CAMFiC
societat catalana de medicina familiar i comunitària

Generalitat de Catalunya
Departament de Salut

CatSalut
Servei Català de la Salut

XIX Jornades d'Actualització Terapèutica 2019

DE LES GUIES A LA PRÀCTICA CLÍNICA

TAULA 2 - Coordinació: Abordatge de la incontinència urinària, optimitzem el flux

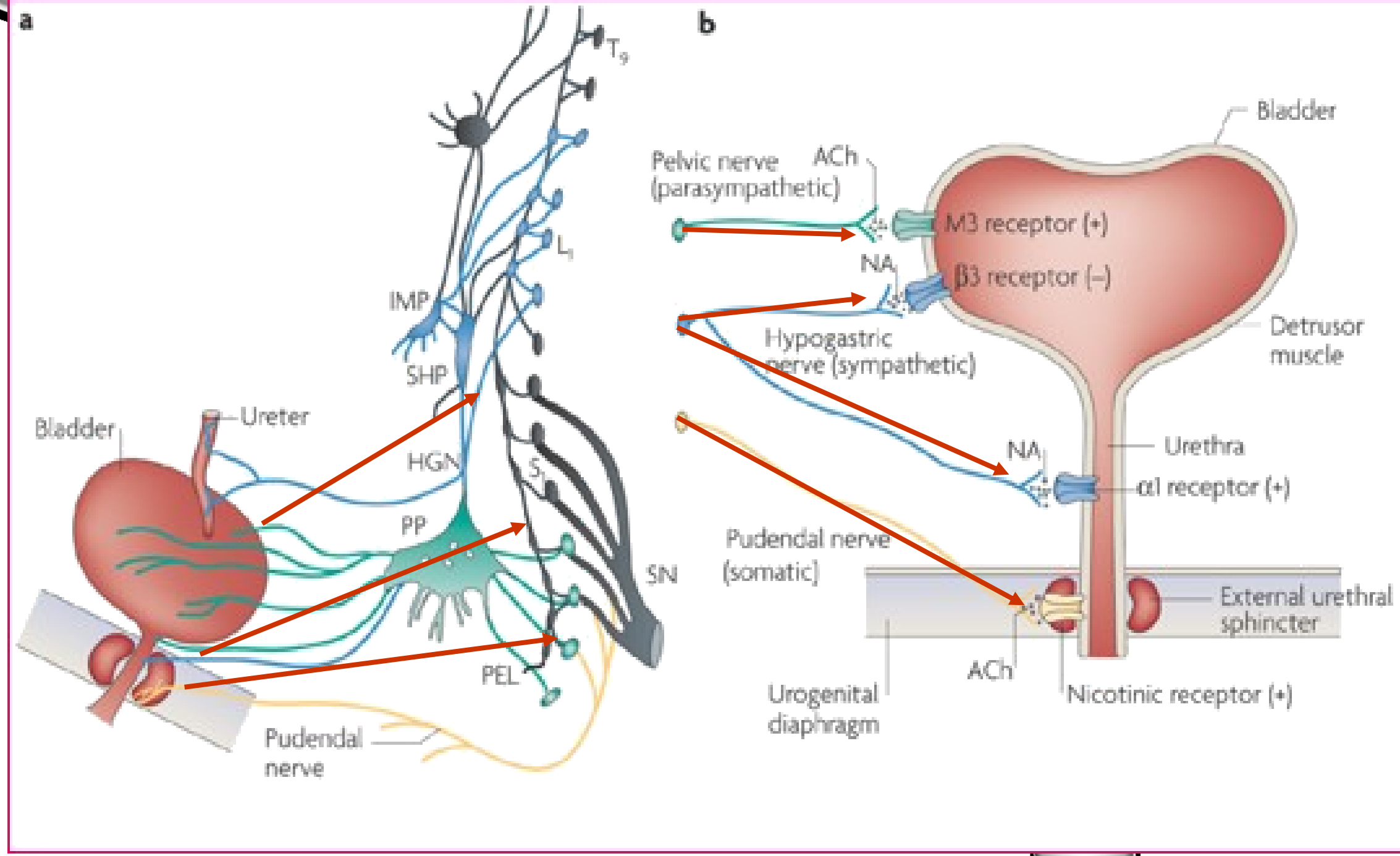
Moderador/a:

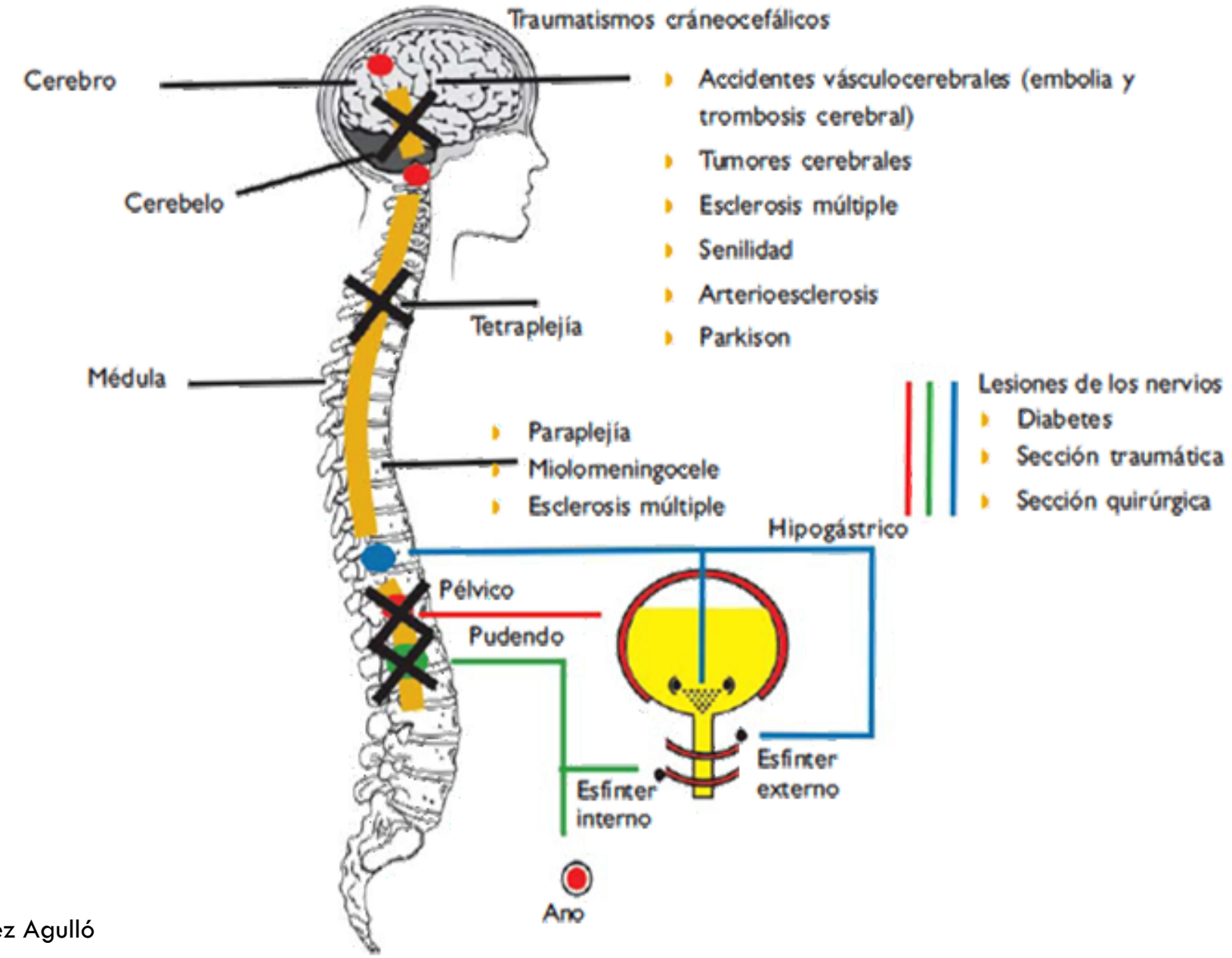
Ponents: **M. Antònia Vila.** Metgessa de família, GdT d'Incontinència urinària de la CAMFiC

Agustín Franco. Uròleg, Hospital Clínic de Barcelona

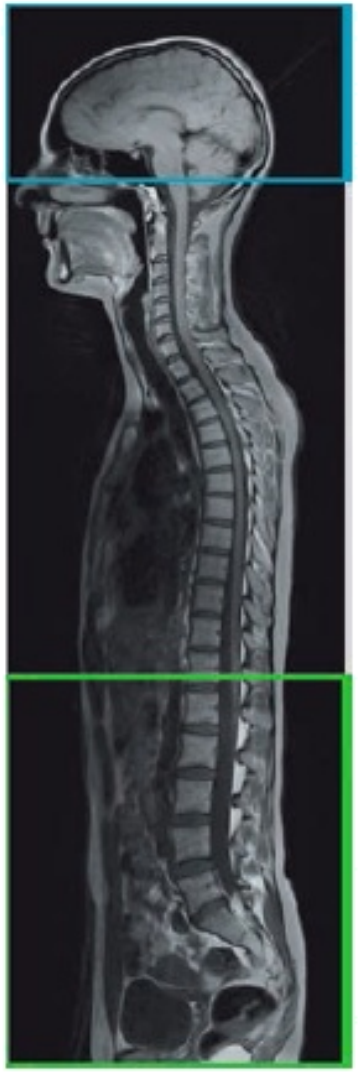
Universitat de Barcelona

CLÍNIC BARCELONA Hospital Universitari


a
T_9
L_1
IMP
SHP
HGN
PP
S_2
SN
PEL
Bladder
Ureter
Pudendal nerve
b
Bladder
Pelvic nerve (parasympathetic)
ACh
M3 receptor (+)
NA
β3 receptor (–)
Hypogastric nerve (sympathetic)
Detrusor muscle
NA
Urethra
α1 receptor (+)
Pudendal nerve (somatic)
External urethral sphincter
ACh
Urogenital diaphragm
Nicotinic receptor (+)



Autor: Eduardo Martínez Agulló



Suprapontine lesion
- History: predominantly storage symptoms
- Ultrasound: insignificant PVR urine volume
- Urodynamics: detrusor overactivity

Spinal (infrapontine-suprasacral) lesion
- History: both storage and voiding symptoms
- Ultrasound: PVR urine volume usually raised
- Urodynamics: detrusor overactivity, detrusor-sphincter dyssynergia

Sacral/infrasacral lesion
- History: predominantly voiding symptoms
- Ultrasound: PVR urine volume raised
- Urodynamics: hypocontractile or acontractile detrusor

Normo-active

Overactive

Normo-active

Underactive

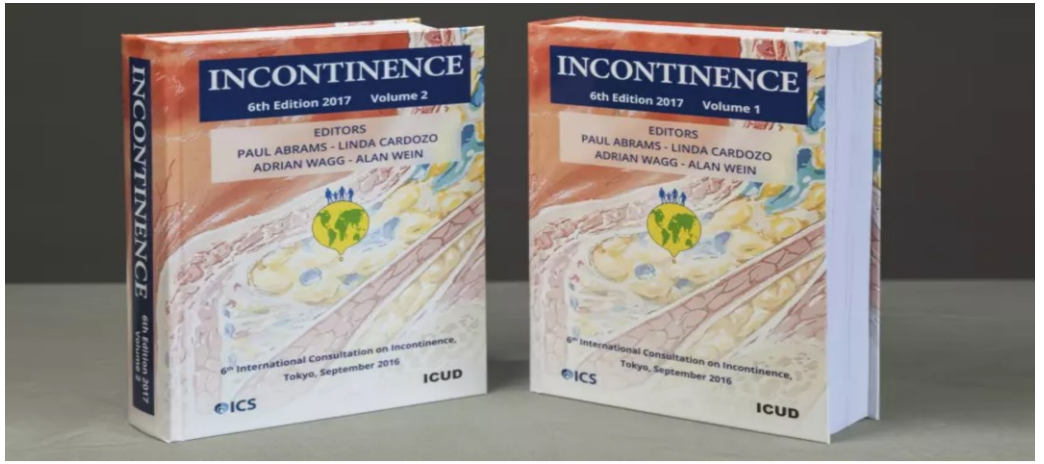
Figure 2 | **Patterns of lower urinary tract dysfunction following neurological disease.** The pattern of lower urinary tract dysfunction following neurological disease is determined by the site and nature of the lesion. The blue box denotes the region above the pons and that in green denotes the sacral cord and infrasacral region. Figures on the right show the expected dysfunctional states of the detrusor–sphincter system. PVR, post-void residual. Reproduced with permission obtained from Elsevier © Panicker, J. *et al. Lancet Neurol.* **14**, 720–732 (2015).

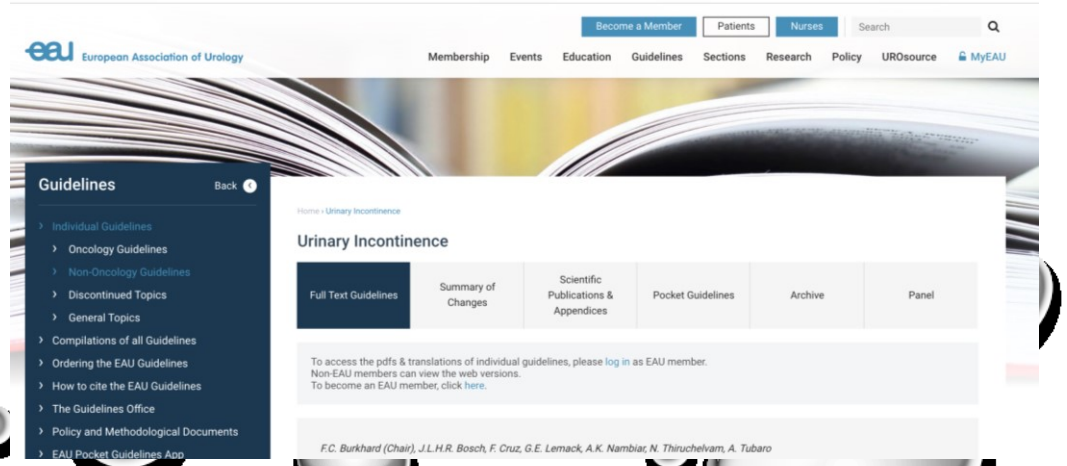
ABORDAJE DE LA INCONTINENCIA URINARIA OPTIMIZACIÓN DEL FLUJO

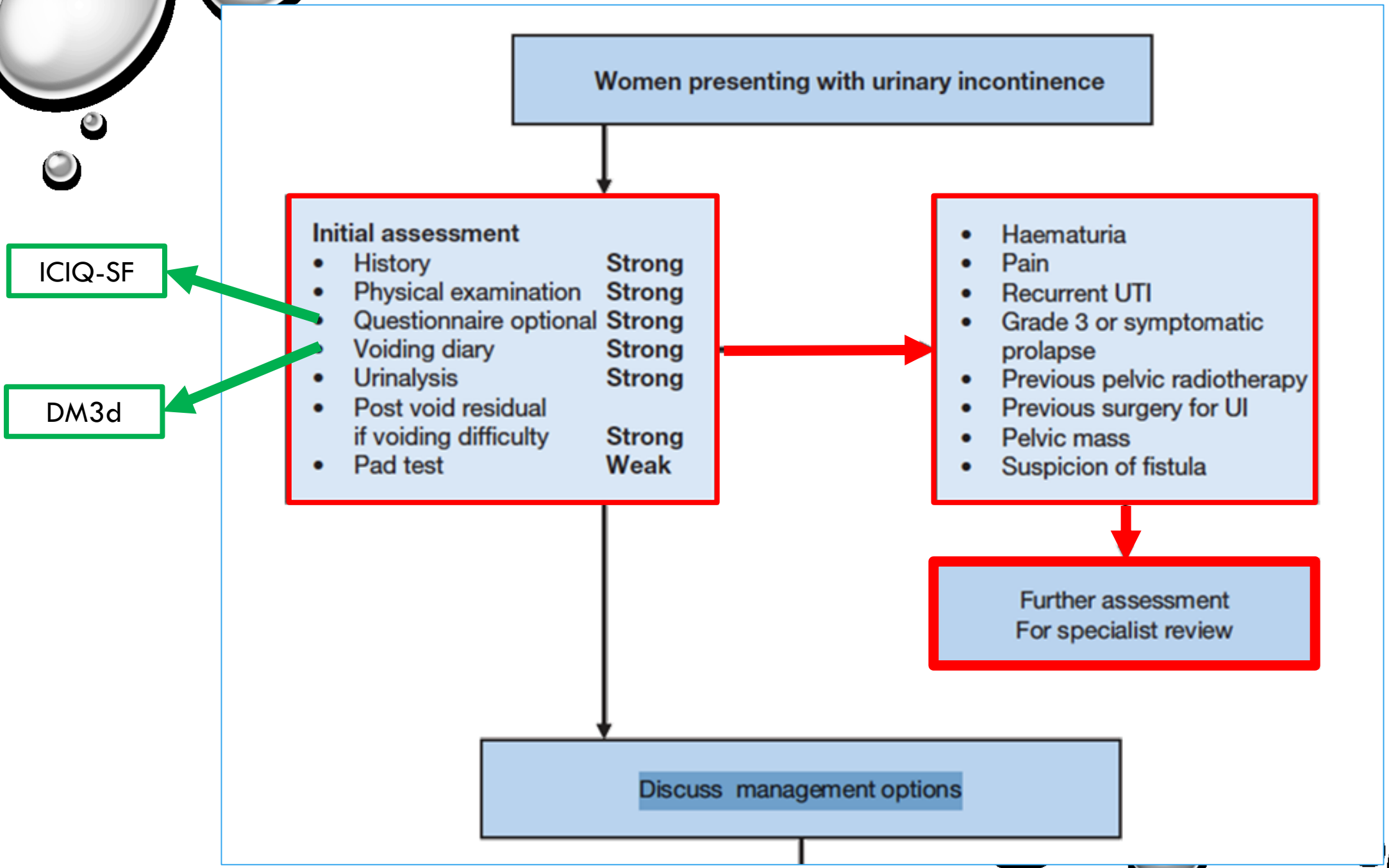
- INCONTINENCIA: **CONDICIÓN**
- **CARGA ASISTENCIAL –** ADECUACIÓN DE RECURSOS A LA **PATOLOGÍA MAS GRAVE**
- **IDÉNTICAS MAGNITUDES** DE INCONTINENCIA → **DIFERENTES IMPACTOS** EN LA CALIDAD DE VIDA
- DIFERENTE **SENSIBILIDAD DE MÉDICOS** (DE FAMILIA Y ESPECIALISTAS) ANTE EL PROBLEMA
- ASISTENCIA PRIMARIA: CENTROS **CON/SIN URÓLOGO**
- USO Y ABUSO DE **GUÍAS CLÍNICAS – DESFASE** ENTRE LA EVIDENCIA ACTUAL Y GUÍAS

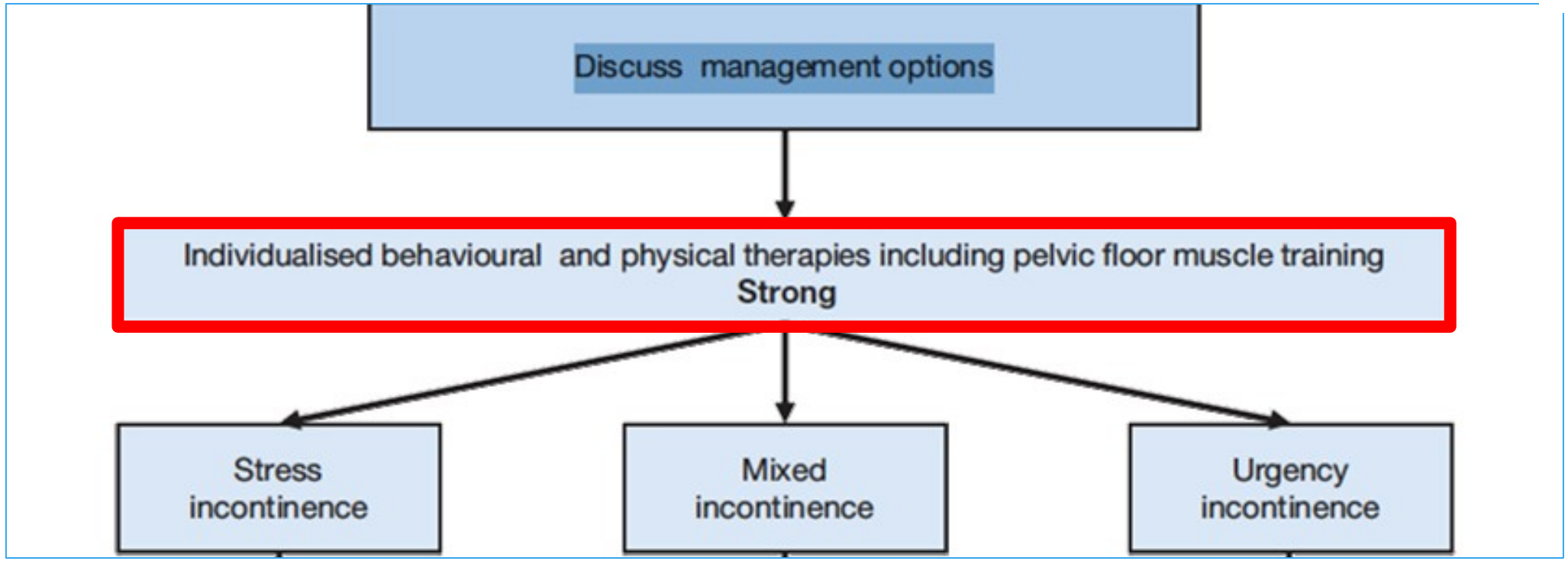
ASISTENCIA ESPECIALIZADA AMBULATORIA/CAP
CAUCES DE DERIVACIÓN PERSONALIZADOS

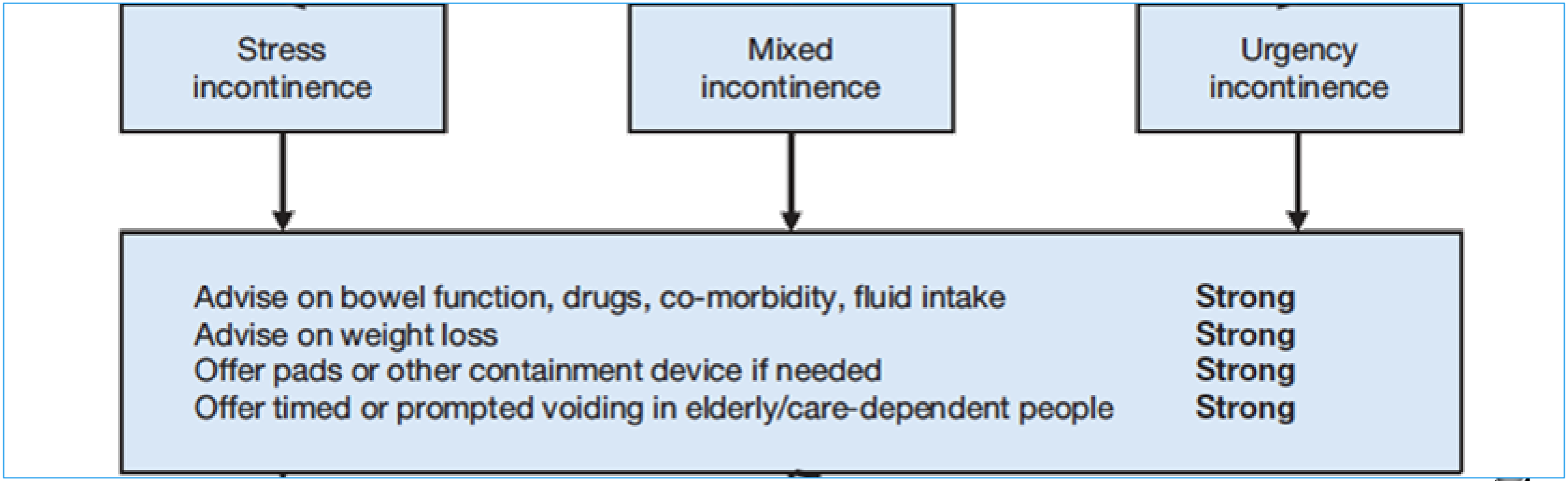
- LA EVIDENCIA DE LAS GUIAS ACTUALES:
  - NTERNATIONAL CONTINENCE SOCIETY (ICS)
    HTTPS://WWW.ICS.ORG/EDUCATION/ICSPUBLICATIONS/ICIBOOKS
  - EUROPEAN ASSOCIATION OF UROLOGY
    HTTPS://UROWEB.ORG/GUIDELINE/URINARY-INCONTINENCE/

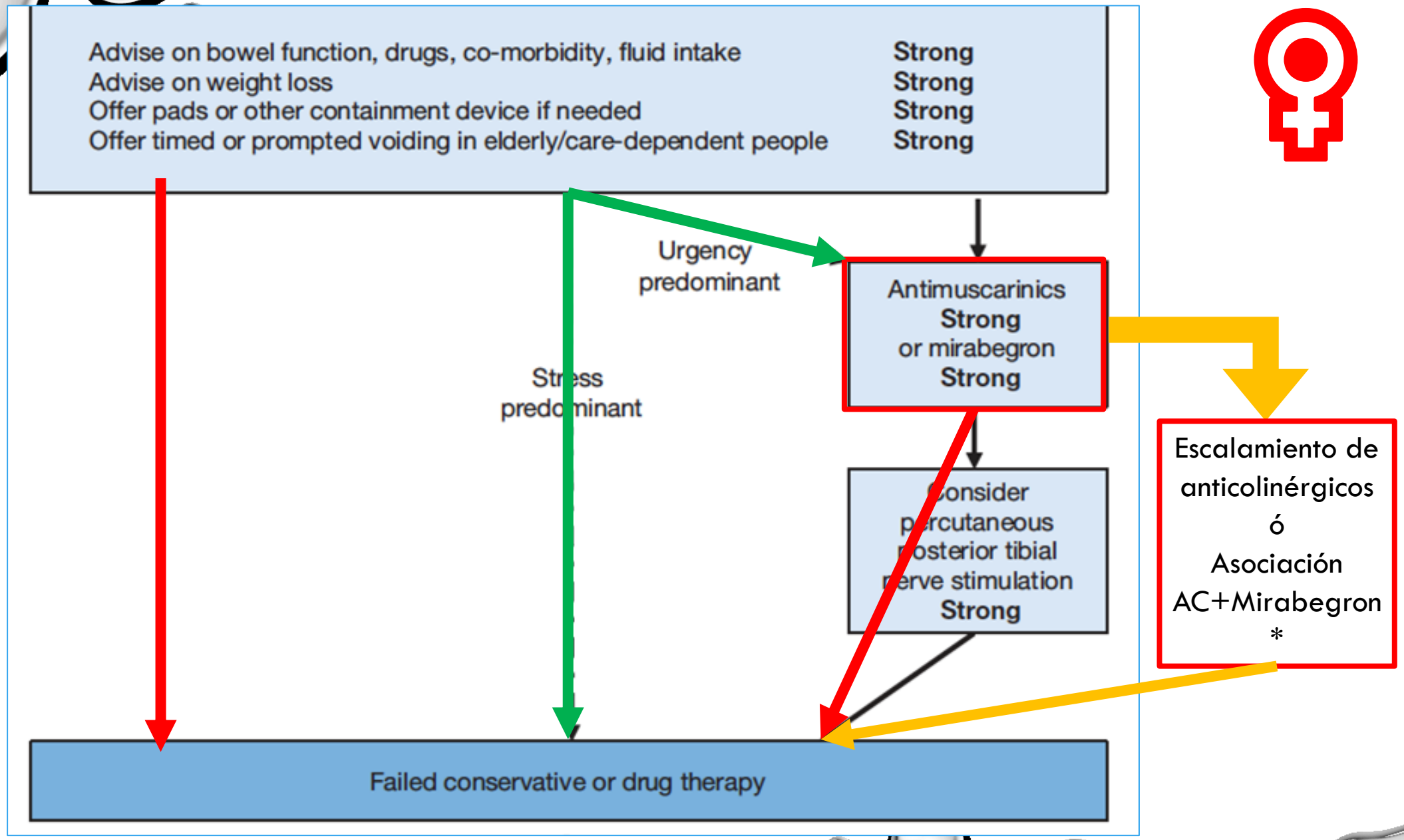





Women presenting with urinary incontinence
Initial assessment
History Strong
Physical examination Strong
Questionnaire optional Strong
Voiding diary Strong
Urinalysis Strong
Post void residual if voiding difficulty Strong
Pad test Weak
ICIQ-SF
DM3d
Haematuria
Pain
Recurrent UTI
Grade 3 or symptomatic prolapse
Previous pelvic radiotherapy
Previous surgery for UI
Pelvic mass
Suspicion of fistula
Further assessment
For specialist review
Discuss management options

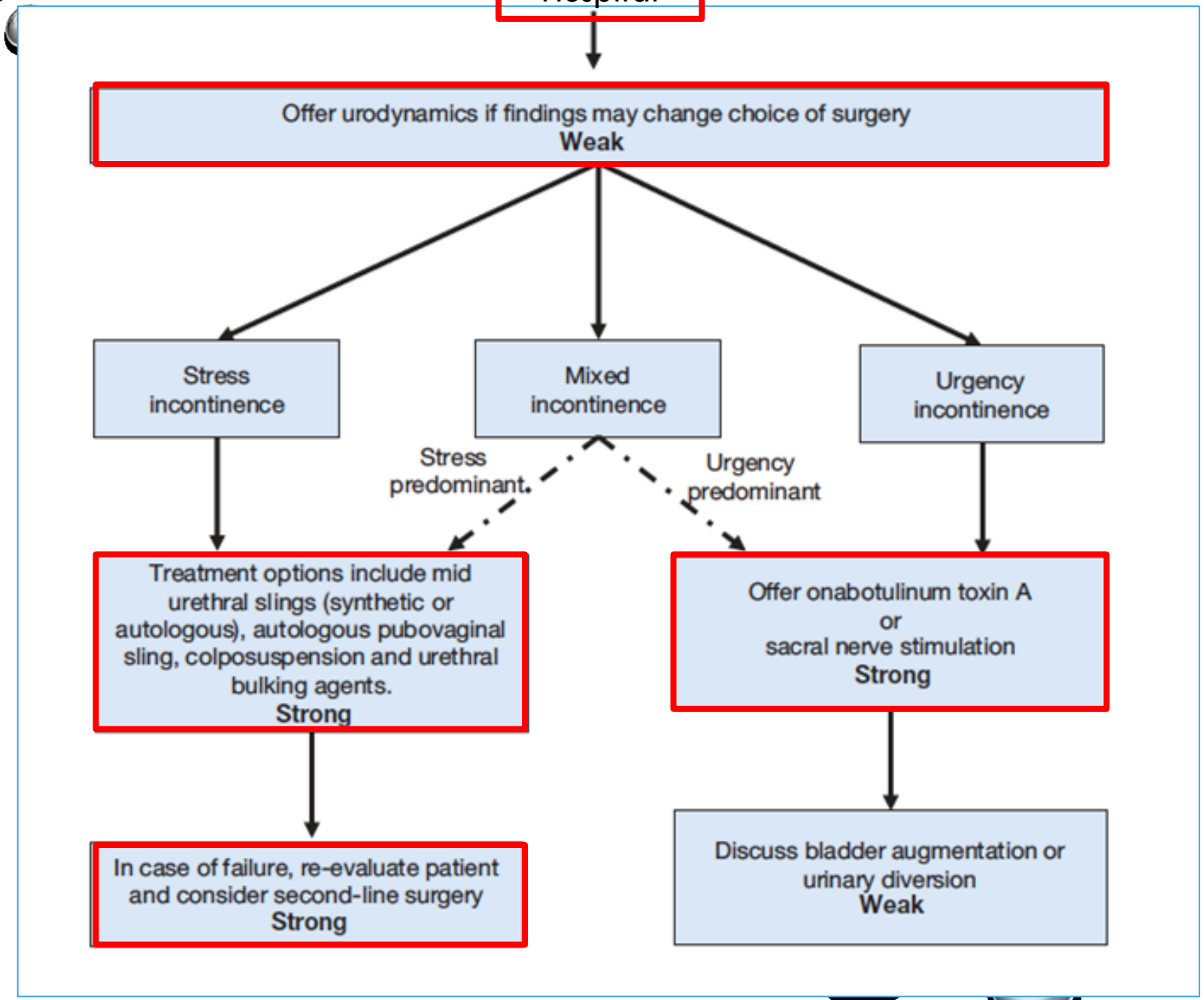

Discuss management options
Individualised behavioural and physical therapies including pelvic floor muscle training
Strong
Stress incontinence
Mixed incontinence
Urgency incontinence

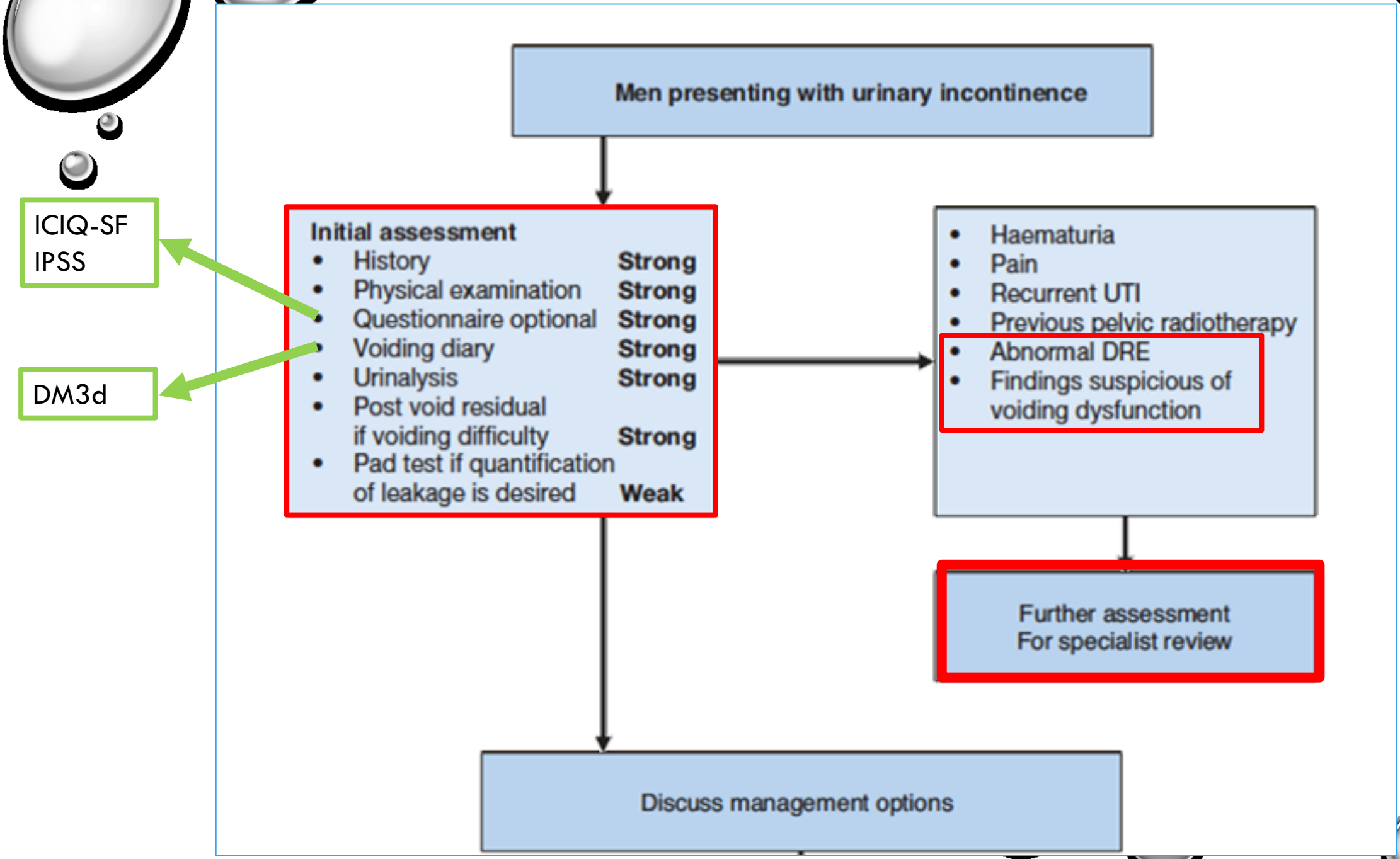

Stress incontinence
Mixed incontinence
Urgency incontinence
Advise on bowel function, drugs, co-morbidity, fluid intake Strong
Advise on weight loss Strong
Offer pads or other containment device if needed Strong
Offer timed or prompted voiding in elderly/care-dependent people Strong

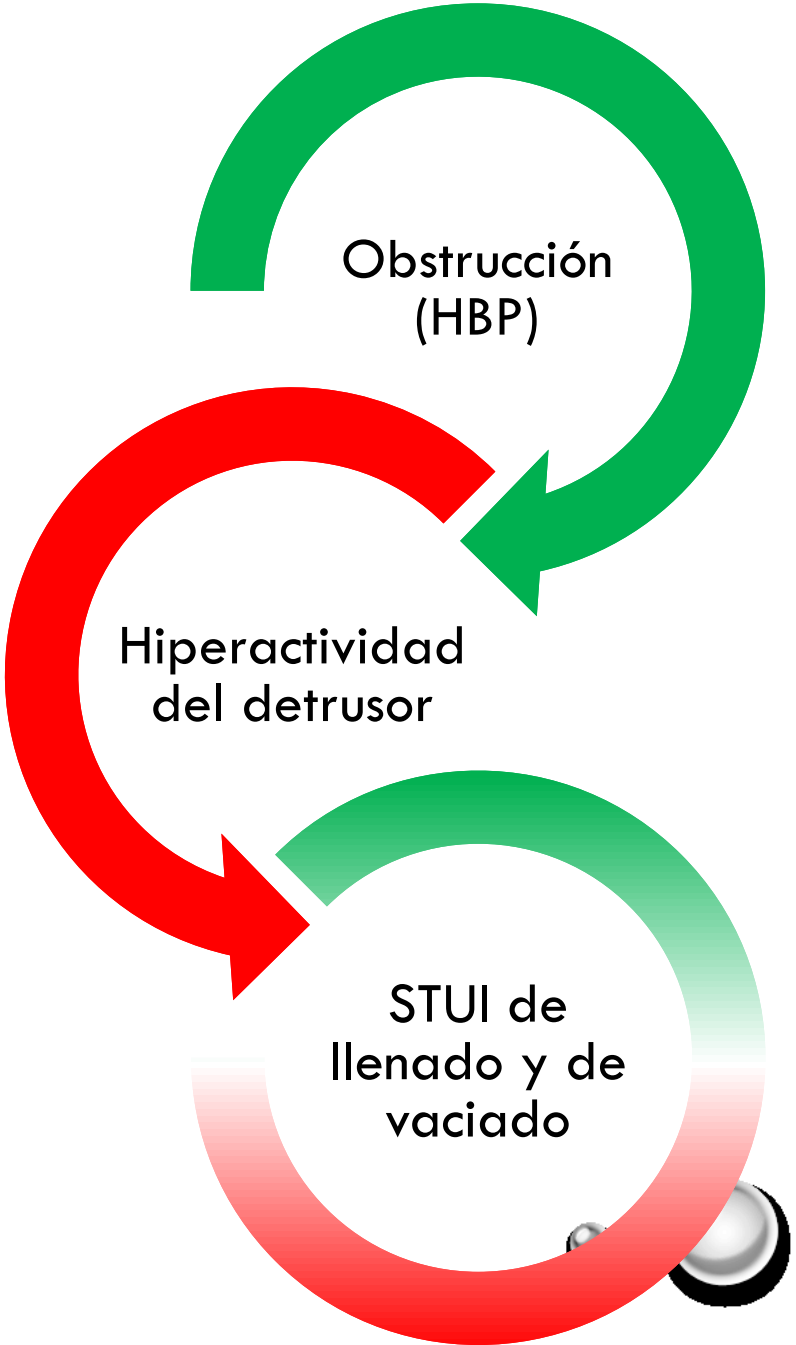


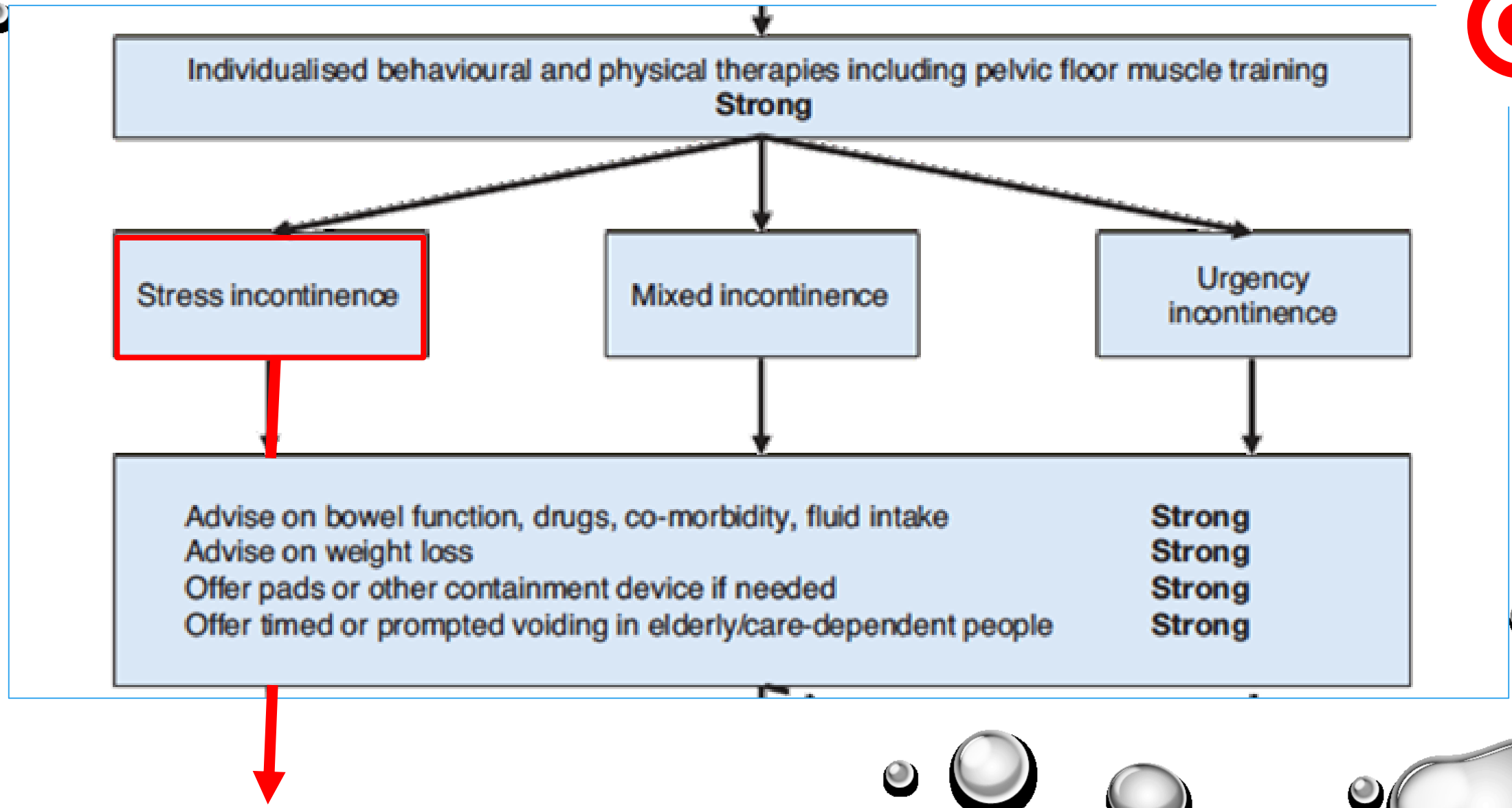
* MacDiarmid, S., et al. Mirabegron as Add-On Treatment to Solifenacin in Patients with Incontinent Overactive Bladder and an Inadequate Response to Solifenacin Monotherapy. J Urol, 2016. 196: 809. https://www.ncbi.nlm.nih.gov/pubmed/27063854 (1b)

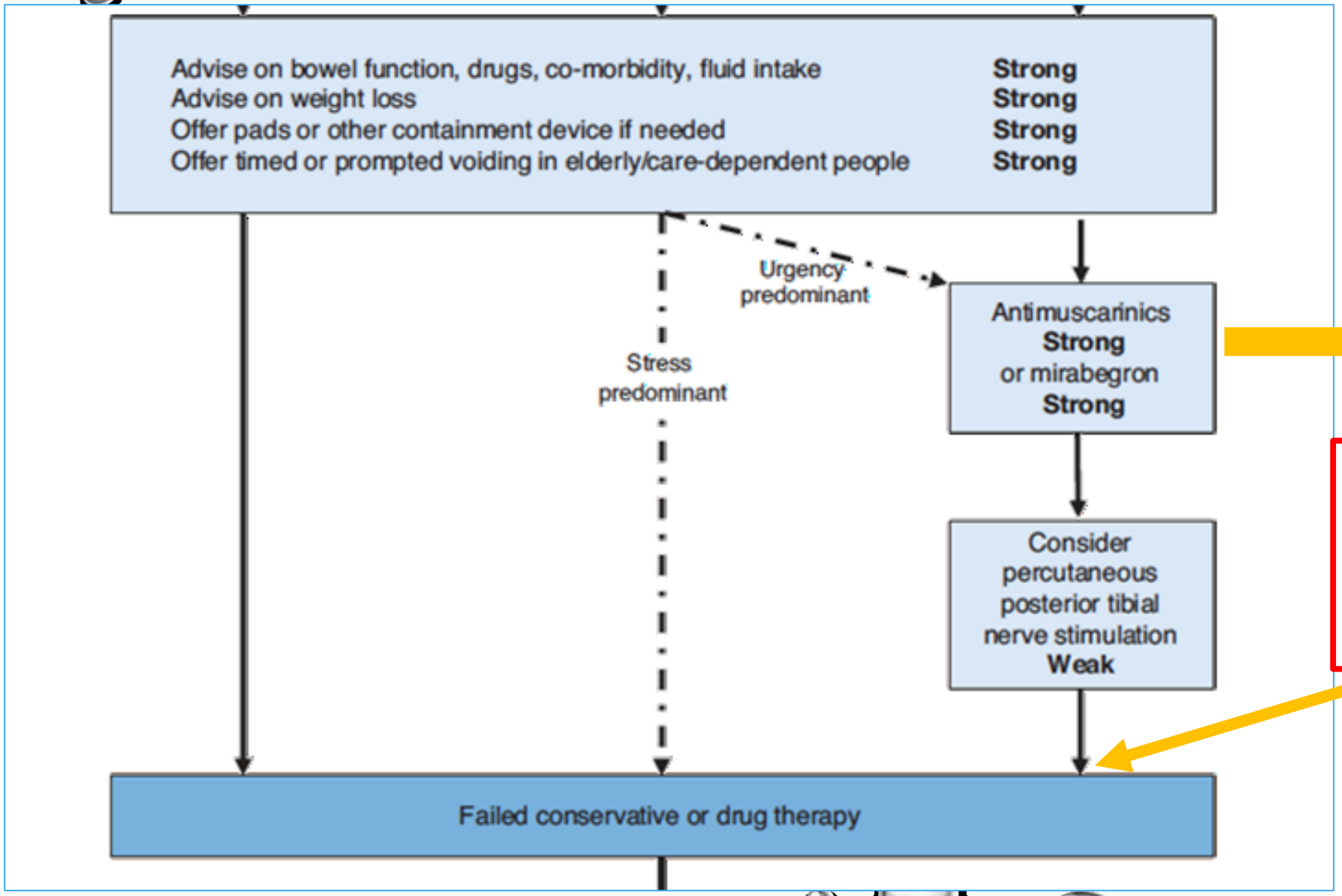
Hospital


Offer urodynamics if findings may change choice of surgery
Weak
Stress incontinence
Mixed incontinence
Urgency incontinence
Stress predominant
Urgency predominant
Treatment options include mid urethral slings (synthetic or autologous), autologous pubovaginal sling, colposuspension and urethral bulking agents.
Strong
Offer onabotulinum toxin A
or
sacral nerve stimulation
Strong
In case of failure, re-evaluate patient and consider second-line surgery
Strong
Discuss bladder augmentation or urinary diversion
Weak

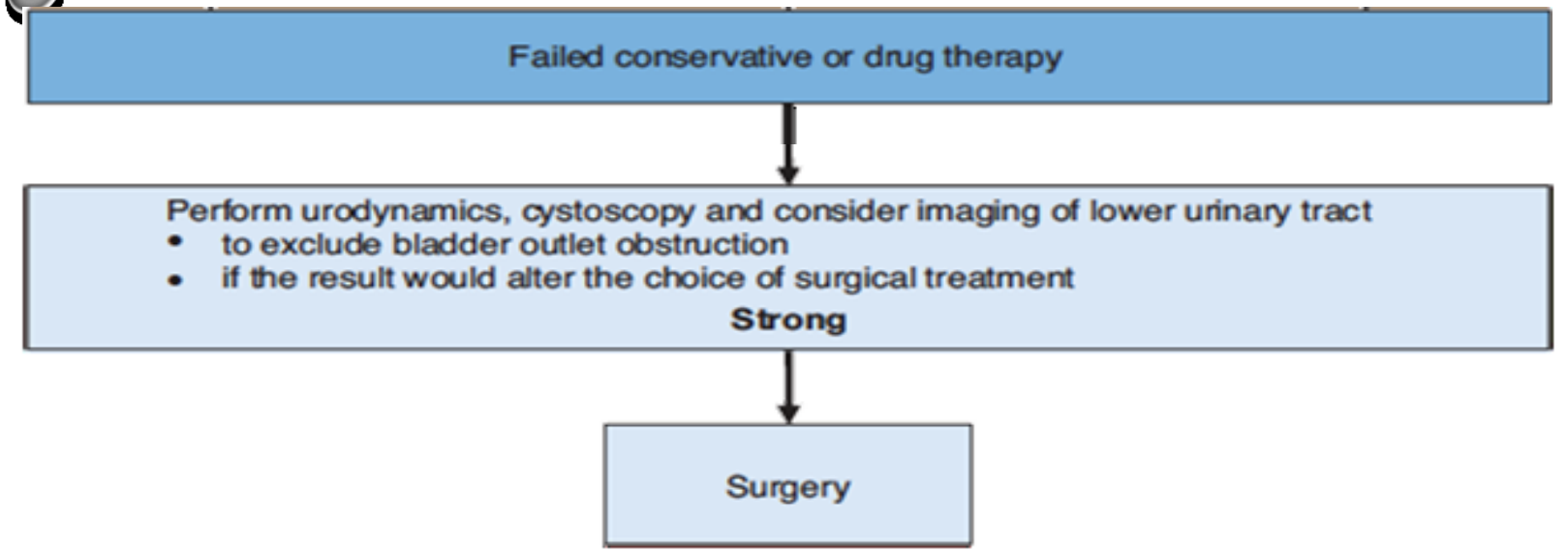

Men presenting with urinary incontinence
Initial assessment
History Strong
Physical examination Strong
Questionnaire optional Strong
Voiding diary Strong
Urinalysis Strong
Post void residual if voiding difficulty Strong
Pad test if quantification of leakage is desired Weak
Haematuria
Pain
Recurrent UTI
Previous pelvic radiotherapy
Abnormal DRE
Findings suspicious of voiding dysfunction
Further assessment For specialist review
Discuss management options
ICIQ-SF
IPSS
DM3d


Obstrucción
(HBP)
Hiperactividad
del detrusor
STUI de
llenado y de
vaciado


Individualised behavioural and physical therapies including pelvic floor muscle training
Strong
Stress incontinence
Mixed incontinence
Urgency incontinence
Advise on bowel function, drugs, co-morbidity, fluid intake
Strong
Advise on weight loss
Strong
Offer pads or other containment device if needed
Strong
Offer timed or prompted voiding in elderly/care-dependent people
Strong



Escalamiento de anticolinérgicos ó Asociación AC+Mirabegron



STUI de llenado y vaciado

1° Tto del vaciado (α-bloq. ó αbloq.+5ARI)

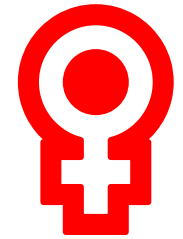
Mejoría de la obstrucción y disminución de los STUI de llenado

Si no mejora el llenado, tto de la HD (AC ó β-3)

IUE sin respuesta a tto conservador

- TOT
- TVT
- Bulkings
- Remeex
- Derivación urinaria

IUU sin respuesta a tto conservador



- Toxina Botulínica
- Neuromodulación
- Derivación urinaria

IUE sin respuesta a tto conservador

- Sling sub-uretral (Pad-test < 500g/24h)
- Esfínter artificial (Pad-test > 500 g/24h)
- Derivación urinaria

IUU sin obstrucción ni respuesta a tto conservador

- Toxina botulínica
- Neuromodulación
- Derivaciónón urinaria

MOLTES GRACIES