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QUICK GUIDE

Overactive bladder: A guide for General Practitioners

Overactive bladder (OAB) is a relatively common condition that significantly impacts patients' quality of life. General practitioners (GPs) are often the first point of contact for those affected.

OAB is defined as urinary urgency, usually accompanied by frequency and nocturia, with or without urgency urinary incontinence (UUI), in the absence of urinary tract infection (UTI) or other obvious pathology.[1]

It affects approximately 16% of adults over 40, with prevalence increasing with age.[2] This article provides a comprehensive overview of OAB for GPs and the recommended approach to diagnosis and management.

Understanding OAB

OAB is characterized by:

- **Urinary urgency**: A sudden, compelling desire to urinate that is difficult to defer.
- **Frequency**: Voiding eight or more times in 24 hours.
- **Nocturia**: Waking one or more times at night to urinate.
- **UUI**: Involuntary leakage accompanied by or preceded by urgency. Not all patients experience UUI.

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OAB can be idiopathic or neurogenic (eg, associated with Parkinson's disease or multiple sclerosis), but most cases seen in primary care are idiopathic.

The condition affects both men and women, with a higher prevalence in women (23% versus 11% in men)[3] and significant variation by ethnicity, being more common among African-American and Hispanic than other groups in a US study.[4] OAB imposes a substantial economic burden, due to healthcare costs, lost productivity, and associated comorbidities like falls, fractures, and depression.

Diagnosis in primary care

Diagnosis of OAB is primarily clinical, relying on a thorough patient history to identify storage lower urinary tract symptoms (LUTS) such as urgency, frequency, nocturia or UUI. GPs should:

- **Take a detailed history**: Assess symptom onset, duration, and impact on quality of life. Ask about aggravating factors (eg, caffeine, alcohol), fluid intake and pad use.[5] Validated tools like the OAB-V3 questionnaire can aid screening, especially in men where symptoms may be misattributed to bladder outflow obstruction (BOO).[6,7]
- **Perform physical examinations**: Include genitourinary examination, digital rectal examination (in men, to assess prostate), and vaginal examination (in women, to check for atrophy and prolapse).[6-8] These help to rule out other pathologies.
- **Conduct urinalysis**: Use dipstick testing to exclude UTI or haematuria. If infection is suspected, treat it before confirming OAB.[6]
- **Use bladder diaries**: Frequency-volume charts provide objective data on voiding patterns and are recommended for accurate assessment.[6]
- **Identify red flags**: Symptoms like haematuria, persistent pain, or recurrent UTIs warrant urgent referral to exclude serious conditions like bladder cancer. Occasionally, further tests such as CA125 (in women) and PSA (in men) may be appropriate, especially in older age groups.[7-9]

Imaging is not routinely required unless bladder outflow obstruction is suspected.

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Management strategies

Management of OAB follows a stepwise approach, starting with conservative measures, progressing to pharmacotherapy, and, if needed, specialist referral for refractory cases.

1. Conservative management (first-line)

Behavioural therapies are the cornerstone of initial treatment and should be offered to all patients, involving:

- **Lifestyle modifications**:[6]
  - Reduce bladder irritants like caffeine, alcohol and fizzy drinks.
  - Optimise fluid intake (avoiding excessive evening fluids for nocturia).
  - Address constipation, as it can exacerbate OAB symptoms.
  - Encourage weight loss in overweight patients, as obesity is a risk factor.
- **Bladder training**: Involves gradually increasing the time between voids to train the bladder to hold more urine. This requires patient commitment and may take weeks to show results.[6]
- **Pelvic floor muscle training (PFMT)**: Effective for women, PFMT strengthens muscles around the bladder and pelvic floor. Referral to a pelvic floor physiotherapist is recommended, as it may take three months to see benefits.[6]
- **Urgency suppression techniques**: Teach patients to distract themselves or contract pelvic floor muscles to delay urination.[10]

GPs should set realistic expectations and monitor progress, as adherence is critical for success.

2. Pharmacotherapy (second-line)

If conservative measures fail after 4–6 weeks, pharmacotherapy is considered. NICE guidelines recommend:[6]

- **Antimuscarinics (anticholinergics)**: Drugs like oxybutynin, tolterodine, solifenacin and trospium relax detrusor muscle contractions, increasing bladder capacity. If the first-line antimuscarinic is ineffective or not tolerated then another should be tried.

Extended-release formulations are generally preferred for older patients to minimise cognitive side effects.[11] Caution is needed in the elderly due

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to anticholinergic burden, which is linked to falls, fractures and dementia.

- **Beta-3 agonists**: Recommended by NICE if antimuscarinics (anticholinergics) are not suitable, do not work well enough or have unacceptable side effects.[6,12,13]
  - Mirabegron: A selective beta-3 agonist (50mg once daily).[12] Dose reduction to 25mg daily advised in moderate hepatic and severe renal (eGFR 15-29mL/min/1.73m²) impairment.[14] Contraindicated in severe uncontrolled hypertension.[14] Blood pressure should be monitored before starting treatment and regularly during treatment, especially in patients with pre-existing hypertension.[14] Common side effects include: arrhythmias; constipation; diarrhoea; dizziness; headache; increased risk of infection; nausea.[14] Combination therapy with solifenacin (5mg) and mirabegron (50mg) may be considered for some cases.[15]
  - Vibegron: Recommended by NICE in September 2024.[13] Vibegron (75mg once daily) is a selective beta-3 agonist that does not have any blood pressure monitoring requirement in the Summary of Product Characteristics, and does not require dose adjustment for mild or moderate hepatic, or mild, moderate or severe renal, impairment.[13,16,17] Tablets may be crushed and mixed with soft food.[16] Common side effects include: UTI; headache; diarrhoea; nausea; constipation; increased residual urine volume.[17] Lower cost to the NHS than mirabegron (£26.68 versus £29.00 per 30 tablets);[12,13] NICE guidance states that cost-comparison analysis indicates vibegron is likely to be cost-saving compared with mirabegron.[13]

Once efficacy and tolerability of a beta-3 agonist is established, medication reviews are appropriate every 6-12 months.[6]

3. Specialist referral (third- and fourth-Line)

For refractory OAB, refer to urology or urogynaecology for:[6]

Third-line treatments

- **Intradetrusor botulinum toxin type A**: Injections reduce detrusor overactivity but may require intermittent catheterization due to urinary retention risk.
- **Percutaneous sacral nerve stimulation (SNS)**: Involves implanting of a device to stimulate nerves at the base of the spine that affect the bladder and surrounding muscles.
- **Percutaneous tibial nerve stimulation (PTNS)**: A minimally invasive option for patients unwilling or unsuitable for other therapies. Involves mild electric current being passed through a fine needle to stimulate a nerve controlling bladder function.

Fourth-line treatments

Rarely, augmentation cystoplasty or urinary diversion may be considered for severe, refractory cases.

Special considerations

- **Older patients**: Frailty, mobility issues and polypharmacy increase risks of anticholinergic side effects.
- **Men**: OAB symptoms may overlap with BOO due to benign prostatic hyperplasia. If BOO is suspected, alpha blockers (eg, tamsulosin) may be trialled before or alongside OAB medications.[7]
- **Postmenopausal women**: Intravaginal oestrogens can help with vaginal atrophy-related OAB symptoms.[6]
- **Comorbidities**: Address conditions like diabetes or neurological disorders that may exacerbate OAB.

Key points

- **Diagnose accurately**: Use history, physical exams, and urinalysis to confirm OAB and exclude other causes.
- **Start with conservative measures**: Emphasize lifestyle changes and bladder training, involving patients in goal-setting.
- **Prescribe judiciously**: Choose cost-effective antimuscarinics or beta-3 agonists, tailoring to patient needs and monitoring side effects.
- **Review regularly**: Assess treatment efficacy and adjust or refer as needed.
- **Educate and empower**: Inform patients about benefits of pelvic floor exercise and bladder training, and the importance of adherence to therapy.

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