NHS
County Durham and Darlington
Area Prescribing Committee

Treatment Pathway for Overactive Bladder

General principles

- Encourage conservative measures initially (weight loss, fluid optimisation, PFMEs and bladder retraining)
- In female patients with LUTs and atrophic vaginitis on examination consider a course of topical oestrogen
- Review after 8 weeks (face to face or by telephone)

First line Options

Oxybutynin (Immediate Release) - not appropriate for frail elderly women

Tolterodine (Immediate Release)

Second Line Options

Solifenacin

Fesoterodine

Darifenacin

Oxybutynin Patch – consider in patients in whom 2 antimuscarinics have proved efficacious but the side effects are intolerable, or for patients who cannot swallow tablets

Third Line - after failure of two antimuscarinics

Mirabegron - as per NICE - recommended as an option for treating the symptoms of overactive bladder only for people in whom antimuscarinic drugs are contraindicated or clinically ineffective, or have unacceptable side effects (NICE TA 290)

Consider referral if patient has failed pharmacotherapy and conservative measures and wishes to discuss further investigation and therapeutic options

Overactive Bladder Treatment Pathway
Approved by: CD&D Area Prescribing Committee
Approval Date: 7.5.2015
Review Date: 7.5.2017 (or sooner if new evidence available)

Before drug treatment is considered, the following Patient Information leaflets may be useful to discuss with the patient
http://www.patient.co.uk/pdf/4768.pdf
http://www.patient.co.uk/pdf/4770.pdf - an example of a bladder chart

Before starting drug treatment, discuss:

- The likelihood of success and common adverse effects
- The frequency and route of administration
- That some adverse effects e.g. dry mouth and constipation indicate that treatment is working
- That the full benefits may not be seen until after at least 4 weeks of therapy

Prescribing Notes:

- Prescribe the lowest recommended dose when starting a new drug treatment
- Move to alternate therapy only after a reasonable therapeutic trial of 4 weeks
- If treatment is effective and well –tolerated, do not change the dose or drug
- Do not offer oxybutynin (immediate release) to frail older women.
- Oxybutynin transdermal – strictly limited to patients unable to take oral medication
- NICE suggest recommending the most expensive OAB drugs as second–line treatment on the basis of improved side-effects profile were inadequate since these drugs had not been widely compared with other OAB drugs in head-to-head trials

Treatment Review

- If treatment is effective and well-tolerated, do not change the dose or drug.
- Offer a face-to-face or telephone review 4 weeks after the start of each new drug treatment
- Titrate doses to achieve maximum benefit from treatment
- If adverse events become intolerable review before 4 weeks
- If adequate benefit has not been achieved for the patient within 6 months, therapy should be
- discontinued
- Review Patients on long term drug treatment annually (or 6 monthly for patients >75 years
- **A referral to secondary care may be an option if drug treatment proves unsuccessful**

Points to consider when prescribing for Urinary Incontinence

Treat conditions that may be causing or contributing to symptoms

- Lower urinary tract symptoms e.g. urinary tract infection
- Neurological conditions e.g. Parkinson's Disease or Multiple Sclerosis
- Systemic conditions e.g. Congestive heart failure or diabetes
- Functional and behavioural disorders e.g. impaired mobility or excess alcohol use
- Adverse effects of medication – Appendix 1

Is anything making the incontinence worse?

- Constipation – stools in the rectum can cause some nerves to be overactive and increase urinary frequency
- Not drinking enough – the bladder then becomes used to holding less volume
- Drinking too much fluid in the evenings
- Smoking is associated with urinary incontinence and overactive bladder, possibly due to associated coughing.

Lifestyle advice

- Modify high or low fluid intake
- Recommend alcohol or caffeine reduction if appropriate
- Constipation advice
- Healthy eating, weight loss and exercise

Other points to consider

- Determine effect of incontinence on quality of life
- Assess desire for treatment, expectations and motivation
- Consider bladder diaries to monitor symptoms, effectiveness of medication and for side effects.
- Consider a trial of supervised pelvic floor muscle training programmes

Potential Complications of Urinary Incontinence to Consider

- Psychological problems e.g. depression, loss of self-confidence
- Social isolation
- Sexual problems e.g. loss of urine during sexual intercourse may cause embarrassment and relationship problems
- Loss of sleep – nocturia is associated with sleep disruption and fear of leakage
- Constipation – due to limiting fluid intake
- Falls and fractures, particularly in older people who have to rush to the toilet
- Financial problems e.g. cost of pads, protective bedding and laundry.

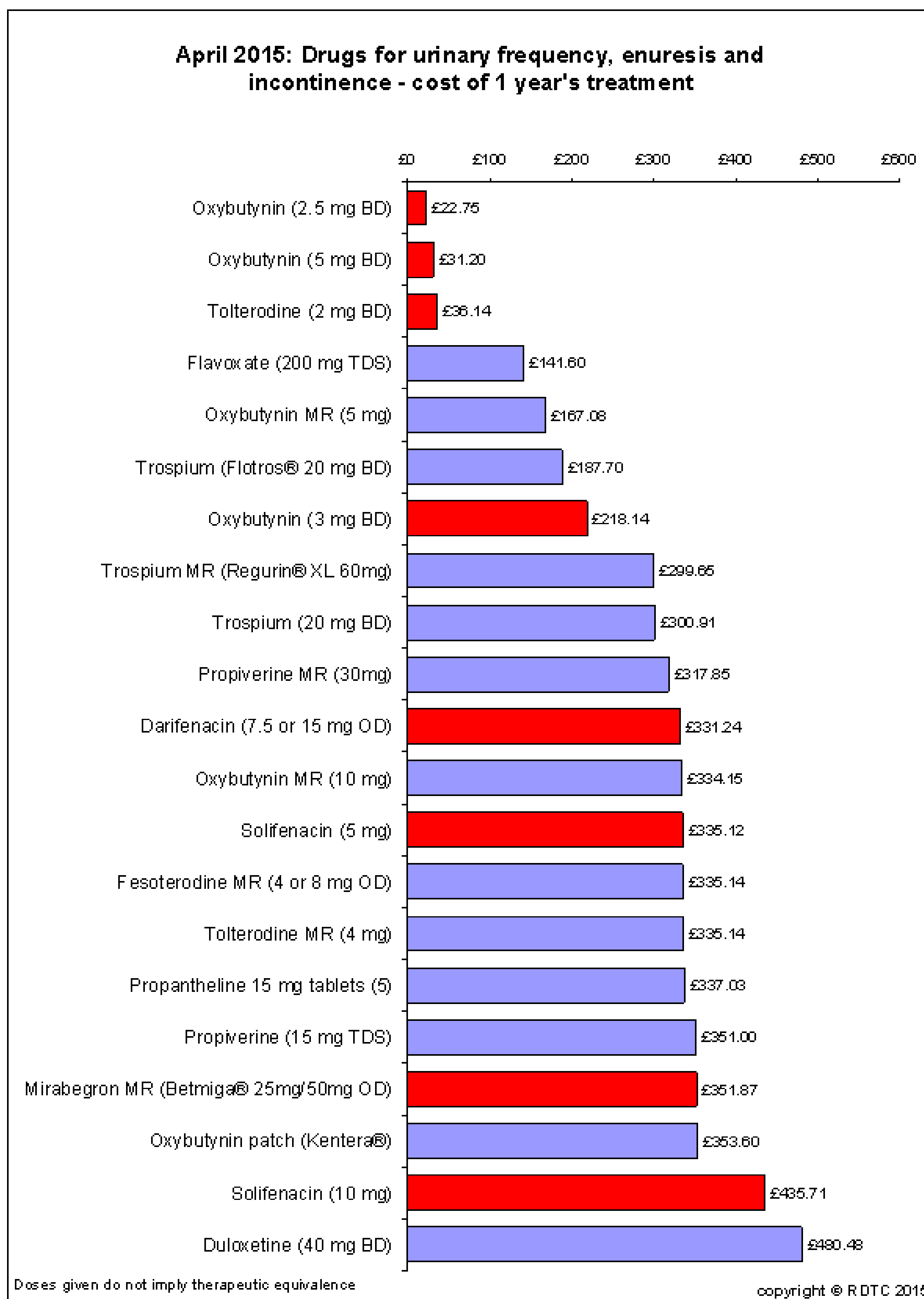
Appendix 1

Examples of drugs that may cause or worsen urinary incontinence

Type of drug	Effects
Alcohol	Increase urine production.
Alpha-adrenergic agonists (for example: pseudoephedrine)	Tighten the urinary sphincter. Can cause urinary retention and overflow incontinence.
Alpha-adrenergic blockers (for example: doxazosin, prazosin, and terazosin)	Relax the bladder outlet and urethra. Can cause stress incontinence in women.
Angiotensin-converting enzyme (ACE) inhibitors	Can cause cough and worsen stress incontinence.
Caffeine	Increase urine production.
Cholinesterase inhibitors (for example: donepezil)	Can increase bladder contractility and contribute to urge incontinence.
Diuretics	Increase urine production.
Drugs with anticholinergic effects (for example: certain antihistamines [such as chlorphenamine], antidepressants [such as amitriptyline and imipramine], and antipsychotics [such as clozapine, haloperidol, risperidone])	Interfere with bladder contraction, sometimes causing urinary retention and overflow incontinence. Can also worsen constipation, worsening urge or overflow incontinence.
Hormone replacement therapy (HRT)	Oestrogen alone or in combination with progesterone can induce urinary incontinence. It has been suggested that the oestrogen decreases total periurethral collagen, leading to damage to the periurethral connective tissue and associated ineffective urethral closure
Opioids	Interfere with bladder contraction, sometimes causing urinary retention and overflow incontinence. Can also worsen constipation, worsening urge or overflow incontinence.
Sedatives and hypnotics (such as benzodiazepines and z-drugs)	Can decrease mobility and reduce awareness to urinate.

Appendix 2

7.4.2 Drugs for urinary frequency, enuresis and incontinence



Appendix 3

References

1. Urinary Incontinence. The management of urinary incontinence in women. NICE clinical guideline 171 (2013).
2. Mirabegron for treating symptoms of overactive bladder. NICE technology appraisal guidance 290 (2013)
3. A summary of prescribing recommendations from NICE guidance. Urinary incontinence in women. *UKMi* NICE Bites No 57 (2013)
4. Guidelines for the drug treatment of female urinary incontinence. County Durham and Darlington NHS Foundation Trust (2007)
5. Cost comparison charts. Regional Drug and Therapeutics Centre (2015)
6. Points to consider when prescribing for urinary incontinence. County Durham PCT (2012)