

Pharmacological management of Urinary Incontinence in Women

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Pharmacological Management of Urinary Incontinence in Women

Initial assessment to include urinalysis and urine culture if UTI is suspected to exclude haematuria and infection. Initial Clinical assessment to categorise Stress, Urgency/Overactive Bladder (OAB) or Mixed. Women should be encouraged to keep a diary for a minimum of 3 days.

Consider referral if

- OAB treatment is not successful
- ≥45 yrs with unexplained visible haematuria without UTI
- ≥45 yrs with visible haematuria that persists or recurs after successful treatment of UTI
- ≥60 yrs with unexplained non-visible haematuria and either dysuria or increased white cell count on blood test
- ≥ 60 yrs with recurrent or persistent unexplained UTI
- Overflow incontinence is present
- Urinary incontinence caused by fistula
- Suspected malignant mass

- Advise re high/low fluid intake
- Advise women with a BMI > 30 to lose weight
- Advise reduced caffeine in OAB
- Stopping smoking

Pelvic floor muscle training for at least 3 months plus bladder training for a minimum of 6 weeks & anticholinergic medication.

-Consider intra-vaginal oestrogens in post menopausal women with vaginal atrophy

Before prescribing anticholinergic medication consider co-existing conditions (e.g. poor bladder emptying), existing medication (affecting total anticholinergic load), contra-indications and risk of adverse effects.

Offer

1st – Oxybutynin IR (avoid in frail elderly) or Tolterodine (IR)

If the first treatment is not effective or well tolerated offer the MR formulation:

2nd – Oxybutynin or Tolterodine or Darifenacin MR

3rd – Mirabegron can be considered where patients have:

- high anticholinergic load
- contraindication to anticholinergics
- unacceptable side effects to anticholinergics
- ineffective treatment with anticholinergics

NB Full benefits may not be seen until the drug has been taken for 4 weeks.

Oxybutynin patch is restricted to patients with unacceptable adverse effects to oral therapy

Stress Incontinence

If pelvic floor exercises and medication fail to manage symptoms refer to ACE

Review at 4 weeks

If no improvement or suboptimal response, change the dose or offer an alternative drug with lowest acquisition cost and refer to incontinence team and gynae.

Further review at 12 weeks then annually (6 monthly for women 75 years and over).

Troublesome nocturia associated with OAB

Consider desmopressin but avoid in elderly

Anticholinergics

Medication	Preparations	Dose	Review	Notes
Oxybutynin	Tablets immediate release: 2.5mg, 3mg, 5mg Tablets MR: 5mg and 10mg Restricted use Patch: 36mg – restricted to patients with unacceptable adverse effects to oral therapy.	Initial 5mg BD -TDS; usual daily dose is 10-15mg. The lowest effective dose should be used. Maximum dose 20mg daily In elderly women, a starting dose of 2.5 mg BD is recommended. May be increased to 5mg BD. Initial dose 5mg daily. Increase to 10mg daily if necessary; maximum dose 20mg. Apply patch twice weekly.	Review at 4, then 12 weeks then annually (6 monthly for women 75 years and over)	Do not offer immediate release oxybutynin to frail older women due to the risk of impairment of daily functioning (for example walking or dressing), chronic confusion, or acute delirium (less common) Oxybutynin patch should not be used routinely. Use with caution in renal or liver impairment
Tolterodine	Tablets immediate release: 1mg, 2mg Tablets MR: Neditol XL 4mg	2mg BD Reduce to 1mg BD when eGFR ≤ 30ml/min/1.73m² or side effects. 4mg OD Reduce to 2mg in liver impairment, eGFR ≤ 30ml/min/1.73m² or side effects.		
Darifenacin	Prolonged release tablets: 7.5mg, 15mg	Initial 7.5mg daily. Review and assess after 2 weeks; only increase to 15mg if greater symptom relief is required.		Contraindicated in severe liver impairment

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Beta 3 Adrenoceptor Agonist

Medication	Preparations	Dose	Review	Additional information
Mirabegron Only indicated when anticholinergics are contraindicated, ineffective or have unacceptable side-effects.	Prolonged release tablets 25mg, 50mg	50mg OD	Review at 4, then 12 weeks then annually (6 monthly for women 75 years and over)	Reduce dose to 25mg if eGFR is less than 30 mL/minute/1.73 m² and in moderate liver impairment.

Troublesome nocturia associated with OAB

Medication	Preparations	Dose	Review	Additional information
Desmopressin (off label for women with nocturnal polyuria)	Tablets: 200mcg	200mcg at bedtime; may be increased to 400mcg at bedtime if required	Reassess after 1 -2 weeks then every 3 months thereafter. Periodic blood pressure and body weight checks are recommended to monitor fluid overload.	Use caution in women with cystic fibrosis Avoid in those over 65 years with cardiovascular disease or hypertension. Avoid in psychogenic polydipsia or alcohol abuse. Measure serum sodium 3 days after the first dose. If serum sodium is reduced to below the normal range, stop desmopressin treatment. Contraindicated in cardiac insufficiency

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Reference

NICE 2013 CG171 'Urinary incontinence in women: management', available at:
<https://www.nice.org.uk/guidance/cg171> (Accessed: 19/04/16)

NICE 2013 TA 290 'Mirabegron for treating symptoms of overactive bladder', available at:
<https://www.nice.org.uk/guidance/ta290> (Accessed: 03/05/2016)

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Summaries of Product Characteristics, available at: <https://www.medicines.org.uk/emc/> (Accessed: 13/04/2016)