



## BLADDER DISORDERS: COMMON ISSUES AND SOLUTIONS- AN UPDATED REVIEW OF OVERACTIVE BLADDER

Abdullah Saleh Alshowmer\*, Abdullatif Suliman Alsayegh, Mohammed Abdullah Alduaybi, Omar Hussain Alsomali, Meshal Ibrahim Zaid Al Owias, Mohammed Ayyat alanazi, Khalid Ali Almzairie and Amal Thani alenazi

KSA, National Guard Health Affairs.

<https://shorturl.at/1jsbh>



\*Corresponding Author: Abdullah Saleh Alshowmer

KSA, National Guard Health Affairs.

<https://shorturl.at/1jsbh>

Article Received on 05/12/2015

Article Revised on 25/12/2015

Article Published on 15/01/2016

### ABSTRACT

**Background:** Overactive bladder (OAB) significantly impacts the quality of life in older adults, with a prevalence of 12.8% among women and 10.8% among men in Europe and Canada. The condition is particularly prevalent in those aged over 65, contributing to an increased risk of falls and fractures. The financial burden associated with urinary symptoms in this demographic is substantial, leading to projections of 52 million adults in the U.S. experiencing lower urinary tract symptoms by 2025. **Aim:** This review aims to provide an updated overview of the evaluation and management of OAB in vulnerable elderly populations, emphasizing the need for tailored approaches due to their unique health challenges. **Methods:** A comprehensive literature review was conducted, focusing on recent guidelines and studies related to OAB management in the elderly. The review also highlights the multifactorial nature of urinary symptoms and the necessity for holistic evaluation methods that address individual health circumstances. **Results:** The findings indicate that OAB in the elderly should not be treated as an isolated condition but as part of a broader spectrum of health issues. Diagnostic evaluations must include assessments of comorbidities, cognitive function, and functional mobility. Treatment strategies emphasize behavioral modifications, lifestyle changes, and individualized care plans to improve outcomes and quality of life. **Conclusion:** A patient-centered, multidisciplinary approach is vital in managing OAB among vulnerable elderly patients. By understanding the interplay of health factors, clinicians can offer more effective treatments that prioritize the patients' overall health and well-being.

**KEYWORDS:** Overactive bladder, Elderly, Urinary incontinence, Geriatric syndromes, Management, Diagnosis.

### INTRODUCTION

Urinary issues, such as urgency, frequency, and incontinence, become increasingly common with advancing age.<sup>[1][2]</sup> A substantial multinational population-based survey estimated that the prevalence of overactive bladder (OAB) is 12.8% among women and 10.8% among men in Europe and Canada.<sup>[2]</sup> The NOBLE (National Overactive Bladder Evaluation) study indicated comparable patterns in the United States, revealing that OAB is twice as prevalent in individuals over 65 years old compared to those aged 45 years or younger.<sup>[3]</sup> Urinary symptoms significantly detriment quality of life and health among the elderly,<sup>[4][5]</sup> and they have been associated with an elevated risk of falls and fractures.<sup>[6][7]</sup> The financial implications of urinary symptoms in older adults are considerable.<sup>[8][9]</sup> With the aging demographic, projections suggest that by 2025, approximately 52 million adults in the United States will experience lower urinary tract symptoms.<sup>[10]</sup>

Consequently, the societal burden of these symptoms is on the rise. Even within the frail elderly population, the morbidity linked to OAB can be significantly alleviated through appropriate assessment and treatment. The frail elderly are, by definition, a particularly susceptible group; thus, the evaluation and management of lower urinary tract symptoms require a cautious approach. In the broader population, protocols for assessment and available treatment options can be contentious and frequently exhibit less-than-optimal efficacy. Given that urinary disorders in older adults are often exacerbated by numerous medical comorbidities, clinical frameworks suitable for the general population may be further compromised. Although there is a lack of level 1 evidence for interventions targeting the frail elderly, and clinical trials seldom include this demographic, we present a review of the evaluation and management of OAB in vulnerable elderly patients within the context of a geriatric syndrome.

### Overactive bladder

Overactive bladder (OAB) is characterized by symptoms such as urinary urgency and frequency, often accompanied by urinary incontinence. The International Continence Society defines OAB as “urgency, with or without urge incontinence, typically with increased frequency and nocturia”<sup>[11]</sup> Consequently, OAB represents a symptom cluster rather than a definitive diagnosis with specific pathophysiological implications. In younger populations, a thorough assessment of OAB symptoms is often unproductive, leading to the interpretation of the OAB symptom complex as a diagnosis itself, which subsequently results in treatment approaches that are primarily aimed at “OAB.” Recently published guidelines by the American Urological Association outline recommended protocols for the diagnosis and management of OAB in the general population.<sup>[12]</sup> However, these guidelines may not be directly applicable to specific demographics, such as the vulnerable elderly. In such cases, it may be more appropriate to regard OAB as a defined symptom complex and to base treatment on a comprehensive diagnostic evaluation that transcends a bladder-centric approach. The guidelines from the American Urological Association/Society of Urodynamics, Female Pelvic Medicine, and Urogenital Reconstruction for diagnosing and managing OAB recommend an initial diagnostic workup that includes a comprehensive history, physical examination, and urinalysis to accurately characterize a patient’s OAB symptoms and rule out other potential disorders with similar presentations. The patient history should encompass information regarding voiding frequency, fluid consumption, comorbidities, and medications. The physical examination should also assess cognitive function. Initial treatment strategies should focus on education and behavioral therapies, prioritizing the establishment of realistic goals tailored to the specific patient. The significance of setting achievable goals and avoiding potentially unsafe or ineffective treatments is particularly pertinent when managing the frail elderly. While the etiology of OAB should be considered in all cases, the depth of evaluation and therapeutic intervention is highly individualized, especially in older adults. OAB is a perceptual syndrome linked to the control of bladder volumes.<sup>[13]</sup> Proper bladder volume management requires maintaining low pressure, having a sufficient urine reservoir in the bladder, the capacity to relax the sphincter mechanism, and the contraction of the smooth detrusor muscle to facilitate voiding at appropriate times and locations, along with the central abilities to perceive and control these dynamics. OAB symptoms reflect the perception of deficiencies in one or more of these areas. Unfortunately, these symptoms often fail to provide significant insight into the specific functional disorder or combination of disorders, which is why some diagnostic evaluation is recommended before initiating treatment.

### Vulnerable or frail elderly

Aging is associated with a continuous (and not necessarily linear) decline in an individual’s ability to adapt to various stressors that arise from the interaction of environmental factors with the physiological and biological impacts of aging on specific organs or tissues. The ability to compensate, maintain a stable internal environment, and remain free from functional and symptomatic disorders is referred to as “homeostasis.” Within this context, the declining capacity to robustly respond to such challenges has been termed “homeostenosis.” When homeostenosis becomes the predominant aspect of an individual’s health, the effects of aging become particularly pronounced. Specifically, the vulnerable elderly are defined as older individuals whose cumulative homeostatic failures reach a level that increases their risk of significant functional decline or mortality in the near future.<sup>[14]</sup> This definition includes the majority of individuals considered frail or vulnerable due to specific frailty phenotypes and/or the accumulation of various deficits and comorbidities. Consistent with its characterization as a symptom complex, OAB does not have a singular etiology. Generally, OAB symptoms reflect the perception of impaired urine storage. In younger patients, this perception may often be accurate; however, in the elderly, voiding disorders and perceptual deficits must also be considered. The influence of other morbidities, environmental factors, medications, prior surgeries, and various other factors should be considered in the assessment and management of OAB.<sup>[15]</sup> Standard clinical paradigms assume that patients present to healthcare providers with a list of symptoms, prompting the provider to identify the underlying pathophysiology, establish a diagnosis, and subsequently recommend treatment based on that diagnosis. However, the multifactorial nature of frailty and other common geriatric syndromes renders this traditional approach insufficient. Relying on such a standard model for the vulnerable elderly may lead to unnecessary interventions, misguided diagnostic and therapeutic measures, increased costs, and, in the worst-case scenario, iatrogenic morbidity or mortality.

### Evaluating Overactive Bladder (OAB) in the Vulnerable Elderly

**Contextualizing OAB in Elderly Patients:** The evaluation of urinary disorders in the elderly should transcend a narrow focus on lower urinary tract pathology. Instead, it should adopt a holistic view, contextualizing functional disturbances within the patient’s broader health situation. This multifaceted approach recognizes that patients may experience overlapping symptoms, physiologic disturbances, and underlying morbidities, each necessitating distinct considerations in their care—particularly for the vulnerable elderly. Understanding how these elements

interact is essential for appropriate evaluation and treatment.

**Understanding the patient:** In elderly patients, the notion that the symptomatic individual is the patient may not always hold true. Many older adults may have adjusted to significant functional limitations, making the burdens associated with symptoms—such as incontinence and frequent urination—more pronounced. Often, the elderly individual is the one presenting with classic OAB symptoms, yet their concerns may not align with medical definitions of OAB. It is crucial to recognize that symptoms may stem from a combination of factors, including caregiver concerns, institutional needs, and financial implications. In cases where patients do not articulate a perception of bladder control issues, the diagnostic evaluation should be proportionate and guided by the available therapeutic options.

**Feasible treatment options:** Standard treatment guidelines for OAB typically advocate for a systematic approach, ranging from conservative to more invasive options. However, in the frail elderly, the rationale for these evaluations may shift significantly due to their unique challenges, such as altered priorities, functional decline, and reduced tolerance for invasive procedures. This necessitates a thoughtful consideration of treatment options that are feasible and aligned with the patient's overall health and preferences.

#### **Consequences of inaction**

It is imperative to recognize that symptoms and physiological abnormalities can exist independently of one another, particularly in frail elderly patients. A patient presenting with OAB symptoms may simultaneously exhibit significant morbidities that warrant attention, such as chronic renal failure due to obstructed bladder. In such scenarios, the healthcare provider must balance the urgency of resolving high-pressure urine storage issues against the patient's overall prognosis. Engaging in extensive evaluations without understanding the patient's competing health risks may be counterproductive. Instead, if preserving quality of life and symptom management take precedence, treatment plans can be streamlined to focus on symptom relief, potentially through non-invasive methods such as catheterization or pharmacologic interventions. For symptomatic patients, prioritizing symptom control over long-term morbidity prevention simplifies the diagnostic and therapeutic process. Conversely, if preserving health is a concern, a thorough assessment, potentially including urodynamics, may be necessary to guide targeted interventions. This nuanced evaluation is essential for the vulnerable elderly, whose limited life expectancy may impact the appropriateness of invasive evaluations and treatments. Evaluating OAB in the vulnerable elderly demands a comprehensive understanding of their unique health circumstances. By placing symptoms within the broader context of overall health, acknowledging the complex interplay between

the patient, caregiver, and healthcare provider, and balancing treatment options with potential consequences, clinicians can develop more effective, patient-centered approaches to managing OAB in this population. This holistic framework not only enhances the quality of care but also aligns treatment strategies with the individual needs and goals of vulnerable elderly patients.

#### **Diagnosis**

What constitutes an appropriate diagnostic evaluation for the vulnerable elderly requires a careful consideration of various factors. It is essential to adjust the existing guidelines that are typically applicable to a general symptomatic population to better fit the unique circumstances of elderly patients. This includes acknowledging patient expectations, the impact of homeostatic frailty, comorbidities, and projected life expectancy. Due to the diverse and fragile nature of this demographic, the assessment of Overactive Bladder (OAB) must be tailored to each individual. Despite this need for personalization, certain overarching principles should guide the evaluation process.

One critical aspect is recognizing that OAB and urinary incontinence are seldom isolated issues; other genitourinary or related pathologies may also be present in elderly patients. Therefore, it is vital to identify potentially treatable or reversible conditions contributing to urinary symptoms. Wagg *et al.* proposed the mnemonic DIPPERSA (Delirium, Infection, Pharmaceuticals, Psychological factors, Excess urine output, Reduced mobility, Stool impaction, and Avoid treatment of asymptomatic bacteriuria) to summarize common conditions affecting urinary symptoms in frail elderly individuals. Although this mnemonic was originally designed for urinary incontinence, it can also be applied effectively to OAB. Assessing the bladder's operating range is another important consideration. This includes evaluating the patient's bladder capacity, post-void residual volume, and the relationship between these two measurements. Understanding these volumes can clarify whether the primary issue lies in urine storage or bladder emptying. Moreover, total daily urine production must be considered. Patients who produce excessive urine may experience frequency and incontinence, even with a fully functional lower urinary tract. In cases where the lower urinary tract is compromised, polyuria can exacerbate existing conditions. Therefore, addressing the underlying cause of polyuria could significantly improve symptoms, potentially making the lower urinary tract pathology more manageable or enhancing the effectiveness of further treatments.

Cognitive status is another critical factor impacting urinary function. Impaired cognition can affect not only the perception of urinary control but also the ability to maintain continence. Recent evidence indicates that urinary control issues may reflect a failure in integrative brain processes. Additionally, other functional domains, such as mobility, also directly influence urinary function

and perceptions. Data from cognitively impaired patients may not yield the same insights as those from cognitively intact individuals, particularly regarding bladder sensory function. Brain imaging studies have demonstrated a link between degenerative changes in relevant areas and patients' perceptions of their urinary symptoms, suggesting that cognitively impaired individuals might report more severe symptoms without a corresponding increase in actual dysfunction. Given these complexities, while vulnerable elderly patients may benefit from a range of evaluative and therapeutic options, careful, individualized decision-making is essential. Finally, the involvement of other healthcare professionals in the management of the vulnerable elderly is nearly inevitable. These patients often engage with a variety of healthcare providers, making it crucial for physicians evaluating and treating OAB to maintain clear communication with the patient's other care providers. This collaborative approach is vital to ensure comprehensive evaluation and effective management of OAB within this population.

### **Treatment of Overactive Bladder (OAB) in the vulnerable elderly**

#### **Behavioral Modification and Pelvic floor therapy**

For the vulnerable elderly, first-line treatment for OAB typically involves lifestyle changes and behavioral modifications. Becher *et al.* identified four key components of nonpharmacologic therapy aimed specifically at urinary incontinence in older adults, namely, communication, behavior, training, and supportive measures. Education regarding the condition and available treatment options should be provided to both the patient and any relevant caregivers. Behavioral interventions may encompass bladder training, timed voiding, and habit training, which can alter bladder symptoms through delayed voiding and enhanced awareness. Pelvic floor muscle training and techniques for urge suppression are also beneficial; while primarily associated with stress urinary incontinence, both the European Association of Urology and the American Urological Association endorse pelvic floor muscle training for urge incontinence and OAB. Supportive measures can include physiotherapy interventions like biofeedback or percutaneous tibial nerve stimulation. However, it is critical to recognize that patient cooperation is essential, and the participation of some vulnerable elderly patients may be hindered by issues related to mobility, motivation, or cognitive function.

#### **Antimuscarinics**

After evaluating and addressing any correctable underlying conditions, pharmacotherapy can be explored. Antimuscarinic medications are generally the first-line pharmacologic treatment for OAB. The efficacy and tolerability of these drugs rely on their interaction with specific muscarinic receptor subtypes (M1–M5) and their ability to cross the blood–brain barrier. The lower urinary tract effects of antimuscarinics are believed to be mediated primarily by the M2 and M3 subtypes, which

are also implicated in side effects like dry mouth, constipation, and blurred vision. Of particular concern for the frail elderly is the potential for cognitive impairment resulting from M1 receptor interactions in the central nervous system. The ability of these drugs to cross the blood-brain barrier can exacerbate this issue, especially as many frail elderly patients may already be taking multiple medications for other health concerns. Polypharmacy raises the risk of drug interactions that can lead to increased exposure and heightened risk of antimuscarinic side effects.

Despite these concerns, there is a lack of level 1 evidence regarding the efficacy and tolerability of antimuscarinic therapy in frail elderly patients. Older individuals, particularly those with multiple comorbidities, are often excluded from clinical trials. Most available data comes from post hoc subanalyses of trials involving a limited number of patients over 65 years, with even fewer over 75 years. The few prospective trials of antimuscarinics in older patients tend to exclude medically complex vulnerable elderly individuals, who generally have a higher disease burden and are more susceptible to adverse events, yet may also stand to benefit the most from treatment. The underlying paradigm for antimuscarinic therapy aims to reduce detrusor motor activity during the filling phase. Thus, the ideal drug would specifically target M3 detrusor receptors while minimizing undesired pharmacologic effects. Newer agents have been developed with a focus on reducing adverse effects through more specific bladder targeting. For instance, trospium chloride is a quaternary amine, which is less likely to cross the blood-brain barrier. This limited central nervous system penetration could theoretically reduce cognitive impacts, although this has yet to be conclusively demonstrated in clinical practice. Darifenacin was designed to selectively target bladder M3 receptors, aiming to reduce muscarinic side effects linked to non-bladder M3 receptors and M1 and M2 receptors. Additionally, preliminary data suggest a potential positive effect on cognitive function in older patients. However, cognitive function assessments have only been conducted in healthy (not frail or vulnerable) older adults, making the results less applicable to the vulnerable elderly. There is limited comparative clinical evidence favoring any specific agent other than oxybutynin.

Recently, Dubeau *et al.* published the first randomized controlled trial of antimuscarinic therapy for urge urinary incontinence in older community-dwelling patients with complex medical comorbidities and polypharmacy that can be generalized to the vulnerable elderly population. They conducted a 12-week, randomized, double-blind, flexible-dose, placebo-controlled trial of fesoterodine in vulnerable elderly subjects with urge urinary incontinence. Participants receiving flexible-dose fesoterodine experienced a significant reduction in their primary outcome measure—the number of urge urinary incontinence episodes per 24 hours—from baseline to

week 12 compared to the placebo group. The fesoterodine group also reported significant decreases in micturitions, daytime and nighttime urgency episodes, and higher rates of dryness in their diaries. Additionally, the fesoterodine group expressed significantly higher satisfaction with their bladder condition and treatment. Fesoterodine demonstrated a safety profile comparable to that seen in trials involving younger, healthier participants. The most commonly reported adverse events were dry mouth and constipation. There was no significant decrease in mean Mini-Mental State Examination scores in patients from either group. However, three patients in the treatment group reported a decline in their self-reported mental status compared to none in the placebo group. This occurred at the 8 mg dose for two patients. Nevertheless, about half of the participants opted to increase their dose from 4 mg to 8 mg and remained at that higher dosage. The authors recommended starting at the 4 mg dose with potential adjustments based on careful monitoring. Although further high-quality trials specifically targeting the vulnerable elderly population are necessary, this study suggests that medically complex, vulnerable elderly patients may safely benefit from pharmacotherapy, particularly with fesoterodine.

### Beta-3 Agonists

Mirabegron, a beta-3 adrenoceptor agonist, is the first pharmacologic agent in its class approved for treating OAB. It acts as a specific agonist of the beta-3 adrenoceptor on the human detrusor, leading to active relaxation during the storage phase, thereby increasing bladder capacity without affecting voiding ability. Wagg *et al.* performed a prospective subanalysis of three 12-week, randomized Phase III trials to evaluate the efficacy and tolerability of mirabegron in patients aged over 65 years and over 75 years. They found that mirabegron 25 mg and 50 mg taken once daily significantly reduced the frequency of incontinence episodes and the number of micturitions from baseline to the last visit compared to placebo, with no apparent loss of efficacy with age. In the group aged over 65 years, the most common treatment-emergent adverse events included hypertension, nasopharyngitis, and urinary tract infections, occurring in 9.9%, 4.1%, and 3.1% of patients, respectively. Similar trends were noted in the group over 75 years, alongside headaches, dry mouth, and extremity pain. However, over a one-year period, the incidence of the most common treatment-emergent adverse events remained similar between both doses of mirabegron and placebo. Notably, the incidence of dry mouth with mirabegron was six-fold lower than that observed with tolterodine, an antimuscarinic agent. While this subanalysis reports findings for older OAB patients, it does not address their comorbidities or frailty status. The impact of renal or hepatic impairment on mirabegron's pharmacokinetics was evaluated in a small open-label, single-dose, parallel-group study, demonstrating that mirabegron was generally well tolerated in subjects with mild, moderate, or severe renal

or hepatic impairment. The observed pharmacokinetic changes in subjects with mild or moderate renal impairment and those with mild hepatic impairment were minimal and likely clinically insignificant.

### CONCLUSION

In conclusion, the management of overactive bladder (OAB) in vulnerable elderly patients necessitates a comprehensive understanding of their unique health profiles. This population is often characterized by a multitude of comorbidities and functional limitations, making a standard diagnostic and treatment approach inadequate. As OAB manifests as a complex symptom cluster rather than a singular condition, healthcare providers must prioritize holistic evaluations that consider cognitive, physical, and psychosocial factors influencing urinary function. Effective management should begin with non-invasive, patient-centered strategies, including behavioral modifications and lifestyle adjustments, tailored to meet individual needs and capabilities. It is crucial to involve caregivers and other healthcare professionals in the treatment process to enhance communication and ensure a collaborative approach. By placing OAB within the broader context of geriatric health, clinicians can develop targeted interventions that improve symptom management, enhance quality of life, and reduce the overall burden of urinary disorders in the elderly. Such an approach not only aligns treatment strategies with patient priorities but also addresses the underlying complexities that contribute to OAB, ultimately fostering better health outcomes in this vulnerable population.

### REFERENCES

1. Schneider, T., Marschall-Kehrel, D., Hanisch, J. U., & Michel, M. C. Do gender, age or lifestyle factors affect responses to antimuscarinic treatment in overactive bladder patients? *International Journal of Clinical Practice*, 2010; 64(9): 1287–1293. <https://doi.org/10.1111/j.1742-1241.2010.02389.x>
2. Irwin, D. E., Milsom, I., Hunskaar, S., & *et al.* Population-based survey of urinary incontinence, overactive bladder, and other lower urinary tract symptoms in five countries: Results of the EPIC study. *European Urology*, 2006; 50(6): 1306–1314. <https://doi.org/10.1016/j.eururo.2006.03.034>
3. Stewart, W. F., Van Rooyen, J. B., Cundiff, G. W., & *et al.* Prevalence and burden of overactive bladder in the United States. *World Journal of Urology*, 2003; 20(6): 327–333. <https://doi.org/10.1007/s00345-003-0274-9>
4. Brown, J. S., McGhan, W. F., & Chokroverty, S. Comorbidities associated with overactive bladder. *American Journal of Managed Care*, 2000; 6(11): S574–S579.
5. Wagner, T. H., Hu, T. W., & Bentkover, J. Health-related consequences of overactive bladder. *American Journal of Managed Care*, 2002; 8(19): S598–S607.

6. Brown, J. S., Vittinghoff, E., & Wyman, J. F. Urinary incontinence: Does it increase risk for falls and fractures? Study of Osteoporotic Fractures Research Group. *Journal of the American Geriatrics Society*, 2000; 48(7): 721–725. <https://doi.org/10.1111/j.1532-5415.2000.tb03913.x>
7. Morris, V., & Wagg, A. Lower urinary tract symptoms, incontinence and falls in elderly people: Time for an intervention study. *International Journal of Clinical Practice*, 2007; 61(2): 320–324. <https://doi.org/10.1111/j.1742-1241.2006.01186.x>
8. Coyne, K. S., Sexton, C. C., Irwin, D. E., Kopp, Z. S., Kelleher, C. J., Milsom, I. The impact of overactive bladder, incontinence and other lower urinary tract symptoms on quality of life, work productivity, sexuality and emotional well-being in men and women: Results from the EPIC study. *BJU International*, 2008; 101(11): 1138–1145. <https://doi.org/10.1111/j.1464-410X.2008.07794.x>
9. Anger, J. T., Saigal, C. S., Madison, R., Joyce, G. B., & Litwin, M. S. Increasing costs of urinary incontinence among female Medicare beneficiaries. *The Journal of Urology*, 2006; 176(2): 472–475. [https://doi.org/10.1016/S0022-5347\(06\)00545-1](https://doi.org/10.1016/S0022-5347(06)00545-1)
10. Litman, H. J., & McKinlay, J. B. The future magnitude of urological symptoms in the USA: Projections using the Boston Area Community Health survey. *BJU International*, 2007; 100(4): 820–825. <https://doi.org/10.1111/j.1464-410X.2007.07041.x>
11. Abrams, P., Cardozo, L., & Fall, M. The standardization of terminology in lower urinary tract function: Report from the standardisation sub-committee of the International Continence Society. *Urology*, 2003; 61(3): 37–49. [https://doi.org/10.1016/S0090-4295\(02\)02243-7](https://doi.org/10.1016/S0090-4295(02)02243-7)
12. Gormley, E. A., Lightner, D. J., & Burgio, K. L. Diagnosis and treatment of overactive bladder (non-neurogenic) in adults: American Urological Association/SUFU guideline. *The Journal of Urology*, 2012; 188(6): 625–640. <https://doi.org/10.1016/j.juro.2012.09.076>
13. Das, R., Buckley, J., & Williams, M. Dimensions of sensation assessed in urinary urgency: A systematic review. *The Journal of Urology*, 2013; 190(4): 1165–1171. <https://doi.org/10.1016/j.juro.2013.04.015>
14. Inouye, S. K., Studenski, S., Tinetti, M. E., & Kuchel, G. A. Geriatric syndromes: Clinical, research, and policy implications of a core geriatric concept. *Journal of the American Geriatrics Society*, 2007; 55(5): 780–791. <https://doi.org/10.1111/j.1532-5415.2007.01136.x>
15. DuBeau, C. E., Kuchel, G. A., Johnson, T. 2nd, Palmer, M. H., & Wagg, A. Fourth International Consultation on Incontinence: Incontinence in the frail elderly: Report from the International Consultation on Incontinence. *Neurourology and Urodynamics*, 2010; 4, 29(1): 165–178. <https://doi.org/10.1002/nau.20832>

## اضطرابات المثانة: القضايا الشائعة والحلول - مراجعة محدثة عن المثانة المفرطة النشاط

### الملخص:

**الخلفية:** تؤثر المثانة المفرطة النشاط (OAB) بشكل كبير على جودة الحياة لدى كبار السن، حيث تبلغ نسبة انتشارها 12.8% بين النساء و10.8% بين الرجال في أوروبا وكندا. وتكون الحالة شائعة بشكل خاص بين من هم فوق 65 عامًا، مما يزيد من خطر السقوط والكسور. العبء المالي المرتبط بالأعراض البولية في هذه الفئة السكانية كبير، مما يؤدي إلى توقعات بأن 52 مليون بالغ في الولايات المتحدة سيعانون من أعراض المسالك البولية السفلية بحلول عام 2025.

**الهدف:** تهدف هذه المراجعة إلى تقديم نظرة محدثة حول تقييم وإدارة OAB في الفئات الضعيفة من كبار السن، مع التأكيد على الحاجة إلى نهج مخصص بسبب تحدياتهم الصحية الفريدة.

**الطرق:** تم إجراء مراجعة شاملة للأدبيات، مع التركيز على الإرشادات والدراسات الحديثة المتعلقة بإدارة OAB لدى كبار السن. كما تسلط المراجعة الضوء على الطبيعة متعددة العوامل للأعراض البولية وضرورة استخدام أساليب تقييم شاملة تعالج الظروف الصحية الفريدة.

**النتائج:** تشير النتائج إلى أن OAB لدى كبار السن يجب ألا تُعتبر حالة معزولة، بل جزء من مجموعة أوسع من القضايا الصحية. يجب أن تتضمن التقييمات التشخيصية تقييمات لحالات الأمراض المصاحبة، والوظيفة الإدراكية، والحركة الوظيفية. تركز استراتيجيات العلاج على التعديلات السلوكية، وتغييرات نمط الحياة، وخطط الرعاية الفردية لتحسين النتائج وجودة الحياة.

**الخاتمة:** من الضروري اعتماد نهج متعدد التخصصات يركز على المريض في إدارة OAB بين المرضى الضعفاء من كبار السن. من خلال فهم تداخل العوامل الصحية، يمكن للأطباء تقديم علاجات أكثر فعالية توضع صحة ورفاهية المرضى في المقام الأول.

**الكلمات المفتاحية:** المثانة المفرطة النشاط، كبار السن، سلس البول، المتلازمات المسنة، الإدارة، التشخيص.