CLINICAL GUIDELINE

Overactive bladder in Women

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Title: Management of Overactive Bladder in Women

Objectives: To provide guidance for the management of patients presenting with overactive bladder symptoms

Scope: Patients with symptomatic overactive bladder wishing treatment

Audience: All health care professionals in women's health working in primary, secondary, and tertiary care

Body of Guideline

Overactive bladder (OAB) is characterised by urinary urgency, often with frequency and nocturia and sometimes leakage (urge incontinence). OAB can have a significant impact upon quality of life.

The following guideline outlines management options available to women wishing treatment to help control symptoms.

Patient with OAB Symptoms

Exclude 'Red Flag' symptoms

Haematuria
Pelvic Masses
Significant Neurological Disease
Recurrent UTI's
Associated stage 3-4 pelvic organ prolapse
Voiding Dysfunction

Conservative Management

- Women with BMI >30 kg/m2 should aim to reduce weight
- Discuss lifestyle modifications e.g. reduce caffeine intake, monitor fluid intake, smoking cessation, food types
- Consider vaginal oestrogen therapy in postmenopausal women with vaginal atrophy (do not offer systemic HRT to treat urinary incontinence)
- Offer advice regarding bladder retraining and consider referral to local GGC Pelvic Floor Physiotherapy Team or SPHERE Bowel & Bladder Service (SCI-gateway) for supervised pelvic floor muscle retraining for a minimum of 3 months for patients with Mixed Urinary Incontinence.

Medication

- Medication for OAB should be introduced together with conservative management (see Appendix 1)
- Oral oxybutynin should **not** be offered to patients over 65 years old or women who may be at higher risk of a sudden deterioration in their physical or mental health (transdermal oxybutynin patches may be considered in any age group)
- If no improvement after 4 weeks or intolerable side effects, an alternative dose or medication may be trialled (see Appendix 1)

Refer urogynaecology team for further management

- Following 2 failed anticholinergics (including transdermal) and mirabegron

Further Management and Urodynamic Assessment with Urogynaecology Team

- Patients should not be referred for Urodynamics unless:
- Conservative management is complete (referral will be declined)
- Patient wishes to be considered for further treatment such as Intravesical BOTOX or sacral nerve stimulation

If patient wishes Botox consider teaching Clean Intermittent self catheterisation (CISC)
Ensure patient is aware that case details will be discussed at the urogynaecology MDT
Provide information leaflets from the British society of Urogynaecology (BSUG) on all procedures

Referral and discussion at GGC Urogynaecology MDT meeting prior to being listed for operation

Please see relevant referral form and send to GGC generic email inbox

Appendix 1 – Medical Management of OAB

1st line:

First line therapy with anticholinergic medication. There is little evidence to show a superior anticholinergic in monotherapy. Clinicians can discuss with patients their wishes for therapy and timing of doses.

Once daily dosing regime

- Oxybutynin MR tablets 5mg OD, max 20mg OD *(oxybutynin should not be used in over 65-year-olds)*;
- Tolterodine MR tablets 4mg OD;
- Solifenacin tablets 5-10mg OD;
- Fesosterodine MR tablets 4-8mg OD;
- Tropsium MR capsules 60mg OD

More than once daily dosing regime

- Oxybutynin tablets 5mg TID, can be increased to 5mg QID (*oxybutynin should not be used in over 65-year-olds)*;
- Tolterodine tablets 2mg BD;
- Trospium tablets 20mg BD

The chosen medication should be trialled for four weeks before increasing dose if there is no improvement in symptoms. Therapy should continue for a further two months at the increased dose, before switching to alternative anticholinergic if required (eg. due to intolerable side effects).

2rd line:

Mirabegron tablets 50mg OD *(1st line if anticholinergics are contraindicated)* should not be given in uncontrolled hypertension.

3rd line:

Transdermal oxybutynin one patch twice weekly (if unable to tolerate oral treatment due to side effects)

It should be noted that combinations of medication may be recommended by specialists in secondary care.

References:

Urinary incontinence and pelvic organ prolapse in women: management NICE guideline Published: 2 April 2019 www.nice.org.uk/guidance/ng123

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