Algorithm for Treatment of Overactive Bladder (OAB) in Primary Care

When diagnosing OAB ask "Can you put off going to pass urine or do you need to go the toilet immediately?"

Counsel patient: OAB is a long term condition and significant lifestyle modification may be necessary. A series of review appointments may be required with treatment goals set for each visit. A frequency/volume chart may be useful during assessment (link below).

Discuss and emphasise behavioural modifications at each review

- Lifestyle changes including cut down on caffeinated drinks, alcohol, chocolate, tannins, tomatoes, citrus and spicy foods. Don't cut back on fluids, recommend at least 25ml/Kg over the course of the day, ensure BMI<30.
- Treat constipation, which can also make OAB worse, eat a high-fibre diet.
- Bladder training.
- Pelvic floor exercises (links below)

Consider topical oestrogen if co-existing vaginal atrophy e.g. estriol 0.1% vaginal cream or estradiol vaginal tablets. Vaginal lubricants (OTC) may be useful. PIL

Eliminate possibility of UTI

The Continence Advisory and Treatment Service (CATS)/ Physiotherapy Service is available via an RMS Referral if required

LINKS AVAILABLE: via Continence Advisory and Treatment Service (CATS) pages on Staffnet

- Pelvic floor exercises for women and men
- Voiding techniques
- Overactive bladder- Urgency and Frequency PIL
- Frequency/volume chart
- Caffeine reduction, fluid intake and constipation
- Urinary Tract Infections

Patient should try 3 months of non-pharmacological management in the first instance. If suboptimal improvement, consider pharmacological treatment. Continue lifestyle interventions and non-pharmacological strategies alongside drug therapy.

First line Drug treatment – Consider contraindications to antimuscarinic agents and total anticholinergic load from concomitant medications before initiating a drug for OAB. **Solifenacin 5mg once daily** is first-line in NHS Tayside formulary. If no or suboptimal response after 6 weeks increase to 10mg once daily.

Review response after 4-6 weeks

Second line Drug Treatment (or if first line treatment is not suitable)**.** Change to **Tolterodine 2mg twice daily**, (consider 1mg twice a day if hepatic/renal impairment or side effects with 2mg twice a day) , MR may be considered if concerns re concordance.

Review response after 4-6 weeks

Third line Drug Treatment Stop antimuscarinic and change to **Mirabegron MR 50mg once daily** (25mg in moderate hepatic/renal impairment) Monitor BP before initiation, one month after and at least annually (risk of severe hypertension)

Review response and BP after 4-6 weeks and consider referral to secondary care

Refer to secondary care in case of:

- Haematuria (urgent referral to urology)
- Urinary retention or voiding difficulties (urgent referral to urogynaecology)
- Bladder or urethral pain
- Recurrent UTIs
- Significant vaginal prolapse
- Suspected neurological disease
- Suspected urogenital fistulae

Other options for consideration under specialist recommendation include, some surgical procedures, or alternative drug treatments. Please consider referral to the specialist continence service as they can refer onwards.

Review continued need for pharmacotherapy after 3 months (for mirabegron) or 6 months (for antimuscarinic). Treatments for OAB need not be lifelong.

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