Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/treatment-of-oab-and-the-managed-care-professional-balancing-the-double-edged-sword/15362/

Released: 08/09/2023
Valid until: 08/11/2024
Time needed to complete: 15 minutes

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Treatment of OAB and the Managed Care Professional: Balancing the Double-Edged Sword

Announcer:
Welcome to CME on ReachMD. This activity, titled “Treatment of OAB and the Managed Care Professional: Balancing the Double-Edged Sword” is provided by Prova Education.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Staskin:
Overactive bladder, or OAB, is under recognized, underdiagnosed, and undertreated. Are you up to date with the latest tools for screening and communication strategies to actively engage your patients in their personal care?

This is CME on ReachMD, and I’m Dr. David Staskin. And I’m here today with Dr. Roger Dmochowski.

Dr. Dmochowski:
Hello, David. Thanks for having me.

Dr. Staskin:
To start the conversation today, can you define overactive bladder?

Dr. Dmochowski:
Thanks, David. Yeah. Overactive bladder is an interesting chronic condition, and I think it’s very important that when we see patients and try to define this condition for them, they understand the chronicity of the condition and its long-term effects, both from a standpoint of needing treatment as well as management. Overactive bladder is really a symptom constellation of 3 primary symptoms. All patients have some component of urinary frequency, frequent toileting; some component of urinary urgency, profound desire to seek toileting facilities for fear of losing urine; and then about a third of patients also have urinary urge incontinence. So obviously, urinary loss incontinence is associated with the urgency component. About one-third of patients are OAB-wet, and about two-thirds are OAB-dry. Urgency, of course, is the core driving symptom of this complex. It is a very fascinating symptom and one that patients really seek therapy for in terms of trying to have improvement because it can really be a life-altering symptom that impacts not only professional but also personal life.

Dr. Staskin:
Let’s talk a little bit about one of those symptoms that you just mentioned, which people don’t think about. I often think about frequency and frequency of incontinence episodes. But this concept of urgency, people getting this sudden, compelling need to go to the bathroom, I think of it like an on-off switch rather than a dimmer switch, which separates people with true OAB. What are your feelings on this?

Dr. Dmochowski:
You know, David, clearly urgency is the core driving symptom that drives behavior and also drives treatment-seeking requests from patients. There is argument about whether urgency is an on-off dichotomous symptom or whether it is sort of a rheostat or a thermistor

that goes up and down depending on the filling of the bladder. But clearly, urgency is that which is the core component of this syndrome, and again, that which drives patients. And again, urgency is defined as the compelling desire to seek for and reach toileting facilities for fear of loss of urine that is unwanted.

Dr. Staskin:
Where do you think it lies in between doctor and patient and the communication issue?

Dr. Dmochowski:
Clearly, it is an embarrassing condition, a condition which implies loss of control for some people. They basically connote it to aging and all the other issues that are associated with aging. So part of this is creating environment where there can be frank and open discussion between the patient and her or his clinician, such that they can have a discussion about what brings them into the office. We all understand that we're under tremendous time pressures in the current circumstances. It's very difficult, especially in primary care and general internal medicine, when you've got many other conditions, to actually have time for these sort of very, very life-altering conditions. But certainly, an opening leading question such as, "What brings you in today?" or "What's really bothering you today?" can sometimes, if you will, lift the veil up from the real underlying factor for that particular visit on that particular day.

Dr. Staskin:
Another interesting group is the elderly patient, both in approaching them, discussing comorbidities and medications they may be on, and also looking at cognitive status and ability to toilet. So that becomes a little bit more of a – it's not a refractory patient, but it's certainly someone who's more complex.

Dr. Dmochowski:
You know, David, it absolutely is a more complex patient because not only do we have the considerations associated with the comorbidities that many patients, as the years have gone by, have acquired, but we also, as you mentioned, have the concerns regarding potential impacts on cognitive function for many of our therapies, and also multidrug interference with cognition. And so we, as we approach those patients, have to really take that into account, and one of the things I really like to do in that population is to have a discussion about any recent issues with short-term memory loss or forgetfulness. Often patients who perhaps may be somewhat older will come with a child or a grandchild, and you'll actually get some very interesting bits of history from those individuals who come with them about some concerns regarding cognitive function. I find that's a very important thing to bring up early in the discussions regarding therapy with that particular age group.

Dr. Staskin:
Let's turn to treatment, and I think that a lot of the behavioral issues and, well, managing fluids, et cetera, I think is important. The comorbidities come into play here when people have peripheral edema or poorly controlled diabetes. I see patients in my office who're referred for nocturia whose glucoses are out of control at night even though they're fine during the day. But given all of dealing with comorbidities and dealing with some of the behavioral things that patients can do with diet, let's talk a little bit about medications. The mainstay of therapy has certainly been anti-muscarinics, which relax the bladder blocking muscarinic receptors, and the other class is the beta-3 adrenergic agonists which increase bladder capacity by relaxing the detrusor muscle by stimulating relaxation though through beta-3s.

Give me a little bit of an idea, Roger, about how you're using these medications now.

Dr. Dmochowski:
I will say that if we take a step back and look at the overall efficacy of both the anti-muscarinic class in general, and also the beta-3 class in general, we're in the same ballpark regarding the efficacy that can be expected with either of those classes for any unique individual. And I think one of the most important connotations of the discussion regarding efficacy is our goal is improvement, not cure. These patients very rarely will actually have complete resolution of their symptoms. Clearly, we've both seen that, but it's unusual. Most times, the goal is improvement of symptoms. And so I think with either class, we can improve symptoms.

The real catch-all comes when we consider the other aspect of the therapeutic balance, and that being adverse events or complications associated with the use. And unfortunately, the muscarinics do have substantial anti-muscarinic side effects – dry mouth, constipation – but increasingly, we're recognizing that anti-muscarinics are associated with cognitive issues, cognitive perception, cognitive memory issues because of their interactions with M3 receptors in the central nervous system. But now there's actually quite compelling data that the anti-muscarinics, especially in patients who may be somewhat older, at least from a calendar year standpoint, being at risk for perhaps inception of or an exacerbation of preexistent early dementia or other cognitive dysfunction.

So it's a very important consideration, especially when we consider the older patient. The beta-3s don't have that burden, and so therefore, the beta-3 class generally is a better-tolerated class because it doesn't have the anti-muscarinic side effects and certainly

doesn't have those cognitive decline effects that, again, are so concerning and give us great pause, especially in that large group of patients which constitute older patients who may have some other coexistence of comorbidities.

Dr. Staskin:
For those of you just tuning in, you're listening to CME on ReachMD. I'm Dr. David Staskin, and I'm here with Dr. Roger Dmochowski. We're discussing overactive bladder and the managed care professional.

Yeah, I've seen this, Roger, in my practice. You know, we used to worry about dry mouth, constipation, blurry vision, and certainly in the elderly patient, the cognitive effects. The beta-3 agents have done a good job of keeping the beta-1 effect low so that the hypertension or tachycardia that might be associated with a beta agonist, a general beta agonist, really is seen or has been minimized. In fact, of the 2 drugs, mirabegron does start at a lower dose, and the physician is asked to check a blood pressure before going to the higher dose. And vibegron has been shown to be relatively clear of this elevation of blood pressure and pulse. So again, the beta-3 class has eliminated a lot of the anti-muscarinic side effects, in fact, all of them – they're not anti-muscarinics – and has minimized any type of beta-1 influence on the cardiovascular system.

Let's get into a little bit of a case presentation just to bring this home as to how one might see this in practice. Patient's a 63-year-old G2 P1 woman. She's concerned about urinary symptoms. She has a lot of frequency and urgency. She knows where all the bathrooms are. Occasionally has an accident if she can't make it. It's increased in the last 2 years. She probably goes 10 times a day and maybe up to 3 times at night. She wears a pad for protection because of this. She's had fluid restriction. She has some mild congestive heart failure and some depression, so she is on an antidepressive drug. She takes a diuretic and an antidepressant. There's some family history of cognitive impairment, so she's a little bit concerned about this. Banker, nonsmoker, urinalysis negative, empties her bladder well. Where do you go with this?

Dr. Dmochowski:
Well, you know, David, this type of patient is a very common sort of presentation, and this individual not only has bothersome symptoms, she also has some comorbidities that we need to consider and has a familial risk for dementia and other cognitive dysfunction. So she's already tried some of the behavioral therapies, again, fluid restriction, behavioral modification are clearly there as from a guideline treatment standpoint, and the issue is, is there any room for further management of those? I suspect not. One consideration is management of diuretics and the use of perhaps short-term versus longer-term diuretics, which sometimes helps individuals who are bothered by late afternoon or evening frequency because of diuretic use, which exacerbates the frequency.

But the question then becomes creating reasonable expectations for this individual about what we can and can't do. And clearly in this individual, it sounds like she's probably ready to at least try a pharmaceutical intervention, and again, one of the considerations is drug-drug interaction. Of course, you've already mentioned the diuretics, but she's also on some antidepressant medications, and so we have to be really cautious about the soup that we create from the cytochrome system in terms of adding multiple other medications.

So again, as we look at the various classes of medications, again, we've talked about the various balance between the anti-muscarinics and the beta-3s, and again, for this particular individual, given her comorbidities, I would probably start with a beta-3, assuming, again, that we've got a permissive, if you will, reimbursement circumstance that allows her to have exposure to that medication.

Dr. Staskin:
Of note, mirabegron is metabolized to some degree by 2D6, vibegron not at all by – primarily by 3A4.

So I can understand where you might go as far as that is concerned, and how do you explain this to the patient?

Dr. Dmochowski:
You know, David, I think you have to go into the goals and reasonable expectations, because if they walk out of the door – many patients, unfortunately, contextualize management for overactive bladder to a very similar circumstance with urinary tract infection: 3 days of something's going to cure your symptoms. That's not the circumstance here. This is a chronic condition, they need to be aware for waxing and waning of their symptoms, and really what we're attempting to do is blunt their symptoms to a greater or lesser extent, and the reasonable expectation for treatment should be improvement, not cure.

Dr. Staskin:
Well, this has been a fantastic conversation. It always is with you, Roger. Before we wrap up, do you want to share a primary take-home message about what we've discussed today?

Dr. Dmochowski:
Yeah, I think from the standpoint of frontline care, I think this is about patient engagement, listening to the patient, and listening to what's driven them in on that day and sort of what's really bothering them symptom-wise, because this condition really is bothersome. And then

of course, creating reasonable expectations. Thank you, David.

Dr. Staskin:
Thank you, Roger. And I'd like to say that I think we've been sort of blessed here at a late-stage of anticholinergic history, to be blessed with a different method of action, different mode of action for these drugs. And beta-3s for bladder relaxation, again, as you mentioned earlier, giving us the same general efficacy but removing the anti-muscarinic issues has really made a difference in the last few years in the way we've been treating our patients.

Thank you for joining us.

Announcer:
You have been listening to CME on ReachMD. This activity is provided by Prova Education.

To receive your free CME credit, or to download this activity, go to ReachMD.com/Prova. Thank you for listening.