Primary Care Management of Overactive Bladder (OAB) In Women

Document history:

Version	Date	Main Changes/Comments
1		Developed by Carolyn Freeman Lead Continence Nurse MCH and Dr S Masood Urologist MFT.
2		Additional diagnostic info added following comments from Sarah Jones and Lina Rehan Continence Nurses Virgincare and Tina Mitchell Urology Specialist Nurse DVH.
3		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		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		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
8		Reviewed document with specialists. No amendments needed. Updated approval date and took to IMOC for information.

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At the initial clinical assessment, <u>categorise</u> 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)

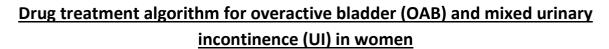
Lifestyle advice

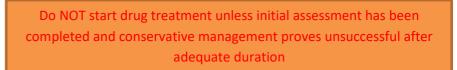
- Modify high or low fluid intake and advice on type of fluid
- Advise on drugs (if appropriate avoid diuretics), comorbidity
- Smoking cessation, weight loss (aim for BMI less than 30), exercise
- Constipation advice, healthy eating
- Consider intervention related to cognitive impairment

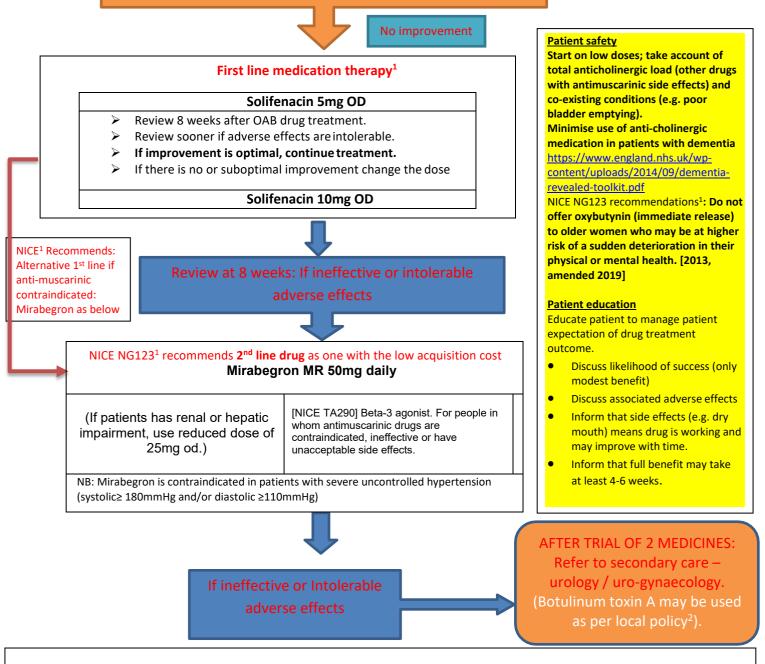
Review at 3 months if no improvement, proceed to drug treatment algorithm

Pharmacological options

- Solifenacin is the first line pharmacological option, as low acquisition cost and effective.
- Solifenacin is not suitable for patients with:
 - o Myasthenia Gravis
 - \circ $\;$ 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.







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).

<u>References</u> (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

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