Current management of OAB:Time to revisit the Guidelines.

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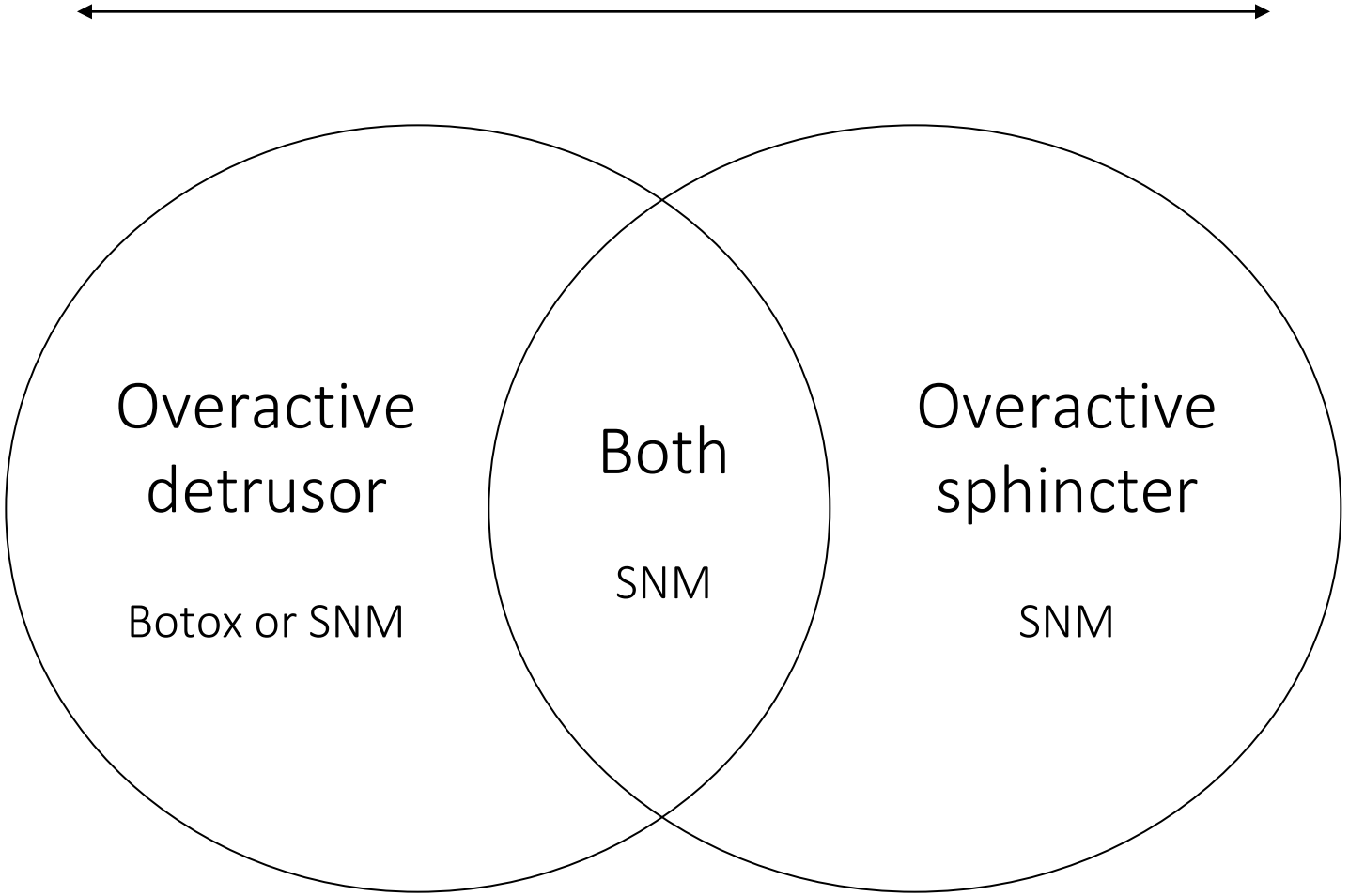
DO and voiding dysfunction

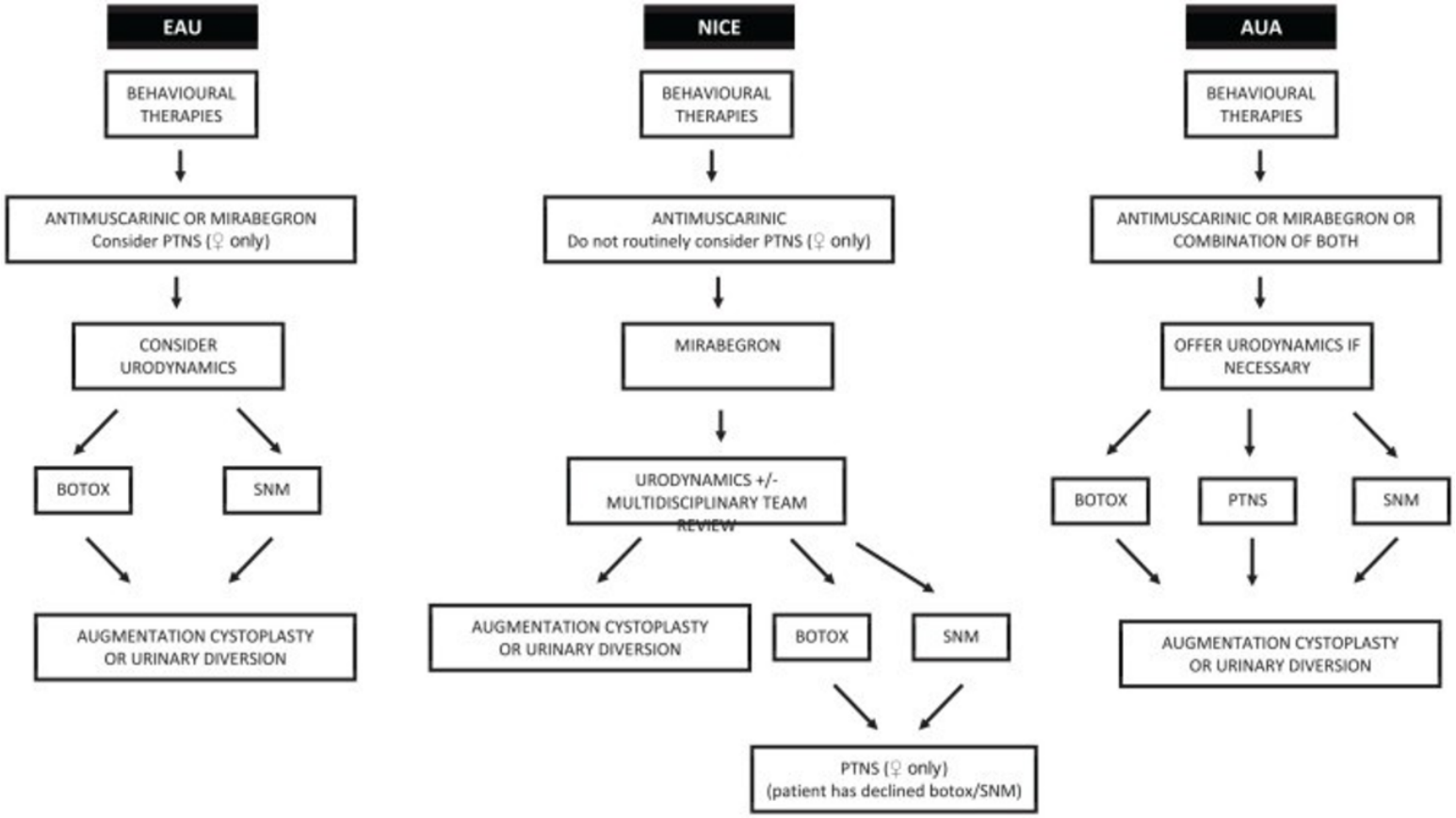


Suitable patients for SNM

- In 2018 the ICS published a best practice statement for the use of sacral neuromodulation. Neurourol Urodynam , ***37***, 1823 (2018).

"Sacral neuromodulation is an accepted therapy for refractory urinary urgency and frequency, urgency urinary incontinence, non-obstructive urinary retention, and faecal incontinence"

Guidelines


EAU
BEHAVIOURAL THERAPIES
ANTIMUSCARINIC OR MIRABEGRON
Consider PTNS (♀ only)
CONSIDER URODYNAMICS
BOTOX
SNM
AUGMENTATION CYSTOPLASTY OR URINARY DIVERSION
NICE
BEHAVIOURAL THERAPIES
ANTIMUSCARINIC
Do not routinely consider PTNS (♀ only)
MIRABEGRON
URODYNAMICS +/- MULTIDISCIPLINARY TEAM REVIEW
AUGMENTATION CYSTOPLASTY OR URINARY DIVERSION
BOTOX
SNM
PTNS (♀ only)
(patient has declined botox/SNM)
AUA
BEHAVIOURAL THERAPIES
ANTIMUSCARINIC OR MIRABEGRON OR COMBINATION OF BOTH
OFFER URODYNAMICS IF NECESSARY
BOTOX
PTNS
SNM
AUGMENTATION CYSTOPLASTY OR URINARY DIVERSION

Current NHSE Commissioning for SNM

- NHS England Commissioning policy
- SNS treatment will be routinely commissioned by NHS England for adult patients with urinary urgency incontinence, urinary urgency-frequency syndrome or double incontinence (urinary and faecal) who meet the following criteria:
- 1. A confirmed diagnosis defined by a quality controlled2 conventional urodynamic assessment or ambulatory urodynamics when indicated. If the urodynamic diagnosis is inconclusive, a decision for further management including SNS must be made at an incontinence MDT.
- 2. Symptoms which are refractory to behavioural and lifestyle modification, pelvic floor exercises and pharmacological therapy; at least two anticholinergics followed by a B3 agonist (NICE TA; http://guidance.nice.org.uk/TA290), unless such treatments are contraindicated.
- 3. Female patients who have been offered intra-vaginal oestrogens for the treatment of symptoms of OAB in postmenopausal women with symptoms of vaginal atrophy where clinically appropriate.
- 4. Patients not suitable for treatment with Botulinum toxin 'A' bladder injections, including any of the following:
- a) The patient is unable to perform clean intermittent catheterization
- b) There is a medical contraindication to Botulinum toxin treatment
- c) Botulinum toxin bladder injections have not had a therapeutically useful effect
- d) An incontinence MDT has recommended that SNS is a more
- appropriate treatment
- 5. Referred to a specialist surgeon at a centre experienced in providing SNS and after review by the incontinence MDT
- 6. Patients who have been counselled about
- a) The surgical and non-surgical options appropriate for their individual circumstances.
- b) The benefits and limitations of each option, with particular attention to long- term results.
- c) Realistic expectations of the effectiveness of SNS including the risk of failure, the long term commitment, the risk of complications requiring reoperation and device removal and possible adverse effects.
- 7. Does not have a physical or mental disability which prevents a safe level of cooperation with the technical demands of the procedure. (Formal evaluation should be performed if necessary).
- OFFICIAL 17
- 8. Does not have a known condition likely to necessitate future MRI scanning (as MRI contraindicated after SNS treatment, except MRI of head)

Clinical Data Review

Amundsen, 2 year outcome of SNS v BTX

9 US Centres, 386 women.

SNS 194 patients, BTX 192 patients @200units.

Data suggest benefit of both therapies.

Analysis of Cost Effectiveness is Critical next step to decide if one treatment should be offered in front of the other.

Sahai, Cost Effectiveness of SNM v BTX.

At 10 year time frame SNM is cost dominant.

BTX cost effective at less than 5 years.

SNM is cost effective long term.

Harris, Eardley, Long terms outcomes for use of BTX in large teaching hospital.

61.3% patients drop out at 3 years.

64% patients drop out at 5 years.

What happens to these drop outs???

Patient choice and the role of the PDA

- Rogerson L. Women's perspective: intra-detrusor botox versus sacral neuromodulation for overactive bladder symptoms after unsuccessful anticholinergic treatment.
  - 50 patients with mean age 61.
  - 74% chose BTX, 26% chose SNS
- Hashim, Patient preferences for treating refractory overactive bladder in the UK
  - 127 patients offered choice of SNS, BTX and PTNS
  - 56.6% PTNS, 34% SNS, 9.4% BTX.
- Harding, Review of SNM and Botox from patients and clinicians.
  - 10000 BTX per annum v 300 SNM implants.
  - When blinded 60% patients would prefer to try SNM first.
  - Of 100 Clinicians 97% have access to BTX v 39% SNM.

Sample BOTOX Costs

Cost per procedure	1063
tariff paid	n/a
Net cost to Trust	1063
net cost per annum 6 monthly use	2126

Catheter costs

	4 per day	6 per day	8 per day
Speedicath compact	3181	4772	6362
Vapro 16 male	3063	4590	6120

SNS Costings

	Test	implant	Budget impact per patient
Equipment cost	420	12252	
Hospital Cost	452	835	
Budget impact	872	13087	13959

100 patient sample	year 0 cost	15 year cost	Annual SNS cost	15 year SNS cost
50 patients OAB	122205	1294190	697950	697590
30 patients retention	143160	2290560	418770	418770
20 patients mixed	106140	1124066	279180	279180
		4708816		1395540

100 patient SNS net Saving	3313276

Local Edinburgh SNS Selection

Patients offered choice of SNS or BTX following UDs

Under 55s do better with SNS than over 55s.

With new technology should we offer SNS to younger patients?

20% patients with OAB have FI- what treatment should these have initially?

Trial phase a reliable indicator for permanent implant.

Misconceptions

- We are all adhering to NICE guidelines in Scotland.
- Patients will wait longer for SNS than Botox.
- BTX is outpatient SNS requires main theatre/resources.
- Patients would choose BTX over SNS
- We are offering patient informed choice.
- There is clinical parity between NHS Scotland and England.