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Overactive bladder syndrome in the ageing population

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Abstract

Overactive bladder syndrome (OAB) is a common problem in the older age group that can seriously affect quality of life. It raises challenges in the assessment and treatment of the patient with attention needed to be given to the presence of co-existent disease, cognition, patient motivation and the potential negative effects of pharmacological treatment. Though with the correct approach a substantial amount of patients should derive some benefit.

Introduction

The overactive bladder syndrome (OAB) is a symptom complex characterised by urgency, with or without urge incontinence, usually accompanied by frequency and nocturia, in the absence of other pathology such as infection or stones. It can be a disabling condition that has been shown to significantly impact upon quality of life, quality of sleep and mental health. Many patients, especially the elderly, defer seeking advice due to either embarrassment or the misconception that nothing can be done for the condition as it is seen as part of the normal ageing process. Those who do present earlier may do so, not necessarily as a direct result of their urinary symptoms as such, but as a result of underlying concerns about what the symptoms may represent. Men in particular may mistakenly associate their lower urinary tract symptoms to prostate disease and be subsequently concerned about the risk of malignancy.

The impact of overactive bladder syndrome on the elderly can vary considerably between individuals. As a group the ageing population is diverse in nature, ranging from fit mobile individuals through to those less mobile with significant co-morbidities. As such the ability to cope with the condition and associated treatments can vary considerably. In some cases incontinence can result in skin breakdown, with its own associated complication, urinary tract infection, an increased risk of falls, feelings of alienation and avoidance behaviour. The consequences of OAB can affect patients and carers alike. Incontinence is the second most common reason for admission to long term care; second only to dementia.

Thus OAB is a significant problem in the ageing population that can have far reaching ramifications. The aim of this review is to explore current understanding of the condition in addition to current management.

Extent of problem

Overactive bladder syndrome is a common condition, affecting nearly 100 million people in the western world and although not life threatening it seriously affects quality of life and ability to work/function. The lower urinary tract symptoms associated with OAB become more prevalent in the ageing population, where approximately 40% over the age of 75 years are affected; 41% of men and 31% of women. Therefore, OAB represents a major problem to individuals, health professions and society alike. More importantly however, as the population within the western world is generally ageing, those affected by OAB is set to increase significantly. Within the European Union current population forecasts, based upon current birth and mortality rates, predict the proportion of people aged >65 years to increase from 17.1% to 30.0% with absolute numbers rising from 83.6 million in 2008 to 151.5 million in 2030. However, the greatest proportion increase is in those aged >80 years with a projected tripling of numbers from 21.8 million in 2008 to 61.4 million in 2060. The total economic cost of this collection of OAB symptoms is high. In 2007 the costs in the USA were approximately $65.9 billion with these set to rise to a predicted $76.2 billion and $82.6 billion in 2015 and 2020, respectively. Though these figures are generally accepted to be an underestimate due to under reporting of the condition.

Nature of problem

The primary clinical problem behind OAB is urgency, described as the complaint of a sudden compelling desire to pass urine which is difficult to defer. Remarkably, despite the prevalence and costs involved, the mechanisms underlying increased urge are not fully understood. In the vast majority of cases where patients with OAB are studied using conventional urodynamics sensations of urgency correlate with rises in intra-vesical pressure, a condition classified as detrusor over activity (DO). In a proportion of patients however, sensations of urgency are not accompanied by pressure changes, described as sensory urgency. The differences seen in the relationship between sensation and overactive detrusor activity may be indicative of different clinical states. Alternatively, it may represent the fact that the nature of the clinical condition is not fully appreciated. What is known, however, is that older people tend to develop more severe disease than younger people. Studies using urodynamics parameters show that older people with detrusor overactivity have reduced bladder capacities and tend to develop urgency at lower volumes than their younger counterparts. Conversely, older adults with no demonstrable detrusor overactivity have reduced sensation during bladder filling.

A number of studies have been performed to examine the age related changes in the structure of the ageing bladder in an attempt to relate these to differences in function. In aged human bladder strips a decrease in acetylcholine (ACH) and an increase in adenosine triphosphate (ATP) release is seen from post-ganglionic parasympathetic axons innervating the bladder. Similar responses are seen in animal models with the suggestion that the mechanisms involved in the underlying increase in ATP and inhibition of ACh are calcium dependent. Further evidence suggesting that these findings are of physiological significance is illustrated by a reduction in muscarinic receptors seen within the detrusor muscle of older men with an associated selective decrease in muscarinic M3 receptor mRNA in both men and women. However, no decrease in muscarinic M2 receptor mRNA is seen. Though these findings may illustrate part of the patho-physiology behind the development of OAB in the elderly it must be emphasised that, in comparison to their younger counterparts, the aetiology behind OAB is likely to be more multi factorial in nature. Co-morbidities, overall cognitive ability and mobility are all likely to play a role in the severity and impact of the condition. Certainly, it has been shown that OAB with or without leakage is considerably more common amongst patients with cancer, diabetes, congestive heart failure or neurogenic disorders. Older patients are also more likely to have a reduced bladder capacity and be less able to suppress involuntary contractions of the bladder.
Transient overactive bladder /incontinence

Symptoms of OAB +/- incontinence can also be transient in nature. Potentially reversible causes of which are best recalled by the mnemonic DIAPPERS. Approximately 33% of community dwelling elderly and more than half of those who are hospitalised develop transient incontinence.18

D – Delirium and confusion related symptoms require treatment of the underlying cause rather than bladder management.

I – Infection of the urinary tract (UTI) can cause the symptoms associated with OAB, namely urgency and frequency. Asymptomatic bacteriuria does not.19

A – Although previously thought to cause incontinence current consensus of opinion suggests that Atrophic vaginitis does not cause urinary incontinence.20 However, it is possible that the symptoms of OAB are symptoms of urogenital atrophy in older post-menopausal women.21,22 A systematic review of the effects of oestrogen on symptoms suggestive of OAB concluded that oestrogen therapy may be effective in alleviating OAB with local administration being the most beneficial route of administration.23 Furthermore, OAB is also a risk factor for urinary tract infection which in itself can result in symptoms of OAB.24

P – Pharmaceuticals such as diuretics, sedative hypnotics and those with antimuscarinic or adrenergic effects may increase the risk of incontinence +/- associated symptoms of OAB.

P – Psychological effects related to factors such as depression, anxiety or neurosis can result in symptoms of OAB.

E – Excess urine production through increased fluid intake, diuretics or metabolic disorders can lead to frequency. Furthermore, conditions such as congestive heart failure can lead to nocturia.

R – Restricted mobility commonly exacerbates the consequences of OAB in the elderly leading onto to increased episodes of incontinence.

S – Stool impaction has been shown to stimulate opioid receptors in cats resulting in decreased bladder activity25 leading to symptoms of OAB/ overflow incontinence.

Patient assessment

Due to the relatively high prevalence of OAB in the elderly active attempts should be made to identify and screen those at risk. The aims should be to confirm the diagnosis, identify potentially treatable underlying causes, assess severity and impact upon quality of life, and to ensure that there are no red flags warranting further investigation.

History

Key areas of the history focus upon urinary and bowel symptoms, fluid intake, identification of co-morbidities and drugs that may exacerbate the problem, and the social history. Furthermore, patients and carers should be asked about the bothersome of symptoms, their expected goals for treatment, and likely co-operation with treatment. Certain symptoms raise the possibility of other conditions. Dysuria may indicate underlying urinary tract infection whilst supra-pubic/bladder pain may raise the possibility of carcinoma in situ.

A history of visible haematuria should be referred for further investigation to exclude malignancy. Nocturia in the presence of daytime symptoms suggests an underlying urological cause (e.g. elevated post void residual). However, in the absence of daytime symptoms causes related to nocturnal polyuria and sleep disturbances need to be considered, though occasionally high pressure chronic retention can present solely with nocturia.

Examination

A general abdominal examination should be performed paying attention to whether the bladder is palpable in addition to rectal examination. The introitus should be inspected for vaginal atrophy and an examination performed to assess pelvic tone and bladder neck descent. The patients mobility and cognitive function should also be assessed.

Basic investigations

Three day voiding diaries which include fluid intake, voiding times, amount voided and the times of retiring to bed and waking in the morning are invaluable in the assessment of these patients. Urinalysis may exclude urinary tract infection. Other abnormalities such as non-visible haematuria, glycosuria or proteinuria require further investigation. A post void residual (PVR) volume estimation is also useful but there is no clear consensus as what constitutes a high post void residual. Though it is suggested that post void volumes of >200-500 mL, in whom the PVR is thought to be the major contributor may benefit from a period of catheterisation.

Further investigations

Urodynamics

Urodynamics are not usually required in the assessment of cases of overactive bladder syndrome where conservative management would be required since the absence of detrusor overactivity will not generally influence treatment since; OAB is a clinical diagnosis. However, urodynamics should be considered should there be extreme doubt as to the diagnosis. But in general urodynamic testing is reserved for patients prior to procedures for stress incontinence. Though many clinicians perform urodynamics in more extreme cases of OAB where intravesical botulinum toxin injections would be considered.

Treatments

Lifestyle and behavioural modification

The evidence base to support lifestyle modification is poor and at times can be contradictory. Obesity has been shown to be associated with an increased risk of stress and urge related leakage.26 Though further studies have shown that weight loss, in obesity, does not improve symptoms of urge related leakage,27,28 but it does help with symptoms of stress leakage. Advice should be given with regards to fluid intake, especially in curtailing fluid intake in the evening should nocturia be a problem. Again, evidence is lacking though the National Institute for Health and Clinical Excellence (NICE) go on to also suggest a trial of caffeine reduction in women.29,30

Behavioural therapy is the first line treatment for both men and women.29 Its aim is to reduce urinary frequency, re-establish voluntary control and to increase bladder capacity. In the cognitively intact the technique of bladder re-training can be employed. This involves timed voiding and attempted suppression of urgency in the intervening time period. To suppress urgency patients are advised to keep still, either standing or sitting, till the sensation has passed. The manner in which patients quell this desire to void can vary; some prefer to relax whilst others actively contract their rectal muscles (as if attempting to hold in flatus). Should the urgency persist despite these measures patients go to the toilet to void. When patients are continent for 48-72 h the time period between voids is increased. The aim is to achieve voiding intervals of 3-4 h without leakage. However, this takes motivation and a degree of determination as successful bladder re-training may take up to a number of months to achieve. This is evidence to show that in cognitively intact, community dwelling elderly bladder re-training in conjunction with medication (such as anti-muscarinics) may be more effective than bladder re-training alone.31,32
For those with cognitive impairment bladder re-training is not practical. These patients tend to benefit from a prompted, or scheduled, voiding regime. The drawback with this, however, is that it requires motivation and continual vigilance on the part of the relatives or carers. In the case of nursing home or hospitalised patients this approach can be quite labour intensive. It comprises of regular observation of the patient to monitor whether they remain continent or have leaked; prompting to void on a pre-determined timed basis; and positive re-enforcement when patients void appropriately themselves.

Drugs

The mainstream of treatment for OAB is currently the anti-muscarinics. Since the symptoms of overactive bladder syndrome were thought to originate from overactive detrusor contractions, it was argued that drugs affecting contractility would alleviate symptoms. Activity in the detrusor muscle is initiated at muscarinic receptors (M3) and drugs designed to target these M3 receptors have been proven to be effective in decreasing urgency and incontinence. However, it has been suggested that, at therapeutic doses, these drugs do not significantly affect bladder contraction, suggesting alternative modes of action. Therefore, if this is so our understanding of the mechanisms through which antimuscarinics act, and in turn our understanding of the generation of the sensation of urge and urgency, is incomplete. There is currently research underway to examine these alternate potential mechanisms in an attempt to develop new treatments.

Although the role of anti-muscarinic medication in the elderly has been established the efficacy and side effect profiles of these drugs have largely been extrapolated from a younger population; one without the associated co-morbidities, poly-pharmacy and potentially decreased cognition. The vast majority of data from randomised controlled trials have excluded the elderly population either on age grounds alone or by virtue of their co-morbidities. Those trials including the elderly by and large do not report the results as a separate cohort. Therefore, in interpreting these data on safety and efficacy some degree of caution needs to be exercised. Side effects of anti-muscarinics on the whole include; dry mouth, constipation, and gastrointestinal symptoms. It was argued that, at therapeutic doses, these drugs do not significantly affect bladder contraction,34-36 suggesting alternative modes of action. Therefore, if this is so our understanding of the mechanisms through which antimuscarinics act, and in turn our understanding of the generation of the sensation of urge and urgency, is incomplete. There is currently research underway to examine these alternate potential mechanisms in an attempt to develop new treatments.

There are a number of anti-muscarinic medications on the market, the most established of which being oxybutynin. Randomised, placebo controlled studies have shown oxybutynin,37 tolterodine,38 solifenacin,39 trosplum chloride40 and darifenacin41 to reduce episodes of urge related leakage in the elderly. With regards to cognitive function trosplum chloride and darifenacin seem to have less of a detrimental impact. In the case of darifenacin this may be related to its selectivity for the M3 receptor with little selectivity for the M1 receptor. Trosplum Chloride, unlike the other tertiary amine anti-muscarinics, is a heavier quaternary amine and as such does not cross the blood brain barrier.42 The role of anti-muscarinics in the presence of anti-cholinesterases is unclear. There is an association with increased rates of OAB after the prescription of anti-cholinesterases,43 though there is little clear literature describing the effects of co-prescription.

Botulinum neurotoxin type A (BoNT-A) is one of seven sub-types of a potent biological toxin produced by the bacterium Clostridium botulinum. BoNT-A acts upon peripheral cholinergic nerve endings inhibiting acetylcholine release. First described by Schuch and Stöhrer, it has rapidly become used as a treatment for OAB in cases unre refractory to more conservative measures or where the side effects of anti-muscarinics were intolerable. It is cytoscopically injected into the bladder and gives symptomatic relief for approximately 6 months. The downside, however, is the small but significant risk of retention necessitating either a long term indwelling urethral catheter or for the patient to be taught intermittent self catheterisation.

Future therapies

In recent years the bladder has been shown to demonstrate a number of structures and cells that illustrate a complex interaction between the urothelium and suburothelial layers. A number of non-cholinergic mechanisms have also been demonstrated that may be involved in the generation of sensation and the modulation of bladder activity. Adenosine triphosphate, nitric oxide and acetylcholine have all been shown to be released from the urothelium in response to stretch. With their corresponding receptors found in the suburothelial layers upon structures such as interstitial cells, ganglia and afferent nerve fibres. With these likely to be involved in the generation of sensations a number of therapies are being developed to target these mechanisms. Unfortunately, potassium-channel openers have failed to show any efficacy. However, Aprepitant, an NK-1-receptor antagonist used for treatment of chemotherapy-induced nausea and vomiting was found to significantly improve symptoms of OAB in postmenopausal women with a history of urgency related leakage. 3 adrenergic receptors have been found predominantly in the human detrusor and there is convincing evidence that they have an important role in both normal and neurogenic bladders. A number of 3 -AR–selective agonists, including GW427353, YM178, and KUC7483, are currently being evaluated as a potential treatment for OAB in humans.

Conclusions

Overactive bladder syndrome is a common problem in the older age group that can seriously effect quality of life. It raises challenges in the assessment and treatment of the patient with attention needed to be given to the presence of co-existent disease, cognition, patient motivation and the potential negative effects of pharmacological treatment. Though with the correct approach a substantial amount patients should derive some benefit.

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