# FOLLOW-UP VISIT EVALUATION FOR URINARY URGE INCONTINENCE (OVERACTIVE BLADDER)

## DEFINITION
Urinary incontinence may be due to several difficult etiologies; the most common forms are urinary stress incontinence and urge incontinence. There are also mixed forms of incontinence. Usually stress incontinence is corrected by treatments that alter anatomical relationships—either with surgical treatment or with pessary support. Urge incontinence is treated medically. This protocol is intended to guide follow-up care of patients who have been previously evaluated and started on medical therapy.

## SUBJECTIVE
1. History of urinary incontinence that has been previously evaluated and found to have at least an element of urge incontinence (“overactive bladder”).
2. List of current medications to rule out drug-drug interactions.
3. Current utilization of therapy (drug, dose, frequency, duration).
4. Recent response to therapy, e.g. new acute problems, dysuria, changes in nocturia, frequency, urgency.
5. Any symptom which could represent contraindications to therapy, e.g. narrow angle glaucoma, blurry vision, urinary retention.
6. Any new symptom from drug use which might trouble patient, e.g. dry mouth, headache, constipation.

## OBJECTIVE
Routine exam per visit.

## LABORATORY
1. Urinalysis and possible urine C&S if any complaints of dysuria.
2. Review recent labs to assess status of other symptoms, causes, e.g. elevated hemoglobin A1C.

## ASSESSMENT
Women with urinary incontinence with urge component on therapy.

## PLAN
1. Advise patient to stop medication immediately if patient has any serious adverse reaction, e.g. urinary retention, narrow angle glaucoma, blurry vision. Consult with physician to manage acute problem. Refer to MD to initiate alternative therapy.
2. If patient doing well, refill prescriptions and reinforce education about life style changes, warning signs and side effects (see patient education).
3. For patients who are responding adequately to therapy but who have undesirable side effects, suggest interventions targeted to their specific problems:
   a. Dry mouth: ingesting fluids (swish and spit); sugarless mouth lozenges or sugarless gum.
   b. Constipation: increase fluids and dietary fiber, advise stool softener.
   c. Headache: recommend over the counter remedies.
4. If patient has nocturia and/or urgency which is not improved by current medication
   a. Consider other source of urinary frequency, e.g. poor diabetic control, UTI diuretic use. If using diuretics, advise to avoid diuretic use at night, if possible.
   b. If persistent nocturia:
      1) Reinforce need to take treatment medication at bedtime.
      2) Consider imipramine 10-25 mg one tab at bedtime (maximum dose 75 mg).
5. If urgency or nocturia with symptomatic vaginal atrophy, consider adding low-dose vaginal estrogen therapy.
6. If needed, increase medication incrementally without exceeding maximal dose (see below).
## Medications Commonly Used to Treat Urge Incontinence (Overactive Bladder)

<table>
<thead>
<tr>
<th>Oral Medication Used</th>
<th>Usual Standard Dose</th>
<th>Incremental change</th>
<th>Maximum daily dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detrol TR (tolterodine tartrate)</td>
<td>2 mg at bedtime*</td>
<td>Add 2 mg in am</td>
<td>4 mg over 24 hours</td>
</tr>
<tr>
<td>Detrol LA (tolterodine tartrate)</td>
<td>2 mg at bedtime*</td>
<td>Add 2 mg at bedtime</td>
<td>4 mg at bedtime</td>
</tr>
<tr>
<td>Ditropan IR</td>
<td>5.0 mg twice a day</td>
<td>3-4 times a day</td>
<td>20 mg over 24 hours</td>
</tr>
<tr>
<td>Ditropan XL (oxybutynine chloride)</td>
<td>5.0 mg once a day</td>
<td>5.0 mg</td>
<td>10 mg once a day</td>
</tr>
<tr>
<td>Vesicare tablet (solifenacin succinate)</td>
<td>5 mg at bedtime</td>
<td>5 mg at bedtime</td>
<td>10 mg at bedtime</td>
</tr>
<tr>
<td>Enablex (Darifenacin)</td>
<td>7.5 mg at bedtime*</td>
<td>7.5 mg at bedtime</td>
<td>15 mg at bedtime</td>
</tr>
<tr>
<td>Tofranil (imipramine)</td>
<td>25 mg at bedtime**</td>
<td>25 mg at bedtime</td>
<td>75 mg at bedtime</td>
</tr>
<tr>
<td>Elmiron</td>
<td>100 mg three times a day</td>
<td>0</td>
<td>300 mg in 24 hours</td>
</tr>
</tbody>
</table>

* Reduce dose in women with liver or renal impairment  
** Consider lower dose in elderly

### PATIENT EDUCATION

1. Reinforce need to stop medication if warning signs (blurry vision, urinary retention) develop.  
2. Reinforce need to take therapy as directed. Emphasize that this is a treatment, not a cure for their problems.  
3. Review possible side effects.  
4. Advise patient to decrease caffeine intake and to increase fiber in diet.  
5. For women with urge incontinence recommend bladder drills, timed voids (bladder training), to increase time between voids.  
6. For women with nocturia, recommend avoidance of fluids late in evening.  
7. Start or continue Kegel exercises.  
8. Encourage weight loss if BMI > 25.

### REFER to MD/ER

1. Patients who develop serious adverse effects.  
2. Women who do not respond to therapy.  

### REFERENCES