2014

OVERACTIVE BLADDER DIAGNOSIS AND TREATMENT OF OVERACTIVE BLADDER IN ADULTS:

AUA/SUFU Guideline (2012); Amended (2014)

For Primary Care Providers

American Urological Association
Education & Research, Inc.
Advancing Urology™

OVERACTIVE BLADDER

Diagnosis and Treatment of Overactive Bladder in Adults: AUA/SUFU Guideline (2012); Amended (2014)

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Diagnosis

1. The clinician should engage in a diagnostic process to document symptoms and signs that characterize OAB and exclude other disorders that could be the cause of the patient's symptoms; the minimum requirements for this process are a careful history, physical exam, and urinalysis.
2. OAB is not a disease; it is a symptom complex that generally is not a life-threatening condition. After assessment has been performed to exclude conditions requiring treatment and counseling, no treatment is an acceptable choice made by some patients and caregivers.
3. Clinicians should provide education to patients regarding normal lower urinary tract function, what is known about OAB, the benefits vs. risks/burdens of the available treatment alternatives and the fact that acceptable symptom control may require trials of multiple therapeutic options before it is achieved.

Treatments

First-Line Treatments:

1. Clinicians should offer behavioral therapies (e.g., bladder training, bladder control strategies, pelvic floor muscle training, fluid management) as first line therapy to all patients with OAB.
2. Behavioral therapies may be combined with pharmacologic management.

Second-Line Treatments:

1. Clinicians should offer oral anti-muscarinics or oral

ß3-adrenoceptor agonists as second-line therapy.

2. If an immediate release (IR) and an extended release (ER) formulation are available, then ER formulations should preferentially be prescribed over IR formulations because of lower rates of dry mouth.
3. Transdermal (TDS) oxybutynin (patch [now available to women ages 18 years and older without a prescription] or gel) may be offered.
4. If a patient experiences inadequate symptom control and/or unacceptable adverse drug events with one anti-muscarinic medication, then a dose modification or a different anti-muscarinic medication or b3-adrenoceptor agonist may be tried.
5. Clinicians should not use anti-muscarinics in patients with narrow angle glaucoma unless approved by the treating ophthalmologist and should use anti-muscarinics with extreme caution in patients with impaired gastric emptying or a history of urinary retention.
6. Clinicians should manage constipation and dry mouth before abandoning effective anti-muscarinic therapy. Management may include bowel management, fluid management, dose modification or alternative anti-muscarinics.
7. Clinicians must use caution in prescribing anti-muscarinics in patients who are using other medications with anti-cholinergic properties.
8. Clinicians should use caution in prescribing anti-muscarinics or ß3-adrenoceptor agonists in the frail OAB patient.
9. Patients who are refractory to behavioral and pharmacologic therapy should be evaluated by an appropriate specialist if they desire additional therapy.

Third-line Treatments (Available through Specialists):
Clinicians should discuss the patient's expectations from treatment and their willingness to participate in therapies other than pharmacotherapy. If the patient would not consider invasive treatment options, a referral to a specialist may not be warranted.

1. *Specialists* may offer intradetrusor onabotulinumtoxinA (100U) as third-line treatment in the carefully-selected and thoroughly-counseled patient who has been refractory to first- and second-line OAB treatments. The patient must be able and willing to return for frequent post-void residual evaluation and able and willing to perform self-catheterization if necessary.
2. *Specialists* may offer peripheral tibial nerve stimulation (PTNS) as third line treatment in a carefully selected patient population.
3. Specialists may offer sacral neuromodulation (SNS) as third-line treatment in a carefully-selected patient population characterized by severe refractory OAB symptoms or patients who are not candidates for second-line therapy and are willing to undergo a surgical procedure.
4. Practitioners and patients should persist with new treatments for an adequate trial in order to determine whether the therapy is efficacious and tolerable. Combination therapeutic approaches should be assembled methodically, with the addition of new therapies occurring only when the relative efficacy of the preceding therapy is known. Therapies that do not demonstrate efficacy after an adequate trial should be ceased.

Additional Treatments:

1. Indwelling catheters (including transurethral, suprapubic, etc.) are not recommended as a management strategy for OAB because of the adverse risk/benefit balance except as a last resort in selected patients.
2. In rare cases, augmentation cystoplasty or urinary diversion for severe, refractory, complicated OAB patients may be considered.

Follow-Up

1. The clinician should offer follow up with the patient to assess compliance, efficacy, side effects, and possible alternative treatments.

This pocket card was developed as a summary of the full AUA Guideline for this subject. The complete AUA Guideline (available at www.AUAnet.org/OAB) should be consulted as the final authority. Please review the online guideline for more information on the appropriate application of the document.

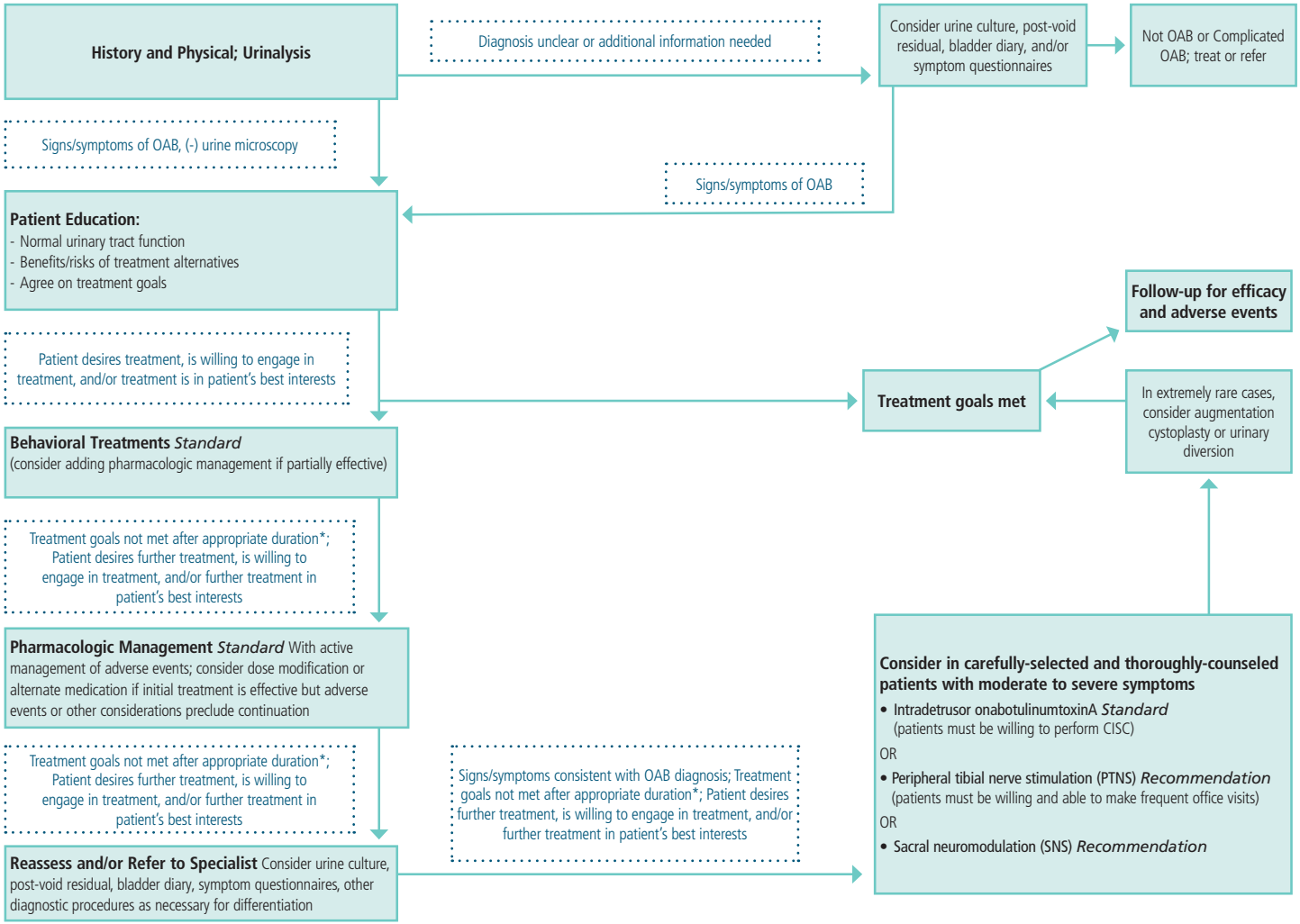
The complete Overactive Bladder Guideline is available at www.AUAnet.org/OAB.

We would like to sincerely thank Astellas Scientific and Medical Affairs for providing an educational grant which combined with AUA funding to support the promotion and distribution of the pocket guide for Overactive Bladder. Consistent with the AUA strict conflict of interest policy, Astellas Scientific and Medical Affairs had no access to the AUA guidelines panels, played no part in the research or development of AUA guidelines and did not review them prior to publication. The co-support offered by Astellas Scientific and Medical Affairs, and gratefully accepted by the AUA, sincerely was in the best interest of the educational mission of the guidelines, to help you and your practice.

Scan the code below to access all AUA resources on OAB, including free videos for CME and online educational activities, plus resources for your patients.

For additional Primary Care resources from the AUA, visit **www.AUAnet.org/OAB**

Diagnosis & Treatment Algorithm: AUA/SUFU Guideline on Non-Neurogenic Overactive Bladder in Adults



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