Pending CCG approval

NHS
Pan Mersey
Area Prescribing Committee

OVERACTIVE BLADDER SYNDROME (OAB) – Management of Adults in Primary Care

The Pan Mersey Area Prescribing Committee recommends the management of overactive bladder syndrome in adults in primary care in accordance with NICE NG 123[1], NICE TA 290[2] and NICE CG 97[3]

GUIDELINE

OAB in neurological disease is outside the scope of this guideline but is covered in NICE clinical guideline 148[4].

Initial Assessment and Conservative Management

For women, this includes categorisation of predominant symptoms (stress urinary incontinence, urge urinary incontinence or mixed), assessment of pelvic floor muscles, urine dipstick +/- mid stream urine specimen, bladder diary, caffeine restriction, fluid management, weight loss if body mass index >30 and bladder training for minimum of 6 weeks.

For men, this includes history, examination and digital rectal examination, frequency - volume chart, urine dipstick and information and advice on prostate specific antigen testing.

Before Starting OAB Medicines

Refer to secondary care if there are any red flag symptoms: haematuria, bladder pain, recurrent urinary tract infection.

- When offering anticholinergic medicines to treat OAB always take into account
  - I. Coexisting conditions (for example: poor bladder emptying, constipation, glaucoma)
  - II. Use of other existing medication affecting total anticholinergic burden
  - III. Risk of adverse effects (see references 5 and 6 for further information)
- Discuss with patients
  - I. The likelihood of success and associated common adverse effects
  - II. The frequency and route of administration
  - III. That some effects such as dry mouth and constipation may indicate that treatment is starting to have an effect, and that they may not see the full benefits until they have been taking the treatment for 4 weeks
  - IV. That the long-term effects of anticholinergic medicines for overactive bladder on cognitive function are uncertain
- Consider relative contraindications of anticholinergic medicines:
  - I. Cognitive impairment
  - II. Older people with frailty
  - III. Glaucoma
  - IV. Chronic constipation
  - V. High anticholinergic burden score
  - VI. Unable to tolerate side effects

Note: Patients who are not eligible for treatment under this statement may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. In this situation, follow locally defined processes.

Is an anticholinergic medicine appropriate for this patient?

YES

1. **Solifenacin** 5-10mg once daily (£1.88-£2.07 per 28 days[7]), or
2. **Tolterodine modified release** 4mg once daily (£12.89 per 28 days, **based on Neditol XL® brand[7])** ***prescribe the most cost effective brand.*** *Ask your medicines management team for advice if unsure.*
3. Or if unable to tolerate oral medicines- **Oxybutynin 3.9mg per 24 hour transdermal patch** (£27.20 per 28 days[7])

Doses are stated for patients with normal renal and hepatic function.

NO

Mirabegron 50mg once daily (£27.07 per 28 days[7])

In accordance with NICE TA 290[2] mirabegron is an option for patients in whom anticholinergic drugs are ineffective, contraindicated or not tolerated.

Mirabegron 25mg once daily is recommended in patients with renal impairment (GFR 15-29 ml/min/1.73m^2) or moderate hepatic impairment[9]. Mirabegron is not recommended in people with GFR <15ml/min/1.73m^2 or severe hepatic impairment. See Summary of Product Characteristics for full information. [9]

Mirabegron is contraindicated in patients with severe uncontrolled hypertension defined as systolic blood pressure ≥180mmHg and/or diastolic blood pressure ≥110mm Hg. Measure blood pressure before starting treatment and monitor regularly during treatment especially in patients with hypertension[8].

REVIEW

Offer a face to face or telephone review 4 weeks after starting a new OAB medicine (sooner if adverse drug reaction or treatment is intolerable).

If improvement is optimal- continue treatment.

If no or sub optimal improvement, or intolerable side effects - review dose or try an alternative medicine and review again after another 4 weeks.

Review patients on long term therapy annually (or every 6 months if aged over 75 years).

If initial OAB treatment with anticholinergic fails, consider mirabegron before referral to secondary care.

OTHER CONSIDERATIONS

- Offer intravaginal oestrogens (but not systemic hormone replacement therapy) for the treatment of OAB in post-menopausal women with vaginal atrophy.
- NICE recommends an alpha blocker in men with moderate to severe lower urinary tract symptoms. An anticholinergic drug should be considered as well as an alpha blocker in men who still have storage symptoms after treatment with alpha blocker alone.[3]

References

1. NICE NG 123. Urinary incontinence and pelvic organ prolapse in women: management. Jun 2019.
2. NICE TA 290. Mirabegron for treating overactive bladder. Jun 2013.
3. NICE CG 97. Lower urinary tract symptoms in men: management. Jun 2015
4. NICE CG 148. Urinary incontinence in neurological disease: assessment and management. Aug 2012.
5. Richardson K et al. Anticholinergic drugs and risk of dementia: case-control study BMJ 2018; 361: K1315.
6. Gray SL Cumulative Use of Strong Anticholinergics and Incident Dementia: a prospective cohort study. JAMA intern Med 2015; 175: 401-7.
7. NHS BSA DM+D Browser. Available on https://applications.nhsbsa.nhs.uk/DMDBrowser/DMDBrowser.do
8. MHRA Drug Safety Update vol 9 issue 3. October 2015
9. Astellas Pharma Ltd. Summary of Product Characteristics, Betmiga 25mg prolonged-release tablets.