Treatment of overactive bladder symptoms and urgency urinary incontinence in women in Primary Care

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Overactive bladder [OAB] /
urgency predominant mixed incontinence
- **urinary urgency**
- **frequency**
- **nocturia with or without incontinence**

Refer urgently
(Suspected bladder cancer pathway referral, for an appointment within 2weeks):

- **Aged 45 years and over with:**
  - Unexplained visible haematuria without urinary tract infection, or
  - Visible haematuria that persists or recurs after successful treatment of urinary tract infection, or
- **Aged 60 and over with**
  - unexplained non-visible haematuria and dysuria or
  - a raised white cell count on a blood test.

Referral to an appropriate specialist
(Use clinical judgement to determine urgency) if:

- persisting bladder or urethral pain:
  - *refer urgently if cancer is suspected.*
- palpable bladder on abdominal or bimanual examination after voiding.
- clinically benign pelvic mass.
- associated faecal incontinence.
- suspected neurological disease.
- symptoms of voiding difficulty.
- suspected urogenital fistulae.
- previous incontinence surgery, pelvic cancer surgery or radiation therapy.
- recurrent or persistent unexplained urinary tract infection in people aged 60 years and over:
  - *consider non-urgent referral for bladder cancer.*

Counsel patient
- OAB is a long-term condition.
- Significant lifestyle modification may be required.

Lifestyle advice
- Reduce caffeine intake: may improve symptoms of urgency and frequency.
- Fluid intake: avoid drinking either excessive amounts, or reduced amounts, of fluid each day.
- Manage constipation, which can make OAB worse.
- Weight loss if BMI≥30kg/m² - For more information Obesity.
- Smoking cessation (if appropriate) - For more information Smoking cessation.

Review current medications; Some drugs could potentially be causing or exacerbating the incontinence, e.g.:

alpha-1 adrenoceptor antagonists	antipsychotics	benzodiazepines
anti-parkinsonism drugs	anticholinergics	diuretics
beta-adrenoceptor antagonists	antidepressants	HRT

Review poorly controlled diabetes
- glucosuria will exacerbate OAB symptoms.

Bladder training (a minimum of 6 weeks)
- As first-line treatment to women with urgency or mixed urinary incontinence
- Contact Continence Advisory Service:
  - ☎ 01743 444062 or
  - Email: shropcom.continencereferrals@nhs.net or
  - Write to Continence Advisory Service, Shropshire Rehabilitation Centre, Lancaster Road, Shrewsbury SY1 3NJ.

Supervised pelvic floor muscle training (of at least 3 months' duration)
- As first-line treatment to women with stress or mixed urinary incontinence
- contact Continence Advisory Service (see above for details)

Provide patient support information:
- https://www.bladderandbowelfoundation.org
- https://www.nhs.uk/conditions/urinary-incontinence/

Review the patient after 6 weeks:
If symptoms persist despite bladder training and frequency is a troublesome symptom, encourage continuation of bladder training and consider adding in an antimuscarinic drug.

Before starting treatment with a medicine, explain to ALL patients:
- The likelihood of treatment success.
- The medicine may take time to work (at least 4 weeks).
- The common adverse effects associated with the medicine.
- That some adverse effects such as dry mouth and constipation may indicate the treatment is starting to have an effect.
- The long-term effects of antimuscarinic drugs on cognitive function are uncertain.

When offering antimuscarinic medicines to treat OAB, take account of the:
- coexisting conditions (such as poor bladder emptying, cognitive impairment or dementia)
- current use of other medicines that affect total anticholinergic load.
  Before initiating a drug for OAB assess Anticholinergic Burden or Anticholinergic Cognitive Burden Scale from concomitant medications
- risk of adverse effects, including cognitive impairment.

For women who have a diagnosis of dementia and for whom antimuscarinic medicines are an option, follow the recommendations on medicines that may cause cognitive impairment in the NICE guideline on dementia

References:
Overview | Urinary incontinence and pelvic organ prolapse in women: management | Guidance | NICE - Last updated: 24 June 2019
Incontinence - urinary, in women | Health topics A to Z | CKS | NICE - Last revised in April 2023
Recommendations organised by site of cancer | Suspected cancer: recognition and referral | Guidance | NICE - Last updated: 15 December 2021

Integrated Care System
Shropshire, Telford and Wrekin

Treatment of overactive bladder symptoms and urgency urinary incontinence in women in Primary Care

NHS
Shropshire, Telford and Wrekin

First line drug treatment

Oxybutynin Immediate release 2.5-5mg twice daily to three times daily
- 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.

Tolterodine Immediate release 1mg - 2 mg twice daily
- **1mg twice daily if eGFR ≤30ml/min or impaired liver function**

For OAB symptoms in post-menopausal women with vaginal atrophy
- Consider intravaginal oestrogens if they do not have any contraindications.
- Review at least annually to re-assess the need for continued treatment and to monitor for symptoms of endometrial hyperplasia or carcinoma in women with a uterus.
- Women with recurrent cystitis will also benefit from vaginal oestrogens.

Review

4 weeks after starting a new medicine (sooner if drug adverse effects are intolerable).
If the first-line drug treatment is not effective or not tolerated, options include:
- change the dose or try an un-tried first line drug treatment or
- second line drug treatment

Second line drug treatment

Tolterodine modified release 2mg - 4 mg daily
- **2mg once daily if impaired liver function**
- **Avoid if eGFR <30ml/min or**

Antimuscarinics | Prescribing information | Incontinence - urinary, in women | CKS | NICE

Solifenacin immediate release 5 mg – 10 mg once daily
- For people with severe renal impairment, moderate hepatic impairment, and if treated with a potent inhibitor of CYP: do not exceed 5 mg daily.

Trospium modified release 60mg XL
- limited blood brain barrier penetration useful if neurological side effects are a problem.
- not suitable for people with renal impairment or severe hepatic impairment.

Oxybutynin transdermal patch 3.9mg/24 hours
- **Apply one patch twice weekly:**
  (Change every 3-4 days; site replacement patch on a different area)
- for patients unable to tolerate oral medication only.

Drug interactions to antimuscarinic drugs

- antiarrhythmics	- citalopram, escitalopram	- antiretrovirals
- tricyclics	- antihistamines	- chloroquine

Contraindications to antimuscarinic drugs

-glaucoma	-GI obstruction
-myasthenia gravis	-intestinal atony; paralytic ileus; pyloric stenosis
-significant bladder outflow obstruction	-severe ulcerative colitis
-urinary retention	-toxic megacolon

If antimuscarinic drugs are contraindicated, consider **a non-antimuscarinic**.
- Omit 1st and 2nd line treatment.
- use 3rd line treatment beta 3 adrenoceptor agonist: Mirabegron in line with NICETA290

Further information: Oxybutinin, tolterodine

Third line drug treatment - non-antimuscarinic

Mirabegron 50 mg once daily
- **25 mg if there is renal or hepatic impairment.**
- in whom antimuscarinic drugs are contraindicated or clinically ineffective, or have unacceptable side effects (NICE TA290)
- BP should be measured before starting treatment and monitored regularly during treatment.

Contraindicated for patients with
- **severe uncontrolled hypertension**
  (Systolic blood pressure ≥ 180mm Hg and/or diastolic BP ≥ 110mm Hg),

Not recommended for patients with
- **severe hepatic impairment,**
- **end stage renal disease.**

See SPC and Mirabegron | Prescribing information | Incontinence - urinary, in women | CKS | NICE for further information.

Do not offer women **flavoxate**, **propantheline** or **imipramine** to treat urinary incontinence or overactive bladder.
The use of **desmopressin** may be considered specifically to reduce nocturia in women with urinary incontinence or overactive bladder who find it a troublesome symptom. **Specialist recommendation/initiation**.
Do not use **duloxetine** as a first-line treatment or routinely offer as second-line treatment although it may be offered second-line as an alternative to surgical treatment in stress incontinence or mixed urinary incontinence. NICE NG123

On-going review

Patients on long term therapy should be reviewed annually (or every 6 months if over 75 years) to assess whether there is benefit from continued treatment and to continue to take into account the woman's total anticholinergic load. Assess Anticholinergic Burden or Anticholinergic Cognitive Burden Scale from concomitant medications.

Referral to secondary care

Patients should try two antimuscarinics or one antimuscarinic and one non-antimuscarinic (unless contraindicated) prior to referral to secondary care.