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Management of Overactive Bladder Syndrome in Primary Care in Adults

Scope: Urology and Gynaecology, Primary Care GP Practices

Aims

To provide a recommended treatment pathway for Overactive Bladder Syndrome including urgency incontinence for primary care clinicians.

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Assessment in Primary Care

- Urine dipstick
- Frequency/volume chart (bladder diary) for 3 days
  - See leaflet and template below.
- Post-void residual – if symptoms suggestive of recurrent urinary tract infection (UTI) or voiding dysfunction
- Quality of Life questionnaire e.g. ICIQ-FLUTS or ICUQ-MLUTS

First Line: Conservative Measures

- Modify fluid intake if excessive or inadequate fluid consumption (aim for ~20ml/kg/day, it can be helpful to recommend reducing individual drinks by 25% i.e. fill a cup by ¾ rather than full)
- Reduce caffeine intake
- Weight loss if BMI >30kg/m^2
- Smoking cessation
- Bladder re-training for a minimum of 6 weeks – ideally 12 weeks, supplemented by pelvic floor exercises
  - Consider referral: Remedy Bladder & Bowel Services
- Female patients with vaginal atrophy should be offered transvaginal oestrogen
  - Menopause (Remedy BNSSG ICB)

NB: Pads and incontinence aids should only be used as a coping strategy and should not be offered as treatment.

Second Line: Medical Management

To be commenced only if conservative measures have failed. **Conservative measures should be encouraged to continue alongside medication.**

See BNSSG Formulary 7.1 Bladder and Urinary Disorders page for more information.

Anticholinergic/antimuscarinic drug

Chronic anticholinergic use can have long-term effects on cognitive function. Short term use can also be associated with adverse reactions such as dry mouth, constipation, cognitive impairment and falls. A full medications review should be conducted prior to commencing anticholinergics particularly in elderly patients with polypharmacy who are more susceptible to anticholinergic effects. See ACB Calculator for more information. **NB:** Anticholinergic side effects can indicate that the medication is starting to work.

1) Solifenacin 5mg once daily.
   i) Minimum 1 month trial then review. Can increase Solifenacin to 10mg OD if beneficial but not curative.
   i) Requires annual review. Review 6 monthly if frail or cognitive impairment.
2) Trospium Chloride 20mg BD (standard release) can be considered if Solifenacin is not tolerated at 5mg daily dose. This may be better tolerated, particularly in frail/elderly patients, as it does not cross the blood brain barrier resulting in fewer anticholinergic effects than other anticholinergic options.
   i) If Trospium Chloride standard release is effective and tolerated but there are compliance issues with twice daily dosage, the modified release preparation can be considered.
3) Transdermal oxybutynin can be used if unable to take oral medications (oxybutynin 3.9mg/24hour patches twice weekly) however oxybutynin oral formulations are routinely reserved for neurosciences patients. Due to high anticholinergic burden oral oxybutynin should be avoided in elderly or frail patients and alternatives considered.

Tolterodine modified release tablets are non-formulary. Alternative, once daily formulations which are more cost-effective are included on the formulary.

Beta-3 adrenoceptor agonist

1) Mirabegron 50mg once daily - For use in patients after bladder training and where antimuscarinics are contraindicated/patient/clinician does not want to trial antimuscarinics due to anticholinergic burden; *or* where one antimuscarinic has been tried at maximum recommended dose and proved ineffective *or* where two antimuscarinics have been tried at suboptimal dose but not tolerated due to adverse effects.
    i) Minimum 6-week trial then review.
    ii) Requires annual review including BP check. Review 6 monthly if frail, cognitive impairment or hypertension.
    iii) Contraindicated in severe, uncontrolled hypertension (Severe uncontrolled hypertension defined as systolic blood pressure ≥ 180 mm Hg and/or diastolic blood pressure ≥ 110 mm Hg) and/or eGFR <30mL/minute.
    iv) Maximum 25mg daily in patients with hepatic or renal impairment.

Consider combination therapy with an anticholinergic plus mirabegron if individual medications fail to control symptoms.

When to Refer

Secondary care referral is appropriate when medical management has failed despite trying TWO different medications for a minimum of 4-6 weeks each. Can consider combination therapy of an anticholinergic and mirabegron prior to referral.

Patient Education

Overactive Bladder Syndrome and/or urgency incontinence are not always possible to cure. The aim is to improve symptoms and patient participation is key. Managing these expectations is important before referral to secondary care and is likely to improve medication compliance.

It can also be useful to inform patients of what to expect following referral to secondary care. Many of the investigations are intrusive and some of the treatments may be unacceptable to certain patients. Please consider whether your patient will accept secondary care investigation and management prior to referral.

See patient information leaflets below.

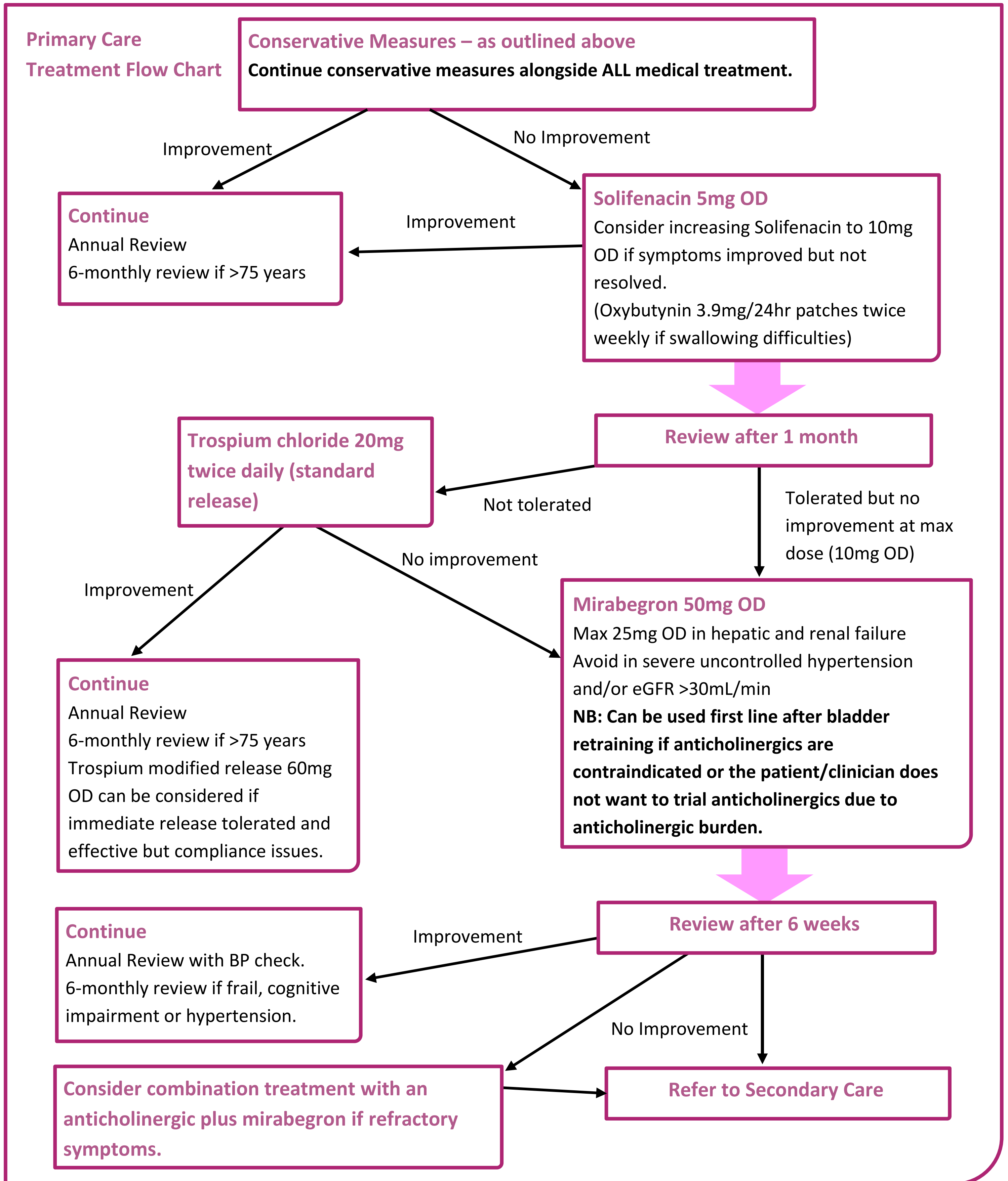
Secondary Care Investigations and Management

Patient's will undergo invasive urodynamic assessment.

If detrusor overactivity is confirmed, patients may be offered treatment with either:

- Percutaneous sacral nerve stimulation/neuromodulation (SNS/SNM) OR;
- Botulinum toxin (Botox) injections into the bladder

Further treatments may be discussed as outlined in the pathway and leaflets below. If interventions are not tolerated, this should be discontinued before an alternative intervention is considered in the pathway.



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Secondary Care Treatment Flow Chart

For Information Only. If interventions are not tolerated, this should be discontinued before alternative intervention considered.

Referred for Urodynamic Assessment and MDT Decision

Idiopathic detrusor overactivity (IDO)
Persistent symptoms despite maximal medical therapy

Neurogenic detrusor overactivity (DO)
Persistent neurogenic DO and/or poor bladder compliance despite maximal medical therapy

Offer Botulinum Toxin A (BOTOX) administration and Sacral Neuromodulation (SNM)

Sacral Neuromodulation
Percutaneous nerve evaluation (PNE) under local/general anaesthetic.

Insertion of Implant

Surgical Intervention
Ileal conduit/ augmentation cystoplasty using intestinal segment.

Botulinum Toxin A administration
Non-neurogenic: 100 units under local/general anaesthetic
Neurogenic: 200 units under local/general anaesthetic

Telephone consultation with Nurse in 6 weeks

Outpatient clinic appointment in 3 months

Stopping criteria
If Botox treatment is contraindicated, not tolerated, causes adverse events, or does not improve symptoms, consider SNM before surgical intervention.

Re-treatment
Following a minimum of a 3-month interval after Botulinum Toxin A treatment, if urinary symptoms symptoms return, usually 6-12 months, patients can self-refer for repeated treatment.

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Ratified by: Area Prescribing Medicines Optimisation Committee, October 2024			

Patient Information

Overactive Bladder NBT Leaflet

Urinary Incontinence & Bladder Problems | North Bristol NHS Trust (nbt.nhs.uk)

Overactive Bladder Treatment Options Overview

OAB options.pdf (baus.org.uk)

Frequency/Volume Leaflet with Template

https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Input%20output%20chart.pdf

Male Pelvic Floor Exercises

Pelvic floor XS male.pdf (baus.org.uk)

Female Pelvic Floor Exercises

Pelvic floor XS female.pdf (baus.org.uk)

Sacral Nerve Stimulation/Sacral NeuroModulation NBT Leaflet

Sacral neuromodulation.pdf (baus.org.uk)

Bladder botulinum toxin injection

https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Botox.pdf

References

(1) NICE, CKS (2019) *Management of a woman with predominantly urgency incontinence.* Available at: https://cks.nice.org.uk/topics/incontinence-urinary-in-women/management/managing-urgency-incontinence/

(2) Lower urinary tract symptoms in men: management (2010). NICE Guideline CG97. Last updated 03 June 2015.

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