Northern Lincolnshire and Goole NHS Foundation Trust

Chief Operating Officer's Directorate

Surgery & Critical Care

Guideline for Overactive Bladder in Females

Female Continence Clinic

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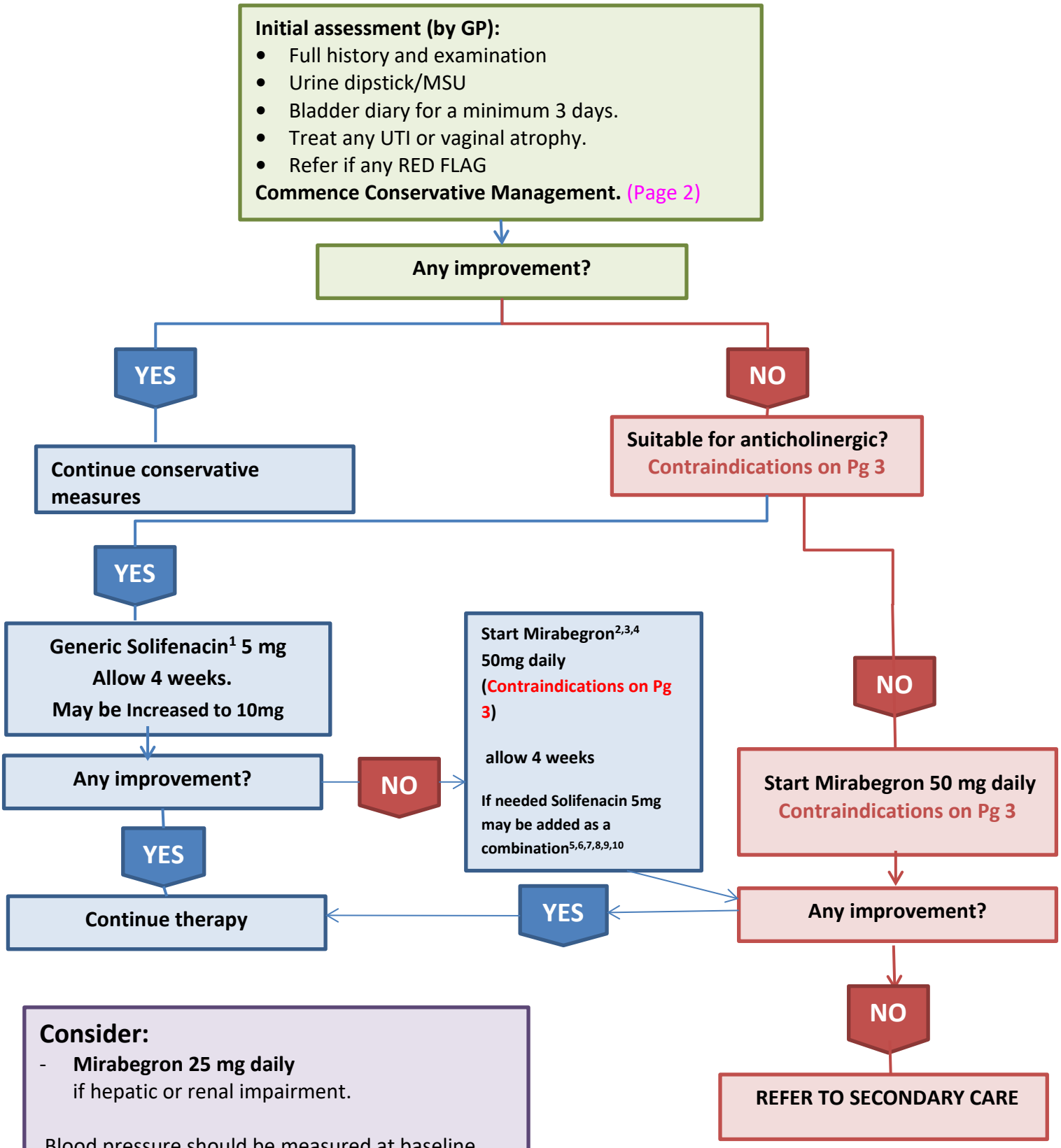
Guideline for overactive bladder.

Referral to Secondary Care
Female Continence Clinic

Northern Lincolnshire and Goole NHS Foundation Trust



Consider:

- **Mirabegron 25 mg daily**
  if hepatic or renal impairment.

Blood pressure should be measured at baseline and periodically during treatment with Mirabegron, especially in hypertensive patients

GUIDELINE FOR REFERRAL TO SECONDARY CARE CONTINENCE CLINIC.

PRIMARY CARE (GP) to carry out:-

1. **Initial assessment**:

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

Conservative Management:

- Lifestyle Interventions- e.g reduce weight if BMI>30, reduce/stop caffeine intake, modify fluid intake.
- Review medications (e.g. diuretics/anti-hypertensives)
- Manage constipation.
- Bladder training for 12 weeks (see Appendix 1)
- Smoking cessation.

Supervised pelvic floor muscle training for at least 3 months.

Consider medical/medication causes if nocturia present in elderly women, as less likely to be caused by OAB.

2. **Pharmacological Treatment-**

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.

● Full benefits may not be seen until they have taken the treatment for 4 weeks (Use for 12 weeks if combined with bladder training &/or pelvic floor exercises).

Consider the bladder training programme in combination with an OAB drug if the frequency is a troublesome symptom.

Choosing OAB Drugs:-

1. First-Line Treatment (antimuscarinic) – **Generic Solifenacin 5-10 mg daily.**
   Not recommended in elderly, dementia, anticholinergic burden score ≥3
   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.*

NOTE: Little evidence to justify a switch to another antimuscarinic if one has failed.

2. Second Line (Beta agonist): **Mirabegron 50 mg daily**, if no satisfactory response to antimuscarinic OR antimuscarinic not suitable or contra-indicated.
   Contraindications*: Contra-indicated in severe uncontrolled hypertension (systolic ≥180 mmHg or diastolic ≥ 110 mmHg). Refer BNF.*
   Cautions*: Caution in patients with stage 2 hypertension (systolic blood pressure ≥160 mm Hg or diastolic blood pressure ≥ 100 mm Hg), History of QT-interval prolongation. Blood Pressure to be measured before starting and regularly monitored (MHRA October 2015)*
3. **Mirabegron 25 mg daily** if hepatic or renal impairment.

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

3. Referral to Secondary care

for Urodynamics and/or Intradetrussor Botulinum Toxin injections, if

- second-line drug therapy fails.
- the patient does not want to try another drug after first-line medication/Bladder training/pelvic floor muscle training have failed.

Also, consider referral if the following were noticed during the initial assessments

(RED FLAGS) -

- **Presence of haematuria.**
- **Visible prolapse.**
- **Clinically benign pelvic mass.**
- **Suspected neurological disease.**
- **Recurrent UTI.**
- **Persistent bladder/urethral pain.**
- **Symptoms of voiding difficulty.**
- **Suspected urogenital fistulae.**
- **Associated faecal incontinence.**
- **Palpable bladder on bimanual or abdominal examination after voiding.**
- **Previous continence surgery.**
- **Previous pelvic cancer surgery.**
- **Previous pelvic radiation therapy.**

Frequency Volume Chart patterns

Voided volume – Normal (1500-2000ml /24hrs) ; Frequency - Normal(5-8 voids in 24hrs) Normal volume per void – 300ml - 500ml ; Normal frequency at night 1-2 times.

Voided volume per void - Normal; Frequency - Increased : Suspect Polydipsia, Occasionally Diabetes Insipidus/Diabetes Mellitus.

Voided volume- reduced and consistently fixed in both Day and Night: Suspect reduced bladder capacity.

Voiding frequency increased with reduced and variable voided volume Day and Night with urgency and urge incontinence : Overactive bladder.

Early morning -Normal voided volume ; Daytime voided volume- Variable with no night time waking – Suspect Psychosomatic.

Voided volume-Normal; Frequency - Normal in the day time; Night time frequency increased with total Voided volume at night- 33% of 24h--- Consider Nocturnal Polyuria.

Appendix 1

Bladder Training

Instead of rushing to the toilet as soon as you get the urge it is important to learn how to hold on and get over the urge to void. This will enable your bladder to hold on to a greater amount of urine rather than your bladder getting used to being sensitive to a smaller amount of urine. It should be carried out in small stages. If you get the urge to go to toilet say, every half an hour, then try to extend it by 10 minutes for a week and then 15 minutes for a week and then 30 minutes etc. Ideally, you should aim to hold on for 3 to 4 hours between toilet visits.

Learn to suppress the urgency

There are different techniques for this. Here are some suggestions:

1) Sit Straight on a hard seat.

2) Take your mind off rather distract yourself with other activities like reading a newspaper, counting fro 100 backwards or solving a crossword puzzle. You need to plan in advance how you will distract yourself.

3) Contract your pelvic floor muscles, which will help to reduce urgency and incontinence.

You may find it helpful to keep a diary of when you go to the toilet before you start bladder training and then again, a few months later. You may see more improvement than you expected.

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