Provincial Female Urinary Incontinence (UI) Primary Care Clinical Pathway

Rule out reversible UI:
Acute onset, ≤6 months, improves when underlying cause addressed.

Assess for DIPPERS
Delirium
Infection (urinary)
Pharmaceuticals
Psychological disorders
Excessive urine output
Restricted mobility
Stool impaction

Not reversible UI

OR

No improvement with treatment

1a. History of Present Illness

- Leakage (frequency and amount)
- Initial screen for subtype
- Pain
- 24-hour urinary frequency pattern (awake/asleep)
- Sensation of vaginal bulge
- Impact on QoL/ADLs

1b. Relevant Medical History

- Assess for general risk factors
- Chronic diseases
- Previous surgeries (abdominal/pelvic surgeries)
- History of pelvic cancers / radiation
- Cognitive decline, frailty, fall risk
- Total daily fluid intake/type of fluids (alcohol, carbonated beverages, caffeine)
- Obstetric/post-menopausal history
- Medications, smoking

For non-urgent advice, please consult specialist advice. See referral guideline tab for details.

2. Physical Exam Guided by patient history, may include:

- General status (mental status, obesity, mobility)
- Abdominal exam
- Pelvic exam (pelvic floor muscles, pelvic organ prolapse, vaginal estrogenization, presence of pelvic mass, evidence of fistula)
- Cough stress test

3. Red Flags

Abdominal/pelvic mass with UI, obtain urgent ultrasound:
a. Non-gynecological mass (bladder/bowel)
b. Mass is of gynecological origin

- a. Refer to Urology/Colorectal surgeon as indicated. See referral guideline for details.
- b. If **suspicious**, refer to Gynecology or Gynecology Oncology. If **benign**, refer to Gynecology. See referral guideline tab for details.

- Gross hematuria **or** microscopic hematuria (≥3-5 rbc/hpf on 2 of 3 specimens)
- UI with diagnosis of neurological disease

→ Refer to Urology. See referral guideline for details.

- Suspicion of vesico/urethral vaginal fistula
- History of mesh pelvic surgery or past pelvic radiation (radiation cystitis)

→ Refer to Urology or Urogynecology. See referral guideline for details.

No red flags

AND

Reversible causes ruled out

4. Investigations

- Routine lab, microscopic UA recommended
- 3-day patient bladder diary
- If concerned about emptying, measure post void residual

5. Diagnose Type of Incontinence

a. Stress
Leak with exertion (cough, laugh, lift, sneeze, strain)

b. Urgency/Overactive Bladder (OAB)
Leak with urgency on way to washroom **OR**
Void > 8x in 24hr or > 2x at night (sleep)

c. Mixed
Leak with urge and exertion

Other
Overflow, neurogenic, disability-associated incontinence

6. Management Therapies (a, b, c can occur concurrently)

a. Trial Conservative Management Therapies for 6 months for all types of Urinary Incontinence

- Pelvic floor muscle training +/- physical therapy
- Patient education and counselling about lifestyle changes
- Scheduled voiding/bladder training
- Vaginal estrogen for genitourinary symptom of menopause (if appropriate)

b. Medication Management *(Urgency/OAB, consider)*
Trial course of Antimuscarinics or Beta 3 agonist

Incontinence persists → Refer to Specialized Continence Service or skilled community provider for **advanced medical management and/or surgical intervention**. See referral guideline tab for details.

c. Pessary Assessment *(Stress incontinence only)*

Patient **not** interested → Refer to Specialized Continence Service or skilled community provider for **advanced medical management and/or surgical intervention**. See referral guideline tab for details.

If failed pessary trial, consider surgery

Patient interested → Refer to Specialized Continence Service or skilled community provider for **pessary trial.** See referral guideline tab for details.

See referral guideline tab for details on useful information to aid triage with all referrals