Worcestershire Acute Hospitals NHS Trust

Gynaecology Key Documents

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Approved by on:	13th November 2020
Review Date This is the most current document and should be used until a revised version is in place:	20th February 2025

Key Amendment

Date	Amendment	Approved by
24th November 2021	Minor amendments	Miss Alex Blackwell
29th December 2023	Document extended for 6 months whilst under review Owner updated	Alex Blackwell
20th August 2024	Document extended for 6 months whilst under review	Alex Blackwell

Gynaecology Bladder Care Guideline

Rationale

Effective post surgical bladder care following gynaecological surgery will enhance patient care, promote recovery and facilitate discharge, demonstrating the Trust 4ward signature behaviour, 'no delays, and every day.'

This guidance applies to all patients under the care of gynaecology across Worcestershire Acute Hospitals NHS Trust and includes pathways to ensure adequate bladder emptying for safe discharge. It refers to catheter removal and Trial Without Catheter (TWOC).

Introduction

Urinary retention (also known as voiding dysfunction) is the inability to empty the bladder normally. Post-operative urinary retention is a common consequence of gynaecology surgery, especially following urogynaecology surgery[2] and surgery to resect severe endometriosis. Urinary retention after incontinence and prolapse surgery, range from 2.5% to 24%[2] and up to 30% with resection of deeply infiltrating endometriosis[3].

Post surgical changes leading to urinary retention are oedema, inflammation, damage to peripheral nerves, over correction of the urethral angle, post-operative pain and regional anaesthesia.[2] Constipation can also be a risk factor.

Urinary retention can cause the bladder to become over distended if not diagnosed and treated promptly. Over distension of the bladder can result in long term damage to the bladder muscle and function, which may require permanent life-long catheter use.

Diagnosis of urinary retention

Signs and symptoms of voiding dysfunction or urinary retention include:

- Urinary frequency
- Voiding small amounts
- Slow or intermittent stream
- Bladder pain or discomfort
- Straining to void
- Reduced sensation to void
- Feeling of incomplete bladder emptying
- Urinary incontinence
- Palpable, distended, tender bladder on abdominal examination.

Women at highest risk of bladder dysfunction

- Urogynaecology surgery for prolapse or urinary incontinence
- Surgery involving resection of deeply infiltrating endometriosis (especially involving retropubic spaces and uterosacral ligaments)
- Use of opiod analgesia
- Spinal anaesthesia
- Low BMI
- UTI
- Age > 50yrs

Post-operative bladder care

Post-operative urinary retention or voiding dysfunction is likely to depend on the type of surgery performed. See post-operative flowcharts for bladder care after gynaecology operations (Appendices 1 – 3). On some occasions the flowchart (Appendices 1 – 3) that should be used for a patient will depend on the perceived risk of post-operative voiding dysfunction. The complexity or nature of the surgery may determine the risk to a greater extent than the surgical procedure by itself.

Patients who have had day case operation with no indwelling catheter (Appendix 1)

- For example, patients who have had hysteroscopy, cystoscopy or Surgical Management of Miscarriage also known as Evacuation of Retained Products of Conception (ERPOC) with no indwelling catheter.
- These patients are at low risk of voiding difficulties or urinary retention.
- Encourage patient to empty bladder within 4 hours of operation.
- The voided volume does not need to be measured.
- Once the patient has passed urine, they can be discharged home.
- If unable to void within 4 hours of operation, refer to flowchart for care of patients who are unable to void (Appendix 4).

Patients who have had laparoscopic surgery with no indwelling catheter (Appendix 2)

- For example, patients who have had a diagnostic laparoscopy, laparoscopic salpingo-oophorectomy or simple endometriosis surgery with no indwelling catheter.
- Encourage patient to empty bladder within 4 hours of operation.
- The voided volume should be measured and a bladder scan performed to check the post-void residual.
- If the patient voids >200mls with a residual of <150mls they can be discharged.
- If patient voids <200mls encourage oral intake and advise to wait to pass urine until feels the urge to empty bladder. Allow further 2 hours to pass urine.

- If a patient has voided >200mls with a residual >150mls, refer to flowchart for care of patients with high post-void residuals (Appendix 4).
- If unable to void within 4 hours of operation, refer to flowchart for care of patients who are unable to void (Appendix 4).

Patients who have had complex laparoscopic or open/urogynaecology surgery with an indwelling catheter/vaginal pack (Appendix 3)

- Patients who have had a complex laparoscopic surgery, e.g. resection of moderate/severe endometriosis with an indwelling catheter are at increased risk of voiding difficulty or urinary retention post-operatively.
- Patients who have had a total abdominal hysterectomy (TAH), prolapse repair surgery or surgery for urinary incontinence with and indwelling catheter are at highest risk of voiding dysfunction or urinary retention.
- Encourage patient to empty bladder within 4 hours of catheter removal.
- The voided volume should be measured and a bladder scan performed to check the post-void residual on 2 consecutive voids.
- If the patient voids >200mls with a residual of <150mls on 2 consecutive voids they can be discharged.
- If patient voids <200mls encourage oral intake and advise to wait to pass urine until feels the urge to empty bladder. Allow further 2 hours to pass urine.
- If a patient has voided >200mls with a residual >150mls, refer to flowchart for care of patients with high post-void residuals (Appendix 4).
- If unable to void within 4 hours of catheter removal, refer to flowchart for care of patients who are unable to void (Appendix 4).

Management of patients who fail to void or have high post void residuals (Appendix 4)

- Patients who have been completely unable to void post-op should have an indwelling catheter inserted and an outpatient trial without catheter (TWOC) arranged via the Emergency Gynaecology Assessment Unit (EGAU) after 48 hours (see appendix 5). Any potential causes of urinary retention (e.g. pain, constipation, UTI) should be addressed.
- For patients with a residual of 150 – 400mls, check for causes of urinary retention (e.g. pain, constipation, UTI) and ask them to try and void again after 1 hour and check residual with bladder scan.
- For patients with a residual of >400mls, ask them to go back to the toilet and try to pass urine again (double voiding). If they pass urine, perform another bladder scan to check if residual now <150mls. If unable to void, pass an in/out catheter (recording residual volume) and restart pathway.
- For *urogynaecology patients* who have a high residual volume on 2 occasions, they should have an indwelling catheter inserted and an outpatient TWOC arranged via GAU in 48 hours (see appendix 5).
    - Includes patients who have had: anterior or posterior repair, sacrospinous fixation, vaginal hysterectomy, sacrocolpopexy, sacrohysteropexy. TVT, bulkamid, colposuspension and colpocleisis.
    - For patients in urinary retention following bulkamid a paediatric (size 10) catheter must be used.
- For *all other post-op laparoscopy patients* who have a high residual volume on 2 occasions, they should be taught how to perform clean intermittent self-catheterisation (CISC) and discharged with a bladder diary to complete and telephone follow-up via GAU in 3 days (see appendix 5).

- All patients who are discharged with an indwelling catheter should receive a copy of the catheter passport for information on catheter care.

Management/follow-up for patients who are performing CISC on discharge

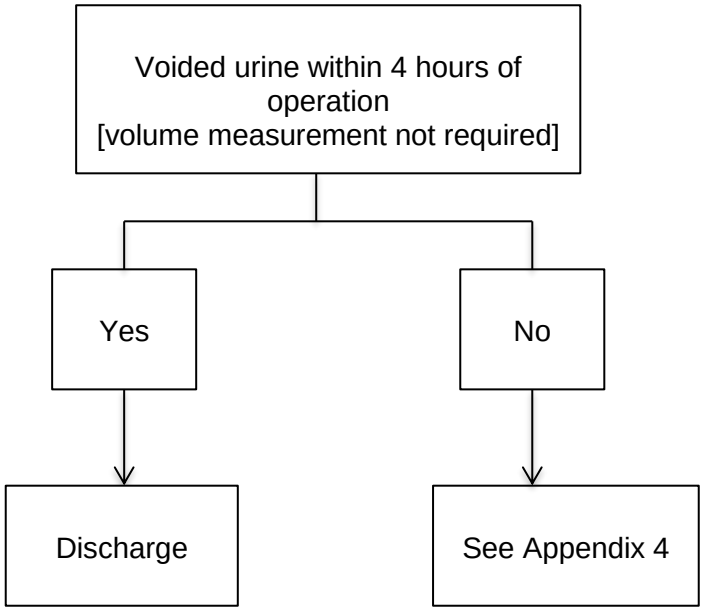
- All patients must be given a bladder passport, which explains catheter care, before discharge.
- Patients performing CISC must be given a bladder diary to complete, to measure their voids and post-void residual drained using the catheter.
- Patients performing CISC will have daily telephone follow-up from GAU to check their recorded voids and post-void residuals. They will continue using CISC until their post-void residuals measure <150mls. If patients are still using CISC 7 days after discharge they should be referred to the urogynaecology specialist nurses.

Outpatient trial without catheter protocol for patients with an indwelling catheter on discharge (i.e. all Urogynaecology patients who fail their first post-op TWOC) (Appendix 5)

- All patients must be given a bladder passport, which explains catheter care, before discharge.
- Patients should have an appointment made for an outpatient TWOC in GAU.
- The catheter should be removed and the patient educated regarding hydration and bladder emptying.
- If the patient is unable to void urine after a mid-urethral tape or vaginal repair, consider loosening of the tape/take down of the repair under general anaesthetic in theatre. The patient should be discussed with the urogynaecology team. It is likely a second period of indwelling catheterisation will be recommended first.
- Patients who have high post void residuals (post void residual of >150mls with a void of >200mls) following TWOC, should have another indwelling catheter inserted and a further outpatient TWOC via GAU arranged in 5 – 7 days.
- If the patient should have a second failed outpatient TWOC, the urogynaecology consultant should be informed. The decision then needs to made by the urogynaecologist with respect to two options:
    1. The patient should be taught CISC and follow-up arranged with the urogynaecology specialist nurses, ***or***
    2. Consideration to obstruction relieving surgery (bladder neck take down/ TVT loosening in theatre)
- If the patient has post void residuals of <150mls with a void of >200mls on 2 consecutive occasions they can be discharged.

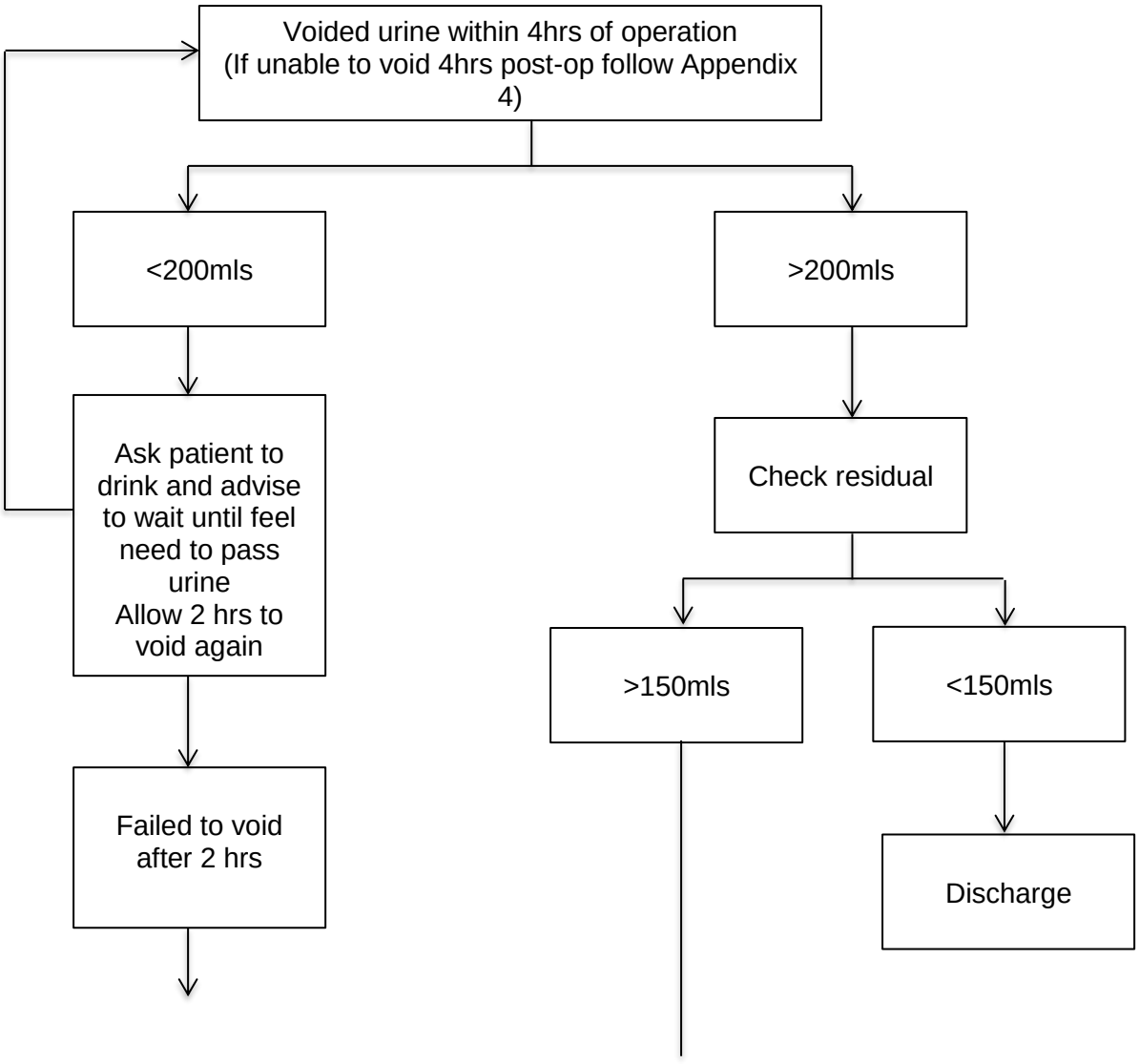
Appendix 1: Day case operation without indwelling catheter

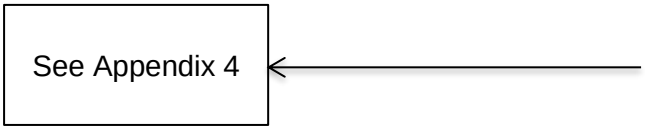
- Hysteroscopy
- Cystoscopy
- ERPOC



Appendix 2: Laparoscopic operation without indwelling catheter

- Diagnostic laparoscopy
- Routine operative laparoscopy (sterilisation, salpingo-oophorectomy, ovarian cystectomy, ablation or excision of mild- moderate endometriosis)
- Routine total laparoscopic hysterectomy/ subtotal hysterectomy





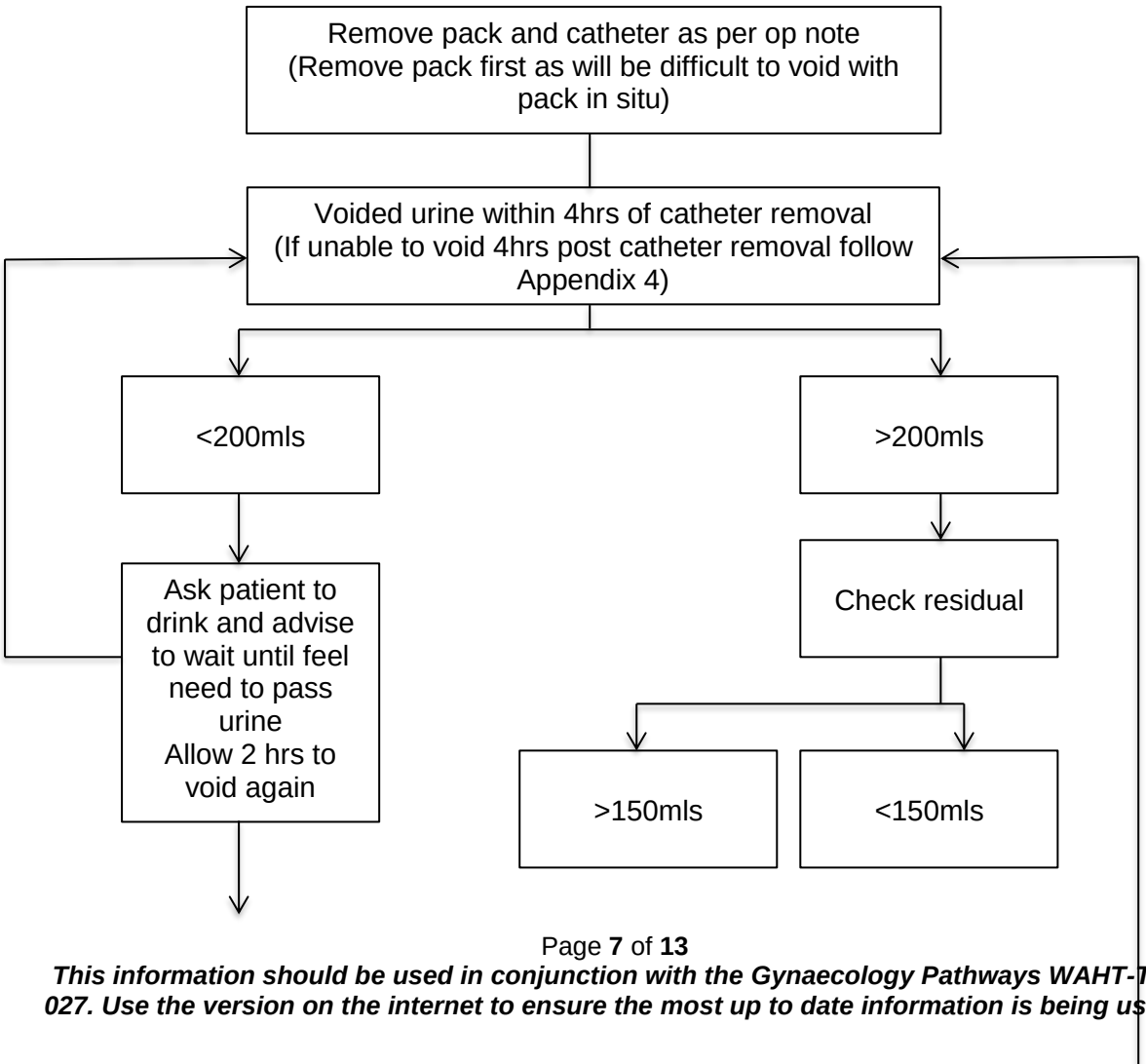
Appendix 3: Laparoscopic or open/urogynaecology operation with an indwelling catheter/vaginal pack

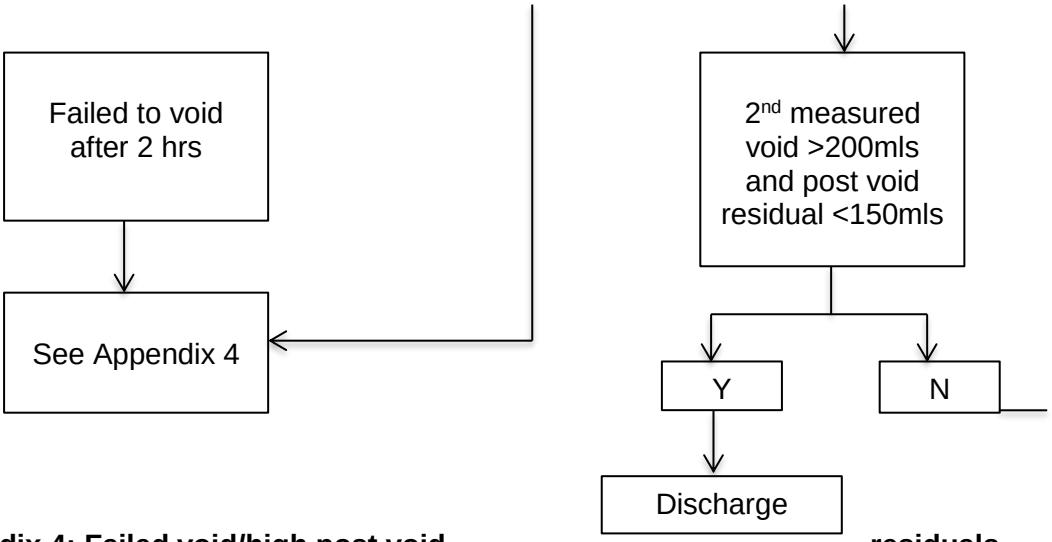
Intermediate risk of voiding dysfunction:

- Complex TLH
- Resection of moderate - severe endometriosis
- Simple prolapse repair
- TAH

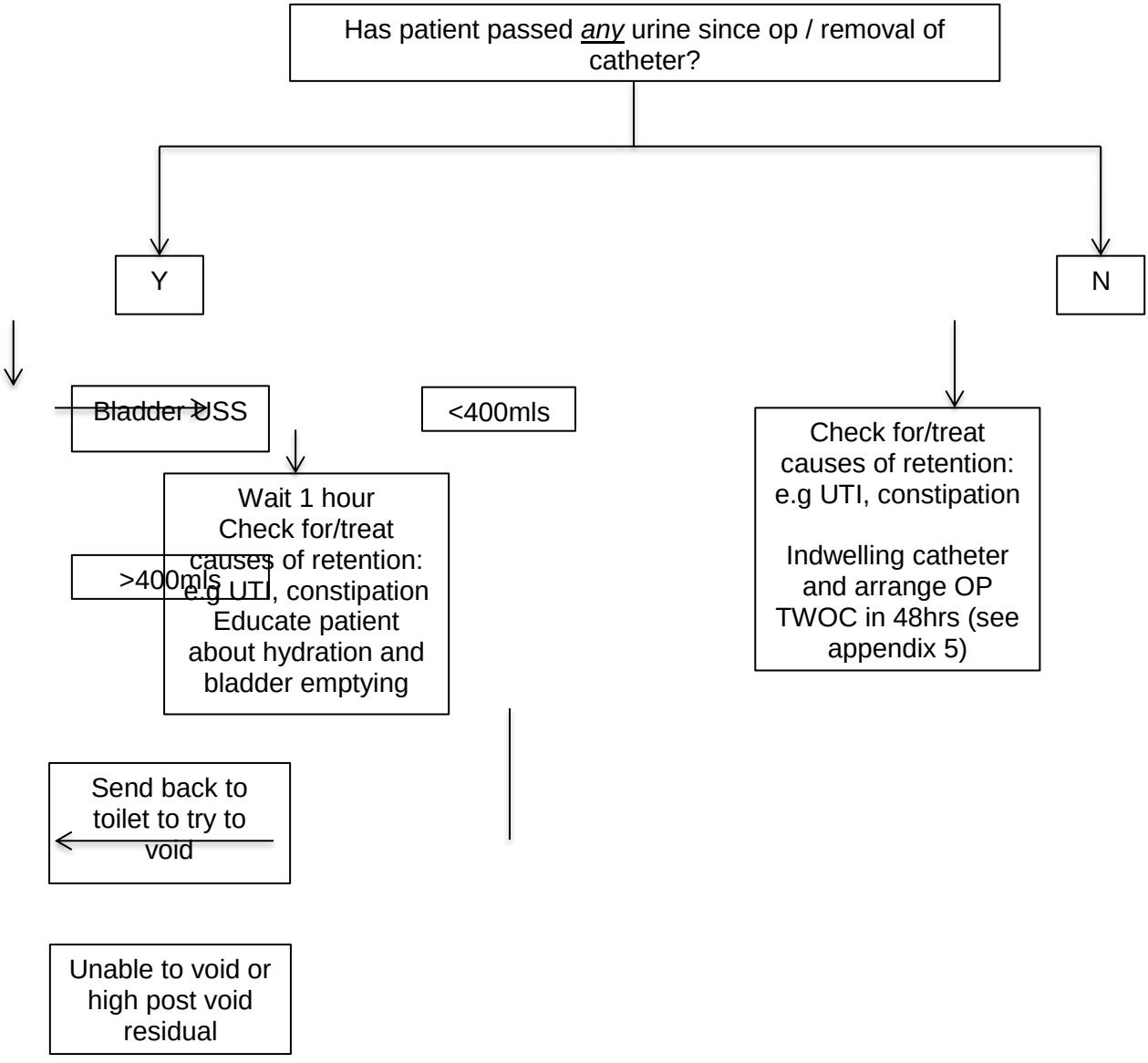
High risk of voiding dysfunction:

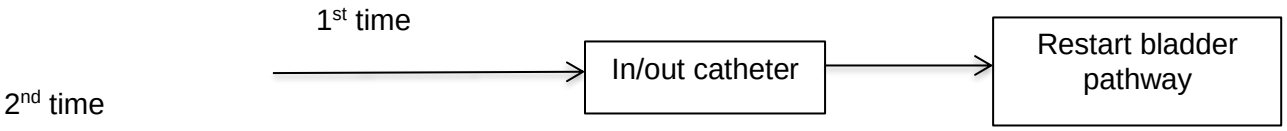
- Vaginal hysterectomy
- SSF
- TVT
- Sacrocolpopexy
- Resection of severe endometriosis





Appendix 4: Failed void/high post void residuals





Inform Gynae SPR on call

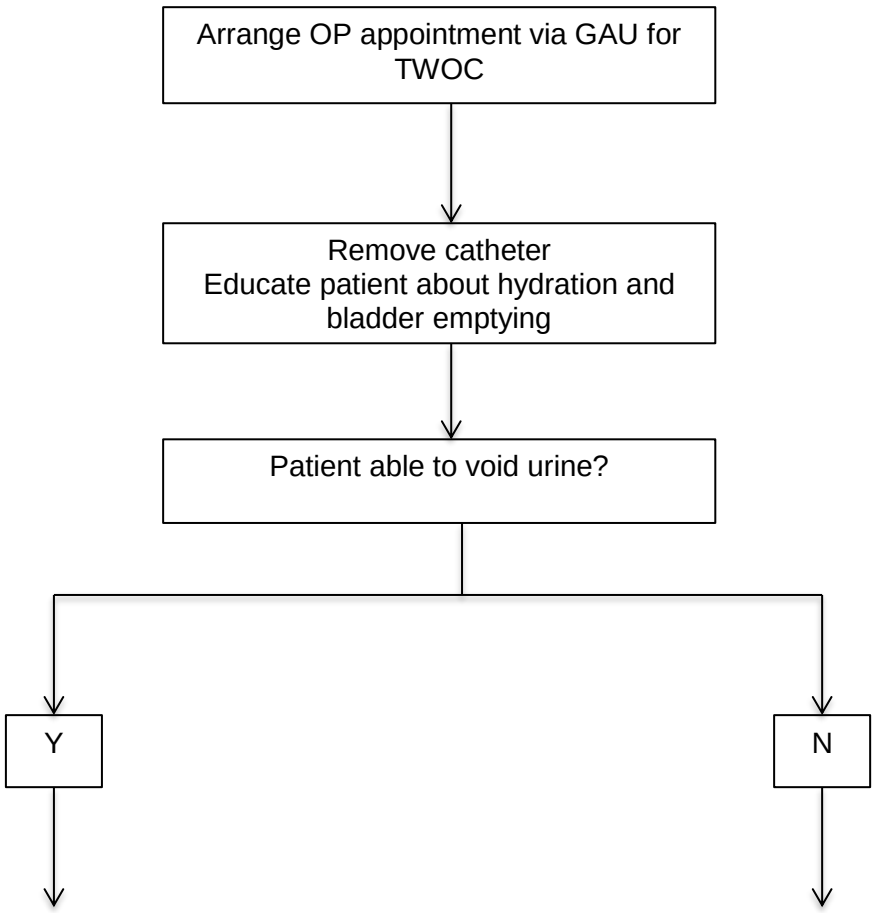
For urogynaecology (UG) patients: Indwelling catheter and contact EGAU Ext 30425 to arrange OP TWOC in 2 days (see Appendix 5)

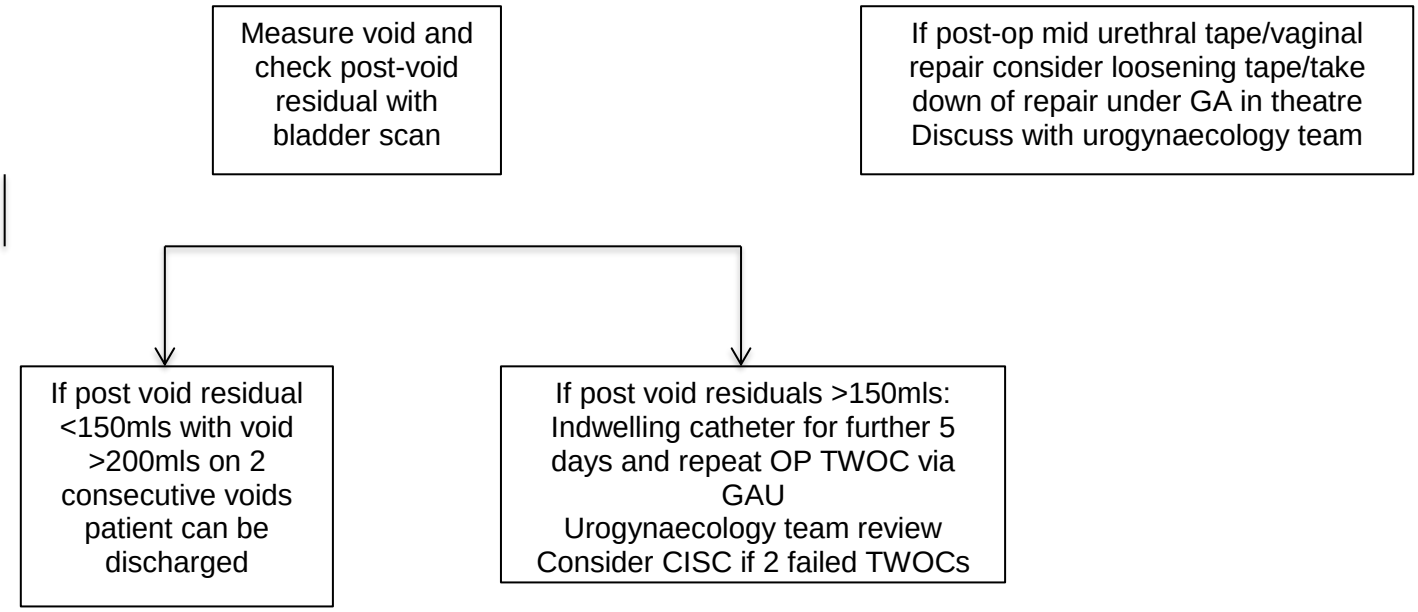
For non-UG patients at WRH: Teach patients CISC to drain residual following void and discharge home with bladder diary.
Telephone follow-up via EGAU in 3 days to review recorded post-void residuals.

For non-UG patients at KTC or AHR: Indwelling catheter and contact EGAU Ext 30425 to arrange OP TWOC in 1-3 days (see Appendix 5)

Appendix 5: Outpatient

TWOC protocol





References

1. Yip SK et al. Postpartum urinary retention. Acta Obstetria et Gynecologica Scandinavia. 2004. 83(10):881 – 891.
2. Geller EJ. Prevention and management of postoperative urinary retention after urogynecologic surgery. 2014. 6:829 – 838.
3. Dubernard G et al. Urinary complications after surgery for posterior deep infiltrating endometriosis are related to the extent of dissection and to uterosacral ligaments resection. J Minim Invasive Gynecol. 2008. 15(2):235 - 240.

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**	No	
	Race		
	Ethnic origins (including gypsies and travellers)		
	Nationality		
	Gender		
	Culture		
	Religion or belief		
	Sexual orientation including lesbian, gay and bisexual people		
	Age		

2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.