

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).
 - **Refer urgently (within 2 weeks) using a suspected cancer pathway referral for bladder cancer if the woman:**
 - Is aged 45 years and over with:
 - Unexplained visible haematuria without urinary tract infection, *or*
 - Visible haematuria that is persistent or recurrent after successful treatment of urinary tract infection, *or*
 - Is aged 60 and over with unexplained non-visible haematuria *and* dysuria or a raised white cell count on a blood test.
 - **Refer to an appropriate specialist (urologist, urogynaecologist, or nephrologist), using clinical judgement to determine urgency, if there is:**
 - A bladder that is palpable on abdominal or bimanual examination after voiding.
 - Voiding difficulty.
 - Persistent bladder or urethral pain (refer urgently if cancer is suspected).
 - A pelvic mass that is clinically benign.
 - Associated faecal incontinence.
 - Suspected neurological disease.
 - A history of previous incontinence surgery, pelvic cancer surgery, or previous radiation therapy.
 - Recurrent urinary tract infection — for recurrent or persistent unexplained urinary tract infection in people aged 60 years and over, consider non-urgent referral for bladder cancer.
 - Suspected urogenital fistulae.
 - If vaginal prolapse, discuss the woman's treatment preferences with her, and refer if needed. ([CKS](#), [NICE NG123](#), [NG12](#))
- 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). Mirabegron is recommended in line with NICE [TA290](#) for restricted use for treating symptoms of overactive bladder in adults.

vibegron 75mg once daily – Vibegron works in a similar way to mirabegron. Vibegron is a recently launched medicine in the UK therefore long-term clinical trial and real-world data is limited. The [SPC](#) for vibegron does not list hypertension as a contraindication or under special warnings and precautions for use or include recommendations for blood pressure monitoring. Hypertension was the most common adverse event reported in the pivotal extension study (NICE [TA999](#)). Consider appropriate patient counselling, monitoring and reporting adverse effects using the MHRA Yellow Card reporting [site](#) as necessary.

Vibegron is recommended in line with NICE [TA999](#) for restricted use for treating symptoms of overactive bladder in adults. Refer to [SPC](#) for full prescribing information.

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.medicheck.com <https://medicheck.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 score	Recommended action based upon AEC scores:
Solifenacin	1	3 Review and withdraw or switch
Mirabegron	0	2 Review and withdraw or switch
Vibegron	*	1 Caution required
Trospium	0	0 Safe to use
Tolterodine	2	
Oxybutynin	3	
Darifenacin	0	

* Vibegron is a new drug so doesn't yet have an Anticholinergic Effect on Cognition (AEC) score but it is likely to be the same as mirabegron ie zero.

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 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 needed 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 recommended 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:

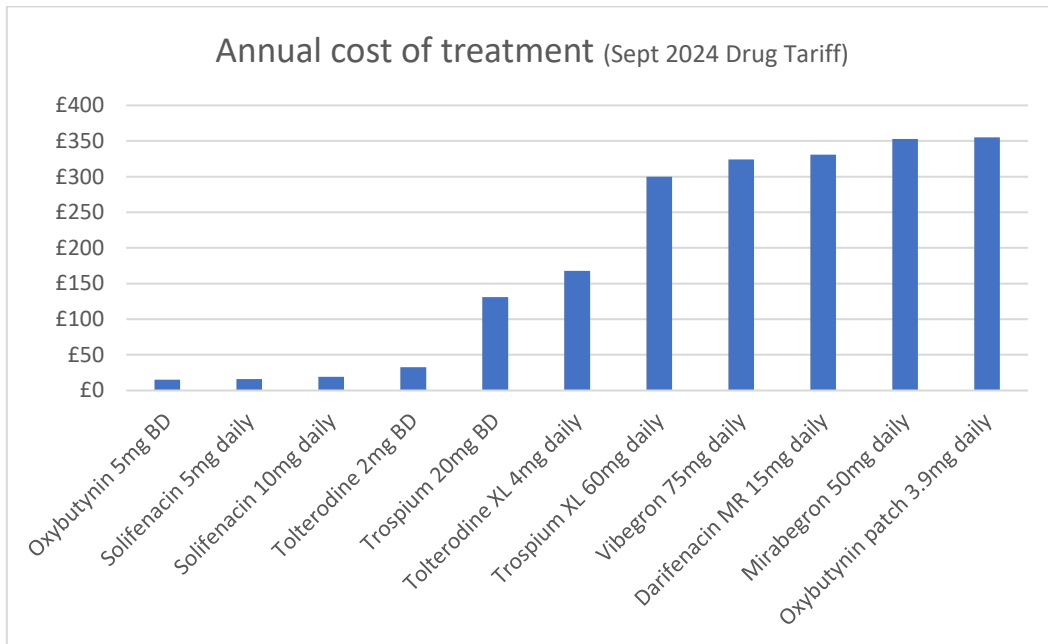
Advise weight loss for patients with a high BMI as this may help both stress and urge incontinence.
For **stress incontinence** refer if no improvement after 3 months of supervised pelvic floor exercises

The management of moderate to severe stress incontinence involves procedures/surgery.
For patients who fail surgery duloxetine 20-40mg twice daily may be started by the specialist and continued by the GP.

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

Version	4.1
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 mirabegron
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Superseded version	3.0 Nov 2024 updated to include vibegron in line with NICE TA 999 with updated costing. Amended referral criteria in line with CKS, NICE NG123 & NG12. Added vibegron to AEC table with explanatory note. 4.0 Jan 2025 update to include duloxetine for stress incontinence omitted in error.

Appendix A – Annual drug costs (based on Sept 2024 Drug Tariff)



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