

Legacy Health

Co-Management and Referral Guidelines

Stress Urinary Incontinence

Legacy Medical Group–Urogynecology

Introduction

Definition

Stress urinary incontinence — Involuntary loss of urine with effort, physical exertion, cough, laugh or sneeze

Evaluation and Management

Basic office evaluation

History

- Duration
- How often
- Inciting events
- How bothersome (this can be assessed with validated questionnaires, or simply global impression)
- Other urinary symptoms — urgency, frequency, nocturia, bladder pain, voiding difficulties (if present might mandate earlier urodynamic testing)

Mitigating factors

Neurologic issues, recurrent UTI, previous GU procedures (again may indicate need for urodynamic testing)

Exam

Screen for prolapse, neurologic impairment (particularly in S2–S4 distribution, lower extremity strength, abnormal reflexes)

Testing

- Urinalysis and culture if indicated. If microscopic hematuria on microscopy (not dip) of > 3 RBCs present in the absence of a cause, would need to begin microhematuria workup (refer to urogynecology or urology for CT urogram and cystoscopy).
- Postvoid residual — Greater than 150 cc would mandate repeat and or further testing (urodynamics). This can be done with bladder scanner, or straight cath. Straight cath is more accurate.
- Cough stress test — During exam have patient cough with a full bladder and observe urethra for urine loss. If negative supine, have patient stand and cough again observing for urine loss. Urine loss that is delayed, with onset clearly after the cough, is an indication of detrusor over activity or urinary urgency incontinence rather than stress incontinence (see urinary urgency incontinence guideline instead).

Management

In the case of straightforward stress urinary incontinence, i.e., no neurologic impairment, no prior GU/prolapse/incontinence surgery, no symptoms of significant urgency/frequency/nocturia, no symptoms of incomplete emptying/voiding difficulty and a normal PVR, therapy can be initiated..

- Behavior modification — timed voids, appropriate fluid intake — we only need 2,000 cc per day!
- Weight loss — 7 percent reduction in weight can lead to a 50 percent reduction in urinary incontinence episodes per day

- Pelvic floor muscle exercise — Needs to be done with trained pelvic floor PT. When compared head-to-head with surgical sling procedure, at one year 58 percent cured with PT and 85 percent cured with surgery. But 58 percent is very reasonable for a risk-free intervention..
- Incontinence pessary — Works by helping to close urethra during activity. Of note when compared with PT, a pessary is less effective.

When to refer

Certain triggers would benefit early referral to urogynecology/female urology:

- Microhematuria or gross hematuria
- Elevated post-void residual greater than 150 ml
- Evidence of neurologic impairment
- Prior incontinence or prolapse surgery

All of these would indicate the need for further testing (urodynamics, cystoscopy, CT). Available at Legacy Medical Group–Urogynecology

Referral process

Legacy Medical Group–Urogynecology

Legacy Good Samaritan Medical Center

Good Samaritan Building 2
1040 N.W. 22nd Ave., Suite 600
Portland, OR 97210
Phone: **503-276-9300**
Fax: 503-276-9351

Legacy Salmon Creek Medical Center

Medical Office Building A
2121 N.E. 139th St., Ste. 430
Vancouver, WA 98686
Phone: **360-487-1414**
Fax: 360-487-1261

Our gynecology providers

Claire Gould, M.D.
Deani Iversen, M.D.
Tricia M. Wright Child, M.D.

Our urogynecology providers

Audrey Curtis, M.D.
Virginia King, M.D.
Blake Osmundsen, M.D.
Lynn Osmundsen, M.D.
Kendra Parkin, N.P.
Meredith Schledorn, P.A.

Find this and other co-management/referral guidelines online at: www.legacyhealth.org/womenshealth

