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Update on Management of Overactive Bladder

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Conservative treatment and pharmacotherapy are the mainstays of treatment in patients with overactive bladder (OAB). The majority of patients will have sufficient relief with these treatment modalities or do not want to go beyond that for a more invasive approach. However a limited group mostly with more severe and longstanding symptoms will request further therapy.

In any patient the first approach must be confirmation of the diagnosis. A control for abnormal drinking and voiding behaviour and exclusion of infection will be the first things to do. After checking for major anatomical abnormalities, the next step most often will be a urodynamic examination in order to elucidate the underlying pathophysiology of the documented symptoms.

If the diagnosis is confirmed it is worthwhile in most patients to check if they had prior pharmacological treatment and if so if it was correctly prescribed (optimal choice of drug and dosage) and if the drugs were taken during an appropriate period in order to have a significant effect on the symptoms. Anyhow it be a good option to switch the drug or the dosage and motivate the patient to try pharmacological treatment again. Different drugs are available.

Antimuscarinic agents have quantifiable clinical benefits in the management of OAB, according to recent analysis of data from 56 randomised controlled trials (RCTs). However, there are clinically significant differences in aspects of efficacy and tolerability among compounds in this class. For example, extended-release (ER) oxybutynin produced a greater reduction in incontinence episodes compared with tolterodine ER, and a greater proportion of oxybutynin ER recipients returned to continence. Furthermore, solifenacin reduced micturition frequency and urgency symptoms to a significantly greater extent than immediate-release (IR) tolterodine.

Similarly, although antimuscarinics are generally safe and well tolerated, there are important tolerability differences among the various antimuscarinic agents. Oxybutynin IR (at dosages >7.5 mg/day) was consistently associated with higher rates of adverse events than other antimuscarinic compounds; the risk of withdrawal from treatment because of adverse events is 40% higher with oxybutynin than with other agents. It is clear that antimuscarinics have different safety and tolerability profiles, which are clinically significant.

Thus, the clinician must consider both the safety and efficacy aspects of antimuscarinic agents when selecting an appropriate treatment for OAB. The "ideal" antimuscarinic agent can be described as one which:

- Relieves symptoms by suppressing involuntary bladder contractions without inhibiting volitional bladder-emptying function
- Is 100% bladder-selective with negligible effects on the muscarinic receptors of other organ systems
- Is easy to administer with no clinically significant drug-drug interactions

Recently we build up experience with a new antimuscarinic, Solifenacin. It is a competitive muscarinic-receptor antagonist with selectivity for the urinary bladder relative to salivary glands. In in vitro and in vivo animal studies to evaluate selectivity to bladder over salivary gland, solifenacin showed higher bladder selectivity than other antimuscarinic agents. The pharmacokinetics of solifenacin are not markedly influenced by age, gender or ethnicity, and solifenacin does not affect the pharmacokinetics of digoxin, oral contraceptives, or warfarin. The half-life of solifenacin is long (45–68 hours), and steady-state plasma concentrations of the compound are attained after 10 days. Solifenacin is administered once daily, at an initial dose of 5 mg with an option to increase to 10 mg, with or without food.

As a last resort in the treatment of OAB if pharmacotherapy fails, four types of treatment are available: intravesical instillations, injection therapy, electrical neuromodulation and finally surgery.

With these modalities available, it must be possible to find a solution for nearly every patient with OAB.