National Institute for Health and Care Excellence guidelines relevant to pelvic, obstetric and gynaecological physiotherapy

Introduction

The National Institute for Health and Care Excellence (NICE, formerly the National Institute for Health and Clinical Excellence) is an executive non-departmental public body of the UK Department of Health that publishes guidelines in four areas:

- the use of health technologies within the National Health Service (NHS) (e.g. the use of new and existing medicines, treatments and procedures);
- clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions);
- guidance for public sector workers on health promotion and the avoidance of ill health; and
- guidance for social care services and users.

The guidelines are mainly based on evaluations of efficacy and cost-effectiveness in various circumstances.

The agency serves the NHS in both England and Wales. Scotland is covered by the Scottish Intercollegiate Guidelines Network.

It was established in an attempt to end the so-called postcode lottery of healthcare in England and Wales, where the treatments that were available depended upon the NHS health authority area in which the patient happened to live. However, NICE has subsequently acquired an excellent reputation internationally as a role model for the development of clinical guidelines.

When a topic is decided on, a project team is assembled that consists of: NICE employees; specialists within the field who have applied to be on the committee; and service users (i.e. patients or their carers). For example, the recent urinary incontinence guidelines (NICE 2013) were drawn up by a committee that included: a number of gynecologists and urogynaecologists; a general practitioner; a continence advisor; a physiotherapist; a nurse; a physician specializing in the care of the elderly; a commissioner; and three laypersons. This committee then co-opted for specific consultations a radiologist, a specialist pain physician and a pharmacist. They then examined all the published evidence, assessing the quality of the research, and made various recommendations based upon the available evidence and cost-effectiveness. From the initial scoping workshop to the publication of the draft document, this process takes about 19 months.

The draft document is then made available to registered stakeholders, who can comment on it during a 5-week consultation period. Bodies that can register as stakeholders include: national organizations for people who use health and social care services, their families and carers, and the public; national organizations that represent health and social care practitioners, and other relevant professionals whose practice may be affected by the guideline; companies that manufacture medicines, devices and equipment; and providers of care and services. A full list of who can register can be found online (NICE 2018a). Individuals cannot register as stakeholders, and individuals/bodies are not invited to be stakeholders. People who want to comment on draft guidelines can do so, but are encouraged to do this through the registered stakeholders. If they want to comment on any aspect of NICE, they are encouraged to do so by joining a committee, attending a question time session, observing a public meeting or speaking to the public involvement team.

The draft document gives direction as to which part of the guidance is available for consultation. When a document is under review, this may not apply to all of the guidance, and therefore, sections will be highlighted if these are up for discussion. As a registered stakeholder for a number of guidelines, when POGP asks for comments for submission, the relevant link will be published on our microsite (https://pogp.csp.org.uk/) and the closed Facebook page (www.facebook.com/groups/1652693234997631/?ref=br_rs). If the subject is one that interests you, please submit any comments to the designated person within POGP, who will be named in the initial post, which will also include a contact e-mail address. Please keep all comments professional and referenced with evidence, if applicable, or if reflecting custom and practice, then explain the clinical reasoning. Please also refer to the relevant section and line number in the draft copy.

All comments are then collated by the POGP representative, and if there are a similar number of views about a section, then a precis of the comments will be compiled. Our feedback is then submitted via the official channels to NICE for their consultation. The comments are debated by the development team, and adjustments made to the document, if these are accepted. All submitted comments and the committee's responses are available to read once the final document is published. During the development of the first urinary incontinence guidelines (NICE 2013), it was the strong views expressed regarding examination of the pelvic floor when teaching pelvic floor muscle (PFM) exercises (PFMEs) that persuaded the then committee to include examination in the final document. At the time, there was insufficient published evidence to make it a recommendation, but the strength of argument presented by the pelvic health physiotherapy lobby enabled the recommendation to be included. The final document is then published 20 weeks after the consultation process closes, POGP is sent an advance embargoed copy of the final document for reading 24 h ahead of any national media launch to enable our communications team to prepare any press release, if needed.

Currently, POGP is a registered stakeholder for the following guidelines. Some of these have been completed and are no longer under discussion, some are currently in the discussion phase, and others will be open for comment in the future. We are updated regularly on all topics that NICE will be working on so that we can apply for POGP to be a stakeholder when relevant new topics arise:

- cannabis-based products for medicinal use;
- urinary incontinence (update) and the management of pelvic organ prolapse (POP) in women;
- prevention of POP;
- management of diabetes in pregnancy from preconception to the postnatal period;
- physical activity: exercise referral schemes;
- physical activity: encouraging activity within the general population;
- postnatal care up to 8 weeks after birth;
- Caesarean section;
- antenatal care for uncomplicated pregnancies (update);
- management of faecal incontinence (FI) in adults;
- diagnosis and management of prostate cancer; and
- assessment and management of urinary incontinence in neurological disease.

Katie Mann
Chairman

Aim

The aim of this article is to summarize the NICE guidelines for:

- antenatal care for uncomplicated pregnancies (NICE 2008, updated 2017);
- postnatal care for up to 8 weeks after birth (NICE 2006, updated 2015);
- the management of urinary incontinence (UI) in women (NICE 2013, updated 2015);
- the management of FI in adults (NICE 2007, reviewed 2018); and
- the management of lower urinary tract symptoms in men (NICE 2010, updated 2015).

Only points relevant to pelvic, obstetric and gynaecological physiotherapy have been included. References to pharmacological, surgical or catheter management that do not directly relate to physiotherapy have been removed, and can be found online in the relevant NICE guideline (www.nice.org.uk/guidance). It should be noted that the numbering of the sections has been eliminated.

Antenatal care for uncomplicated pregnancies (NICE 2008)

Common conditions treated

Back pain and sciatica. Women should be informed that exercising in water, massage therapy, and group or individual back-care classes might help to ease backache during pregnancy.

Constipation. Women who present with constipation in pregnancy should be offered information regarding diet modification (e.g. bran or wheat fibre supplements).

Nausea and vomiting in early pregnancy. Women should be informed that most cases of nausea and vomiting in pregnancy will resolve spontaneously within 16–20 weeks, and that these problems are not usually associated with a poor pregnancy outcome.

If a woman requests or would like to consider treatment, the following interventions appear to be effective in reducing symptoms:

- non-pharmacological:
  - ginger; and
  - P6 (wrist) acupressure.

- pharmacological:
  - antihistamines.

Information about all forms of self-help and non-pharmacological treatments should be made available for pregnant women who experience nausea and vomiting.

Heartburn. Women who present with symptoms of heartburn in pregnancy should be offered information regarding lifestyle and diet modification. Antacids may be offered to women whose heartburn remains troublesome despite lifestyle and diet modification.

Haemorrhoids. In the absence of evidence of the effectiveness of treatments for haemorrhoids in pregnancy, women should be offered information about diet modification. If clinical symptoms remain troublesome, standard haemorrhoid creams should be considered.

Varicose veins. Women should be informed that varicose veins are a common symptom of pregnancy that will not cause harm, and that compression stockings can improve the symptoms, but will not prevent varicose veins from emerging.

Vaginal discharge. Women should be informed that an increase in vaginal discharge is a common physiological change that occurs during pregnancy. If it is associated with itching, soreness, an offensive smell or pain on passing urine, the cause may be an infection, and investigation should be considered.

Postnatal care for up to 8 weeks after birth (NICE 2006)

Maternal health information-giving

Women should be counselled about the signs and symptoms of potentially life-threatening conditions (Table 1), and advised to contact their healthcare professional immediately or call for emergency help if any signs and symptoms occur.

Women should also be offered information and reassurance about:

- the physiological process of recovery after birth (within the first 24 h);
- normal patterns of emotional changes in the postnatal period, and that these usually resolve within 10–14 days of giving birth (within 3 days); and
- common health concerns, as appropriate (weeks 2–8).

Life-threatening conditions: core care and raised concern

Postpartum haemorrhage. Sudden or profuse blood loss, or blood loss accompanied by any of the signs and symptoms of shock, including tachycardia, hypotension, hypoperfusion and change in consciousness, should be evaluated (emergency action).

Pre-eclampsia/eclampsia. Routine assessment of proteinuria is not recommended.

Women with severe or persistent headache should be evaluated and pre-eclampsia considered (emergency action).

If diastolic blood pressure is greater than 90 mmHg and accompanied by another sign or symptom of pre-eclampsia, evaluate further (emergency action).

Thromboembolism. Women should be encouraged to mobilize as soon as appropriate following the birth.

Women with unilateral calf pain, redness or swelling should be evaluated for deep venous thrombosis (emergency action).

Women experiencing shortness of breath or chest pain should be evaluated for pulmonary thromboembolism (emergency action).

Table 1. Signs and symptoms of potentially life-threatening conditions (NICE 2006, Table 2, p. 12)

Signs and symptoms	Condition
Sudden and profuse blood loss, or persistent increased blood loss Faintness, dizziness or palpitations/tachycardia	Postpartum haemorrhage
Fever, shivering, abdominal pain and/or offensive vaginal loss	Infection
Headaches accompanied by one or more of the following symptoms within the first 72 h after birth: visual disturbances nausea and vomiting	Pre-eclampsia/eclampsia
Unilateral calf pain, redness or swelling Shortness of breath or chest pain	Thromboembolism

Routine use of Homans' sign as a tool for evaluation of thromboembolism is not recommended.

Obese women are at higher risk of thromboembolism, and should receive individualized care.

Mental health and well-being. All healthcare professionals should be aware of the signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after the birth.

At 10–14 days after birth, women should be asked about the resolution of symptoms of baby blues (e.g. tearfulness, feelings of anxiety and low mood). If these symptoms have not resolved, the woman should be assessed for postnatal depression, and if symptoms persist, evaluated further (urgent action).

Women should be encouraged to help look after their mental health by looking after themselves. This includes taking gentle exercise, taking time to rest, getting help with caring for the baby, talking to someone about their feelings and ensuring that they can access social support networks.

Physical health and well-being

Perineal care. At each postnatal contact, women should be asked whether they have any concerns about the healing process of any perineal wound. This might include experience of perineal pain, discomfort or stinging, an offensive odour, or dyspareunia.

The healthcare professional should offer to assess the perineum if the woman has pain or discomfort.

Women should be advised that topical cold therapy (e.g. crushed ice or gel pads) are effective methods of pain relief for perineal pain.

If oral analgesia is required, paracetamol should be used in the first instance, unless this is contraindicated.

If cold therapy or paracetamol is not effective, a prescription for oral or rectal non-steroidal anti-inflammatory medication should be considered in the absence of any contraindications (non-urgent action).

Signs and symptoms of infection, inadequate repair, wound breakdown or non-healing should be evaluated (urgent action).

Women should be alerted to the importance of perineal hygiene, including frequent changing of sanitary pads, washing hands before and after doing this, and daily bathing or showering to keep the perineum clean.

Dyspareunia. Women should be asked about resumption of sexual intercourse and possible dyspareunia 2–6 weeks after the birth.

If a woman expresses anxiety about resuming intercourse, reasons for this should be explored.

Women with perineal trauma who experience dyspareunia should be offered an assessment of the perineum (see the section on perineal care above).

A water-based lubricant gel to help ease discomfort during intercourse may be advised, particularly if a woman is breast-feeding.

Women who continue to express anxiety about sexual health problems should be evaluated (non-urgent action).

Headache. For severe headache, see the section on pre-eclampsia/eclampsia above.

Women should be asked about headache symptoms at each postnatal contact.

Women who have had epidural or spinal anaesthesia should be encouraged to report any severe headache, particularly one that occurs while sitting or standing.

The management of mild postnatal headache should be based on a differential diagnosis of headache type and local treatment protocols.

Women with tension or migraine headaches should be offered advice on relaxation, and how to avoid factors associated with the onset of headaches.

Fatigue. Women who report persistent fatigue should be asked about their general well-being, and offered advice on diet, exercise and planning activities, including spending time with their babies.

If persistent postnatal fatigue has an impact on the woman's care of herself or baby, underlying physical, psychological or social causes should be evaluated.

If a woman has sustained a postpartum haemorrhage, or is experiencing persistent fatigue, her haemoglobin level should be evaluated, and if this is found to be low, treated according to local policy.

Backache. Women experiencing backache in the postnatal period should be managed in the same way as the general population.

Constipation. Women should be asked if they have opened their bowels within 3 days of the birth.

Women who are constipated and uncomfortable should have their diet and fluid intake assessed,

and be offered advice on how to improve their diet.

A gentle laxative may be recommended if dietary measures are not effective.

Haemorrhoids. Women with haemorrhoids should be advised to take dietary measures to avoid constipation, and should be offered management based on local treatment protocols.

Women with a severe, swollen or prolapsed haemorrhoid, or any rectal bleeding should be evaluated (urgent action).

Faecal incontinence. Women with FI should be assessed for the severity, duration and frequency of their symptoms. If the symptoms do not resolve, evaluate further (urgent action).

Urinary retention. If urine has not been passed by 6 h after the birth, and measures to encourage micturition are not immediately successful, bladder volume should be assessed, and catheterization considered (urgent action).

Urinary incontinence. Women with involuntary leakage of a small volume of urine should be taught PFMEs.

Women with involuntary leakage of urine that does not resolve or becomes worse should be evaluated.

Six- to 8-week check

At the end of the postnatal period, the coordinating healthcare professional should ensure that the woman's physical, emotional and social well-being is reviewed. Screening and medical history should also be considered.

Management of urinary incontinence in women (NICE 2013)

Key priorities for implementation

History-taking and physical examination. At the initial clinical assessment, categorize the woman's UI as stress UI (SUI), mixed UI (MUI) or urgency UI/overactive bladder (OAB).

Start the initial treatment on this basis.

In MUI, direct treatment towards the predominant symptom.

If stress incontinence is the predominant symptom in MUI, discuss the benefit of conservative management, including OAB drugs, before offering the woman surgery.

During the clinical assessment, seek to identify relevant predisposing and precipitating factors, and other diagnoses that may require referral for additional investigation and treatment.

Assessment of the pelvic floor muscles. Undertake routine digital assessment to confirm PFM contraction before the use of supervised PFM training (PFMT) for the treatment of UI.

Assessment of prolapse. Refer women with UI who have symptomatic prolapse that is visible at or below the vaginal introitus to a specialist.

Urine testing. Undertake a urine dipstick test in all women who present with UI in order to detect the presence of blood, glucose, protein, leucocytes and nitrites in the urine.

If women have symptoms of urinary tract infection (UTI), and their urine tests are positive for both leucocytes and nitrites, send a midstream urine specimen for culture and analysis of antibiotic sensitivities. Prescribe an appropriate course of antibiotic treatment pending the culture results.

If women do not have symptoms of UTI, but their urine tests are positive for both leucocytes and nitrites, do not offer antibiotics without getting the results of a midstream urine culture.

Assessment of residual urine. Measure post-void residual volume by bladder scan or catheterization in women with symptoms suggestive of voiding dysfunction or recurrent UTI.

Use a bladder scan in preference to catheterization on the grounds of acceptability, and the lower incidence of adverse events.

Refer women who are found to have a palpable bladder on bimanual or abdominal examination after voiding to a specialist.

Referral. In women with UI, further indications for consideration for referral to a specialist service include:

- persistent bladder or urethral pain;
- clinically benign pelvic masses;
- associated FI;
- suspected neurological disease;
- symptoms of voiding difficulty;
- suspected urogenital fistulas;
- previous continence surgery;
- previous pelvic cancer surgery; and
- previous pelvic radiation therapy.

For further indications for consideration for referral, see the recommendations for assessment of prolapse, and the last paragraph of those for the assessment of residual urine above.

Symptom scoring and quality-of-life assessment. Use the following incontinence-specific quality-of-life scales when therapies are being evaluated: the International Consultation on Incontinence Questionnaire; the Bristol Female Lower Urinary Tract Symptoms questionnaire; the Incontinence Quality of Life questionnaire; the Stress and Urge Incontinence and Quality of Life Questionnaire; the Urinary Incontinence Severity Score questionnaire; the SEAPI-QMM incontinence classification system; the Incontinence Severity Index; and the King's Health Questionnaire. See the full guideline (NICE 2013) for details.

Bladder diaries. Use bladder diaries in the initial assessment of women with UI or OAB.

Encourage women to complete a minimum of 3 days of the diary, covering variations in their usual activities, such as both working and leisure days.

Pad testing. Do not use pad tests in the routine assessment of women with UI.

Lifestyle interventions

Caffeine. Recommend a trial of caffeine reduction to women with OAB.

Fluid intake. Consider advising modification of high or low fluid intake in women with UI or OAB.

Weight. Advise women with UI or OAB who have a body mass index greater than 30 to lose weight.

Physical therapies

Pelvic floor muscle training. Offer a trial of supervised PFMT of at least 3 months' duration as first-line treatment to women with SUI or MUI.

Pelvic floor muscle training programmes should comprise at least eight contractions performed three times per day.

Do not use perineometry or pelvic floor electromyography as biofeedback as a routine part of PFMT.

Continue an exercise programme if PFMT is beneficial.

Therapeutic stimulation. Do not routinely use electrical stimulation in the treatment of women with OAB.

Do not routinely use electrical stimulation in combination with PFMT.

Electrical stimulation and/or biofeedback should be considered in women who cannot actively contract their PFMs in order to aid motivation and adherence to therapy.

Behavioural therapies

Bladder training. Offer bladder training lasting for a minimum of 6 weeks as the first-line treatment to women with urgency or MUI.

Multicomponent behavioural therapy. If women do not achieve satisfactory benefit from bladder training programmes, the combination of an OAB drug with bladder training should be considered if frequency is a troublesome symptom.

Neurostimulation

Within this guideline, neurostimulation covers transcutaneous sacral nerve stimulation (TSNS), i.e. surface electrodes placed above the sacrum.

Transcutaneous sacral nerve stimulation. Do not offer TSNS, which is often known as transcutaneous electrical nerve stimulation, to treat OAB in women.

Transcutaneous posterior tibial nerve stimulation. Transcutaneous posterior tibial nerve stimulation (TPTNS) involves the placement of surface electrodes above the posterior tibial nerve.

Explain that there is insufficient evidence to recommend the use of TPTNS to treat OAB.

Do not offer TPTNS for OAB.

Percutaneous posterior tibial nerve stimulation. Percutaneous posterior tibial nerve stimulation (PPTNS) involves needles inserted close to the posterior tibial nerve.

Do not offer PPTNS for OAB unless:

- there has been a multidisciplinary team (MDT) review;
- conservative management, including OAB drug treatment, has not worked adequately; and
- the woman does not want botulinum toxin A or percutaneous sacral nerve stimulation (PSNS).

Explain that there is insufficient evidence to recommend the use of PPTNS to routinely treat OAB.

Alternative conservative management options

Absorbent products, urinals and toileting aids. Absorbent products, hand-held urinals and toileting aids should not be considered as a treatment for UI. Use these only as:

- a coping strategy pending definitive treatment;
- an adjunct to ongoing therapy; and
- long-term management of UI only after other treatment options have been explored.

Products to prevent leakage. Do not use intravaginal and intraurethral devices for the routine management of UI in women.

Do not advise women to consider such devices other than for occasional use when necessary to prevent leakage; for example, during physical exercise.

Complementary therapies. Do not recommend complementary therapies for the treatment of UI or OAB.

Preventive use of conservative therapies. Offer PFMT to women in their first pregnancy as a preventive strategy for UI.

Women who choose not to have further treatment

If a woman chooses not to have further treatment for urinary incontinence:

- offer her advice about managing urinary symptoms; and
- explain that, if she changes her mind at a later date, she can book a review appointment to discuss past tests and interventions, and reconsider her treatment options.

The multidisciplinary team

Inform any woman who wants to consider surgical treatment for UI about:

- the benefits and risks of surgical and non-surgical options; and
- her provisional treatment plan.

Include consideration of the woman's childbearing wishes in the counselling.

Offer invasive therapy for OAB and/or SUI symptoms only after an MDT review.

When recommending optimal management, the MDT should take into account:

- the woman's preference;
- past management;
- comorbidities; and
- treatment options (including further conservative management, such as OAB drug therapy).

The MDT for urinary incontinence should include:

- a urogynaecologist;
- a urologist with a subspecialist interest in female urology;
- a specialist nurse;
- a specialist physiotherapist;
- a colorectal surgeon with a subspecialist interest in functional bowel problems for women with coexisting bowel problems; and
- a member of the care of the elderly team and/or occupational therapist for women with functional impairment.

Inform the woman of the outcome of the MDT review if it alters the provisional treatment plan.

All MDTs should work within an established regional clinical network to ensure that all women are offered the appropriate treatment options and high-quality care.

Invasive procedures for overactive bladder

Percutaneous sacral nerve stimulation. Offer PSNS to women after MDT review if:

- their OAB has not responded to conservative management, including drugs; and
- they are unable to perform clean intermittent catheterization.

Consider PSNS after MDT review if a woman's OAB has not responded to conservative management (including drugs) and botulinum toxin A. [At the time of publication (September 2013), most Botulinum toxin type A preparations did not have a UK marketing authorization for this indication. Evidence was only available for the licensed botulinum toxin A (Botox, Allergan plc, Dublin, Ireland) preparation.]

Discuss the long-term implications of PSNS with women, including:

- the need for test stimulation and the probability of the test's success;
- the risk of failure;
- the long-term commitment;
- the need for surgical revision; and
- the adverse effects.

Tell women how to self-refer for prompt specialist review if symptoms return following a PSNS procedure.

Management of faecal incontinence in adults (NICE 2007)

Good practice in managing faecal incontinence

People who report or are reported to have FI should be offered care managed by healthcare professionals who have the relevant skills, training and experience, and work within an integrated continence service (DH 2001).

Because FI is a socially stigmatizing condition, healthcare professionals should actively yet sensitively enquire about symptoms in high-risk groups (see Box 1).

Box 1. High-risk groups

- Frail older people
- People with loose stools or diarrhoea from any cause
- Women following childbirth (especially following a third- and fourth-degree obstetric injury)
- People with a neurological or spinal disease/injury (e.g. spina bifida, stroke, multiple sclerosis and spinal cord injury)
- People with severe cognitive impairment
- People with urinary incontinence
- People with pelvic organ prolapse and/or rectal prolapse
- People who have had colonic resection or anal surgery
- People who have undergone pelvic radiotherapy
- People with perianal soreness, itching or pain
- People with learning disabilities

When assessing FI healthcare, professionals should:

- be aware that FI is a symptom, often with multiple contributory factors for an individual patient; and
- avoid making simplistic assumptions that causation is related to a single primary diagnosis (i.e. "diagnostic overshadowing").

Baseline assessment and initial management

Healthcare professionals should carry out and record a focused baseline assessment for people with FI to identify the contributory factors. This should comprise:

- relevant medical history;
- a general examination;
- an anorectal examination; and
- a cognitive assessment, if appropriate.

People with the following conditions should have these addressed with condition-specific interventions before healthcare professionals progress to initial management of FI:

- faecal loading (see also the first paragraph of the section on people with faecal loading below);
- potentially treatable causes of diarrhoea (e.g. infective, inflammatory bowel disease and irritable bowel syndrome);
- warning signs for lower gastrointestinal cancer (NICE 2015);
- rectal prolapse or third-degree haemorrhoids;
- acute anal sphincter injury, including obstetric and other trauma; and
- acute disc prolapse/cauda equina syndrome.

Healthcare professionals should address the individual's bowel habit, aiming for ideal stool consistency and satisfactory bowel emptying at a predictable time.

A bowel habit intervention should contain the following elements:

- encouraging bowel emptying after a meal (to utilize the gastrocolic response);
- ensuring that toilet facilities are private and comfortable, and can be used in safety, with sufficient time allowed;
- encouraging people to adopt a sitting or squatting position, where possible, while emptying the bowel; and
- teaching people techniques to facilitate bowel evacuation, and stressing the importance of avoiding straining.

When problems with toilet access are being addressed in any home or healthcare setting:

- locations of toilets should be made clear to the individual, where appropriate;
- equipment to help people to gain access to a toilet should be provided;
- advice should be given to people with FI on easily removable clothing to reduce the time needed for access;
- if a person with FI is dependent on others for access to the toilet, help should be readily available; and
- if appropriate, people with FI should be referred to the relevant professionals for assessment of their home and/or mobility.

Medication

When reviewing medication, healthcare professionals should consider alternatives to drugs that might be contributing to FI (see NICE 2007, Table 4).

Antidiarrhoeal medication should be offered to people with FI associated with loose stools once other causes (e.g. excessive laxative use, dietary factors and other medication) have been excluded. Antidiarrhoeal medication should be prescribed in accordance with the summary of the product's characteristics.

The antidiarrhoeal drug of first choice should be loperamide hydrochloride (Imodium). It can be used long term in doses from 0.5 to 16 mg per day, as required. For doses under 2 mg,

loperamide hydrochloride syrup should be considered. People who are unable to tolerate loperamide hydrochloride should be offered codeine phosphate or co-phenotrope. [Prescribers should check the summary of product characteristics (SPC) for current licensed indications. Informed consent is needed when using it outside the licensed indications. This should be discussed and documented in the notes.]

Loperamide hydrochloride should not be offered to people with:

- hard or infrequent stools;
- acute diarrhoea without a diagnosed cause; and
- an acute flare-up of ulcerative colitis.

When loperamide hydrochloride is used:

- It should be introduced at a very low dose, and the dose should be escalated, as tolerated by the individual, until the desired stool consistency has been achieved.
- It should be taken as and when required by the individual.
- Individuals should be advised that they can adjust the dose and/or frequency up or down in response to stool consistency and their lifestyle.

Coping strategies

During assessment and initial management, healthcare professionals should offer people with FI advice on coping strategies including:

- the use of continence products and information about product choice, supply sources and use;
- where to get emotional and psychological support, including counselling or psychological therapy, where appropriate, to foster acceptance and positive attitudes;
- how to talk to friends and family about incontinence and its management; and
- strategies such as planning routes for travel to facilitate access to public conveniences, and carrying a toilet access card or Radar key (R.A.D.A.R. Key Company, Exmouth, Devon, UK) to allow access to "disabled" toilets in the National Key Scheme.

People with FI should be offered:

- disposable body-worn pads in a choice of styles and designs, and disposable bed pads, if needed;
- pads in quantities sufficient for the individual's continence needs – it is inappropriate to limit the number of pads given;
- anal plugs (for people who can tolerate these);
- skin-care advice that covers both cleansing and barrier products;
- advice on odour control and laundry needs; and
- disposable gloves.

The use of reusable absorbent products in the management of FI is not generally recommended.

Review of treatment

After each intervention, healthcare professionals should ask the person whether their FI has improved. People continuing to experience symptoms should be:

- involved in discussions about further treatment options (including effectiveness and adverse effects) or alternative coping strategies; and
- asked if they wish to try further treatments.

The options for long-term management should be considered for people who prefer symptomatic management to more invasive measures (see the recommendation in the "Long-term management" section below).

Specialized management

People who continue to have episodes of FI after initial management should be considered for specialized management. This may involve referral to a specialist continence service, which may include:

- PFMT;
- bowel retraining;
- specialist dietary assessment and management;
- biofeedback;
- electrical stimulation; and
- rectal irrigation.

Some of these treatments might not be appropriate for people who are unable to understand and/or comply with instructions. For example, pelvic floor re-education programmes might not be appropriate for those with a neurological or spinal disease/injury resulting in FI.

Healthcare professionals should consider in particular whether people with a neurological or spinal disease/injury resulting in FI, who have some residual motor function, and are still symptomatic after baseline assessment and initial management, could benefit from specialized management (see also the "Management of specific groups" section below).

Any programme of PFMT should be agreed with the person. A patient-specific exercise

regimen should be provided based on the findings of digital assessment. The progress of people performing PFMT should be monitored by digital reassessment carried out by an appropriately trained healthcare professional who is supervising the treatment. There should be a review of the person's symptoms on completion of the programme, and other treatment options should be considered, if appropriate.

Specialist assessment

People with continuing FI after specialized conservative management should be considered for specialist assessment, including:

- anorectal physiology studies;
- endoanal ultrasound (if this is not available, magnetic resonance imaging, endovaginal ultrasound and perineal ultrasound should be considered); and
- other tests, including proctography, as indicated.

Long-term management

Healthcare professionals should offer the following to symptomatic people who do not wish to continue with active treatment or who have intractable FI:

- advice relating to the preservation of dignity and, where possible, independence;
- psychological and emotional support, possibly including referral to counsellors or therapists if it seems likely that a person's attitude towards and ability to manage and cope with his or her FI could improve with professional assistance;
- a 6-monthly review of symptoms at the very least;
- discussion of any other management options (including specialist referral);
- contact details for relevant support groups;
- advice on continence products, and information about product choice, availability and use;
- advice on skin care;
- advice on how to talk to friends and family; and
- strategies such as planning routes for travel to facilitate access to public conveniences, carrying a toilet access card or Radar key.

Management of specific groups

Pay special attention to the recommendation about diagnostic overshadowing in the second bullet point in the last paragraph of the "Good practice in managing faecal incontinence" section above.

Healthcare professionals should take a proactive approach to bowel management for specific groups of people (see Box 2).

Box 2. Specific groups

- People with faecal loading or constipation
- People with limited mobility
- Hospitalized patients who are acutely unwell, and who develop acute faecal loading and associated incontinence.
- People with cognitive or behavioural issues
- People with neurological or spinal disease/injury resulting in faecal incontinence
- People with learning disabilities
- Severely or terminally ill people
- People with acquired brain injury

People with faecal loading. People in whom acute severe faecal loading is identified as contributing to FI should initially be offered a rectally administered treatment to satisfactorily clear the bowel. Treatment will often need to be repeated daily for a few days, depending on tolerance and whether satisfactory bowel clearance is achieved.

If rectal interventions are not appropriate or fail to satisfactorily clear the bowel, and bowel obstruction has been excluded as a possible cause, a potent oral laxative should be offered. People should be informed that oral laxatives may cause griping abdominal pain, loose stools and prolonged bowel activity. Toilet access should be ensured.

Healthcare professionals involved in the management of FI associated with chronic ongoing faecal loading/impaction should aim to reduce the chance of recurrence by recommending a combination of initial management options tailored to the individual (see recommendation 1.3.1 in NICE 2007). If this fails, the use of orally administered laxatives to promote bowel emptying should be considered. Rectally administered preparations should be used if oral laxatives cause episodes of FI, and there is a need to produce planned bowel evacuations.

People with limited mobility. People with limited mobility who continue to have episodes of FI after initial management should be offered a regimen that will produce a planned, predicted bowel action when carers are present if needed. This may be achieved by a combination of oral or rectal laxatives and/or constipating agents. This regimen should also consider:

- toilet access (see the recommendations in the last paragraph of the "Baseline assessment and initial management" section above);
- appropriate disposable products (see the recommendations in the second paragraph of the "Coping strategies" section above); and
- that the stool needs to be in the rectum at the time of the planned bowel action.

People using enteral tube feeding and reporting faecal incontinence. Healthcare professionals should ensure that people with FI who are receiving enteral tube feeding have their type and timing of feed modified on an individual basis to establish the most effective way to manage FI.

People with severe cognitive impairment. If baseline assessment and initial management have failed to resolve FI, people with confirmed severe cognitive impairment should be referred for a behavioural and functional analysis to determine if there is any behavioural reason for FI. Following analysis, people should be offered cause-specific interventions founded on structured goal planning that aim to resolve as well as manage behavioural aspects that may be contributing to FI. In cases of severe cognitive impairment, further specialist management of FI may be inappropriate.

People with neurological or spinal disease/injury. People with neurological or spinal disease/injury resulting in FI who continue to have episodes of FI after initial management should be offered a neurological bowel management programme. This aims to achieve a predictable routine, and avoid FI and severe constipation. Management should involve progressing through the following steps until satisfactory bowel habit is established:

- ascertaining individual preferences;
- ascertaining premorbid bowel habit, if possible;
- maximizing the individual's understanding of normal bowel function and how it has been altered;
- modifying diet, and/or administrating rectal evacuants and/or oral laxatives, adjusted to individual response, to attempt to establish a predictable pattern of bowel evacuation;
- consideration of digital anorectal stimulation for people with spinal cord injuries or other neurogenic bowel disorders; and
- consideration of manual/digital removal of faeces, particularly for people with a lower spinal injury, if there is a hard plug of faeces in the rectum, presence of faecal impaction, incomplete defecation, an inability to defecate, and/or all other bowel-emptying techniques have failed to achieve bowel emptying and continence within a time acceptable to the individual.

Healthcare professionals should discuss the following management options with people who are unable to achieve reliable bowel continence after a neurological bowel management programme:

- coping and long-term management strategies for symptomatic individuals (see recommendations in the first paragraphs of the "Coping strategies" and "Long-term management" sections above);
- rectal irrigation if appropriate; and
- other surgical options (including stoma) if FI or the time taken for bowel emptying imposes major limits on their lifestyle.

People with learning disabilities. People with severe learning disabilities may have had FI from childhood. Others may experience FI for the first time in adulthood. It is essential that these individuals follow the same initial care pathway as other people with FI. They may require additional support during assessment and management to achieve equal outcomes.

Severely or terminally ill people. Healthcare professionals should consider a faecal collection device for people in intensive care settings, and people receiving palliative care with FI and associated loose stools.

Management of lower urinary tract symptoms in men (NICE 2010)

Initial assessment

The initial assessment refers to an assessment carried out in any setting by a healthcare professional without specific training in managing lower urinary tract symptoms (LUTS) in men.

At the initial assessment, offer men with LUTS an assessment of their general medical history to identify possible causes of LUTS, and associated comorbidities. Review current medication, including herbal and over-the-counter medicines, to identify drugs that may be contributing to the problem.

At the initial assessment, offer men with LUTS a physical examination guided by urological symptoms and other medical conditions, an examination of the abdomen and external genitalia, and a digital rectal examination (DRE).

At the initial assessment, ask men with bothersome LUTS to complete a urinary frequency volume chart.

At the initial assessment, offer men with LUTS a urine dipstick test to detect blood, glucose, protein, leucocytes and nitrites.

At the initial assessment, offer men with LUTS information, advice and time to decide if they wish to have prostate-specific antigen (PSA) testing if:

- their LUTS are suggestive of bladder outlet obstruction secondary to benign prostatic enlargement (BPE);
- their prostate feels abnormal on DRE; or
- they are concerned about prostate cancer.

Manage suspected prostate cancer in men with LUTS in line with the NICE guidelines on prostate cancer (NICE 2014) and referral guidelines for suspected cancer (NICE 2005; now updated and replaced by NICE 2015).

At the initial assessment, offer men with LUTS a serum creatinine test (plus an estimated glomerular filtration rate calculation) only if you suspect renal impairment (e.g. the man has a palpable bladder, nocturnal enuresis, recurrent urinary tract infections or a history of renal stones).

Do not routinely offer cystoscopy to men with uncomplicated LUTS (i.e. without evidence of bladder abnormality) at the initial assessment.

Do not routinely offer imaging of the upper urinary tract to men with uncomplicated LUTS at the initial assessment.

Do not routinely offer flow-rate measurement to men with LUTS at the initial assessment.

Do not routinely offer a post-void residual volume measurement to men with LUTS at the initial assessment.

At the initial assessment, give reassurance, offer advice on lifestyle interventions (e.g. fluid intake) and information on their condition to men whose LUTS are not bothersome or complicated. Offer a review if the symptoms change.

Offer men referral for specialist assessment if they have bothersome LUTS that have not responded to conservative management or drug treatment.

Refer men for specialist assessment if they have LUTS complicated by recurrent or persistent urinary tract infection, retention, renal impairment that is suspected to be caused by lower urinary tract dysfunction, or suspected urological cancer.

Offer men considering any treatment for LUTS an assessment of their baseline symptoms with a validated symptom score (e.g. the International Prostate Symptom Score) to allow assessment of subsequent symptom change.

Specialist assessment

Specialist assessment refers to assessment carried out in any setting by a healthcare professional with specific training in managing LUTS in men.

Offer men with LUTS who are having specialist assessment an assessment of their general medical history to identify possible causes of LUTS, and associated comorbidities. Review current medication, including herbal and over-the-counter medicines, to identify drugs that may be contributing to the problem.

Offer men with LUTS who are having specialist assessment a physical examination guided by urological symptoms and other medical conditions, an examination of the abdomen and external genitalia, and a DRE.

At the specialist assessment, ask men with LUTS to complete a urinary frequency volume chart.

At the specialist assessment, offer men with LUTS information, advice and time to decide if they wish to have PSA testing if:

- their LUTS are suggestive of bladder outlet obstruction secondary to BPE;
- their prostate feels abnormal on DRE; or
- they are concerned about prostate cancer.

Offer men with LUTS who are having a specialist assessment a measurement of flow rate and post-void residual volume.

Offer cystoscopy to men with LUTS who are having specialist assessment only when clinically indicated; for example, if there is a history of any of the following:

- recurrent infection;
- sterile pyuria;
- haematuria;
- profound symptoms; and
- pain.

Offer imaging of the upper urinary tract to men with LUTS who are having specialist assessment only when clinically indicated; for example, if there is a history of any of the following:

- chronic retention;
- haematuria;
- recurrent infection;
- sterile pyuria;
- profound symptoms; and
- pain.

Consider offering multichannel cystometry to men with LUTS who are having specialist assessment if they are considering surgery.

Offer pad tests to men with LUTS who are having specialist assessment only if the degree of urinary incontinence needs to be measured.

Conservative management

Explain to men with post-micturition dribble how to perform urethral milking.

Offer men with storage LUTS (particularly urinary incontinence) temporary containment products (e.g. pads or collecting devices) to achieve social continence until a diagnosis and management plan have been discussed.

Offer a choice of containment products to manage storage LUTS (particularly urinary incontinence) based on individual circumstances and in consultation with the man.

Offer men with storage LUTS suggestive of OAB supervised bladder training, advice on fluid intake, lifestyle advice, and if needed, containment products.

Inform men with LUTS and proven bladder outlet obstruction that bladder training is less effective than surgery.

Offer supervised PFMT to men with SUI caused by prostatectomy. Advise them to continue the exercises for at least 3 months before considering other options.

Refer men with SUI for specialist assessment.

Do not offer penile clamps to men with storage LUTS (particularly urinary incontinence).

Offer external collecting devices (e.g. sheath appliances and pubic pressure urinals) for managing storage LUTS (particularly urinary incontinence) in men before considering indwelling catheterization.

Offer intermittent bladder catheterization before indwelling urethral or suprapubic catheterization to men with voiding LUTS that cannot be corrected by less-invasive measures.

Consider permanent use of containment products for men with storage LUTS (particularly urinary incontinence) only after assessment and exclusion of other methods of management.

Providing information

Ensure that, if appropriate, men's carers are informed and involved in managing their LUTS, and can give feedback on treatments.

Make sure that men with LUTS have access to care that can help with:

- their emotional and physical conditions; and
- relevant physical, emotional, psychological, sexual and social issues.

Provide men with storage LUTS (particularly incontinence) containment products at the point of need, and advice about relevant support groups.

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