HONG KONG MEDICAL JOURNAL 香港醫學雜誌

Supplementary material

The supplementary material was provided by the authors and some information may not have been peer reviewed. Any opinions or recommendations discussed are solely those of the author(s) and are not endorsed by the Hong Kong Academy of Medicine and the Hong Kong Medical Association. The Hong Kong Academy of Medicine and the Hong Kong Medical Association disclaim all liability and responsibility arising from any reliance placed on the content.

Supplement to: Wong WKK, Kan RWM, Lam PS, et al. Management of overactive bladder: consensus statements from the Hong Kong Urological Association and the Hong Kong Geriatrics Society. Hong Kong Med J 2024 Aug;30(4):310-9 | Epub 14 Aug 2024. https://doi.org/10.12809/hkmj2310921.

Supplementary Table 1. Predefined judgement criteria for consensus statement voting

Practicability of recommendation*	
A	Accept completely
B	Accept with some reservations
C	Accept with major reservations
D	Reject with reservations
E	Reject completely

* Consensus statements were accepted if ≥75% panellists chose A or B and rejected if <75% panellists chose A or B

Supplementary Table 2. Full list of statements for voting

		Responses					Accepted (A + B ≥75%) or Rejected (A + B <75%)		
		A	B	C	D	E	A + B	Accepted	Rejected
Section 1: Diagnosis and referral to specialists									
1.1	The clinician should begin the diagnostic process with careful history taking and physical examination.	100%					100%	**Accepted**	
1.2	Storage lower urinary tract symptoms may be a sign of more serious underlying conditions, and their management can be complicated by co-morbidities and polypharmacy. The clinician should seek a specialist's opinion if red flag features are detected.	92%	8%				100%	**Accepted**	
Section 2: Initial assessment									
2.1	Urinalysis should be considered during the initial assessment of overactive bladder syndrome.	83%	17%				100%	**Accepted**	
2.2	A bladder diary should be considered during the assessment of overactive bladder syndrome.	83%	17%				100%	**Accepted**	
2.3	Urine culture, post-void residual urine, plain X-rays of the kidney, ureter, and bladder, and patient questionnaires may be performed during the initial assessment of overactive bladder syndrome at the clinician's discretion.	100%					100%	**Accepted**	

2.4	If questionnaires are used for assessment of overactive bladder syndrome, appropriate questionnaires validated in the patient's language should be used.	100%			100%	**Accepted**
2.5	Cystoscopy, urodynamics, ultrasonography of the urinary system, and pad tests should not be routinely included in the initial assessment of overactive bladder syndrome.	92%	8%		100%	**Accepted**
Section 3: Non-pharmacological treatments						
3.1	Non-pharmacological treatments, including fluid management, bladder training, and pelvic floor exercises, should be offered to patients with overactive bladder, regardless of drug treatment initiation.	92%	8%		100%	**Accepted**
3.2	Clinicians should identify medications and substances that may contribute to overactive bladder and consider modifications or alternatives.	100%			100%	**Accepted**
3.3	Weight reduction should be advised for obese individuals with overactive bladder.	67%	33%		100%	**Accepted**
3.4	For patients who have difficulty performing pelvic floor exercises and bladder training, early pharmacological therapy should be considered.	75%	25%		100%	**Accepted**
Section 4: Considerations before initiating drug treatment						
4.1	Before initiating treatment, clinicians should educate patients and caregivers about the symptoms and natural course of overactive bladder, and the benefits and risks of currently available treatments.	83%	8%	8%	92%	**Accepted**

4.2	Antimuscarinics should be used cautiously in patients with cognitive impairment or a high anticholinergic burden.	83%	8%	8%		92%	**Accepted**	
4.3	Because polypharmacy is very common, a detailed review of drug history is recommended to avoid creating a clinically significant anticholinergic burden in patients.	83%	8%		8%	92%	**Accepted**	
Section 5: Antimuscarinics								
5.1	Antimuscarinics should be offered to patients who have been unsuccessful with non-pharmacological approaches.	33%	58%	8%		92%	**Accepted**	
5.2	Extended-release antimuscarinics are preferred over immediate-release antimuscarinics because of better tolerability, particularly regarding dry mouth.	83%	17%			100%	**Accepted**	
5.3	Antimuscarinics should not be used in patients with narrow-angle glaucoma unless approved by an ophthalmologist.	92%	8%			100%	**Accepted**	
5.4	Antimuscarinics are effective in treating overactive bladder but regular monitoring of voiding symptoms is recommended, especially among older individuals.	83%	17%			100%	**Accepted**	
5.5	Antimuscarinics should not be used in patients with post-void residual urine >150 mL.	25%	33%	17%	25%	58%		**Rejected**
5.6	Regular monitoring of post-void residual urine is recommended in patients with a high risk of urinary retention.	25%	25%	8%	42%	50%		**Rejected**
Section 6: Beta-3 agonists								
6.1	Beta-3 agonists provide overall efficacy similar to that of commonly used antimuscarinic monotherapies.	100%				100%	**Accepted**	

6.2	Beta-3 agonists appear to be better tolerated than antimuscarinics (eg, in terms of dry mouth, constipation, and urinary retention).	100%					100%	**Accepted**	
6.3	Mirabegron should not be used in patients with severely uncontrolled hypertension.	75%	25%				100%	**Accepted**	
6.4	Blood pressure monitoring is encouraged before initiating and during mirabegron treatment, especially among patients with pre-existing hypertension.	25%	25%	17%	25%	8%	50%		**Rejected**
Section 7: Combination therapy									
7.1	Combination drug treatment (a beta-3 agonist and an antimuscarinic agent) may be considered for overactive bladder that is unresponsive to monotherapy with either antimuscarinics or beta-3 agonists.	92%	8%				100%	**Accepted**	
7.2	Combination treatment using a beta-3 agonist and an antimuscarinic is preferred over the use of two antimuscarinics due to fewer side-effects and a lower anticholinergic burden.	100%					100%	**Accepted**	
7.3	Combination treatment using an antimuscarinic agent and a beta-3 agonist has a significantly higher rate of adverse events compared with monotherapy.	42%	17%	17%	25%		58%		**Rejected**
Section 8: Surgical treatments									
8.1	Posterior tibial nerve stimulation should be considered for patients who have been unsuccessful with pharmacological treatment.	67%	33%				100%	**Accepted**	

8.2	Intravesical botulinum toxin injection or sacral neuromodulation should be considered in carefully selected patients who have been unsuccessful with pharmacological treatment.	75%	25%		100%	**Accepted**