Management of Adult Urinary Incontinence for Primary Care clinicians

These guidelines have been based on https://www.nice.org.uk/guidance/ng123

INITIAL ASSESSMENT

- Take history and dipstick test urine (treat UTI if present).
- Urgently refer patients with certain symptoms (table)

URGENTLY refer	- visible haematuria - recurrent or persisting UTI associated with haematuria if ≥ 40 years - microscopic haematuria & ≥ 50 years - suspected pelvic mass arising from the urinary tract	
Refer	- symptomatic prolapse visible at or below the vaginal entrance - palpable bladder on bimanual pelvic examination (BPE) or physical examination after voiding	
Consider referring	- persisting bladder/urethral pain - associated faecal incontinence - previous pelvic radiation therapy - clinically benign pelvic masses	- suspected neurological disease - voiding difficulty - suspected urogenital fistulae - previous continence or pelvic cancer surgery - - Severe stress incontinence

- Use a validated symptom and quality of life questionnaire e.g. ICIQ-UI Short Form
- Categorise Urinary Incontinence (UI) - see below:

Stress UI	Mixed UI	Over Active Bladder with or without Urge UI
>Pelvic floor muscle training	>Pelvic floor muscle training >Bladder training	>Bladder training
>Lifestyle changes and patient education	>Lifestyle advice and patient education	>Lifestyle changes and patient education

Non-pharmacological conservative management:

- Bladder diary (minimum 3 days)
- Lifestyle interventions (reduce caffeine intake, fluid modification, reduce weight if BMI>30)
- Pelvic floor muscle training (minimum 3 months)
- Bladder training (minimum 6 weeks)
- Patient education on self-management

Consider intravaginal oestrogens for women with concurrent Genitourinary symptoms of the Menopause

If main complaint is **nocturia** then assess for other reasons for this e.g. heart failure, medication, snoring, poor sleep etc. Desmopressin (oral or s/l may help).

If no improvement in 6-8 weeks, **and** symptoms are bothering the individual, a referral can be made to local Bladder and Bowel service for further assessment, a post void bladder scan, supervised pelvic floor training treatment, advice and support.

DRUG TREATMENT (Over Active Bladder & MIXED UI) –

Conservative measures should be tried before drug treatment.

Manage patient expectation of drug treatment outcome. Including:

- Modest likelihood of success and there are significant adverse effects
- Tachyphylaxis to side effects.
- Full benefit may take 8 weeks, so persistence beyond first few weeks is needed.
- Treatment goals must be clear and objective. Use a bladder diary to assess response.
- When required (PRN) use suits some patients i.e. for symptom control at key times.

Drug Choice

The aim is to achieve symptom control.

There is no evidence that one treatment is more effective than another. Choices are determined by appropriateness, side effects, once daily dosing having compliance benefits and costs.

When choosing therapy consider the risks of anticholinergic (ACh) side effects.

-Those patents at high risk may not be suitable for anticholinergic medicines.

Start on low doses to minimise side effects

Review at 4-8 weeks for efficacy and if tolerated

Recommended choices:

1st line = Solifenacin 5 to 10mg once daily (unless contraindicated – when this choice will be unsuitable move directly to "2nd line" choices)

2nd line = one of the following:

tolterodine 2mg twice daily if alternative ACh choice is needed

trospium 20mg twice daily: does not cross the blood brain barrier so preferred e.g. for patients who experience headaches, confusion or insomnia with solifenacin or where its low potential for drug interactions make it more suitable

mirabegron 25mg to 50mg once daily Novel mode of action; no ACh side effects; can raise BP and so may not be suitable in some patients with high BP or CVS disease (MHRA alert). (25mg dose in renal and liver impairment)

oxybutynin patch if nil by mouth. Consider also no treatment when nil by mouth if symptoms are not troublesome

3rd Choice - Pick a different choice from 2nd line choices group above

How to decide if an anticholinergic medication is contraindicated:

Risk benefit assessment is required in frail older people (65+) especially if they have co-morbidities, functional impairments (walking/dressing difficulties) or cognitive impairment. See NICE Dementia CG N97. Consider also risk factors for falls, family history of dementia and cumulative AEC score from medication (if 1 or more on AEC scale then avoid additional anticholinergic burden). Avoid in closed-angle glaucoma and inflammatory bowel disease.

Table 1: Over Active Bladder (OAB) medicines - AEC: Medichec. The Anticholinergic Effect on Cognition (AEC) Tool: www.medichec.com https://medichec.com/assessment

Note: This scale scores drugs according to anticholinergic safety. The AEC scale takes into account the anticholinergic effect of a drug, the extent of this effect, whether it is able to penetrate the brain or not and whether there are in fact reports of cognitive impairment with the drug to support the score given.

OAB medicine	AEC	Recommended action based upon AEC
Solifenacin	1	
Mirabegron	0	3 Review and withdraw or switch
Trospium	0	2 Review and withdraw or switch
Tolterodine	2	1 Caution required
Oxybutynin	3	0 Safe to use
Darifenacin	0	

The individual AEC scores of drugs are added together for each patient to calculate the total AEC score. Patients with higher scores might be expected to have higher risks of falls and of cognitive impairment.

At review especially if a patient has a has a high cumulative AEC score - consider if medication can either be withdrawn or switched to a drug with a lower AEC score. Review benefits versus risks.

NOTE: This guideline is aimed at all healthcare professionals in secondary and primary care. Information about medicines in this guideline should be read in conjunction with the BNF & Summary of Product Characteristics (SmPC) available at www.medicines.org.uk/emc

Recommended primary care prescribing practice:
ACUTE prescriptions *only* for new lines of drug treatment.
Put on REPEAT after review at 4-8 weeks after starting.

At review only continue drug treatment if benefit maintained, PRN use for symptom control suits many patients, given that these drugs are used for symptomatic benefits.
Do not change drug if therapy is beneficial. Review need for continued use in patients annually or every 6 months if >75 years.

If drug still needed, always review choice of drug is the most appropriate one.

- Flavoxate, propantheline and imipramine are not recommend for UI.
- oral oxybutynin is not recommended because AEC score is 3 – risk of side effects high.
- Patients on oral oxybutynin, flavoxate, propantheline and imipramine should be reviewed and other therapies should usually be considered instead.
- If all UI drugs are not effective, **and** patients are having significant bother with their symptoms **consider** referral to local community bladder and bowel services.
- Do not prescribe UI drugs for stress UI. Refer.

Referral for procedures to secondary care:
Advise weight loss for patients with a high BMI as this may help both stress and urge incontinence.
For ***stress incontinence*** refer if no improvement after 3 months of supervised pelvic floor exercises

For ***urge incontinence*** refer if symptomatic despite the above interventions and a trial of three drugs for 1-3 months.

Version	3.0
Developed by	Sarah Crotty Senior Pharmacist, Andrew Hextall (consultant, WHHT) and Clinical staff with an interest in incontinence of the ICB. Updated in 2023 to include significant changes to the formulary, with earlier use of solifenacin and mirebegron
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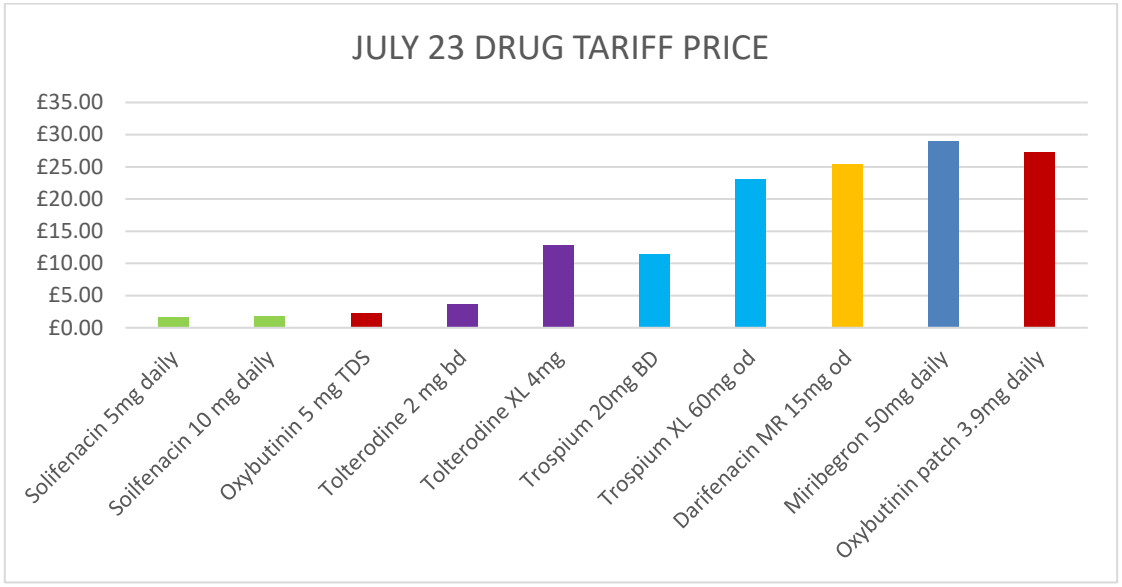
Superseded version	2.0

Appendix A – Drug Costs/month (based on July 23 Drug Tariff)



Note XL formulations of tolterodine, trospium, oxybutynin are more expensive than solifenacin