

## Calming the overactive bladder: a nurse practitioner perspective\*

By Helen A. Carcio, MS, MEd, ANP-BC



Overactive bladder (OAB) is not a single entity but, rather, a symptom complex consisting of urgency, with or without *urge incontinence*, and often frequency and nocturia. The hallmark symptom is urgency, a compelling desire to urinate that is difficult or impossible to defer.<sup>1</sup> The urgency is caused by detrusor hyperactivity. Urge incontinence ranges from leakage of a few drops of urine to a full gush, and occurs when contractile forces of the bladder overcome the ability of the pelvic floor muscles (PFMs) and urethral sphincter to retain urine.<sup>2</sup> Urgency and leakage can be triggered by certain events, such as unlocking the door to one's house upon return (*key-in-lock syndrome*), approaching a toilet, or hearing running water.<sup>3</sup> Like urge incontinence, *stress urinary incontinence* (SUI) entails an involuntary loss of urine. With SUI, urine loss occurs as a result of physical exertion (e.g., heavy lifting) or performing certain activities (e.g., coughing, sneezing, running), whereas with urge incontinence, urine loss is preceded by a sudden, intense urge to urinate.<sup>1</sup>

OAB is not life threatening, but it is *lifestyle* threatening.<sup>4</sup> Patients with OAB need not suffer with it, though. OAB can be identified quickly, by a nurse practitioner (NP) or even by a woman herself, and it can be managed fairly easily.

### Assessment

If properly educated about OAB, a woman can recognize the symptoms of it herself—urgency, alone or with urge incontinence, and possibly accompanied by frequency and nocturia—and then seek help from her NP in managing the symptoms. A detailed assessment enables the NP to confirm the di-

agnosis of OAB.<sup>5</sup> The assessment includes a health history, a focused physical examination, and office-based tests. The health history includes a symptom review, precipitating events, fluid intake, and medication use. A bladder diary, in which patients record fluid intake, voids, urges, and incontinence episodes for 3 days, lends objectivity to information provided in the health history.<sup>6</sup>

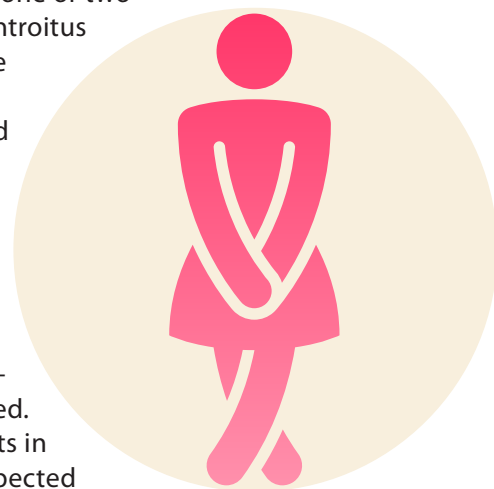
The focused physical examination includes a gynecologic exam to assess the bladder and PFM strength. The levator ani is palpated just inside the introitus at the 5 o'clock and 7 o'clock positions. The examiner inserts one or two fingers into the introitus to the level of the first knuckle. The fingers are placed directly on the levator ani and the woman is asked to squeeze tightly. Strength and symmetry of contractions are noted.

Diagnostic tests in women with suspected OAB include a urinalysis (UA), a postvoid residual (PVR), and a simple cystometrogram (CMG). A UA is performed to rule out a urinary tract infection. Presence of glucosuria, proteinuria, or hematuria requires further investigation. A PVR, ideally obtained within 5 minutes of voiding, helps determine bladder emptying capability. The amount of PVR is the integral result of bladder contractility and urethral resistance testing; a value of  $\leq 100$  cc is considered normal. A high value may indicate an inability to contract against an increase in urethral pressure or a hypotonic bladder. A simple CMG documents the presence of detrusor contractions related to OAB. Presence of involuntary bladder contractions and/or severe urgency at relatively low bladder volumes (250 cc) suggests urge incontinence.<sup>7</sup>

### Management

Several conservative therapeutic options are available. Combination therapies are most effective.<sup>8</sup> These measures are summarized and prioritized:

- Bladder training to re-educate the bladder to



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- delay the urge between voids;
- Following a prescribed voiding schedule to "normalize" bladder habits;
- Dietary changes to exclude consumption of acidic substances that irritate the bladder;
- PFM rehabilitation to strengthen the PFMs for better control;
- Biofeedback to isolate the PFMs and increase strength;
- Urge control distraction techniques (e.g., using active PFM contraction to reflexively calm the bladder);
- Electrical stimulation to promote bladder relaxation;
- Support devices (e.g., pessaries) to realign the pelvic anatomy;
- Anticholinergic medication to calm the bladder muscles and allow for better bladder filling;
- Vaginal estrogen therapy to revascularize the vaginal mucosa, urethra, and PFMs; and
- Other lifestyle changes such as fluid management, weight loss, and control of constipation.<sup>8</sup>

Percutaneous tibial nerve stimulation can be used for refractory cases. Surgery is rarely indicated.<sup>8</sup>

### Closing the gap

A major gap exists between the number of women affected by OAB and the number seeking treatment for it. Many women hesitate to discuss their symptoms with a healthcare provider; in fact, 50% of women with bladder problems, no matter how bothersome, do not mention them at patient visits.<sup>4</sup> Women wait an average of 3 years before seeking treatment, despite the fact that bladder symptoms dramatically interfere with quality of life.<sup>4</sup> Toilet-seeking activities compromise social interactions, sleep, job opportunities, sexual relations, and overall health, often leading to depression and isolation. These feelings are compounded by a sense of hopelessness about gaining relief for their bothersome symptoms. If these women were more knowledgeable about OAB, they would recognize it when it arises and understand that treatment is available.

However the very nature of the symptom complex—urgency, with or without urge incontinence, and often frequency and nocturia—makes it possible

**Table.** NPWH member survey data on OAB

Are you confident....	Yes	No
In your in ability to accurately identify patients with OAB?	48.3%	51.7%
In your ability to effectively treat OAB?	41.1%	58.9%
That most patients with OAB in your practice have been identified?	28.5%	71.5%

NPWH, National Association of Nurse Practitioners in Women's Health; OAB, overactive bladder.

for women to easily identify their own symptoms as being OAB. NPs are in an excellent position to be proactive and educate all their patients about the symptoms of OAB—an easily self-recognizable condition.

**50% of women with bladder problems do NOT mention them at patient visits.**

The National Association of Nurse Practitioners in Women's Health (NPWH) surveyed 300 NPs to ascertain their own level of recognition and treatment of OAB in their practice (H.A.C., unpublished NPWH member survey data, 2013). Although most respondents could identify common symptoms of OAB and its adverse effect on quality of life, more than half reported that they lacked confidence in their ability to accurately identify OAB and more than half reported lacking sufficient knowledge to effectively treat OAB (*Table*).

### Clinical implications

Nurse practitioners have an opportunity to emerge as front-line practitioners in educating patients about OAB, as well as in diagnosing and treating OAB.<sup>3</sup> NPs are ideally suited for this role because they have the motivation, teaching skills, and enthusiasm needed to support patients in pursuing better bladder health. NPs can start by posing a simple question to each patient: "Do you feel you have total control of your bladder?" Even if a patient denies having urinary symptoms at a given visit, she can be informed about OAB so that if it develops, she can recognize it on her own and bring it to her NP's attention.

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With continued emphasis on OAB in academic programs and national conferences, NPs can educate themselves to face this challenge. Nearly all NPs in the NPWH survey (99.3%) responded affirmatively when asked if they wanted to receive more information on OAB. To get more information, including templates for use in OAB management, and to access educational resources and training seminars, readers can contact the **Health & Continence Institute website**. ●

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