OVERACTIVE BLADDER (OAB) / URGE INCONTINENCE

Overactive bladder is common in women particularly after the menopause. The exact cause is unknown but it is more common in women who have had children and after menopause.

Normally, the bladder slowly distends with urine until it reaches a good volume of urine (approx. 300-400mls). Then, via nerves to the brain, the bladder informs the brain that a toilet will soon be needed. Urgency should only occur if urination is delayed and the bladder distends to even larger volumes. The bladder emptying process then begins once the woman has consciously decided to urinate (that is, when you are on the toilet).

In women with OAB, the bladder signals the brain that there is a large volume of urine in the bladder when there is not (the bladder has become overly sensitive). The process of emptying the bladder (an automatic squeezing down of the bladder muscle – the detrusor muscle) then begins before the woman gets to the toilet.

Often there are psychological triggers such as getting to the front door, seeing a toilet or running water.

It is important to understand, that this condition tends to be long term. There is no "quick fix" and the process of slowly expanding the bladder capacity needs time and continued maintenance with a combination of bladder retraining and/or medications.

What are the symptoms?

Urgency: The feeling of being "desperate" to pass urine or unable to delay urination. Often triggered by psychological events such as putting the key in the lock, running water or as the feet hit the floor when getting out of bed.

Urge incontinence: Leakage of urine while trying to get to the toilet or as getting to the toilet.

Urinary frequency: The feeling of needing to urinate frequently or almost constantly, often without much urine being present in the bladder resulting in a slow stream of urine. The sensitivity of the bladder often means women feel that they then need to return immediately to the toilet.

Nocturia: Needing to get up from sleep to pass urine 2 or more times per night.

Restricting activities: Many women will then avoid activities which may lead them to being away from a toilet.

How is it diagnosed?

- A urine sample to exclude urinary infection.
- A physical examination.
- Bladder diary to measure urinary voids and exclude other causes of frequent urination.

- Urodynamics- a test of bladder function.
- Cystoscopy -A small medical telescope is passed through the urethra (the tube that passes urine from the bladder) and no incisions are required. Sterile fluid is used to inflate the bladder and the inside of the bladder is then inspected to exclude any other cause of symptoms.

How is it treated?

Different treatments work for different people. A range of treatments may need to be tried or a combination of treatments may be best for you.

Water: Drinking enough water each day (about 1 ½ to 2 litres per day) is important to ensure that the urine is not concentrated which irritates the bladder further. Women with OAB tend to fluid restrict which results in the amount the bladder will hold slowly decreasing and this in turn becomes a vicious cycle. Try to slowly increase the amount of water you drink.

Reduce caffeine: Caffeine in tea, coffee and cola tends to be diuretic and causes the urine to “rush” to the bladder making symptoms worse. The caffeine and any artificial sweeteners are also a bladder irritants. Try to limit these drinks to 1-2 per day and avoid sweeteners. Try herbal teas without caffeine.

Weight loss: Women who are overweight are more likely to have OAB symptoms and studies now confirm that weight loss (even as little as 8% of body weight) can significantly improve urinary symptoms. Ask for a referral to a dietician or weight loss advise from your GP.

Physiotherapy: Pelvic floor physiotherapy for a number of symptoms including frequency and urgency by teaching bladder training techniques. The physiotherapist will teach you pelvic floor exercises which are helpful for bladder control and other bladder tips which will help you reduce the urgency symptoms such as not going to the toilet “just in case”.

Vaginal estrogen: This is essential for women who are post menopausal. Studies confirm that use of estrogen in the vagina improve the bladder’s capacity and decrease urgency symptoms. The estrogen acts on the vagina and bladder resulting in less sensitivity. To be useful, it must be placed into the vagina as the tablet and patch form of estrogen is not helpful for the pelvic floor. Vaginal estrogen can be used in the long term as it has only a small uptake into the blood stream and does not have the risks of tablet or patch form estrogen.

It also helps the action of the anti cholinergic medications- see below.

Medications:
There are a number of medications available to help with symptoms of OAB. These medications work on the bladder muscle to relax them and increase the bladder capacity. These medications can have side effects of dry mouth, dry eyes and constipation.

They may not be used if you have some types of glaucoma- please notify your doctor to check if this is OK.

OFTEN A NUMBER OF DIFFERENT MEDICATION NEED TO BE TRIALLED AND SOMETIMES IN COMBINATION.

MEDICATIONS AVAILABLE ON PBS (NORMAL PRICED SCRIPT):

- Ditropan (Oxybutynin tablets): Two to three times per day tablet. Used for many years to help the bladder hold more urine and decrease feelings of urgency. Very commonly causes dry mouth as a side effect.
- Oxytrol (Oxybutynin patches): The same medication as ditropan but applied as a patch on the skin and changed twice a week. Much less likely to cause the side effects of dry mouth etc. Can cause **skin irritation** and the patch must be moved around the abdominal and loin area. Use baby oil to remove any residual marks.

MEDICATIONS AVAILABLE ON PRIVATE SCRIPT:
These medications cost approximately $60-70 per month.
Your private insurance may refund some of the cost of these medications.

- Vesicare (Solifenacin): Once per day tablet with much less side effects compared to ditropan. Dose can be increased after 2-4 weeks depending on the effect.
- Enablex (Darifenacin): Once per day tablet with much less side effects compared to ditropan. Dose can be increased after 2-4 weeks depending on the effect.
- Detrusitol (Tolteridine): Twice per day tablet with much less side effects compared to ditropan.

OTHER MEDICATIONS ON PRIVATE SCRIPT COST $60-70 PER MONTH:

- Betmiga (Mirabegron): Once per day tablet without the side effect of dry mouth and constipation as it belongs to a different class of medications. Cannot be used if your blood pressure is not well controlled.
- May be used in combination with the other medications listed above.

Surgery:

- Botox injections into the bladder muscle: This is performed under local anaesthetic and multiple injections of botox are put into the bladder wall. The effect lasts 6-12 months. Side effects include difficultly passing urine which occasionally requires catheter use until the botox effect wears off. This is performed as a day procedure in the hospital.
- Sacral nerve neuromodulation (SNS): A pacemaker type device is inserted into the sacrum (tailbone) area. The lead is inserted under anaesthetic and a pacemaker device inserted into the buttock area if the initial test period (1-2 weeks) is successful. Constant stimulation to the pelvic nerves results in improvement in urgency and urination symptoms. The device lasts 7-8 years and is available with private health insurance.

Other symptoms which often occur with overactive bladder but require different treatments:

- Vaginal prolapse: This is a sensation of discomfort or bulging from the vagina. While occasionally vaginal prolapse can cause increased urinary frequency, usually overactive bladder and urgency symptoms are separate complaints and these symptoms need to be addressed separately depending on which complaint is most bothersome for you.
- Urinary stress incontinence: Leakage of urine with cough, sneeze and exercise. This is treated with pelvic floor physiotherapy and surgery. Surgery for stress incontinence usually does **not** help overactive bladder and urgency symptoms and all the above treatments will need to be continued after surgery for stress incontinence.

Other resources you may find helpful:
UGSA patient information sheets on Overactive bladder, Bladder Retraining and Treatment for overactive bladder:

https://www.ugsa.com.au/patient-resources/