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Strategies of Care in OAB: Individualizing Treatment Based on Patient Profile

Dr. McDonough:

Overactive bladder is associated with significant morbidity. It's recognized as a significant health issue. It affects about 16.5% of you as adults. Despite a high rate of prevalence, OAB is underdiagnosed. Join us as we discuss communication methods for proper engagement in a discussion about overactive bladder with your patients, also recommended treatment options. Joining me today is Dr. Matt Rosenberg. He's Director at MidMichigan Health Centers in Jackson, Michigan. We're going to be talking about this topic.

And, Dr. Rosenberg, welcome.

Dr. Rosenberg:

Thank you very much.

Dr. McDonough:

We're in front of a group that just saw you speak, talk about the issues. My big question for you is: How common is overactive bladder, as you see it, and how prevalent is it in our practices? Should we be looking for it more?

Dr. Rosenberg:

That's a great question. And we use numbers to say something like 33 million Americans will have this, and when we talk about that, this is 33 million in the age group of young adults to old adults. We also talk about the fact that it's as common in men as it is in women, especially as they get older. There's this idea that it's only a female disease, but that's not correct at all. It may be more common in women as they're younger, but as they get older, it's the same.

The interesting thing is when we see a male with LUTS, the first thing that comes to our mind is BPH, whereas, in fact, it's OAB in about half the cases, so we really need to evaluate that and kind of look at the symptoms the patient is having to decide if the situation is their bladder, if the situation is their prostate. And there's another part of this that's really important is there's a lot of medically related LUTS, so when we talk about the commonality of these symptoms, there could be still a lot of reasons for this, and it's not always prostate or bladder.

Dr. McDonough:

One of the things you did quite well in your talk and I want to share with the audience is describing the adverse consequences to treatment of overactive bladder that sometimes people may experience. You recognize the problem. You treat it. But there are some consequences as well.

Dr. Rosenberg:

Sure. There are consequences with everything. Now, there is consequences of not treating the problem, a worsening of symptoms, decreased quality of life. There's consequences of the treatments, and that's why we have to pick the right treatment for the patient. We have two classes of medications that are out there, the antimuscarinics and the beta- 3s. They each have side effect profiles that we need to be aware of as we're picking the patient. We have some invasive procedures that are out there, some that are minimally invasive that you can do in a family practice office and some that are a little more invasive that you need to do probably with a specialist in an outpatient surgical setting.

Dr. McDonough:

And there's issues with adherence, I'm sure, as well. You probably face that.

Dr. Rosenberg:

Oh, absolutely. Medication adherence with all medications is rather poor. We know that. And I think a lot of times it's patients not understanding the medication that they're taking or why they're taking it. So, when you're dealing with overactive bladder, you want to make sure the patients actually know exactly why they're taking it and what they're taking it for, what are the goals that they can achieve? If I tell you, let's say you're voiding every 2 hours and I give you a beta-3, beta-3 agonist, and I don't tell you what to expect. Well, I'm going to be really happy if you can go an hour between voids more, so 3 hours instead of 2 hours or 4 hours instead of 2 hours. The patient needs to be aware that that's not a failure if we only get there. That's actually a success for them, so we really want to delineate that ahead of time.

Dr. McDonough:

And that's part of patient communication. I know it's critical, especially in this issue, because you mentioned in your talk people just don't come in and they volunteer this information and want to talk about it. You have to talk with them about it, not make them feel ashamed. There are just so many aspects.

Dr. Rosenberg:

Right.

Dr. McDonough:

What are the kind of complaints they come in with normally, like the things that maybe you wouldn't be thinking of, for those out there in practice?

Dr. Rosenberg:

Well, the interesting thing is they don't come in with those complaints at all. They suffer in silence. And one of the things I mentioned to the group is one of the largest or the largest expense associated in the world of OAB, of overactive bladder, are diapers. Patients don't have to talk to anybody about that except for the clerk when they are checking it out. They don't have to bring it up to the doctor at all, and that's unfortunate. So, I think one of the things is we have to be able to address what is normal, that your bladder should hold 300 to 500 mL's and it should be able to void comfortably when you can get to the bathroom. It shouldn't make you run to the bathroom. If you explain normal to the patient, then they'll be able to address abnormal.

Now, having said that, patients will come in frequently, they have urinary tract infections. “Oh, I’ve got a family history of urinary tract infections,” or, “a family history of small bladders, and I need some therapeutic intervention for that,” or, “I need something for it,” whereas really, it’s probably overactive bladder in a lot of cases. And that’s an important point that I teach is that an infection, a urinary tract infection, is not an infection until you get a culture. You may want to treat it empirically, but if you're treating that patient and they don't have a positive culture, then that wasn't an infection. Remember, when we were in school we were told, “Well, not every urinary tract infection will show up. You’ll miss some bacteria.” And that was our way of saying, “We don’t know.” And the reality is now we do know.

Dr. McDonough:

What about men who experience dribbling, a little bit. It's not enough that they're that worked up about it, but they start to notice and they are a little embarrassed.

Dr. Rosenberg:

Right. Well, I think a lot of guys do, and I think it's our job to open up to them about it. I'll tell patients, you know, my males will come in and I say, “You should have a good void when you stream,” and I use an analogy -- and we spoke about it in the lecture -- about writing your name in the snow in script as opposed to Braille, and everybody laughs because it's kind of funny, which it is, but the bottom line is a guy will know his stream, and when you're dribbling... Let's say you're at a ballgame and you gotta void, and it's the bottom of the 9th inning and you run to the bathroom and you can't void fast enough, and you're rushing out and then you’re dribbling down your leg because you couldn't get everything out. That's unfortunate. And that's what I tell patients. You should be able to void well with a good stream and efficiently. And sometimes they need prompting for that. Sometimes we need to tell them it's not something to be embarrassed about.

I don't mean this to sound odd, but I'll have patients come in and, you know, no one likes taking their clothes off in the doctor's office, but it's something we need to do, and sometimes you'll see a little bit of a stain on the underwear. Right? And you could do one of two things. You can ignore it if it's a urine stain and you could say, you know, maybe, “Do you have this issue? It's not anything to be embarrassed about. It's something we can treat.”

Dr. McDonough:

And what about a man or a woman who has that dribbling? They come in. Do you immediately go to medications? Are you looking at other, cut back on the coffee, things like that? What do you suggest?

Dr. Rosenberg:

No, you've got to start with behavioral modification, and that's really understanding what the bladder does. If we understand the bladder holds and the bladder empties and it should have good volumes when you void, so we talk about bladder hygiene, knowing to empty your bladder in a comfortable way and empty it fully. Count to 10 and void again type of things, that's what I call bladder hygiene, and it really does work.

For males, standing at the toilet, voiding and maybe counting to 10 and voiding again. For older males, you're up at 2:00 in the morning, you have to pee, and you're half asleep bouncing against the walls, and you're standing... You're not actually standing at the toilet. You're kind of leaning against the wall while you void. You can't really empty your bladder very well that way, so I tell guys, “Just sit on the toilet. Who cares? Sit on the toilet. Empty your bladder. Relax, void again, and then just go back to sleep.” So, that's the hygiene issue.

There's the fluid issues though that are very important. I mean, if you're going to have overactive bladder, it's a 24-hour-a-day, 7-day-a-week event. All right? And if you go home from the office with a 40-ounce Big Gulp or a triple latte and you're going to be stuck in traffic for 2 hours, it's a recipe for disaster. And that is not overactive bladder. That's just behavioral issues that you can modify. So, there are a lot of opportunities, and medications are what I will do only after I explain, I talk to them about their habits and adjust or offer habit changes.

Dr. McDonough:

Earlier, you talked about maybe the discomfort of having to get naked in the doctor's office, but two things come up. One is the genital exam, why that's important, and also, wasn't the need for the prostate exam removed by USPSTF?

Dr. Rosenberg:

Yes. Boy, you just opened up a big one there. First of all, you have to do a genital exam if somebody is coming in for LUTS. You have to make sure the opening that they void from is open. That's the urethral meatus in both the men and the woman. Make sure it's open. I've seen cases in both genders where it's not open. Of course they can't void. Make sure that if a male has a foreskin, you can bring the foreskin up and around the glans and you're not having a phimosis. In a female, make sure there's not vaginal atrophy. Make sure there's not a prolapse of the bladder, a cystocele urethral diverticulum, because your anatomy has to be normal for you to have normal emptying function.

In regards to a prostate exam, it's really interesting. The United States Preventive Service Task Force did not actually say don't do a prostate exam. However, the American Academy of Family Practice on their website stated that, that was their interpretation of the United States Preventive Service Task Force, so what you're stating is actually what's out there in the real world, so you're absolutely right, and that's unfortunate, because we didn't -- I say we -- they did not say get rid of the prostate exam. And I just read something last week or two -- it was either in the New York Times or Wall Street -- saying that males don't need prostate exams, and the main reason was they bellyache about it, and the reality is they're going to bellyache about it one way or another, but the rectal exam is very, very important as a part of our evaluation. First of all, it's not screening in this case. You have a patient who's coming in with symptoms, so you have to evaluate that part of the body, all right? So we are not even discussing screening here. You want to be able to detect sphincter tone. You want to be able to detect for lesions, for fissures. You want to check for impaction. You want to check the prostate for tenderness. You want to check the prostate for nodules or for size. In a female, you're still checking for sphincter tone, lesions, abnormalities, things like that. And I actually have had three cases of MS that I found in the office of patients who were coming in with bladder issues and they all three had decreased sphincter tone, so it's an important part of the evaluation. And we're still doctors and we have to do the right evaluations on these patients.

Dr. McDonough:

What are some points I didn't ask you that you think we should have brought up or talk about?

Dr. Rosenberg:

I think we've called outa lot of things. As you know, I kind of wear two hats. I'm trained as a urologist, and then I switched fields into primary care, and what I've been doing for the last 20 years or so is teaching my colleagues in primary care about urologic issues, because most of us don't get training in urology, yet there's so much that we see in a given basis. So, I think there needs to be a Call to Arms for urologists to train primary care. There needs to be a Call to Arms for primary care to explain these issues to their patients, because if our patients understand these, this is going to be very helpful. And OAB is absolutely that disease. It absolutely fits in that case. I need the urologists to be aware, to share with the primary care doctor of what to do, that they can be used in the refractory case, but these are the things that they should do to initiate therapy, because if we do those things in a simple, effective and safe manner, we're actually going to be treating the overwhelming masses of patients that are at this point untreated.

Dr. McDonough:

Well, Dr. Rosenberg, I want to thank you for joining us today, sharing your thoughts on overactive bladder. A pleasure having you with us.

Dr. Rosenberg:

Thank you.

Dr. McDonough:

I am your host, Dr. Brian McDonough, for ReachMD.