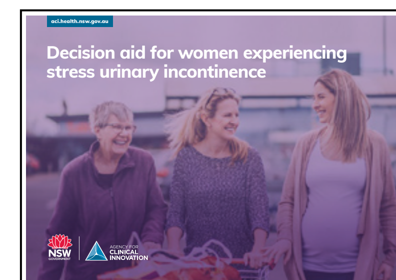
Stress urinary incontinence in women: Management option overview



The Agency for Clinical Innovation *Decision aid for women experiencing stress urinary incontinence* is for women with incontinence and their health professionals (e.g. primary care doctors, continence clinicians and surgeons). The 16-page decision aid provides a detailed overview of urinary incontinence, management options and a worksheet to help women consider these options. This factsheet is an abridged overview of the non-surgical (conservative) and surgical management options.

We recommend to refer to the full decision aid – view or download it at **aci.health.nsw.gov.au/go/incontinence-decision-aid**.

Overview of conservative management options

	DO NOTHING OR WAIT	LIFESTYLE CHANGES	PELVIC FLOOR EXERCISES	CONTINENCE AIDS
What is it?	Not doing anything (or delaying doing something) to manage your incontinence.	Changing your habits or making different choices, such as: • losing weight and maintaining a healthy body weight • avoiding heavy lifting • doing lower impact activities • reducing coughing by quitting smoking or getting treatment • avoiding things that irritate the bladder (such as caffeine) • practising good bladder and bowel habits (such as avoiding constipation).	Exercising the muscles around your vagina, urethra and anus (front and back passage) to strengthen the pelvic floor. Talk to a women's health physiotherapist or continence specialist who will teach you the correct methods, so you get the best possible result.[2]	Using products, such as pads or specially designed underwear, to absorb leakage.
Will it reduce leakage?	No, however there may be natural changes in your incontinence over time.	It depends on what changes are made and other factors – talk to a health professional about your situation.	Half of women (5 out of 10) said their incontinence was cured[3,4] and most women (7 out of 10) said it improved[2].	There is no change in the incontinence, but you may feel more comfortable.
What are some other potential benefits?	You may not feel ready to make a decision about another management approach. You can change your mind any time (at any age).	Overweight and obese women who lose 5–10% of their body weight can expect the incontinence to significantly improve.[3]	Exercises can improve symptoms by helping to increase bladder control.	Using aids may help you feel more confident and be more active.
What are the risks or side effects?	There is a risk that urine leakage may irritate your skin. It is possible for incontinence to worsen as you get older, but this won't make it harder to treat.	It depends on what changes are made and other factors – talk to a health professional about your situation.	Exercises are low risk. In rare cases, they cause pain or discomfort, and if you overdo it, they can make leakage worse temporarily.[4]	An allergic reaction to the aid is possible but rare.
What are the costs?	None.	There may be costs associated with some lifestyle changes, for example with weight loss or quitting smoking.	There may be appointment fees to see specialists. Sometimes this is subsidised or free if in a continence clinic or part of a GP management plan.	It depends on what aids are used and how often. You may be eligible for a subsidy.

Overview of surgical management options

	COLPOSUSPENSION	PUBOFASCIAL/ PUBOVAGINAL SLING	MID-URETHRAL SLING (ALSO KNOWN AS PELVIC MESH TAPE)	PERI-URETHRAL BULKING INJECTIONS
Description	The tissues between the bladder and urethra are lifted and stitched into place. The stitches will remain in the body. This can be an open procedure (through a cut in the lower abdomen) or done through several small cuts (laparoscopic 'keyhole' surgery).[5]	Through a cut in the lower abdomen, a strip of your own tissue is placed under the urethra. The tissue is usually from the thigh or tummy area (there will be a wound where it is removed). Each end is stitched to the abdominal wall tissue. This creates a 'sling', providing support to the urethra and bladder. The stitch will remain in the body.	Through a cut in the vagina, mesh tape is placed under the urethra. Scar tissue forms to keep the mesh in place. This creates a 'sling', providing support to the urethra and bladder. The mesh is designed to stay in the body permanently. The name of the procedure describes how the surgeon inserts the mesh. This can be either behind the pubic bone (retropubic) or into muscles in the upper leg and groin (transobturator).	A water or silicone-based gel is injected around the urethra. This procedure creates an artificial cushion and helps close the urethra.
How long do I stay in hospital?	For open procedures: 3–5 days For laparoscopic procedures: 1–2 days	3–5 days	Overnight or 1 day	1 day
How long does it take to recover?	4–6 weeks	6+ weeks	1 week	1 day
What type of anaesthesia is used?	General anaesthesia (you are unconscious (asleep and numb) during the procedure)	General anaesthesia (you are unconscious (asleep and numb) during the procedure)	General anaesthesia is usually used, but local anaesthesia, which numbs only the area affected by surgery, may be used in some cases.	General anaesthesia (you are unconscious (asleep and numb) during the procedure)
Does it improve SUI* in the short-to medium-term (up to 5 years)?	Improvement in 8 out of 10 women.[5]	Improvement in 8 out of 10 women.[6]	Improvement in 8 out of 10 women.[7]	Results vary. 3–7 women out of 10 see improvement in their continence. More research is needed.
Does it improve SUI* in the long-term (5+ years)?	Improvement in 6 out of 10 women after 5 years.[7]	Improvement in 6 out of 10 women on average.[8]	Improvement in 6 out of 10 women on average.[7,8]	No. Another injection is needed for most women (7–8 out of 10 women) within 2 years.[8]
What are some of the complication rates?[5–12]	1–10 women out of 100 – difficulty urinating; urgency incontinence; tissue damage, pain 1–30 women out of 100 – infection Less than 1 woman out of 100 – Vaginal prolapse – there is a risk that the nearby organs drop into the vagina. This may require later treatment	1–10 women out of 100 – difficulty urinating; urgency incontinence; tissue damage, pain 1–30 women out of 100 – infection	1–10 women out of 100 – difficulty urinating; urgency incontinence; tissue damage, pain, mesh damage 6–10 women out of 100 – chronic leg/groin or abdominal pain (more common with the transobturator approach) 1–30 women out of 100 – infection 1–10 women out of 100 – the mesh can cause damage to other organs (erosion), or may become exposed in the vagina (extrusion)[7]	Complications are unlikely. However, there is an increased risk of urinary tract infection (UTI). Less than 1 woman out of 100 – long term pain, difficulty urinating
Can it be reversed (undone)?	Yes, but it is difficult and must be done by a highly trained surgeon.	Yes, but it is difficult and must be done by a highly trained surgeon.	Yes, but it is difficult and must be done by a highly trained surgeon.	No
What is the cost?	Medicare covers most costs for public patients. If you have surgery as a private patient, the out-of-pocket costs depend on your private insurance cover and doctors' charges.			

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