# Regional Stress Urinary Incontinence MDM

[INSERT NAME OF REGION HERE]

Please complete electronically, no handwritten referrals will be accepted. Email to [xxx@yyyy.org.nz](mailto:xxx@yyyy.org.nz)

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| **MDM Referral**  (Filled in by referring practitioner) |

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| **Patient and Referrer details** | | | | | | |
| Patient Name | | | | | | |
| DOB  Age | NHI | | Recorded Ethnicity | BMI | | ACC accepted claim for Maternal Birth Injury  🞎 Yes 🞎 No |
| Referring Clinician Name | | Referring Hospital | | | Referrer email | |
| Reason for referral:  Are you considering SUI surgery on your patient? 🞎 Yes 🞎 No If **Yes** – case must be presented at MDM  🞎 recurrent incontinence 🞎 Discuss complex case | | | | | | |
| Preferred date of MDM dd/mm/yyyy | | Does this case reach the Manatū Hauora’s criteria for SUI   * Exception for surgical mesh 🞎 Yes 🞎 No | | | | |

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| **Patient History** | | | | | | | | | | |
| Presenting complaint (including severity of symptoms) | Stress 🞎 Yes 🞎 No  Urge or urge incontinence 🞎 Yes 🞎 No  Nocturnal enuresis 🞎 Yes 🞎 No  Flooding incontinence 🞎 Yes 🞎 No  **Severity:**  Degree of bother (free text)  Pads used/day (box to enter number)  Number of episodes (free text option) | | | | | | | | | |
| Screening for non-index features | Presence of voiding dysfunction (slow flow/ hesitancy etc) | | | | | | | | 🞎Yes 🞎 no | |
| Presence of complex features (haematuria, pelvic radiotherapy, neurological disease, recurrent UTI, radical pelvic surgery) | | | | | | | | 🞎Yes 🞎 no | |
| Diagnosis |  | | | | | | | | | |
| Effects on QoL |  | | | | | | | | | |
| Patient goals of treatment |  | | | | | | | | | |
| Previous pelvic surgery | 🞎 Yes  🞎 No | | If yes:  Incontinence surgery  🞎 Yes 🞎 No | If yes; what type  🞎 mesh 🞎 sling 🞎 fascia 🞎 Burch 🞎bulking 🞎 other  Specify other\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Prolapse surgery  🞎 Yes 🞎 No  If yes specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Significant/relevant surgical history | 🞎 Yes 🞎 No  If yes -specify | | | | | | | | | |
| Significant/ relevant medical history | 🞎 Yes 🞎 No  If yes, select as many as required  🞎 diabetes 🞎 neurological disease/event 🞎pelvic radiotherapy 🞎 chemotherapy 🞎 MI 🞎 other | | | | | | | | | |
| Parity  (free text box) | | Future fertility desired  🞎 Yes  🞎 No | | | | Patient has been informed of MDM discussion and process.  🞎 Yes  🞎 No | | PROMs captured  🞎 Yes 🞎 No  Responses  \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Sexual function  Sexually active  🞎 Yes  🞎 No | | If No, is this due to (select as many as indicated)  🞎 pain 🞎 obstruction 🞎 incontinence 🞎 not due to gynaecological issues  🞎 no partner 🞎 not planning on becoming SA | | | | | | | | |
| Pain (describe)  🞎 Yes 🞎 No  If yes tick as many boxes as indicated  🞎 Dyspareunia 🞎 Chronic pelvic pain endo/adenomyosis 🞎 CRPS 🞎 Rheumatology type pain 🞎 Bladder pain  🞎 other – specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Prolapse Symptoms  vaginal bulge symptoms only  🞎 Yes  🞎 No | | Significant/relevant bowel symptoms  🞎 Yes 🞎 No  Bowel exam  🞎 Yes 🞎 No  Findings:  \_\_\_\_\_\_\_\_\_\_\_\_  Free text what is relevant to this diagnosis  \_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **Examination findings** | General | | | | | | | | Urine stress test  Urethral hypermobility:  🞎 Yes 🞎 No | |
| Bimanual exam  🞎Normal 🞎 Abnormal 🞎 Not done  Reasons for not completed.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | Pelvic floor  Pain 🞎 Yes 🞎 No 🞎 not assessed  Strength (use modified Oxford grading)  🞎 no contraction 🄋  🞎 Flicker ➀ 🞎 Weak ➁  🞎 Moderate➂ 🞎 Good ➃  🞎strong ➄ | |
| Uroflow/PVR | | | MSU result normal/ abnormal | | | | | Mesh exposure 🞎 Yes 🞎 No  Pain over mesh 🞎 Yes 🞎 No | |
| POP-Q (optional)  <https://www.augs.org/patient-services/pop-q-tool/>  Click on link to tool – enter scores here.   |  |  |  | | --- | --- | --- | | Aa | Ba | C | | gh | pb | tvl | | Ap | Bp | D | | | | | | | | | | Other (Mandatory)  POP-Q Grade  (enter score)  Anterior:  Apical:  Posterior: |
| **Urodynamics** | Date performed & location | | | | | | | | Bladder Diary  🞎 Yes 🞎 No | |
| Free Flow/PVR | | | | | | | | First sensation | |
| Bladder Capacity | | | | | | | | DO Yes/no | |
| SUI – LPP  (cmH20) | | | | | | | | Voiding  Qmax  Pdet@Qmax | |
| Optional   * Comment on detrusor contraction * BOOif * BCI * Tracing attached for review 🞎 Yes 🞎 No | | | | | | | | | |
| **Radiology Findings** | Date | Location | | | | Modality | | Finding | | |
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| **Non-surgical management to date** | Supervised pelvic floor training.  🞎 Yes 🞎 No  Date completed dd/mm/yyyy | | | | Continence Pessary offered/trialled.  🞎 Yes 🞎 No | | | | | Relevant medications trialled. |
| **Written information on treatment options given to patient.** | Name MH document here[[1]](#footnote-1)  🞎 Yes 🞎 No | | Other – name  Propose drop down option for NZ PDA, etc. and “other: option allowing type in for literature options | | | | | | | |
| **Surgical options discussed with patient** | List surgical options discussed with patient (tick all that apply).   * Mesh 🞎 Yes 🞎 No * Fascial sling 🞎 Yes 🞎 No * Burch Colposuspension 🞎 Yes 🞎 No * Urethral bulking 🞎 Yes 🞎 No   If **NO** to any of above enter reason enter rationale why it has not been offered, including clinical reasons if not suitable. | | | | | | Patient preference for treatment options discussed:  **Tick all that apply**  🞎 Mesh  🞎 Fascial  🞎 Burch Colposuspension  🞎 Urethral bulking  🞎 Other - (free text) | | | |
| **Referring clinician recommend surgery type** | 🞎 Mesh  🞎 Fascial  🞎 Burch colposuspension  🞎 Urethral bulking  🞎 Other – please type | | | | | | **Rational for referring surgeon recommendation**  **Note:** *Index = standard, clear diagnosis without UDS v's non-index where diagnosis is not so clear cut* | | | |

# MDM Outcome Form

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| **MDM Discussion** | | | |
| Date | | Chair | |
| Attendees’ designation and name | | | |
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| Quorum achieved 🞎 Yes 🞎 No  Present: 🞎 2 SMO ideally from 2 different centre who meet ToR criteria 🞎 CNS - Continence) 🞎 Pelvic health physiotherapist 🞎 Radiology (quorum for specified cases only) | | | |

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| **MDT Recommendations** | |
| Additional investigations recommend |  |
| Additional non-surgical treatment recommended |  |
| Surgery considered appropriate | 🞎 Yes 🞎 No |
| Type of surgery recommended |  |
| Rationale for treatment recommendation |  |
| Will this treatment option help achieve the patients’ goals for treatment | 🞎 Yes 🞎 No |
| Suggested place of surgery |  |
| Follow up plan |  |
| Other MDT recommendations |  |
| Place holder row for information required to send to the national registry provider | No action required |

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| **High Vigilance Monitoring** | | |
| Does the patient meet the High Vigilance criteria | | 🞎 Yes 🞎 No |
| Have pelvic floor muscle exercises been trialled | | 🞎 Yes 🞎 No |
| Have urodynamics been performed and interpreted by an appropriately trained clinician | | 🞎 Yes 🞎 No |
| Has the patient been through a shared decision-making | | 🞎 Yes 🞎 No |
| Has the patient been through an informed consent process including the use of a patient decision aid? | | 🞎 Yes 🞎 No |
| Has the patient been offered treatment that would benefit the patient but is not offered by the referring clinician | | 🞎 Yes 🞎 No |
| Is the surgeon credentialed to perform the recommended surgery | | 🞎 Yes 🞎 No |
| Is a follow up plan documented | | 🞎 Yes 🞎 No |
| Does the patient reach the threshold for escalation to the Mesh Exceptions group | | 🞎 Yes 🞎 No |
| Name of person recording outcome of discussion |  | |

1. Insert link to MH SUI patient information site [↑](#footnote-ref-1)