



**PHILIPPINE OBSTETRICAL AND GYNECOLOGICAL  
SOCIETY (Foundation), INC.**



**PHILIPPINE SOCIETY OF UROGYNECOLOGY AND  
RECONSTRUCTIVE PELVIC SURGERY**

## **Guidelines for the Management of Common Urogynecological Conditions during the COVID-19 Pandemic**

*This guideline provides a framework for decision-making and the health care provider should follow using one's professional judgment to specific case scenario. Furthermore, this guideline has been adapted following guidelines set forth by the International Urogynecological Association (IUGA) and the British Society of Urogynecology (BSUG).*

Most patients seen in Urogynecology clinics present with non-urgent conditions such as prolapse and/or incontinence. There would be very few situations where they would present as an acute medical emergency or where an emergency admission to hospital is required. Concurrently, it is also vital to remember that a large proportion of these patients are over 60 years of age making them more vulnerable should they contract Covid -19 as they are more likely to require hospitalization.

### **Objective:**

To reduce the risk of person to person (horizontal) transmission of the virus SARS CoV-2 in urogynecology patients.

## **1. Pelvic Organ Prolapse**

### **1.1. Assessment**

- Women with prolapse should initially be managed by remote communication. Facilities for virtual communication can vary and include telephone/ video conferencing.
- A relevant clinical history should be taken to elucidate severity of the symptoms. If possible, it may be useful to obtain a history prior to the hospital visit using a structured general history questionnaire with validated condition specific questionnaires returned via secure email access or Electronic Personal Assessment Questionnaire such as EPAQ-Pelvic Floor. Non-computer literate patients can be asked questions over the phone or sent the documents in the post with a return addressed stamped envelope.
- Reassure the patient that prolapse is not dangerous and not cancerous.
- If prolapse is mild (e.g. POP-Q stage 2), patient should be advised to perform pelvic floor muscle training.
- If there is a large bulge affecting bladder and bowel emptying and/or in presence

of ulceration, a face-to-face appointment will be required. In patients with sudden onset of complete procidentia when they have bladder and bowel problems may need to be reviewed within 30 days. If however this is a long standing condition and the condition causes minimal inconvenience then consult may be delayed.

## **1.2. New Referrals of Prolapse Patients**

- Most new referrals to the Urogynecology clinic can be deferred whilst the directive for social distancing and staying at home is in place. Telephone consultations may be feasible. For prolapse patients however, where the assessment and examination of the patient is key to further management and discussion of the various options for treatment, a telephone consultation is more limited in value.

## **1.3. Management of Pessaries**

- Women with vaginal pessaries are a particular group who require regular follow up. We would recommend telephone consultations in the first instance where most women can be reassured that a slight delay of a few months to the pessary change will have no harmful effects. This telephone consultation can also be used to identify which patients can have a delayed follow-up (over 3 months), within 30 days and those who need to be seen semi-urgently.
- When women are asked to come in for face-to-face follow-up, it should be ensured that they are not symptomatic for Covid or in an extremely vulnerable group. If this is the case, their follow-up should be deferred where possible and until safe to do so.
- Severe problems arising from a pessary left in situ is usually in relation to Gellhorn and shelf pessaries. When this occurs a follow-up within 7 days may be required for removal of the pessary.
- Where it is identified that the pessary is causing problems such as bleeding, pain or ulceration, patients should be asked to attend for a face-to-face consultation provided they fulfill the aforementioned criteria (they are not symptomatic for Covid or in an extremely vulnerable group).
- Post-menopausal bleeding in women with intact uterus and a vaginal pessary for prolapse should be referred via the local post-menopausal bleeding cancer pathway.
- An alternative strategy would be to send out a letter to say that they cannot be seen at present but to contact the department immediately if they develop symptoms such as bleeding or they may wish to self-remove. A recent randomized study<sup>1</sup> showed that in women who receive office-based pessary care and are using a ring, Gellhorn, or incontinence dish pessary, routine follow-up every 24 weeks is non-inferior to every 12 weeks based on the incidence of vaginal epithelial abnormalities.

#### 1.4. Follow-up of Post-surgical Case

- Some women may have had surgery prior to the covid-19 pandemic crisis and may have their face-to-face appointments cancelled or postponed.
- Follow-up appointments can be carried out virtually using telephone or video conferencing.
- If a reason to see patient is identified, a face-to-face appointment may be the only option. If so, recommended PPE should be worn.

## 2. Urinary Incontinence

### 2.1. Assessment

- Women with urinary incontinence should initially be managed by remote communication (virtual consultation). Facilities for remote communication can vary and include telephone/video conferencing.
- If possible, it may be useful to obtain the history prior to the hospital visit using structured general history questionnaire with validated condition specific questionnaires returned via secure email access or Electronic Personal Assessment Questionnaires such as EPAQ-Pelvic Floor. Non-computer literate patients can be asked questions over the phone or sent the documents in the post with a return addressed stamped envelope.
- Bladder diary could be sent to the patient before consultation.
- A relevant clinical history should be taken to elucidate the type and severity of the symptoms. Categorize the woman's urinary incontinence as stress urinary incontinence, mixed urinary incontinence or urgency urinary incontinence/overactive bladder. Start initial treatment on this basis. In mixed urinary incontinence, direct treatment towards the predominant symptom.
- Exclude symptoms of urinary tract infection (If suspected, follow UTI guidance below)
- Women should be referred to secondary care for further management in presence of:
  - Visible hematuria
  - Persistent bladder or urethral pain
  - Suspected fistula
  - Previous continence surgery with pain and/or recurrent UTI
  - Urinary retention/ voiding difficulty
- Explain that in keeping with current practice, conservative management will be offered first.
- Further investigations and surgical management will take place after services return to “new” normal.
- Maintain a paper copy of the remote assessment for future reference.

## 2.2. New Referrals of Urinary Incontinence Patients:

- For urinary incontinence, a virtual consultation will permit an assessment of the type of incontinence and preliminary advice to be given over the phone. Information sources can be provided which will allow commencement of initial treatment.

## 2.3. Non-surgical management of urinary incontinence

### 2.2.1 Lifestyle interventions<sup>2</sup>

- Recommend a trial of caffeine reduction to women with overactive bladder.
- Consider advising women with urinary incontinence or overactive bladder a high or low fluid intake to modify their fluid intake.
- Advise women with urinary incontinence or overactive bladder who have a BMI greater than 30 to lose weight.
- Try and limit calorie intake and take daily exercise during the Covid-19 lockdown.

### 2.2.2 Physical therapy

- Pelvic floor muscle training of at least 3 months' duration should be offered as first-line treatment to women with stress or mixed urinary incontinence.
- In the current climate where face to face consultations are not possible, other possibilities need to be considered:
  - Telephone consultation
  - Video consultation
  - Use of Specific Apps e.g. Squeezy app
  - Instructional videos
  - Information leaflet
- Remote telephone follow-up recommended on a monthly basis. Validated Questionnaires and bladder diary may be used.

### 2.2.3 Behavioral therapies

- Offer bladder training lasting for a minimum of 6 weeks as first-line treatment to women with urgency or mixed urinary incontinence.
- If women do not achieve satisfactory benefit from bladder training and pelvic floor programmes, the combination of an overactive bladder medicine with bladder training should be considered.

### 2.2.4 Medicines for overactive bladder

- Before starting treatment with a medicine for overactive bladder, explain to the woman:
  - the likelihood of the medicine being successful
  - the common adverse effects associated with the medicine

- that some adverse effects of anticholinergic medicines, such as dry mouth and constipation, may indicate that the medicine is starting to have an effect
- that she may not see substantial benefits until she has been taking the medicine for at least 4 weeks and that her symptoms may continue to improve over time
- that the long-term effects of anticholinergic medicines for overactive bladder on cognitive function are uncertain
- When offering anticholinergic medicines to treat overactive bladder, take account of the woman's:
  - coexisting conditions (such as poor bladder emptying, cognitive impairment or dementia)
  - current use of other medicines that affect total anticholinergic load
  - risk of adverse effects, including cognitive impairment
- The choice of medication depends on availability of medications in your setting.
- Offer intra-vaginal estrogens to treat overactive bladder symptoms in post-menopausal women with vaginal atrophy.
- Offer remote/virtual consultation 4 weeks after starting a new medicine for overactive bladder. Ask the woman if she is satisfied with the treatment and:
  - if improvement is optimal, continue treatment
  - if there is no or suboptimal improvement, or intolerable adverse effects, change the dose or try an alternative medicine for overactive bladder
  - Offer a review before 4 weeks if the adverse events of a medicine for overactive bladder are intolerable.
- Offer a further virtual follow-up if a medicine for overactive bladder or urinary incontinence stops working after an initial successful 4-week review.
- Offer a follow-up to women who remain on long-term medicine for overactive bladder or urinary incontinence every 12 months, or every 6 months if they are aged over 75; this can be accomplished with telemedicine.
- Refer women who have tried taking medicine for overactive bladder, but for whom it has not been successful or tolerated, to secondary care to consider further treatment. Explain that this may be delayed.
- If the need arises to visit the hospital for respiratory symptoms suggestive of the viral illness, carry a copy of the prescription as anti-muscarinic medications, particularly Solifenacin, have a side effect of prolongation of QT syndrome on electrocardiogram that may be detrimental with concurrent use of medications used for potential treatment of the current viral illness.

### 2.2.5 Absorbent containment products, urinals and toileting aids

- Many women use containment products and toileting aids as a coping/management strategy for bladder and bowel symptoms. There are many different products available and women can be advised to visit the Continence Product advisor website for information and an online assessment about aids

and devices that may be helpful to manage their symptoms whilst awaiting further review. [www.continenceproductadvisor.org](http://www.continenceproductadvisor.org)

- Consider incontinence pessaries to control SUI with exercise.
- For those that are self-shielding or unable to get to the shops to buy their normal products, most supermarket home delivery services will be able to deliver the pads with normal groceries. Many products are also available for home delivery through online pharmacies and retailers.
- Advice should be given on skin care and basic vulvar health and hygiene.

### 2.3 Follow up

- Some women may have had surgery prior to the crisis and may have their face to face appointments cancelled or postponed.
- Follow-up appointments can be carried out remotely using telephone or video conferencing. A randomized trial has shown that postoperative phone visits are not inferior to in-person visits in terms of patient satisfaction, complications and adverse events<sup>3</sup>
- If a reason to see patient is identified, a face-to-face appointment may be the only option. If so, recommended PPE should be worn.

## 3. Urinary Tract Infection

### 3.1 Acute urinary tract infection

- Women with urinary tract infection symptoms should initially be managed by remote communication (virtual consultation).
- A relevant clinical history should be taken to elucidate the type and severity of the symptoms (burning micturition, urgency, frequency).
- If diagnosis is unclear, urine sample for urinalysis; and if positive, a sample may be sent for culture and sensitivity.
- Women should be referred to secondary care for further management if they have visible hematuria.
- Advise the woman on self-care measures<sup>4</sup>:
  - Simple analgesia such as Paracetamol (or if preferred and suitable, Ibuprofen) can be used for pain relief.
  - Consider the need for antibiotics depending on the severity of symptoms, risk of complications, and previous urine culture results and antibiotic use.
- If severe voiding difficulty bladder scan (if available) will need to be done or to check for residual urine and possible intermittent self-catheterization and a face-to-face appointment may be unavoidable.

### 3.2 Recurrent lower urinary tract infections

- Women can be provided with conservative advice regarding:
  - Bladder retraining
  - Toileting techniques: sitting to void, feet flat on the floor, elbows

- leaning on thighs and relaxing.
  - Hygiene advice (See below).
  - Double voiding techniques: When the patient has finished voiding, they count to 120, slightly lean forward and pass urine again or stand up move around a bit and sit down again.
- Avoid long intervals between passing urine.
- Drink at least 1-1.5L of fluid per day (preferably water; avoid those containing caffeine).
- Avoid using any feminine hygiene sprays and scented douches.
- Emptying bladder after sexual intercourse, as sexual relations can often trigger UTIs.
- After a bowel movement, clean the area around the anus gently, wiping from front to back and never repeating with the same tissue. Soft, white, non-scented tissue is recommended.
- Some patients find that drinking cranberry juice or taking cranberry tablets regularly can reduce the numbers of infections they get. Cranberry juice should be taken with caution if you are on Warfarin tablets.
- Initial management should be based on culture and sensitivity results.
- If infections are recurrent, consideration may be given to providing self-start antibiotic therapy, long term prophylactic therapy or continuous low dose rotating antibiotics until further investigations can be safely arranged.
- Vaginal estrogen therapy should be considered in postmenopausal women as a prophylactic measure assuming there are no contraindications.
- Nitrofurantoin, an antiseptic may also be considered as prophylaxis in both pre- and postmenopausal women.
- Advise patients of symptoms of ascending urinary tract infection and the potential need for earlier assessment due to possibility of acute pyelonephritis.

#### **4. Emergency/urgent Review (within 12 hours):**

##### **4.1. Urinary retention:**

- Patients presenting with urinary retention (postnatally or otherwise) if newly diagnosed need an urgent review to prevent bladder injury. It may be possible to see these patients within a gynaecology/ postnatal ward where nurses/midwives are trained to catheterise patients and monitor residual urine. The initial management will usually be with an indwelling catheter with a review in a week for a Trial Without Catheter (TWOC).

##### **4.2. Trial Without Catheter (TWOC):**

- Patients requiring a TWOC need to be seen to ensure their post void residuals are within normal ranges (follow hospital guidelines). If post-void residuals are raised patients should be taught self-catheterization where appropriate to avoid repeat admissions to hospital. It may be possible to defer TWOC for few weeks

but this needs to be reviewed on a case-by-case basis, especially for those patients who may have been in contact with a suspected or COVID positive person, or have symptoms themselves.

#### **4.3. Suprapubic catheter changes:**

- Change of suprapubic catheters can be delayed for up to 3 months. Where feasible a nurse may be asked to visit the patient and perform the change at home to avoid a visit to the hospital.

### **5. Anal incontinence**

#### **5.1 Assessment**

- Women with anal incontinence should initially be managed by remote communication. Facilities for remote communication can vary- telephone/ video conferencing.
- If possible, it may be useful to obtain history prior to the hospital visit using a structured general history questionnaire with validated condition specific questionnaires returned via secure email access or Electronic Personal Assessment Questionnaire such as EPAQ-Pelvic Floor. Non-computer literate patients can be asked questions over the phone or sent the documents in the post with a return addressed stamped envelope.
- A relevant clinical history should be taken to elucidate the type and severity of the symptoms. Categorize the woman's anal incontinence as urge anal incontinence (needs to rush to toilet and may have a bowel accident before getting there,) passive anal incontinence (urgency not associated with incontinence, fecal matter just comes out) or flatus incontinence or mixed. Start initial treatment on this basis.
- Symptom profile for anal incontinence to include:
  - What the problem is and how bothersome
  - What kind of anal incontinence and when does this happen
  - If passive can this be anytime or mainly post defecatory
  - Stool type (Bristol Stool chart)
  - Length time she has had the problem
  - Pain on defecation (possible hemorrhoids or anal fissure)
  - Bloating
  - Incomplete emptying
  - Constipation with overflow
- Exclude any red flag symptoms for colorectal cancer:
  - Unexplained weight loss
  - Change in bowel habit in last 3 months for no reason
  - Unexplained lethargy
  - Passing blood with or without mucus mixed with stool
  - Abdominal pain
  - History of bowel cancer in family



- Explain that in keeping with current practice, conservative management will be offered. Further investigations and surgical management will occur after services return to normal.

## 5.2 Non-surgical management of Anal Incontinence<sup>5</sup>

### 5.2.1 Assessment

Often patients with anal incontinence have loose stool (type 5-6) so modifying food and fluid often helps to make the stool firmer and give better control, for example they can be given advise as follows:

- Drink 1.5 litres/3pints/8 cups of varied fluids every day. Avoid drinking all types of coffee caffeinated or decaffeinated. Avoid fizzy drinks, especially diet types.
- Reduce the fiber in diet (low residue diet).
- Marshmallows, jelly, apple sauce, tapioca, Bio natural yoghurt and rice are all foods that may help to firm your stool.
- Trial of avoiding wheat products, especially bread, pasta, biscuits, cakes and pastry.
- Have a probiotic yoghurt drink or bio yogurt daily.
- Reduce or stop foods that may have a laxative effect such as prunes, papaya
- Peel fruit to reduce fiber content.
- Avoid spicy foods, fatty or foods that contain monosodium glutamate, such as in oriental food.
- Avoid sugar free products as sweetener replacement such as sorbitol or aspartame, as it will have a laxative effect on your bowel.

### 5.2.2 Behavioral advice

- Use the toilet half an hour after meals to have your bowels open.
- When sitting on the toilet make sure that knees are higher than hips by elevating legs on a footrest. Rest elbows on your knees and let your tummy relax forward. This will enable better emptying of the bowel.
- Specifically for passive anal incontinence:
  - After bowels open, clean anus with a minimal amount of toilet paper or use water to wash (hand-held shower if you have one) or toilet wipes. Don't over wipe.
  - Apply a barrier cream such as petroleum jelly around anal area.
- To help manage soiling, fold a round flat cotton wool pad in half and put the straight side up by back passage.

### 5.2.3 Medication

- Antidiarrheal medication can be offered to people with fecal incontinence associated with loose stools once other causes (such as excessive laxative use, dietary factors and other medication, impaction) have been excluded.

- The antidiarrheal drug of first choice should be Loperamide hydrochloride. It can be used long term in doses from 0.5 mg to 16 mg per day as required. Often a small dose of under 2mg can help and in these cases loperamide hydrochloride liquid should be prescribed (1mg per 5mls.) starting with a small dose and increase as required.
- Remote telephone follow-up recommended on a monthly basis. Validated Questionnaires and bowel diary may be used.

## 6. Outpatient treatments/investigations

- These include procedures such as PTNS (Percutaneous Tibial Nerve Stimulation, bladder instillations, Botox injections, Urethral Bulking agents and diagnostic cystoscopy (non-cancer indications). These are non-urgent procedures and should be suspended for the duration of the Covid pandemic crisis. These can be resumed again once normality returns.

## References:

1. Propst K, Mellen C, O’Sullivan DM, Tulikangas PK. Timing of Office-Based Pessary Care: A Randomized Controlled Trial. *Obstet Gynecol.* 2020;135 (1):100–105.
2. Urinary incontinence and pelvic organ prolapse in women: management. NICE guideline [NG123] Published date: 02 April 2019 Last updated: 24 June 2019.
3. Thompson, J.C., Cichowski, S.B., Rogers, R.G. et al. Outpatient visits versus telephone interviews for postoperative care: a randomized controlled trial. *Int Urogynecol J* 2019;30:1639–1646
4. Urinary tract infection (lower): antimicrobial prescribing. NICE guideline [NG109] Published date: 31 October 2018
5. Initial management of fecal incontinence: NICE Pathway Published date: 25 June 2019

## Reading materials and related publications:

1. Rogers, R.G., Swift, S. The world is upside down; how coronavirus changes the way we care for our patients. *Int Urogynecol J* (2020). <https://doi.org/10.1007/s00192-020-04292-7>
2. BSUG (British Society of Urogynaecology) Guidance on management of Urogynaecological Conditions and Vaginal Pessary use during the Covid 19 Pandemic <https://bsug.org.uk>