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University Hospitals Birmingham NHS Foundation Trust

Overactive Bladder (OAB): GUIDELINE FOR REFERRAL TO SECONDARY CARE at UHB

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Purpose:	To guide primary care regarding the algorithm of treatment in Overactive bladder symptoms, which is the common cause of referral to Benign Urology Clinic
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Distribution: • **Essential Reading for:** **Information for:**	Clinical Commissioners All Regional GP Practices Medical staff of other specialities within the Trust Junior Doctors Nurses and support staff

Overactive Bladder (OAB): GUIDELINE FOR REFERRAL TO SECONDARY CARE at UHB

Overactive bladder syndrome (OAB) is defined as symptoms of urinary urgency with or without incontinence usually with urinary frequency and nocturia (ICS 2018). It is common and can affect men and women.

Primary care assessment and management (Based on NICE EAU and ICI guidelines) :-

1. **Initial assessment**:

- Full history, examination and urinalysis.
- Rule out red flag symptoms as below
- Bladder diary for a minimum of 3 days
- Treat confirmed UTI, Treat vaginal atrophy.

2. **Conservative Management**:

- Lifestyle Interventions- e.g reduce weight if BMI>30, reduce/stop caffeine intake, modify fluid intake (< 2000mls).
- Review medications (e.g. diuretics/anti-hypertensives)
- Manage constipation.
- Smoking cessation
- Bladder training for minimum 6 weeks.

Referral for supported bladder training and or supervised pelvic floor muscle training should be made via community continence teams.

3. **Pharmacological Treatment (**After failed conservative management).

Before starting OAB Drugs discuss with the patient:

● Likelihood of success and associated common side effects such as dry mouth and constipation.

● Adverse effects may indicate that treatment is starting to have an effect.

● Substantial benefits may not be seen until at least 4 weeks and that symptoms may continue to improve over time.

● That the long term effects of anticholinergic medications for OAB on cognitive function is unclear.

Choosing OAB Drugs:-

First-Line Treatment – Anticholinergic drug with a low acquisition cost eg generic **Solifenacin 5 mg daily**.

Contraindications: Patient with narrow-angle glaucoma, Sjogren syndrome, significant bladder outflow obstruction or urinary retention, severe ulcerative colitis, toxic megacolon, gastrointestinal obstruction,
and Myasthenia Gravis.
Caution in elderly, dementia, anticholinergic burden score Greater than or equal to 3

If first line anticholinergic treatment proves ineffective consider dose escalation eg **Solifenacin 10mg daily**, alternative anticholinergic preparation or Beta 3 agonist.

Second Line Treatment (If no satisfactory response to anticholinergic OR anticholinergic not suitable or contra-indicated) - Beta 3 agonist eg **Mirabegron 50 mg daily**.

Contraindications: severe uncontrolled hypertension (systolic Greater than or equal to 180 mmHg or diastolic Greater than or equal to 110 mmHg). Refer BNF.
Cautions: Caution in patients with stage 2 hypertension (systolic blood pressure Greater than or equal to 160 mm Hg or diastolic blood pressure Greater than or equal to 100 mm Hg), History of QT-interval prolongation. Blood Pressure to be measured before starting and regularly monitored (MHRA October 2015)
Mirabegron 25 mg daily if hepatic or renal impairment.

Third Line of treatment- Combination therapy with anticholinergic and Beta 3 agonist: **Solifenacin 5 mg with 50 mg of Mirabegron.**

4. Review:

● Offer face to face or telephone review 4 weeks after the start of new OAB drug treatment or before 4 weeks if adverse events of OAB drug are intolerable, and until stable

● Review patients on long term treatment annually or every 6 months if over 75 years if treatment is effective and well-tolerated, do not change the dose or the drug.

5. Referral to Secondary care

● Inadequate response to pharmacological therapy for consideration of invasive therapy (intravesical botulinum toxin, neuromodulation, cystoplasty)**.**

- **Presence of Red Flags should prompt secondary care referral**
- **Haematuria**
- **Significant prolapse – (Urogynaecology referral)**
- **Pelvic mass**

- **Suspected neurological disease**
- **Recurrent UTI**
- **Persistent bladder/urethral pain**
- **Significant voiding difficulty**
- **Suspected urogenital fistulae**
- **Palpable bladder on bimanual or abdominal examination after voiding**
- **Recent pelvic cancer surgery**
- **Previous pelvic radiation therapy**

REF:

1. Urinary incontinence and pelvic organ prolapse in women: management

NICE guideline [NG123]Published: 02 April 2019 Last updated: 24 June 2019

2. Urinary incontinence in women

Quality standard [QS77]Published: 22 January 2015 Last updated: 09 December 2021

3. Mirabegron for treating symptoms of overactive bladder ; Technology appraisal guidance [TA290]Published: 26 June 2013
4. Urinary incontinence in neurological disease: assessment and management

Clinical guideline [CG148]Published: 08 August 2012

Overactive bladder: Assessment and management