key points

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Urinary incontinence is a common symptom that can affect women of all ages. It has been estimated that there are more than 3.5 million sufferers in the UK alone.

History taking guides the investigation and management of patients by evaluating symptoms, their progression and the impact of symptoms on lifestyle. The onset of urinary symptoms, their duration and their severity should be recorded. The predominant bother symptom, e.g. urgency, urge incontinence or stress incontinence, should be identified. The clinician should also enquire about colorectal symptoms and genitourinary prolapse. Accompanying symptoms that may indicate the possibility of a more serious diagnosis and which require referral, such as haematuria, persistent bladder or urethral pain, or recurrent UTI, can also be identified when taking a urinary history.

Clinical examination should include an abdominal examination to exclude abdominal mass or palpable bladder, a bimanual examination to exclude pelvic mass, and a vaginal examination. Neurological assessment of the lower limbs and perineum is required if a neurological cause is suspected.

Patients are categorised according to their symptoms into those with stress, mixed or urge incontinence. Women with mixed urinary incontinence, who have an involuntary leakage associated with urgency and also with exertion, are treated according to the symptom they report to be the most troublesome.

Conservative treatment for OAB should be initiated in primary care. Reducing fluid intake and cutting out caffeinated products will often have a dramatic effect. Various drugs, such as diuretics and antipsychotics, alter bladder function and should be reviewed. Bladder training lasting for a minimum of 6 weeks should be offered as first-line treatment to patients with OAB with or without urinary incontinence. Pharmacological suppression of detrusor overactivity with anticholinergics is the most widely used treatment for this condition. Immediate release non-proprietary oxybutynin should be offered to women with OAB or mixed urinary incontinence as first-line anticholinergic drug treatment, if bladder training has been ineffective. Surgery is reserved for those with debilitating symptoms who have failed to derive benefit from medical and behavioural therapy.

Treatment for stress urinary incontinence involves treating the predisposing conditions, e.g. through adjustment of lifestyle (weight reduction if BMI>30, smoking cessation, treatment of chronic cough and constipation), pelvic floor exercises and pharmacotherapy. Duloxetine is the only drug licensed for the treatment of moderate to severe stress incontinence. Surgery can be considered when conservative measures have failed and the woman's quality of life is compromised.