Learning Objectives

1. Demonstrate a systematic approach to evaluating patients with urinary incontinence.
2. Describe the different types of urinary incontinence and their key clinical features.
3. Compare evidence-based strategies for the management of patients with urinary incontinence in the primary care setting.

Disclosures

- I have nothing to disclose.
Prevalence

ARS: True or False?

Women over the age of 65 living in residential facilities (e.g., assisted living, nursing home) have a higher prevalence of urinary incontinence than similarly aged women living in the community.

Prevalence

2007-2010, Adults living in community or noninstitutionalized


Prevalence

2007-2010, Adults living in residential care facility

So, what is the estimated prevalence?

Risk Factors

- Age
- Obesity
- Parity
- Mode of delivery
- Family history (UUI)
- ? Race
- Comorbidities – smoking, diabetes, CVA, menopause/vaginal atrophy, h/o pelvic radiation

Financial Burden


Affected Domains

Increased Caregiver Burden
Morbidity
Mental Health
Sexual Function
Increased Caregiver Burden
Quality of Life

Mental Health

- Increase in depression and anxiety
  - Depression: 37.6%
  - Anxiety: 53.3%
  - Associated with social isolation


Quality of Life

Sexual Function

- Coital incontinence
  - Almost 1/3 of women
  - Anxiety and fear of leaking related to restricting sexual intercourse
  - Almost 1 in 5 women


Quality of Life

Increased Caregiver Burden

- Caregiver burnout
- Risk factor for nursing home placement (6-10% of admissions)


Quality of Life

Morbidity

- Associated with falls
  - Estimated OR = 1.5-2.3
- Increased frequency → increased self-reported falls (n = 66)
  - 17% with 1X week
  - 60% with daily

Patient Case

TF is a 68 year old G6P5 woman who has a history of obesity (BMI 32), generalized anxiety disorder, and hypertension. She presents to clinic for a follow-up visit. She does not have any acute concerns to discuss.

Her BP today is 126/72 and vital signs are otherwise WNL.

Medications: HCTZ 25mg daily and citalopram 20mg daily

ARS: Multiple Choice

Do you want to screen TF for urinary incontinence?

A. Yes because she has risk factors
B. Yes because all patients should be screened
C. Yes because all geriatric patients should be screened
D. No because she is asymptomatic and would mention symptoms of urinary incontinence if she experienced them
E. No because it is not recommended that all patients should be screened

Screening for Urinary Incontinence

- Most societies are in agreement that we should screen higher risk patients routinely
- Of note, 50% of women with urine leakage at least once per week did not seek care for their symptoms
Should we routinely screen our patients for urinary incontinence?

How many of us routinely screen?

Screening Guidelines

Examples

ARS: Multiple Choice
You decide to screen TF for urinary incontinence. How would you do this?

A) I would just ask her if she’s having symptoms
B) I would ask as part of my ROS
C) I would use a screening tool
D) I do not need to ask because my team in clinic (e.g., MA or RN) already asks patients about these symptoms
Screening Tools

Clinical Tool: The 3IQ
The 3 Incontinence Questions

- Really a screening and diagnostic tool
- For screening, use question 1:

  "During the last 3 months, have you leaked urine (even a small amount)?"


Summary
Background and Screening

- Urinary incontinence is highly prevalent affecting almost 1/3 of women
- Core professional societies are in agreement that we should screen patients
- A useful screening tool is "The 3IQ" and is freely available in PDF version online (Annals, JAMA, NEJM)

Evaluating Urinary Incontinence
Patient Case

TF reports that she has had years of leaking a little urine which started after the birth of her second child. It used to be manageable but became more bothersome in the last 10 years. Now, she leaks urine every time she coughs and sneezes. She also reports that at times she gets the urge to urinate and has an accident when she can’t make it to the toilet in time. This happens a couple of times a month.

She hasn’t told you about it before because she thinks it’s “just a part of getting older.”

Approach to Evaluation of UI: 4 Key Steps

- **History**
  - Identify type, assess severity, and rule out other causes
- **Exam**
- **Workup**
- **Treatment**

**History**

**Main Goals**

1. Identify the type of urinary incontinence
2. Assess the severity of symptoms
3. Rule out reversible causes
Three Main Types of Urinary Incontinence

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>50%</td>
</tr>
<tr>
<td>Urges</td>
<td>16%</td>
</tr>
<tr>
<td>Mixed</td>
<td>34%</td>
</tr>
</tbody>
</table>

Comparison of Urinary Incontinence

<table>
<thead>
<tr>
<th>Type</th>
<th>Stress</th>
<th>Urges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Loss of urine associated with increased abdominal pressure</td>
<td>Sudden desire to urinate</td>
</tr>
<tr>
<td>Pathophysiology</td>
<td>Sphincter weakness; bladder pressure &gt; urethral resistance</td>
<td>Detrusor muscle overactivity + uninhibited bladder contraction</td>
</tr>
<tr>
<td>Examples</td>
<td>Childbirth</td>
<td>Idiopathic</td>
</tr>
<tr>
<td>of Etiology/Comorbid Conditions</td>
<td>Obesity</td>
<td>Recurrent UTIs</td>
</tr>
<tr>
<td>History</td>
<td>Can usually predict activities that will lead to leakage</td>
<td>Atrophic vaginitis</td>
</tr>
<tr>
<td></td>
<td>Two key features: frequency, nocturia</td>
<td>Impaired functional status</td>
</tr>
</tbody>
</table>

Back to the Clinical Tool: The 3IQ

The 3 Incontinence Questions

- Really a screening and diagnostic tool
- Test characteristics (n = 300)
  - Stress (sens 86%, spec 60%)
  - Urge (sens 75%, spec 77%)
- For diagnosis urinary incontinence, use question 3

History
Main Goals

1. Identify the type of urinary incontinence
2. Assess the severity of symptoms
3. Rule out reversible causes

Questionnaires: Symptoms and QoL
Examples of Validated Questionnaires from ACOG Practice Bulletin

UDI: Symptoms and QoL

Simplest Questionnaire
Patient Global Impression of Severity and Improvement (3 Items)
History

Main Goals

1. Identify the type of urinary incontinence
2. Assess the severity of symptoms
3. Rule out reversible causes

Reversible Causes

DIAPPIERS mnemonic

D Delirium
I Infection (urinary tract) or Irritants
A Atrophic vaginitis or urethritis
P Pharmaceuticals
P Psychiatric conditions
E Endocrine disorders (diabetes, hypercalcemia)
R Restricted mobility
S Stool impaction

Patient Case

TF completes the 3IQ and is diagnosed with stress-predominant urinary incontinence.

Her UDI score is 6 and she is moderately distressed by her symptoms of frequency, urge, and stress equally.

Her symptoms occurred before the initiation of her HCTZ and SSRI and she has not noted any worsening of symptoms since starting this medication.

ARS: Yes or No

Do we need a physical exam to make the diagnosis of stress-predominant urinary incontinence for TF?

A. Yes
B. No
Approach to Evaluation of UI: 4 Key Steps

- **History**
  - Identify type, assess severity, and rule out other causes

- **Exam**
  - Cough stress test

- **Workup**

- **Treatment**

When is a physical exam necessary?

- Can be part of routine preoperative evaluation
- Atypical symptoms
- Diagnostic uncertainty
- Concern for:
  - Vaginal atrophy
  - Pelvic mass
  - Advanced pelvic organ prolapse beyond the hymen

---

**Physical Exam Maneuvers**

**Cough Stress Test**

- PE not required to make diagnosis of stress UI
- How to perform
  - Start with patient in lithotomy position or standing
  - Comfortably full bladder
  - Ask patient to cough
  - Objective demonstration of fluid loss
  - PPV for stress: 78-97%

**Reference:**

---

**Physical Exam Maneuvers**

**Cough Stress Test**

- If **POSITIVE** → treat for stress urinary incontinence/proceed to surgery
- If **NEGATIVE** → repeat
  - Full bladder (≥ 300 cc)
  - Standing only
- If **NEGATIVE TWICE** but high pretest probability → consider urodynamic testing

**Reference:**
Physical Exam: Pelvic Floor Muscle Examination

Physical Exam: Urethral Mobility Testing (Ob/Gyn)

Approach to Evaluation of UI: 4 Key Steps

- **History**
  - Identify type, assess severity, and rule out other causes

- **Exam**
  - Cough stress test

- **Workup**
  - Urinalysis
  - +/- Postvoid residual

- **Treatment**

Workup

- Urinalysis for ALL patients to rule out:
  - Infection
  - Microscopic hematuria
  - Proteinuria and glycosuria

- PVR (negative is < 100 mL) – not required for all patients
  - If elevated, test should be repeated
  - If persistently elevated → urodynamic testing
When should I refer a patient for urodynamic testing?

### Urodynamic Testing

**Indications**
- No consensus guidelines
  - Do not recommend in initial evaluation
- AHRQ systematic review of office evaluation vs urodynamic testing
- Exceptions:
  - Red flags (e.g., hematuria, neuro)
  - Unclear diagnosis
  - Culture-proven recurrent UTIs (≥3 in 1 year or 2 in 6 months)

### Approach to Evaluation of UI: 4 Key Steps

- **History**
  - Identify type, assess severity, and rule out other causes
- **Exam**
  - Cough stress test
- **Workup**
  - Urinalysis
  - +/- Postvoid residual
- **Treatment**
  - Goals and expectations
  - Review behavioral treatments

### Summary

- Identifying the type and severity of UI is important for the management and treatment of this condition
- The diagnosis of UI may not require a general physical exam or specific maneuvers but can be helpful for some patients with diagnostic uncertainty or to aid in surgical treatment plans
- A urinalysis should be performed for all patients
- Engage the patient in a discussion of goals and expectations before initiating treatments
Patient Case

After a discussion of TF’s symptoms and affect on her quality of life, she decides that she would like to discuss what treatments are available for her.

Given that she has stress-predominant urinary incontinence, you start by discussing all the available treatments this condition.

ARS: Multiple Choice

Which of the following treatments for stress urinary incontinence has poor evidence to support its use?

A. Pelvic floor muscle therapy (aka Kegel exercises)
B. Weight loss
C. Pessaries
D. Surgery

Treatment for Urinary Incontinence

<table>
<thead>
<tr>
<th>Nonpharmacologic or Behavioral Therapy (First line, at least 6 weeks)</th>
<th>Stress</th>
<th>Urge</th>
</tr>
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<tbody>
<tr>
<td>Pelvic floor muscle therapy (aka Kegel exercises)</td>
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<td>Weight loss</td>
<td>• Weight loss</td>
<td>• Weight loss</td>
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<tr>
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<td>• Biofeedback</td>
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</tr>
<tr>
<td>Other Therapies</td>
<td></td>
<td>Fluid recommendations</td>
</tr>
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<td>• Vaginal estrogen</td>
<td>• Fluid recommendations</td>
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<tr>
<td>Pessaries</td>
<td>• Pessaries</td>
<td>• Bladder training</td>
</tr>
<tr>
<td>Surgery</td>
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</tr>
</tbody>
</table>

Other Therapies

- Vaginal estrogen
- Pessaries
- Surgery
- Anticholinergics
- Beta agonists

Evidence for Kegel Exercises

Top 3 Learning Points

1. First line therapy
2. 3s and 10s
3. Increased continence rates and improved symptoms

How do we teach Kegel exercises?
Evidence for Kegel Exercises
Top 3 Learning Points

1. First line therapy
2. 3s and 10s
3. Increased continence rates and improved symptoms
   - NNTs = 2-3


Evidence for Weight Loss
Top 3 Learning Points

1. Obese women have >4x risk of incontinence
2. Moderate weight loss (5-10%) can improve symptoms
   - RCT with decrease in weekly incontinence episodes (28% vs 47%) for women assigned to intensive 6 month weight loss program (n = 338)
   - > 50% reduction in SUI after bariatric-surgery induced weight loss
3. Stress > urge


Evidence for Biofeedback
Top 3 Learning Points

1. Helpful if unable to isolate pelvic floor muscles
2. Improved continence rates when compared to PFMT alone and no treatment
3. May be covered by Medicare

Treatment for Urinary Incontinence

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<tr>
<td>• Surgery</td>
<td></td>
<td></td>
</tr>
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</table>


Topical Estrogen

**Top 3 Learning Points**

1. Trial for peri- or postmenopausal women with vaginal atrophy due to genitourinary syndrome of menopause (GSM)
2. Can take up to 3 months for treatment response
3. Systemic estrogen therapy can worsen incontinence symptoms

Dosing of Topical Estrogen for GSM

<table>
<thead>
<tr>
<th>US trade name</th>
<th>Formulation</th>
<th>Available strength</th>
<th>FDA-approved regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premarin</td>
<td>Cream</td>
<td>0.625mg conjugated estrogens per g</td>
<td>0.5g intravaginally twice weekly</td>
</tr>
<tr>
<td>Estrace</td>
<td>Cream</td>
<td>100mcg estradiol per g</td>
<td>0.5g intravaginally daily x 2 weeks → reduce to twice/wk</td>
</tr>
<tr>
<td>Estring</td>
<td>Ring</td>
<td>7.5mcg estradiol/day released over 90 days</td>
<td>Ring is inserted and removed/replaced every 90 days</td>
</tr>
<tr>
<td>Vagifem</td>
<td>Vaginal insert</td>
<td>10mcg estradiol per insert</td>
<td>1 tablet intravaginally daily x 2 weeks → reduce to twice/wk</td>
</tr>
</tbody>
</table>

Evidence for Pessaries
Evidence for Pessaries
Top 3 Learning Points

1. Fit is important!
2. Follow-up is needed
3. May be effective non-surgical management (though data are mixed)

Evidence for Surgical Repair
Top 3 Learning Points

1. Dependent on type of repair and presence of prolapse
2. Most robust data for midurethral sling
3. Satisfaction generally significantly higher than conservative treatments
Summary: Treatment

Stress Urinary Incontinence

- Behavioral therapies should be initiated first for all patients regardless of type of incontinence
- PFMT has high-quality evidence to support its use
- Consider topical estrogen for patients with GSM
- Pessaries may be helpful for some patients but need more robust data to understand who may benefit
- Surgical repair, especially in the presence of pelvic organ prolapse, can lead to higher satisfaction and cure rates as compared to conservative treatments

Patient Case

You counsel TF on behavioral treatments for her urinary incontinence. You spend time in your visit teaching her how to perform Kegel exercises. You plan to follow-up with a telephone visit in 2 weeks to check and see how the exercises have been going and to offer support.

You discuss weight loss strategies and provide additional support with your clinic nutritionist.

Treatment for Urinary Incontinence

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<tr>
<td>Bladder training</td>
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</tr>
</tbody>
</table>

Other Therapies

- Vaginal estrogen
- Pessaries
- Surgery
- Anticholinergics
- Beta agonists

Evidence and Recommendations for Fluid Intake

Top 3 Learning Points

1. Expert/consensus opinion
2. Trickle versus bolus
3. The power of voiding diaries


Clinical Tool: Daily Bladder Diary

Your Daily Bladder Diary

The diary will help you and your healthcare team figure out the cause of your bladder control trouble. The next steps show how to use the diary.

<table>
<thead>
<tr>
<th>Time</th>
<th>Urine</th>
<th>Time to the Bathroom</th>
<th>Accident</th>
<th>leak</th>
<th>What were you doing 1 hour before the leak?</th>
<th>Where were you when you got the urge?</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-9 AM</td>
<td>yes</td>
<td>6 PM</td>
<td>No</td>
<td>No</td>
<td>Walking</td>
<td>Running</td>
</tr>
<tr>
<td>1-2 PM</td>
<td>no</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Deep breathing</td>
<td></td>
</tr>
<tr>
<td>2-3 PM</td>
<td>yes</td>
<td>6 PM</td>
<td>No</td>
<td>No</td>
<td>Knowledge puzzle</td>
<td></td>
</tr>
</tbody>
</table>

Evidence for Bladder Training

Top 3 Learning Points

- First, what comprises bladder training?

Bladder Training

Steps

- Day 1: Document all voids for 24 hours
- Day 2: Choose the shortest voiding interval (e.g., 45 minutes) and try to void at this interval regularly while you are awake
  - If you get a strong urge to go to the bathroom before the time interval, use relaxation/distraction methods (e.g., deep breathing, knowledge puzzle) and only go to bathroom when in control of bladder.
- Keep this schedule until you can go a full day without leakage
  - Then, add 15 minutes to the time interval and repeat Day 2


Clinical Tool: Bladder Training

Educational & behavioral processes to re-establish urinary control & reduce symptoms

Scheduled voiding regimen

Urgency control strategies

Self-monitoring of voiding behaviors (diaries)

Positive enforcement by primary care team

Evidence for Bladder Training

Top 3 Learning Points

1. Expert/consensus opinion
2. Urge > Mixed > Stress
3. Data is mixed


Treatment for Urinary Incontinence

<table>
<thead>
<tr>
<th></th>
<th>Stress</th>
<th>Urge</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td></td>
<td>Pessaries</td>
<td>Beta agonists</td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
<td></td>
</tr>
</tbody>
</table>


Patient Case

Six months later at an in-person follow-up visit with TF, she notes that she has had some improvement in her stress symptoms.

She continues to have some urge symptoms as well which are only mildly bothersome to her based on her UDI scoring.

She wonders what her options are for treatment of her urge symptoms.

ARS: Multiple Choice

If you were to choose a first line anticholinergic for TF, what would it be?

A. Darifenacin (Enablex)
B. Fesoterodine (Toviaz)
C. Mirabegron (Myrbetriq)
D. Oxybutynin (Ditropan)
E. Solifenacin (Vesicare)
F. Tolterodine (Detrol)
G. Trospium (Sanctura)
Evidence for Anticholinergics

Top 3 (or 4!) Learning Points

Medications Used in Urinary Incontinence
For Women

- Anticholinergics/antimuscarinics
  - Darifenacin (Enablex)
  - Fesoterodine (Toviaz)
  - Oxybutynin (Ditropan)
  - Solifenacin (Vesicare)
  - Tolterodine (Detrol)
  - Trospium (Sanctura)
- Beta agonist
  - Mirabegron (Myrbetriq)

Summary of Anticholinergics (decr contractility)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Formulation</th>
<th>Starting Dose</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darifenacin (Enablex)</td>
<td>ER</td>
<td>7.5mg daily</td>
<td>15mg daily</td>
</tr>
<tr>
<td>Fesoterodine (Toviaz)</td>
<td>ER</td>
<td>4mg daily</td>
<td>8mg daily</td>
</tr>
<tr>
<td>Oxybutynin (Ditropan)</td>
<td>IR, ER, TD</td>
<td>5mg BID-TID (IR)</td>
<td>30mg daily (ER)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5mg daily (ER)</td>
<td>Patch belt per week</td>
</tr>
<tr>
<td>Solifenacin (Vesicare)</td>
<td>ER</td>
<td>5mg daily</td>
<td>10mg daily</td>
</tr>
<tr>
<td>Tolterodine (Detrol)</td>
<td>IR, ER</td>
<td>1mg BID (IR)</td>
<td>2mg BID (IR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2mg daily (ER)</td>
<td>4mg daily (ER)</td>
</tr>
<tr>
<td>Trospium (Sanctura)</td>
<td>IR, ER</td>
<td>20mg daily (IR)</td>
<td>20mg BID (IR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>60mg daily (ER)</td>
<td>Same as starting (ER)</td>
</tr>
</tbody>
</table>
### Evidence for Anticholinergics

Top 3 (or 4!) Learning Points
1. Magnitude of effect is modest for all 6 and need more head to head trials
   - Reduction in episodes (53-80%) and frequency (12-32%)
     - Placebo = 30-47% and 8-15%, comparatively
2. Discontinuation due to adverse effects is common (dry mouth = #1)
3. Role of ER versus IR
4. Medication + behavioral therapy is more effective than either alone

### Medication Summary

<table>
<thead>
<tr>
<th>Medication</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Darifenacin (Enablex) | *Geriatric population*  
- CNS effects (does not cross blood-brain barrier)  
- Dose adjustments in liver failure |
| Fesoterodine (Toviaz) | - CNS effects (does not cross blood-brain barrier)  
- Dose adjustments in renal and liver failure |
| Oxybutynin (Ditropan) | *First line*  
- IR may be useful when continence is needed at specific times  
- Patch has less AEs  
- Most AEs as compared to other meds in this class  
- Reduced doses/avoid for older adults |
| Solifenacin (Vesicare) | - CNS effects (does not cross blood-brain barrier)  
- Dose adjustments in renal and liver failure  
- QTc prolongation |
| Tolterodine (Detrol) | *First line with fewer AEs*  
- Fewer AEs than oxybutynin  
- Dose adjustments in renal and liver failure  
- QTc prolongation |
| Trospium (Sanctura) | *Geriatric population*  
- Not metabolized by CYP  
- Few drug-drug interactions  
- CNS effects (does not cross blood-brain barrier)  
- Dose adjustments in renal failure |

### How much do these medications cost?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Cost (Avg/mo per GoodRx)</th>
<th>SFHP MediCal Target</th>
<th>Target $15/mo/$10 (1 mos)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darifenacin (Enablex)</td>
<td>$331.77</td>
<td>Not on formulary</td>
<td>No</td>
</tr>
<tr>
<td>Fesoterodine (Toviaz)</td>
<td>$408.73</td>
<td>Not on formulary</td>
<td>No</td>
</tr>
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| Oxybutynin (Ditropan) | $43.33 for IR  
$99.48 for ER  
IR and ER tablets covered (T1) | Yes                  |                          |
| Solifenacin (Vesicare) | $443.51                  | Not on formulary     | No                       |
| Tolterodine (Detrol) | $221.66                  | Covered but PA required (T3) | No                      |
| Trospium (Sanctura) | $110.20                  | Covered but PA required (T3) | No                      |
| Mirabegron (Myrbetriq) | $442.64                  | Not on formulary     | No                       |

### Mirabegron

**Summary**
- **Class** = beta-adrenergic agonist
- Can be used as initial (likely needs PA) or adjuvant therapy
- **AEs** = hypertension and cardiac arrhythmia
- **How does it compare to antimuscarinics?**
  - Less AEs (e.g., dry mouth, constipation) and less retention
  - Median time-to-discontinuation is delayed (169 days for mirabegron vs 30-78 days for antimuscarinics)
  - Similar clinical outcomes to antimuscarinics
Summary: Treatment

Urge Urinary Incontinence

- Behavioral therapies, including PFMT, fluid guidelines, and bladder training should be initiated first for all patients though the latter two are based on expert opinion
- Reasonable to start with ER formulations and monitor Q2-4 weeks
- Oxybutynin has most adverse effects of all the anticholinergics though is typically still 1st-line agent
- Mirabegron could be considered as a 2nd-line agent (instead of 3rd or 4th) though cost may limit its use in clinical practice

Patient Case

TF chooses not to start a pharmacologic therapy at this time though she is interested in learning about other therapies that are available.

She has heard of acupuncture and nerve stimulation for urinary incontinence treatment and wants to know if you would recommend this or not?

Additional Therapies

- Vaginal weighted cones – held in place during PFMT, no rx needed
- Duloxetine for stress incontinence – low quality, small trials suggest improvement in QoL and decreased incontinence episodes
  - 1 in 3 patients reported AEs
- Intravesical balloon device and urethral bulking agents
- Botulinum toxin – injection into detrusor mm, high risk of urinary retention
Areas for Future Research in UI Treatments

- Medications for stress urinary incontinence
- Urinary microbiome
- Treatments for overactive bladder (+/- incontinence sx)
  - Sacral neuromodulation
  - Percutaneous tibial nerve stimulation
- Acupuncture and Electroacupuncture
  - Initial studies show short-term improvements in QoL and decreased urinary frequency

Summary

- Urinary incontinence is common and our patients may be affected by this so we should ask them about it.
- The evaluation of urinary incontinence involves 4 key areas:
  1. History
  2. Physical exam = if helpful or additive for diagnosis or mgmt
  3. Workup = urinalysis for everyone
  4. Treatment
- Nonpharmacologic treatments for urinary incontinence are first-line and should be initiated prior to referral to specialist clinics.

References

References