SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

STANDARD OPERATING PROCEDURE- POLICY

INITIAL (1st and 2nd line) TREATMENTS FOR URGENCY URINARY INCONTINENCE/OVERACTIVE BLADDER

SCOPE/APPLICABILITY:

Idiopathic Urgency Urinary Incontinence (UUI) and Overactive Bladder (OAB) are common conditions in women. The Standardization Subcommittee of the International Continence Society (ICS) defines UUI as the complaint of involuntary leakage accompanied by or immediately preceded by urgency. OAB is defined as urgency, with or without urge incontinence, usually with frequency and nocturia. 1st and 2nd line therapies may be initiated by primary care providers, general gynecology providers as well as by Urogynecologists. The Division of Female Pelvic Medicine and Reconstructive Surgery (FPMRS) encourages primary care providers to use the recommendations in this policy to treat women who suffer from UUI/OAB.

This policy applies to women with idiopathic UUI/OAB. Idiopathic UUI/OAB refers to women who do not have neurogenic abnormalities causing their symptoms. Examples of neurogenic UUI/OAB include women with multiple sclerosis, spina bifida and Parkinson's Disease. The majority of UUI/OAB sufferers do not have neurogenic causes. Those without a history of significant neurologic abnormalities may be assumed to have idiopathic UUI/OAB and routine treatment may be initiated. If those patients are refractory to these treatments, they may then be referred to the FPMRS (Urogynecology) Clinic.

PURPOSE:

The purpose of this policy is to describe initial treatments (1st and 2nd line) for women with idiopathic UUI/OAB.

EVIDENCE

The recommendations for initial (1st and 2nd line) UUI/OAB treatments are based on the American Urological Association (AUA) Guidelines approved by the AUA Board of Directors in May of 2014. These recommendations were based on the Agency for Healthcare Research and Quality (AHRQ) Evidence Report/Technology Assessment Number 187 titled Treatment of Overactive Bladder in Women (2009). The AHRQ report searched English-language databases for studies relevant to OAB. Portions of the guidelines were also based on a review of AUA Clinical Principles and Expert Opinion. When sufficient evidence existed for a particular treatment, that treatment was assigned a rating of A (high), B (moderate) or C (low).

PROCEDURES

Diagnosis:

The clinician should document the signs and symptoms that characterize UUI/OAB and exclude other disorders, such as stress urinary incontinence or urinary tract infection. The basic workup should include a history, physical exam and urinalysis or urine dipstick in the clinic. Other tests such as a urine culture or post void residual assessment may be performed based on clinical

judgment. Information from bladder diaries or symptom questionnaires may be obtained, based on clinical judgment.

Interventions:

1. Since OAB/UUI are symptom complexes and not a specific disease and are not life-threatening conditions, after excluding conditions that require treatment (such as a urinary tract infection), no treatment is an acceptable option for patients who choose not to proceed with further interventions. (Expert Opinion)
2. Clinicians should educate patients regarding normal lower urinary tract function, what is known about OAB, benefits vs. risks/burdens of the various treatments, and clinicians should inform patients that acceptable symptom control may require trials of multiple treatment options. (Clinical Principal)

First Line Treatments:

1. Clinicians should offer behavioral therapies. These include bladder training (timed voiding), bladder control strategies, pelvic floor muscle training and fluid management. (Grade B)
2. The behavioral therapies may be combined with medications (below) to manage symptoms. (Grade C)

Second Line Treatments:

1. Clinicians may offer oral anti-muscarinics or oral Beta 3 agonists as second line therapy. (Grade B)
2. An extended release (ER) formulation is preferred over an intermediate release (IR) preparation, if available to the patient. ER formulations have lower rates of dry mouth. (Grade B)
3. Transdermal oxybutynin patches (available to women 18 years and older without prescription) or in gel formulations may be offered. (Grade C)
4. If symptom control is inadequate or side effects are unacceptable, dose modification or a different anti-muscarinic medication or beta 3 agonist may be tried. (Clinical Principal)
5. Patients with narrow-angle glaucoma should not be given anti-muscarinics unless approved by their ophthalmologist. Anti-muscarinics should be used with extreme caution in patients with impaired gastric emptying, particularly patients currently take KCL supplementation, with a history of urinary retention or in the elderly. (Clinical Principal)
6. Clinicians should try to assist patients in managing medication side-effects such as constipation and dry mouth with bowel management, fluid management, dose modification or alternative anti-muscarinics. (Clinical Principal)
7. Clinicians should use caution in prescribing anti-muscarinics in patients using other medications with anti-cholinergic properties. (Expert Opinion)
8. Clinicians should use caution prescribing anti-muscarinics or beta 3 agonists in frail patients.
9. Emerging data suggests anti-cholinergic use may be associated with cognitive decline and dementia, these risks should be discussed with patients prior to initiating therapy.

10. Patients who are refractory to behavioral and pharmacologic therapy may be evaluated/treated by an appropriate specialist if the desire additional treatment. (Expert Opinion)

REFERENCES:

1. Abrams P, Andersson KE, Birder L, et al. Fourth International Consultation on Incontinence Recommendations of the International Scientific Committee: Evaluation and treatment of urinary incontinence, pelvic organ prolapse, and fecal incontinence. Neurourol Urodyn. 2010;29(1):213-40. PMID: 20025020
2. Diagnosis and Treatment of Overactive Bladder (Non-Neurogenic) In Adults: AUA/SUFU guideline. http://www.auanet.org/common/pdf/education/clinical-guidance/Overactive-Bladder.pdf Accessed 1.3.15.
3. Hartmann KE, McPheeter ML, Biller DH, et al. Treatment of overactive bladder in women. Evid Rep Techno1 Assess. 2009;187:1-120. PMID: 19947666.

APPROVALS:

SOP Owner:	Peter Jeppson, MD	Date: 6/24/2020
Chair Approval:		Date: 6/29/2020
Effective Date:	June 24, 2020	