Primary Care Management of Overactive Bladder (OAB) In Women

Document history:

Version	Date	Main Changes/Comments
1	April 2021	Developed by Carolyn Freeman Lead Continence Nurse MCH and Dr S Masood Urologist MFT.
2	May 2021	Additional diagnostic info added following comments from Sarah Jones and Lina Rehan Continence Nurses Virgincare and Tina Mitchell Urology Specialist Nurse DVH.
3	June 2021	Removal of men from pathway following comments from Dr Hidekazu Yamamoto, MTW Urology Consultant. Noted that comment received from Dr Adrian Simoes, Urology consultant EKUFT no changes required.
4	June 2021	Incorporated comments from Joint Formulary Group Members including: formatting changes, addition of document history and contributors, removal of any reference to male OAB guidance from body of document.
5	July 2021	Removed MCH header. Comments received from Jai Abbaraju- Urological Surgeon- DVH- no changes required. Changes made as a result of commenst made by Ian Rudd Urology Consultant MTW.
6	July 2021	Adjustments made as a result of feedback from JPC.
7	September 2021	Addition of ≥ to BP contraindications for Mirabegron

At the initial clinical assessment, **categorise** the urinary incontinence as stress urinary incontinence (SUI), urgency urinary incontinence (UUI)/overactive bladder (OAB), or mixed UI. Start initial treatment on this basis:

- OAB is urgency with or without urge incontinence, usually with frequency and nocturia
- UUI is involuntary leakage of urine associated with urgency
- Mixed urinary incontinence is involuntary leakage of urine associated with both urgency and physical stress (exertion, sneezing or coughing).
- SUI is the complaint of involuntary leakage on effort or exertion or on sneezing or coughing.

Initial assessment

- Full history (to include smoking status, history of constipation and any red flags)
- Frequency/volume chart (assess type of fluid and caffeine Intake)
- Measurement of post-void residual (referral to continence team for assessment)
- Urinalysis (if the patient is symptomatic)
- If patient has UTI symptoms and dipstick test shows leucocytes and/or nitrates send MSU
- Physical examination

Conservative management – non-pharmacological treatments remain the mainstay for patients with OAB

- All patients should have conservative treatment prior to commencement of medication or referral to secondary care. This may include referral to local continence service or women's health physio.
- Should include patient education, lifestyle advice, and review of bladder diary, bladder training and pelvic floor exercises (for women).
- **Post-Menopausal Women**: Intravaginal oestrogens are recommended for women with vaginal atrophy or OAB symptoms e.g. Ovestin 0.1% cream or Vagifem
- **Pelvic floor exercise (For Women)**: For at least 3 months
- **Bladder Training: Minimum of 6 weeks (NICE 2019)**

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Lifestyle advice

- Modify high or low fluid intake and advice on type of fluid
- Advise on drugs (if appropriate avoid diuretics), co-morbidity
- Smoking cessation, weight loss (aim for BMI less than 30), exercise
- Constipation advice, healthy eating
- Consider intervention related to cognitive impairment

Review at 3 months if no improvement, proceed to drug treatment algorithm

Pharmacological options

- Solifenacin is the first line pharmacological option, as low acquisition cost and effective.
- Solifenacin is not suitable for patients with:
  - Myasthenia Gravis
  - Significant bladder outflow obstruction or urinary retention
  - Severe ulcerative colitis or toxic megacolon
  - GI obstruction, intestinal atony, paralytic ileus or pyloric stenosis
- If patient has severe renal impairment (CrCl <30ml/min), moderate hepatic impairment (Child-Pugh score of 7-9) or treated with a potent inhibitor of CYP 3A4, the dose should not exceed 5mg od.
- If Solifenacin is contra-indicated alternative first line agents include:
  - Oxybutinin (avoid in frail/elderly patients- high risk of side effects)
  - Trospium (more suitable in frail/elderly patients as does not cross the blood brain barrier)
- When prescribing consider the anti-cholinergic burden for each patient. There is evidence to suggest that antimuscarinics and a high anticholinergic load, increase the risk of dementia and mortality.
- With any pharmacological treatment consider a drug holiday to assess benefit, after 6 months.

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Drug treatment algorithm for overactive bladder (OAB) and mixed urinary incontinence (UI) in women

Do NOT start drug treatment unless initial assessment has been completed and conservative management proves unsuccessful after adequate duration

No improvement

First line medication therapy[1]

Solifenacin 5mg OD
➢ Review 8 weeks after OAB drug treatment. ➢ Review sooner if adverse effects are intolerable. ➢ **If improvement is optimal, continue treatment.** ➢ If there is no or suboptimal improvement change the dose
Solifenacin 10mg OD

NICE[1] Recommends: Alternative 1st line if anti-muscarinic contraindicated: Mirabegron as below

Review at 8 weeks: If ineffective or intolerable adverse effects

NICE NG123[1] recommends **2nd line drug** as one with the low acquisition cost

Mirabegron MR 50mg daily

(If patients has renal or hepatic impairment, use reduced dose of 25mg od.)	[NICE TA290] Beta-3 agonist. For people in whom antimuscarinic drugs are contraindicated, ineffective or have unacceptable side effects.

NB: Mirabegron is contraindicated in patients with severe uncontrolled hypertension (systolic≥ 180mmHg and/or diastolic ≥110mmHg)

If ineffective or Intolerable adverse effects

AFTER TRIAL OF 2 MEDICINES: Refer to secondary care – urology / uro-gynaecology. (Botulinum toxin A may be used as per local policy[2]).

Patient safety

Start on low doses; take account of total anticholinergic load (other drugs with antimuscarinic side effects) and co-existing conditions (e.g. poor bladder emptying).

Minimise use of anti-cholinergic medication in patients with dementia https://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf

NICE NG123 recommendations[1]**: Do not offer oxybutynin (immediate release) to older women who may be at higher risk of a sudden deterioration in their physical or mental health. [2013, amended 2019]**

Patient education

Educate patient to manage patient expectation of drug treatment outcome.

- Discuss likelihood of success (only modest benefit)
- Discuss associated adverse effects
- Inform that side effects (e.g. dry mouth) means drug is working and may improve with time.
- Inform that full benefit may take at least 4-6 weeks.

Review treatment after 6 months of prescribing with a view to stopping - if patient is symptom free, consider trial without drug treatment. Patients requiring long-term drug treatment - review annually in primary care (every 6 months for patients over 75yrs old).

References (Refer to The British National Formulary or The Summary of Product Characteristics for more information).

1. NICE Guidance NG123, 2nd April 2019: Urinary incontinence: The management of urinary incontinence in women available via http://www.nice.org.uk/guidance/ng123

Approved by:
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