

SYMPTOMS, IMPACT AND COPING STRATEGIES AMONG WOMEN WITH OVERACTIVE BLADDER (OAB)

Hypothesis / aims of study

The 2002 ICS Standardisation Report and the 2009 ICS-IUGA Standardisation Report imply that urinary urgency is the 'cardinal' symptom of the OAB syndrome. However, as identified by the report from the ICS Standardisation Steering Committee (1), the Standardisation Reports are exclusively based on expert opinion and not on any existing literature. Furthermore, there is very limited qualitative understanding of the most bothersome symptom(s) of OAB, as perceived by patients, the life impact of OAB symptoms and the extensive coping mechanisms that are employed by patients. This influences how patient reported outcome measures (PROMs) for OAB are evaluated, which, in turn, impacts end points used in OAB clinical research. Therefore, the aims of the study are to: (i) evaluate urinary urgency as the 'cardinal' symptom of the OAB syndrome (ii) gain an understanding of patient-reported most bothersome OAB symptom(s) and any other symptoms that can be addressed to improve patient outcomes (iii) explore the life impact of OAB symptoms and the coping mechanisms employed by patients.

Study design, materials and methods

This is an original prospective qualitative focus group study. Prior to this study, women with refractory OAB were recruited from a separate randomised control trial (RCT), and preliminary data were obtained. For this study, women with symptoms of OAB, from a primary (primary community continence clinics) and secondary (Urogynaecology Clinics, University Hospitals) setting were given a participant information pack. Interested patients returned a completed reply slip to the research team and were contacted to determine appropriate dates and times for focus groups. The focus groups aimed to include 6 – 8 participants, lasting for 90 – 120 minutes. Before starting the focus groups, participants individually completed a Symptom Bother Chart and a Visual Analogue Scale (VAS) Sheet. The focus group was conducted using a focus group schedule, and was audio recorded and transcribed verbatim. Transcribed data was imported into Nvivo. The transcripts were read multiple times to initially generate 'open codes', which were then organised into themes, using the constant comparative method(2).

Results

Work is on-going. Four focus groups have been completed so far, two with patients with refractory OAB recruited from the RCT (n= 12), one with patients with refractory OAB from urogynaecology clinics (n = 2) and one with patients with mixed symptom severity from urogynaecology clinics (n = 7). Data from the Symptom Bother Chart and the VAS Sheet formed part of the descriptive statistics. Some of the themes identified have been included.

Table 1: Patient bothersome symptoms, obtained from the symptom bother chart. Symptoms are ranked; 1 = most bothersome symptom and the highest number being least bothersome.

Symptoms	Overall Median Rank (Range), n = no bothered (out of total 21)	Median Rank, Refractory OAB patients, (Range), n = no bothered (out of total 14)	Median Rank, Moderate symptom severity patients, (Range), n = no bothered (out of total 7)
Daytime frequency	3 (1 – 10), n= 19	3 (1 – 10), n=12	3 (1 – 6), n=7
Urgency	1 (1 – 5), n= 21	1 (1 – 3), n = 14	2 (1 – 5), n = 7
UUI	3 (1 – 8), n= 19	3 (1 – 8), n = 12	1 (1 – 5), n = 7
Nocturia	4 (1 – 8), n= 15	6.5 (4 – 8), n = 8	1 (1 – 4), n = 7
Night time leakage	5 (1 – 10), n = 13	8 (2 – 10), n = 6	5 (1 – 5), n = 7

Table 2: Selective patient derived answers from blank spaces on Symptom Bother Chart

"Patient derived answers"	Median Rank (Range)	Answer given by 'n' participants
"Toilet mapping"	5 (1 – 7)	8
"Life Adjustment"	2.5 (1 – 8)	6

Table 3: Impact of symptoms obtained from the VAS sheet. Symptoms are scaled on a 100mm scale; 0 = 'No impact at all' and 100 = 'The greatest impact I can imagine'

Symptoms	Overall median scale (Range), n = 21	Median scale, Refractory OAB patients (Range), n = 14	Median scale, Moderate symptom severity patients (Range), n = 7
Day time frequency	75 (19 – 97)	84.5 (34 – 97)	52 (19 – 82)
Urgency	91 (30 – 100)	94.5 (70 – 99)	64(30 – 100)
UUI	91 (12 – 98)	94 (12 – 98)	60(27 – 94)
Nocturia	75 (4 – 100)	62.5 (4 – 98)	82(20 – 100)
Night time leakage	50 (0 – 97)	40.5 (1 – 97)	65 (0 – 90)

Table 4: Selective patient derived answers from blank spaces on VAS Sheet

"Patient derived answers"	Median Scale (Range)	Answer given by 'n' participants
"Long journeys"	92 (63 – 95)	7
"Toilet mapping"	82 (48 – 96)	8

Table 5: Selective themes highlighting life adjustments made and coping strategies employed

Life Adjustment and Coping Strategies (physical, emotional and psychosocial)	Participant Quotes
Continence pads	<i>"I wear a pad all the time and I just never give it a thought. It's just part of getting dressed in the morning. Doesn't bother me."</i>
"Toilet" – Toilet mapping and preventative toileting	<i>"Also, passing urine before I go out, gets a habit but I find as soon as I arrive where I am going, I need to go again."</i>
Talking about symptoms	<i>"I will say this though; talking with all these ladies now has made me think that I should talk more about it."</i>

Table 6: Selective themes highlighting life impact of symptoms

Life Impact (physical, emotional and psychosocial)	Participant Quotes
Hygiene (Smell of urine)	<i>"And I think because I smell of wee. When I go out, I asked my friends do I smell of wee?"</i>
Depression	<i>"Particularly I found I've always been a really happy person but I was really depressed at one point. Never had that in before. That was the biggest impact I think."</i>
Degrading	<i>"Yes. It was trying to hide it and having to ring people to fetch me. And that's where the feeling of being degraded comes from."</i>

Interpretation of results

Urgency seemed to be the most bothersome symptom with the greatest impact, based on the Symptom Bother Chart and VAS data (Table 1 & 3). However, UII also had significant impact. Patients with moderate symptom severity regarded nocturia to be bothersome with impact. Extensive self-management strategies were employed and the life impact of the symptoms was profound. For some, the consequences of the symptoms were equally, if not more, significant than the physical manifestation of the symptoms. A key concept was the role of the 'support system' in patients' management of their symptoms, especially the specialist continence nurses.

Concluding message

Multi-thematic analysis indicates that it is imperative for both healthcare professionals as well as pharmacological companies to understand how symptoms are viewed by OAB patients, and data from this study can supplement other subsequent quantitative studies in the field.

References

1. Rosier et al. Developing evidence-based standards for diagnosis and management of lower urinary tract or pelvic floor dysfunction. *Neurourology & Urodynamics*. 2012 Jun;31(5):621-4.
2. Glaser BG SA. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. . Chicago, IL: Aldine, 1967.

Disclosures

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