Choosing the best treatment for your stress incontinence at East Sussex healthcare NHS Trust

This information is to help you decide which treatment is the best option to treat your stress urinary incontinence. It is written by the Uro-gynaecology Unit team at East Sussex Healthcare NHS Trust and reflects their experience of treating women over the past 15 years.

There is so much information now available on the internet and in the media - some of which is alarming - but it is difficult to know how much it applies to you. The words that doctors use are often confusing. This information will guide you to find the best treatment for you and answer any questions that you have.

What is Stress Urinary Incontinence?

Your bladder and urethra are supported by your pelvic floor muscles and ligaments. If this support is weakened, urine leaks with coughing, sneezing, laughing or with lifting and exercising.

Non-surgical treatments

Pelvic floor muscle exercises are the most effective non-surgical treatment. Many women who perform these exercises regularly will not require surgery. Some women require training to help them perform the exercises more effectively.

Weight loss is an effective treatment option for overweight women with stress urinary incontinence. Women with a body mass index greater than 30 will often see an improvement in their symptoms if they lose weight. We would usually advise women to lose 5% to 10% of their current weight if we think it might help. We would usually advise joining a weight loss activity group such as slimming world or weight watchers. Even if weight loss does not help, then subsequent treatments are likely to be safer, more affective and last for a longer time.

Drug treatment (Duloxetine tablets) may also be a suitable option for some women. Unfortunately, they are not effective and their side-effects are often troublesome - nausea and sleep disturbance are common. They can be used when other treatments have failed.

Surgical treatments

Transvaginal Tape operation (TVT)

This operation involves placing a piece of synthetic mesh material, like sling, under your urethra to support it. Over the past few years, concerns have been raised about the safety of using mesh materials in the vagina. Vaginal meshes can be used to treat both incontinence and prolapse, and most of the problems have arisen after its use to treat prolapse. We recognised this problem many years ago and have inserted very few vaginal meshes to treat prolapse.

Tapes are thin pieces of mesh are used to treat incontinence. There are two ways to insert tapes: Retropubic route and Trans-obturator route. You will be given a separate information leaflet about the TVT. It is a minimally invasive operation and is usually performed as a day case under a general anaesthetic. Around 85%of our patients report that their leakage is moderately to greatly improve.

All operations have risks and potential side-effects. Some of these relate purely to the procedure but many are influenced by the experience of the surgeon. A good surgeon selects patients for surgery wisely and can manage minor complications well, usually preventing them from causing long - term harm.

Behind every good surgeon is an excellent team of nurses and physiotherapists and as clinicians we endeavour to follow the best evidence when treating our patients. Good evidence has been produced of a high quality in favour of sub urethral synthetic mesh approach that points to a high success rate of 90% with a complication rate of 5%.

These are not all serious complications and can be dealt with immediately and resolve. The more serious complications like erosion and pain can necessitate revisiting the tape and either removing it totally or partially depending on the complaint and therefore resolving the symptoms completely.

The Uro-gynaecology Unit at East Sussex Healthcare NHS Trust has been through a process of ‘accreditation’ from the British Society of Uro-gynaecology. This means that our training and processes are of a high standard and that we constantly measure our performance using a national database of patient outcomes.

Between 2006 and 2018, our Uro-gynaecology unit performed nearly 1500 TVT operations. Of these, 41 women have had complications related to tape erosion or pain which have resolved completely after removal of the tape.

This rate of repeat surgery is much lower than the rate of repeat surgery following other operations for this condition.

Urethra Bulking
This treatment has been around from many years (with different substances) and involves injecting the bladder neck (through the urethra) with a bulking substance which obstructs the flow of urine.

Usually performed under local anaesthetic, this procedure has a success rate of 65% with 81% improvement. Possibly repeated injections may be required to maintain this benefit after a few years. Women can normally return to work after a day or two. The long term outcome of bulking is not well known.

The implanted substance is intended to be permanent and there is no long-term data on safety. A separate information leaflet is available.

Colposuspension operation
This is an abdominal operation to lift the vagina underneath the water-pipe using permanent synthetic sutures. This was the main operation performed back in the 1990s.

Although the success rate is reasonably good, the recovery period quite prolonged, many women require a urethral catheter for several weeks and patients have a substantially increased risk of requiring future surgery for vaginal prolapse. We can perform this operation at ESHT but we don’t perform it in adequate number to assure quality so you may need a referral to a nearby trust.

Fascial sling operation
This is an operation in which a strip of tissue is removed from the lower wall of the abdomen and used like a hammock to support the urethra. This is an old operation with a success rate of 75% but with a voiding difficulty in terms of a long-term need to intermittently self-catheterise to empty the bladder of 10%.

Your individual risk
The risks of any surgical procedure are increased above the average risk if you have any significant medical conditions (such as diabetes), if you smoke or are overweight or if you have previously had surgery for a similar problem. Please discuss your own individual risks with your surgeon.

Pregnancy and childbirth
It is highly advisable you consider surgery only after your family is complete. While it will not affect your ability to become pregnant, there is increased risk of recurrent incontinence following pregnancy and childbirth. It is not clear whether a future caesarean section could help prevent this and your obstetrician may offer this to possibly reduce the risk. You should tell your surgeon if you intend to have more children.

Consent
Although you consent for this treatment, you may at any time after that withdraw such consent. Please discuss this with your medical team.

Sources of information
Information available on the British Society of Uro-gynaecology website - www.BSUG.org or the Clinical Nurse Specialist – Tel: (01323) 413877

Important information
The information in this leaflet is for guidance purposes only and is not provided to replace professional clinical advice from a qualified practitioner.

Your comments
We are always interested to hear your views about our leaflets. If you have any comments, please contact the Patient Experience Team - Tel: (01323) 417400 Ext: 5860 or by email at: esh-tr.patientexperience@nhs.net

Hand hygiene
The Trust is committed to maintaining a clean, safe environment. Hand hygiene is very important in controlling infection. Alcohol gel is widely available at the patient bedside for staff use and at the entrance of each clinical area for visitors to clean their hands before and after entering.

Other formats

If you require any of the Trust leaflets in alternative formats, such as large print or alternative languages, please contact the Equality and Human Rights Department.

Tel: 01424 755255 Ext: 2620

After reading this information are there any questions you would like to ask? Please list below and ask your nurse or doctor.

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Reference

The following clinicians have been consulted and agreed this patient information:

The directorate group that have agreed this patient information leaflet:
Women and Children Directorate

Next review date: March 2022
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