, your doctor may suggest making some changes in order to improve your symptoms. These can include:

- Lowering your caffeine and alcohol intake, since these substances increase urine production
- How much fluid you drink, since drinking too much or being dehydrated can worsen urinary incontinence
- Losing weight if you are overweight or obese
- Incontinence products

Whilst incontinence products such as pads and catheters cannot treat urinary incontinence, they can help you manage it as you wait for assessment, or for the above treatments to begin having an effect.

Medication

If the above non-surgical treatments are ineffective for stress incontinence, surgery will usually be the next step. However, for those who cannot undergo surgery or choose not to, a medicine called duloxetine may sometimes be prescribed. Duloxetine increases the tone of the urethral sphincter, which helps to keep it closed to prevent leaks.

If non-surgical treatments are ineffective for urge incontinence, a type of medicine called an antimuscarinic may be prescribed. Antimuscarinics decrease the unwanted bladder contractions that cause urge incontinence. If antimuscarinics are ineffective or unsuitable for you, you may be offered a medicine called mirabegron instead, which has a similar effect.

All medications can come with side effects, and some are not suitable for everyone. Your doctor will discuss this with you prior to commencing treatment.

If conservative treatments have been ineffective, your doctor may consider surgery or another medical procedure to treat your incontinence. To find out more about such treatments, see 'Surgery and procedures for female urinary incontinence'.

Surgery and procedures for stress incontinence

Surgical treatments and other procedures are usually only recommended if non-surgical treatments have been ineffective. Your doctor will discuss the benefits and suitability of potential treatments with you. Surgeries used

to treat stress incontinence include:

Colposuspension

A colposuspension involves lifting the tissue around the neck of the bladder and using stitches to secure it in this position. This surgery is an effective long-term treatment for stress incontinence.

Colposuspension can be performed as open surgery, where a cut is made in the lower abdomen, or as keyhole (laparoscopic) surgery, where several smaller cuts allow the surgeon to perform the operation using small cameras and surgical tools. This operation is done under general anaesthetic, so you will be asleep during the operation.

You'll usually need to stay in hospital 1-2 days after the operation. The time it takes to recover and return to activities is usually about 6 weeks, but can be longer.

Sling surgery

Sling surgery may also be referred to as a 'rectus fascial sling' since it involves making a 'sling', usually from part of the the rectus fascia, which is the tissue that covers your abdominal muscles. The sling is stitched in place behind the neck of the bladder where it connects to the urethra to support it and prevent urine leaking. This surgery is an effective long-term treatment for stress incontinence. This operation is done under general anaesthetic, so you will be asleep during the operation.

You'll usually need to stay in hospital 1-3 days after the operation. The time it takes to recover and return to activities is usually about 6 weeks, but can be longer.

Vaginal mesh

A strip of synthetic surgical mesh – a plastic product that looks like a net – is placed behind the neck of the bladder where it connects to the urethra to support it and prevent urine leaking. The strip of mesh may be called a 'tape', so this surgery can also be referred to as 'tape surgery'. The mesh stays in the body permanently. Vaginal mesh surgery is an effective long-term treatment for stress incontinence.

This operation is usually done under general anaesthetic.

It is often performed as a day surgery, meaning many women do not have to stay in hospital overnight, although some might.

The time it takes to recover and return to activities is usually shorter than colposuspension and sling surgery at about 2 weeks, but it can be longer.

Complications of stress incontinence surgeries

Most people who undergo colposuspension, sling surgery, or vaginal mesh surgery experience a reduction or complete cessation of stress incontinence symptoms. However, some may still experience stress incontinence afterwards. All surgeries involve some level of risk, which your surgeon will discuss with you prior to your operation. Possible complications associated with these surgeries include:

Bleeding

- Infection – this can be at the wound site, inside the pelvis, or in the urinary tract – Problems urinating or fully emptying your bladder – you may need a catheter to help with this
- Needing to urinate more frequently or more urgently

- Damage to your bladder or bowels, which may require another operation to fix
- Damage to surrounding nerves, which can cause changes in sensation (e.g. numbness or tingling) or pain
- Pelvic organ prolapse – this is when part of one of the pelvic organs (such as the womb or bowel) bulges into the vagina, which may require another operation to fix if it causes problems
- Pain in abdomen or pelvis, or during sex

In addition, mesh surgeries can carry additional risks and are currently not available within the NHS unless there is no alternative. This is because, in rare cases, mesh can erode through tissue and cause damage to pelvic organs, resulting in pain and potential infection.

What To Expect After Surgery – In Hospital

- When you return from the operating theatre you will need to rest until the effects of the anaesthetic have worm off.
- You may have some pain and discomfort. It is important you let the nurses know, as they may be able to give you some pain medication.
- You may have some bleeding from the vagina, which can last for a few weeks. Use sanitary towels, not tampons, to minimise risk of infection.
- You may have a catheter in to drain your bladder. This is usually removed the morning after surgery. However, if you have any problems emptying your bladder once the catheter has been removed, it may need to be re-inserted, or you may need to be taught to self-catheterise. If this is necessary, it's usually only for a few days.
- You may have some tubes, bags or bottles attached to your wound sites to drain blood or fluid. These are usually removed the morning after surgery.
- You will be encouraged to get out of bed and walk around the ward as soon as possible. This improves lung and cardiovascular function and helps prevent blood clots. Getting out of bed after surgery will help you get home and back to normal functioning you leave hospital, you will be taught how to care for your wound to avoid infection.

What To Expect After Surgery – At Home

- It is important to avoid constipation as straining can put stress on the surgical site. Speak to your nurse or doctor if you are experiencing constipation, as they may be able to give advice and/or medication to ease it.
- It is important to stay active and use your muscles – particularly your leg muscles – to avoid blood clots and other complications. Gentle walking is appropriate at this time.
- You will usually be able to build your activity level up after 6 weeks, and return completely to your usual activity levels after about 3 months. However, this depends on a number of factors, such as your age, fitness, and what type of activities you want to do. High impact or strenuous lifting activities will take longer to be able to return to, and may need specialist rehabilitation advice from a physiotherapist.
- You can begin sexual activities from 6 weeks onwards, once you feel comfortable enough. Start gently, and consider using lubrication.

- You can drive once any pain or discomfort from your operation has subsided. However, check your insurance policy as some providers require waiting 6 weeks post surgery.
  Urethral bulking agents

If surgery for stress incontinence is not suitable for you, having a bulking agent injection is a potential treatment option. This involves a 'bulking agent' – a synthetic substance – being injected into the walls of the urethra (the tube that carries urine from your bladder out of your body), increasing its size so it can stay closed more easily. This is done by inserting a small scope with a camera into the urethra. This procedure doesn't involve any cuts, so is less invasive than surgery, with fewer complications. It is usually performed under local anaesthetic, so you will be awake but given a numbing injection beforehand.

Whilst bulking agents can improve stress incontinence, they are generally not as effective as surgery and the effects can wear off over time.

Complications include experiencing a burning sensation or bleeding whilst urinating for a short period after the procedure. There is also a risk of developing a urinary tract infection.