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Overactive Bladder: Key Considerations for Primary Care

Announcer:
You're listening to *Clinician's Roundtable* on ReachMD, and this episode is sponsored by Sumitomo Pharma. Here's your host, Dr. Brian McDonough.

Dr. McDonough:
Welcome to Clinician's Roundtable on ReachMD. I'm Dr. Brian McDonough, and today, I'm joined by Dr. Gary Lemack to discuss how primary care physicians can play a pivotal role in the early detection and management of overactive bladder. Dr. Lemack is a Professor of Urology at UT Southwestern Medical Center and a urologist at North Texas VA Medical Center in Dallas. Dr. Lemack, thanks for being here today.

Dr. Lemack:
My pleasure. Thanks for having me.

Dr. McDonough:
To start us off, Dr. Lemack, can you provide some background on overactive bladder and its symptoms?

Dr. Lemack:
Sure. So overactive bladder generally encompasses a variety of bladder symptoms, principally urinary frequency and urgency. And it's always difficult to distinguish what's normal urge to urinate and what's urgency. And urgency is best described as it's almost impossible to or can't stop the urge to urinate. Now, sometimes it's associated with incontinence, or what we call urge incontinence, and sometimes it's not. It's just having to go very often and just having this urgency and you can just barely get there. Sometimes we call it, for example, garage door syndrome. So I have lots of patients who come in and they're fine, and they may drive 2 or 3 hours, and they get to the garage door and they just can't get in the bathroom quick enough. A lot of times, it's also associated with nocturia, or getting up at night to urinate several times—so that constellation of symptoms. Now, it's not always overactive bladder; occasionally, it's other things too, so that's why it's good to be checked out.

Dr. McDonough:
And since symptoms can present in different ways, how can primary care physicians recognize that a patient has overactive bladder and make an early diagnosis?

Dr. Lemack:
Yeah, I think it's really important for primary care physicians to do this and to take care of these patients and give them options and offer treatment possibilities. So screening to start—asking patients what they're experiencing and having them fill out various questionnaires can be helpful if that's possible. But if not, just ask them how frequently they're going. So if typically they're voiding more than, say, eight times a day on average, and maybe getting up once or twice a night, that may be a sign. Certainly, the feeling of urgency or not being able to get there in time may be a sign. Leakage associated with urgency may be a sign. It's super important to check urinalyses in these folks because that also, of course, can be a sign of other things—stones, infections, and rarely things like cancer, but that's very, very uncommon. But getting a urinalysis, doing an examination, and assessing for these urinary symptoms are the starting point.

Dr. McDonough:
Knowing that this can be a sensitive topic, how should primary care physicians approach conversations with patients about overactive bladder?

Dr. Lemack:
You just have to say that a lot of people associate with urinary symptoms with aging, and people just accept it. And you bring up how often people are urinating, or how often you're getting up at night to urinate, and just let them know that, yes, while there are changes that are associated with aging, it doesn't mean that those changes always have to be accepted.

The good news is, compared to where we were 20 or 30 years ago, people are more willing to talk about it. It's not as taboo subject as it once was. But it is imperative to bring it up. And for a lot of primary care physicians, they have a lot of important things that they have to talk about with patients, and this may not be at the top of the list. But I can tell you from a symptom standpoint and a bother standpoint, it's often at the very top of the list for many of our patients. So it is important to bring it up and say, “Listen, is there anything on your mind with regard to your urinary symptoms that's bugging you? Are you going too often? Are you getting up at night to urinate? Are you having accidents?” And just initiate that conversation. And many times, after you initiate it, they’ll take over, and just tell you all about their symptoms.

Dr. McDonough:
For those just tuning in, you're listening to Clinician’s Roundtable on ReachMD. I'm Dr. Brian McDonough, and I'm speaking with Dr. Gary Lemack about how primary care physicians can diagnose and manage overactive bladder.

So now that we've spoken about diagnostic strategies, let's move on to management. Dr. Lemack, what are some of the common first-line treatment strategies?

Dr. Lemack:
So commonly, we call first-line treatment strategies conservative strategies, or behavioral interventions, if you will. And those things sound simple, but if you talk to people, it's sometimes difficult to change behaviors that are ingrained in people. So, we talk about volume of fluid intake; normally we'd like to see patients have about 60 ounces of fluid a day. That would be great. We want people to make about 1500 ccs of urine a day or so. And of course, that depends on your hydration status and everything else. But monitoring the volume of fluid is really important. Because, again, people are getting a lot of advice from physicians and maybe from media and even from family members that they need to be drinking and drinking and drinking. To some extent, of course, that's true to take in enough fluid. But also, that has its consequences. So the volume of intake is super important.

Then what they're actually taking in is really important too. And so you talk to patients who say, “I have to go like four or five times in the morning. Yes, well, I had three or four cups of coffee.” So caffeine, spicy food, citrusy fruits, acidic food, carbonated beverages, artificial sweeteners, those are all ones that really are closely associated with urinary symptoms. And it's not like getting rid of those things gets rid of the problem entirely, but often it can make it much better. And giving people recognition that that's what they're doing and that's having the impact—then, all of a sudden, a light bulb goes off and they understand it, and they can modify their own behavior. So volume of fluid, types of fluid they're taking in, and then time voiding, going every couple of hours so you don't let your bladder get too full—those are sort of the main things to do from a first-line treatment.

It's interesting you say first-line because the latest guidelines from the American Urological Association—we previously had a very strict first-, second-, and third-line therapies, and actually, we've gone away from that—it's more of a shared decision-making model where, yes, in general, of course, you'd recommend conservative strategies first. But you don't necessarily have to, and you can move on to so-called second- or third-line treatments, medications, and other interventions early on if you want to.

Dr. McDonough:
How can primary care physicians collaborate with urologists to ensure all the patient’s needs are met?

Dr. Lemack:
That's a challenging one because it’s tough to meet all the patient’s needs. And so for most urologists, they really encourage patients to be seeing their primary care physicians, and to initiate some of these strategies early on. But once they see a urologist and get started on a medication and then see back with their primary care physician, assess their degree of improvement and reinforce the strategies that help the medications work better by continuing on some of these dietary changes and so forth. And then, importantly, if they're not meeting their expectations, or they don't or they're not sure if they are, then get them back to urologist to discuss some of the more advanced therapies that we can also offer in addition to some of the medications.

Dr. McDonough:
As a family doctor, I appreciate that advice. It's important to keep that conversation going. Now, as we approach the end of our program, Dr. Lemack, do you have any final thoughts that you'd like to share with our audience?

Dr. Lemack:

It's important to know that there are some strategies that are out there. The medications have improved with time. There classically have been a lot of side effects associated with many of the medications that we classically have given for years. And some of the newer agents, including a group of agents called beta agonists, had much fewer side effects. So that's nice to have in our armamentarium for these patients. And then, of course, some other strategies, including injections of the bladder and various forms of neuromodulation, both in the sacrum and the latest one is in the ankle, the tibial neuromodulation that's implanted. So some nice, new, interesting things are out there for these patients who have these symptoms that really can effectively treat them. So lots of options are out there and emerging.

Dr. McDonough:
With those key takeaways in mind, I want to thank my guest, Dr. Gary Lemack, for joining me to discuss the primary care physicians' important role in the early diagnosis and management of overactive bladder. Dr. Lemack, it was really great having you on the program.

Dr. Lemack:
My pleasure. Thank you very much.

Announcer:
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