

OVERACTIVE BLADDER

- Epidemiology, aetiology, pathophysiology**

Overactive bladder (OAB) syndrome is a chronic condition that can have debilitating effects on quality of life (QoL) defined as “urinary urgency, usually accompanied by frequency and nocturia, with or without urinary urgency incontinence (UUI), in the absence of urinary tract infection (UTI) or other obvious pathology”. Various theories have been proposed to explain the pathophysiology of OAB, mainly relating to imbalances in inhibitory and excitatory neural pathways to the bladder and the urethra or sensitivity of muscle receptors. No definite identifiable causes have been established.

- Diagnostic evaluation**

The diagnosis of OAB is exclusively based on symptoms.

- Disease management**

There is a lack of evidence that improving any co-morbid condition and adjustment of specific medications improves existing symptoms.

Urinary containment

Pads are effective in containing urine.

Lifestyle interventions

Reduction of caffeine and fluid intake may reduce symptoms of OAB. Obesity is a risk factor for UI in women, but the relationship to other OAB symptoms remains unclear.

Behavioural and physical therapies

- Prompted voiding**, improves continence in elderly, care-dependent, people in the short-term.
- Bladder training** is effective for improvement of UUI in women, but efficacy appears to be lower than that of pharmacotherapy.
- Pelvic floor muscle training** may improve symptoms of frequency of OAB.
- Electrical stimulation** may improve symptoms of OAB in some women, but the type and mode of delivery remains variable and poorly standardised. **Posterior tibial nerve stimulation** is more effective than antimuscarinics in reducing UUI episodes.

Pharmacological management

- Anticholinergic drugs** are effective in improving OAB symptoms, decreasing UUI episodes and daily urgency and frequency episodes and increasing mean voided volumes but caused higher adverse events including dry mouth, cognitive impairment, and constipation.
- No anticholinergic drug is clearly superior to another for cure or improvement of OAB/UUI.
- Transdermal oxybutynin is associated with lower rates of dry mouth than oral drugs but has a higher rate of withdrawal due to skin reactions.
- The combination of antimuscarinics plus another treatment modality was more effective than antimuscarinics alone.
- Beta-3 agonists** are better than placebo for improvement of symptoms and adverse event rates are similar to those of placebo and are as effective as antimuscarinics but with lower dry mouth rates.

Recommendations	Strength rating
Request that patients complete at least a three-day bladder diary at initial evaluation for overactive bladder (OAB).	Strong
Do not routinely carry out urodynamics when offering first-line treatment to patients with uncomplicated OAB symptoms.	Strong

Recommendations	Strength rating
Take a history of current medication use from all patients with overactive bladder (OAB).	Strong
Review any new medication associated with the development or worsening of OAB symptoms.	Strong

Recommendations	Strength rating
Ensure that women with overactive bladder (OAB) and/or their carers are informed regarding available treatment options before deciding on urinary containment alone.	Strong
Offer incontinence pads and/or containment devices for management of OAB wet, either for temporary symptom control or when other treatments are not planned.	Strong

Recommendations	Strength rating
Advise adults with OAB that reducing caffeine intake may improve symptoms of urgency and frequency, but not incontinence.	Strong
Review type and amount of fluid intake in patients with OAB.	Weak
Encourage overweight and obese adults with overactive bladder (OAB)/urinary incontinence to lose weight and maintain weight loss.	Strong
Provide smoking cessation strategies to patients with OAB who smoke.	Strong

Recommendations	Strength rating
Offer prompted voiding to adults with overactive bladder (OAB) who are cognitively impaired.	Strong
Offer bladder training as a first-line therapy to adults with OAB/urge urinary incontinence (UUI).	Strong
Ensure that pelvic floor muscle training programmes are as intensive as possible.	Strong
Consider posterior tibial nerve stimulation as an option for symptomatic improvement of OAB/UUI.	Strong

Recommendations	Strength rating
Offer beta-3 agonists as an alternative to anticholinergics to women with OAB who fail conservative treatment.	Strong
Offer mirabegron as an additional therapy in patients who are inadequately treated with solifenacin 5 mg.	Weak

Recommendations	Strength rating
Long-term anticholinergic treatment should be used with caution in elderly women, especially those who are at risk of, or have pre-existing cognitive dysfunction.	Strong
Assess anticholinergic burden and associated co-morbidity in women being considered for anticholinergic therapy for overactive bladder syndrome.	Weak

Recommendation	Strength rating
Offer vaginal oestrogen therapy to women with LUTS and associated symptoms of genitourinary syndrome of menopause.	Weak

Recommendations	Strength rating
Offer anticholinergic drugs to woman with overactive bladder (OAB) who fail conservative treatment.	Strong
Consider extended-release formulations of anticholinergic drugs whenever possible.	Strong
If an anticholinergic treatment proves ineffective, consider dose escalation, offering an alternative anticholinergic formulation, or the use of mirabegron (alone or in combination with an anticholinergic).	Strong
Encourage early review (of efficacy and adverse effects) of patients on anticholinergic medication for OAB.	Strong

- Vaginal Oestrogens therapy** may improve symptoms associated with genitourinary syndrome of menopause.

Surgical management

- A single treatment session of botulinum toxin A (100 U) in the bladder wall is more effective than placebo at curing and improving symptoms and QoL
- Sacral nerve stimulation is more effective than continuation of failed conservative treatment for OAB/ UUI and as effective as botulinum toxin A 200 U injection at 24 months.
- Do not offer vaginal laser therapy to treat OAB outside of a clinical trial.
- There is limited evidence of the effectiveness of augmentation cystoplasty and urinary diversion specifically for treatment of idiopathic OAB or UUI and are associated with high risks of short- and long-term severe complications.

Recommendations	Strength rating
Offer bladder wall injections of onabotulinumtoxinA (100 U) to patients with OAB/UUI refractory to conservative therapy or drug treatment.	Strong
Warn patients of the limited duration of response, risk of UTI and possible prolonged need for clean intermittent self-catheterisation prior to offering treatment with onabotulinumtoxinA.	Strong

Recommendation	Strength rating
Offer sacral nerve stimulation to patients who have overactive bladder/urge urinary incontinence refractory to anticholinergic therapy.	Strong

Recommendations	Strength rating
Ensure patient counselling and life-long support both prior to and after major surgery as a treatment for overactive bladder (OAB) is provided by a specialist nurse or equivalent health care provider.	Strong
Offer augmentation cystoplasty to patients with OAB/urge urinary incontinence (UUI) who have failed all other treatment options and have been informed about all possible complications.	Weak
Inform patients undergoing augmentation cystoplasty of the high risk of clean intermittent self-catheterisation (ensure they are willing and able to do so) and that they will need life-long surveillance.	Strong
Do not offer detrusor myectomy as a treatment for UUI.	Weak
Only offer urinary diversion to patients who have failed less-invasive therapies for the treatment of OAB/UUI, who will accept a stoma and have been warned about the possible small risk of malignancy.	Weak