Worcestershire Acute Hospitals NHS Trust

Referral to Uro-dynamics within the Uro-gynaecology department

Key Document code:	WAHT-TP-027	
Key Documents Owner:	Mr Moran	Consultant Gynaecologist
Approved by:	Gynaecology Governance Meeting	
Date of Approval:	14th December 2020	
Date of review: **This is the most current version and should be used until a revised document is in place**	20th February 2025	

Key Amendments

Date	Amendment	Approved by
26th January 2019	Documents extended for 3 years	Mr Hughes
14th December 2020	Documents approved for 3 years	Miss Blackwell
29th December 2023	Document extended for 6 months whilst under review	Alex Blackwell
20th August 2024	Document extended for 6 months whilst under review	Alex Blackwell

Introduction

Staffing groups to who this pathway applies:

- Primary care trusts
- Gynaecology and obstetric consultants
- Community continence advisors
- Women's Health Physiotherapists
- Clinical nurse specialist in urogynaecology
- Urogynaecology specialist nurses

Rationale

Urodynamics is an invasive procedure carried out to determine the cause of urinary symptoms such as incontinence and voiding difficulties.

The term urodynamics can be used to describe all investigations of the lower urinary tract, this document will cover the following investigations;

- Uroflowmetry
- Filling cystometry
- Voiding cystometry

Uroflowmetry – A free flow void into a recording device, which provides the practitioner with information about the volume of urine passed and the rate of urine flow.

Cystometry – the measurement of intravesical pressure, which can be carried out through fluid filled recording channels and involves the synchronised measurement of both bladder and intra-abdominal pressures by the means of catheters inserted into the bladder and the rectum or vagina. The aim is to replicate the woman's symptoms by filling the bladder and observing pressure changes or leakage caused by provocation tests.

Through activities such as coughing and moving and describing bladder symptoms the graph can be annotated and used to enable a medical diagnosis to be reached. Only following urodynamic investigations can a diagnosis of detrusor overactivity or urodynamic stress incontinence be made.

This pathway has been produced to provide:-

- Guidelines for referral to the urogynaecology department for urodynamic investigations to assist care and treatment planning *(DOH 2002).*
- A frame work for teaching and good practice.
- Standards for audit.

Policy standards

All practitioners must comply with their professional organisations guidance on expanding roles.

All nursing staff must comply with the NMC code of conduct.

Evidence should exist in the patient's records that the following standards have been met:

- A clear rationale for the purpose of the referral.
- In cases of urinary incontinence without prolapse, evidence of conservative treatment commenced before referral for urodynamics *(NICE 2007).*
- Evidence of discussion with the patient about the reason and purpose of the referral for urodynamics.
- Urodynamic information leaflet and bladder diary/frequency volume chart has been given to the client with the appointment details to enable informed choice and reduce anxiety about the procedure. Contact numbers should be included for any queries or concerns.
- A telephone call a week before the appointment for urodynamics by a member of the urogynaecology specialist nursing team to provide an opportunity for the patient to ask questions and express concerns.

Indications to offer Urodynamic investigations

The use of multi-channel cystometry, ambulatory urodynamics or videourodynamics is not recommended before starting conservative treatment.

Patients will be offered Urodynamic investigations:

- If a diagnosis cannot be reached following a full continence assessment.

- Where the initial treatment for continence has not been successful.
- To increase diagnostic accuracy above that which can be achieved by non-urodynamic means.
- To make a clinical observation on which a management plan can be based.
- If there are co-existing abnormalities to provide evidence to determine which should be treated first.
- To define the current situation, knowing the likely abnormalities, as a baseline for future surveillance.
- To predict problems that may follow treatment interventions.
- To assess the natural history of lower urinary tract dysfunction.
- To provide evidence that influences the timing of treatment.
- To exclude abnormalities which may interfere with the management of that patient?
- To assess the results of treatments designed to affect lower urinary tract function.
- If there is a neurological history such as CVA, MS, Parkinson's and baseline data would aid treatment.

Urodynamics should be undertaken prior to surgery in all cases (RCOG).

Urodynamic investigation appointments will be requested by letter to the Urogynaecology department based at Room 4, Ground floor, Management block, Worcestershire Royal Hospital, Charles Hastings Way, Worcester WR5 1DD.

NICE guidance states that multi-channel filling and voiding cystometry is recommended in women before surgery for SUI if:

- There is clinical suspicion of detrusor overactivity, or
- There has been previous surgery for stress incontinence or anterior vaginal prolapse, or
- There are symptoms to suggestive of voiding dysfunction.

Ambulatory urodynamics or videourodynamics may also be considered where diagnosis is still in doubt, but these tests are not performed at WAHT and would require referral to Birmingham Women's Hospital.

Exclusions or contra-indications

- Lack of informed verbal/written consent
- Lack of previous conservative treatment in women where prolapse surgery is not also indicated.

Precautions and risk factors

- Painful bladder syndrome
- Acute urinary tract infections – if symptoms and signs of UTI are present the test should be delayed or an MSSU should be sent and antibiotics given (at the direction of the clinician performing the investigation).

Consent

A full verbal explanation of the test must be given as a supplement to the written information given to the patient with their appointment details.

Verbal consent for the procedure will be discussed and requested from the patient immediately prior to the procedure in the urodynamic department.

Best practice suggests that to enable the patient to give informed consent the procedure should be discussed at the time of referral and an information leaflet provided. In addition, an information leaflet will be sent in the post with the appointment details.

When obtaining valid consent the aim is to ensure patients are given consistent and adequate information together with a dedicated patient information leaflet and following generic clinical standards related to patient expectations as set by the GMC. The clinician obtaining informed consent should discuss the following with the patient.

- ✓ Name of proposed procedure or course of treatment.
- ✓ The proposed procedure – The procedure should be explained as it is described in the accompanying information.
- ✓ Intended benefits – How the results will be used.

Royal College of Obstetricians and Gynaecologists 2004 (www.rcog.org.uk)

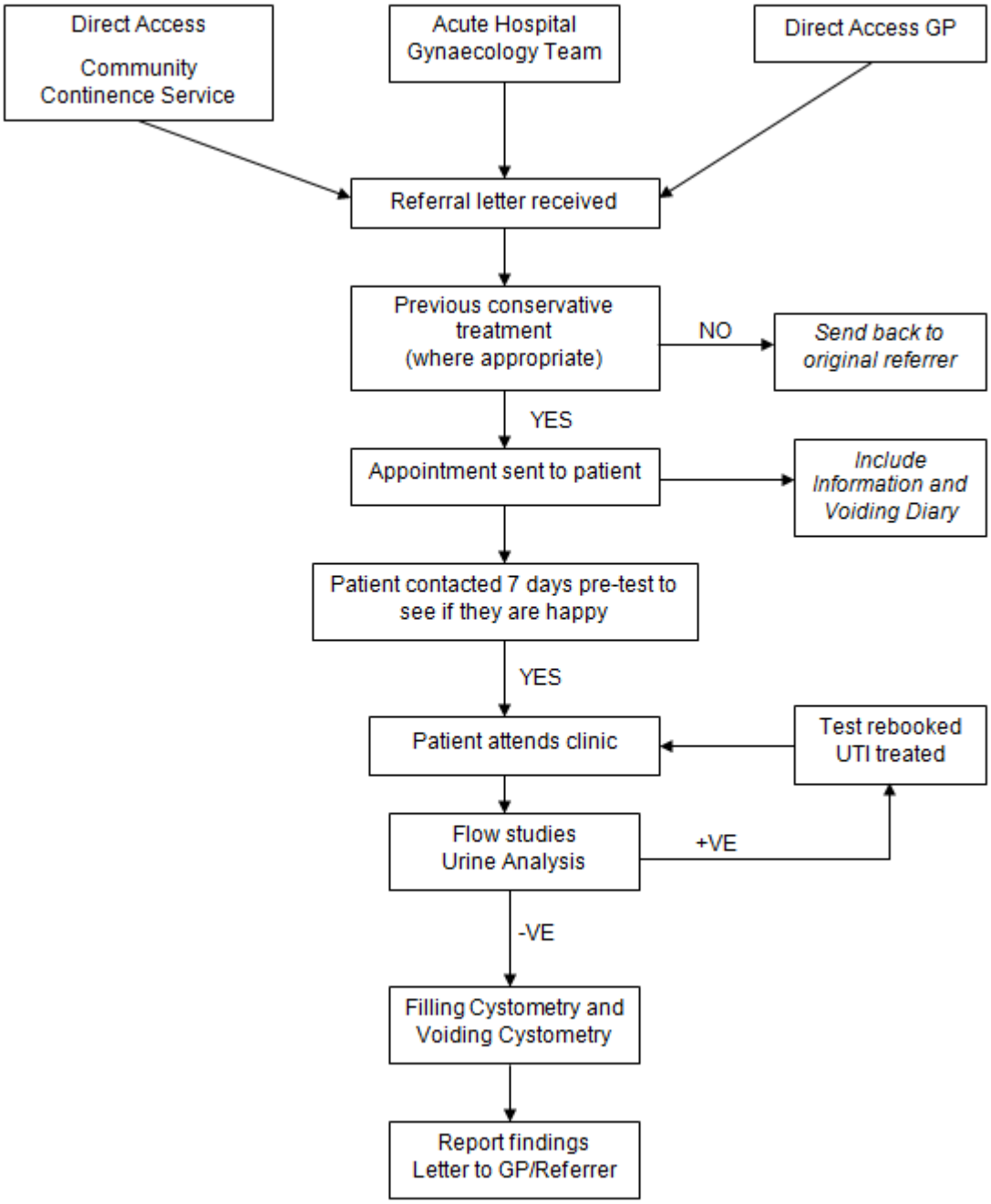
Consent should be obtained as per the trusts policy for obtaining informed consent. Reference guide to consent for examination or treatment. **(DOH 2001)** www.dh.gov.uk

From April 2007 healthcare professionals will need to follow a code of practice accompanying the mental capacity act. www.dca.gov.uk/menincap/bill-summary.htm

Action	Rationale
All potential referrals will have a full continence assessment. To include:- • Urinalysis • Frequency/ volume chart • Residual urine measurement by bladder scan • Pelvic floor muscle assessment • Medical and continence history	(DOH 2000) • To identify any urine abnormalities • To identify any patterns or symptoms • To identify incomplete bladder emptying • To assess tone, endurance and strength of muscles • To facilitate a holistic continence assessment.
A referral for urodynamic investigations may be under the following circumstances:- • Where the Urogynaecology clinical nurse specialist or other is unable to make a satisfactory diagnosis following the assessment. • Where the initial conservative treatment has been unsuccessful. • If the patient has a neurological history e.g. CVA, MS, Parkinson's disease.	To obtain an objective baseline for treatment

The Urogynaecology clinical nurse specialist / other will inform the client's GP in writing of the referral	To ensure the GP is fully aware of any interventions carried out
All clients will be given a full explanation of the procedure and a leaflet explaining the procedure. Contact numbers will be given and a telephone call a week before the appointment should be made by the urogynaecology department	To ensure sufficient information is available for client to give informed consent, and ensure dignity and privacy. To give the client the opportunity to ask questions
A letter of referral to the urogynaecology department will be sent from referring department	To ensure correct referrals are made and waiting times are within the 18 week pathway
Following the urodynamic investigations all results will be interpreted by the urogynaecology clinical nurse specialist / other and discussed / reported to the referring department	To enable a plan of care to be devised for the client
No further cost incurring action will be taken without consultation with the clients GP	To maintain GP budgets

Uro-Gynaecology Pathway
WAHT-TP-030



This information should be used in conjunction with the URO-GYNAECOLOGY PATHWAY WAHT-TP-027. Use the version on the internet to ensure the most up to date information is being used.