**ADDITIONAL MATERIAL**

Abstract of statistical results obtained from expert consensus and group consensus achieved for the issues examined. They are shown in blocks: 1. Definition, classification, detection and diagnosis of overactive bladder (OAB); 2. Medical treatment of overactive bladder (OAB); 3. Surgical treatment of (OAB); 4. Role of onabotulinumtoxin A in overactive bladder (OAB)

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| **BLOCK 1: DEFINITION, CLASSIFICATION, DETECTION ANAD DIAGNOSIS OF OAB** | | | | |
|  | **Median** | **% Panelists against** | **Interquartile range** | **Result** |
| **A. Do you believe that present definition and classification of overactive bladder is appropriate and covers the possible clinical and functional aspects?** | | | | |
| 1. The present definition of OAB is appropriate for the assistance and covers the possible clinical and functional aspects. | 3 | 19.5 | 0 | Rejected |
| 2. The present definition of OAB is appropriate for the assistance but should include the chronic nature of the disease and the possibility that the symptoms are produced by organic disease. | 7 | 30.8 | 3 | Accepted |
| 3. The present definition of OAB is not appropriate because clinical aspects are well identified but not the possible underlying etiology that, besides idiopathic and neurogenic, may be secondary to other pathologies (secondary symptoms to obstructive disease, estrogenic deficiency, polyuria and nocturia of different etiologies, metabolic, secondary to drugs, bladder stones, in situ carcinoma, voiding dysfunction, etc.). | 8 | 23.1 | 1 | Accepted |
| 4. Consideration of OAB as uniform clinical entity avoids the study of underlying causes of each symptom, favors overmedication and overtreatment of the light symptoms and the pharmacologic treatment prescription without the study of underlying physiopathology of each symptom. | 8 | 23.1 | 2 | Accepted |

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| **B. Are there differences between sexes and among age groups in the etiology and the physiopathology of OAB?** | | | | |
| 5. The prevalence of OAB increases with the age and is more frequent in the woman. | 8 | 7.7 | 2 | Accepted |
| 6. There are relevant differences in etiology and physiopathology of OAB between both sexes and among different age groups. | 8 | 7.7 | 2 | Accepted |
| 7. The possibility of different etiologies among both sexes and different ages forces to seek the etiology of OAB in order to implement appropriate treatment. | 8 | 5.1 | 1 | Accepted |
| 8. The etiology and physiopathology of OAB in elderly is often multifactorial. | 9 | 0.0 | 1 | Accepted |

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| **C. In Primary care, Is it necessary a screening tool for OAB/ urinary incontinence (UI)?** | | | | |
| 9. In Primary care, it is not necessary a screening tool for OAB/UI because the diagnosis are easy. | 3 | 19.5 | 0 | Rejected |
| 10. In Primary care, it is not convenient to use a screening tool for OAB/UI because it can induce overtreatment and unnecessary referrals to specialized care. | 3 | 20.0 | 0 | Rejected |
| 11. It is necessary to improve the knowledge about the pathology in Primary care, Specialized care (including Gynecology, Geriatrics, Internal Medicine) and in the general population. | 8 | 7.7 | 2 | Accepted |
| 12. It would be convenient to have a screening tool in Primary care. It shall be a test with few items, fast and easy to use, even in nursing consultation. | 8 | 14.6 | 2 | Accepted |
| 13. The role of the urologist as a specialist who refers complicated or not responding cases has been reinforced. | 9 | 2.6 | 1 | Accepted |

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| **D. In patients with OAB, Does the presence or absence of detrusor overactivity show specific clinical, diagnostic, therapeutic or prognostic differences?** | | | | |
| 14. It is a hotly debated issue that has to be individualized for each type of OAB (neurogenic, idiopathic, secondary and its types). | 8 | 10.3 | 2 | Accepted |
| 15. Patients with idiopathic OAB with detrusor overactivity exhibit more urge urinary incontinence. | 7 | 26.8 | 3 | Accepted |
| 16. The best or the worst response to treatment (either with drugs, with neuromodulation or with onabotulinumtoxin A) is not conditional on detrusor overactivity. | 3 | 34.1 | 4 | Non-consensus |
| 17. If a more aggressive treatment is administered, urodynamic study must be carried out in patients with neurogenic OAB and in those patients with idiopathic OAB not responding to appropriate initial treatment. | 9 | 2.6 | 1 | Accepted |
| 18. Urodynamic study also must be performed in patients with complex UI. | 9 | 5.3 | 1 | Accepted |

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| **E. Is it unavoidable the use of frequency-volume charts, micturition diary and urgency scale in OAB assessment?** | | | | |
| 19. In primary and secondary care, micturition diary is the most efficiency test in the assessment of SUI or UUI. | 8 | 12.8 | 2 | Accepted |
| 20. The assessment of low urinary tract symptomatology by micturition diary has a therapeutic and diagnostic value because it gives to physician and patient information about micturition pattern and actual intakes, quantifies the symptoms and allows measuring the effect of treatment. | 8 | 5.1 | 2 | Accepted |
| 21. 3-days micturition diary is the best way to assess the symptoms, although not all patients can or want to complete it, nor all physicians have the time and the training necessary for its interpretation. | 8 | 15.4 | 1 | Accepted |
| 22. In specialized care and investigation, frequency-volume charts may be used to confirm the presence of the symptoms. The micturition diary should be used in the cases in which clinical history data are discordant with frequency-volume charts. | 7 | 12.2 | 1 | Accepted |
| 23. In OAB assessment, frequency-volume chart, micturition diary and/or urgency scale are not essential, though desirable. | 7 | 27.5 | 3 | Accepted |
| 24. In OAB assessment, frequency-volume chart, micturition diary and/or urgency scale do not improve the diagnosis of patients with OAB and therefore are dispensable. | 2 | 7.7 | 2 | Rejected |

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| **BLOCK 2: MEDICAL TREATMENT** | | | | |
|  | **Median** | **% Panelists against** | **Interquartile range** | **Result** |
| **A. Given that OAB is a benign pathology, Should the therapeutic algorithm follow a stepwise and progressive scheme?** | | | | |
| 25. In the implementation of treatment alternatives, therapeutic algorithm should follow a stepwise and progressive scheme, although this should be individualized for each patient to optimize response and minimize adverse effects. | 8 | 0.0 | 1 | Accepted |
| 26. Two treatment levels are suggested: initial treatment (conservative treatment, antimuscarinic drugs) and specialized treatment (neuromodulation, onabotulinumtoxin A, surgery, posterior tibial nerve stimulation). | 9 | 0.0 | 1 | Accepted |
| 27. The use of this therapeutic scheme may vary regarding patient preferences. | 8 | 12.2 | 2 | Accepted |
| 28. The use of this therapeutic scheme may vary regarding treatment contraindications. | 8 | 7.9 | 2 | Accepted |
| 29. Some patients may benefit from combination therapy. | 8 | 5.1 | 1 | Accepted |

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| **B. Are the changes in the way of life beneficial in the treatment of OAB?** | | | | |
| 30. In OAB treatment, recommendations for changes in the way of life are beneficial for those patients who have to modified their behavior (high fluid and caffeine intake, obesity, chronic constipation, etc.) | 8 | 7.7 | 2 | Accepted |
| 31. In OAB treatment, recommendations for changes in the way of life are of low efficiency and little applicable to clinical practice. | 3 | 14.6 | 1 | Rejected |
| 32. In OAB treatment, patients show low adherence to recommendations for changes in the way of life. | 7 | 22.0 | 0 | Accepted |
| 33. The efficiency of temporary removal of caffeine or other substances (spicy, alcohol, etc.) from the diet must be checked before they are removed permanently. | 7 | 7.5 | 0 | Accepted |
| 34. Recommendations for changes in the way of life must be associated with pharmacological treatment of OAB. | 7 | 25.6 | 2 | Accepted |
| 35. In patients with OAB, diuretics should be replaced by other antihypertensive agent. | 8 | 12.5 | 1 | Accepted |

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| **C. Do you consider useful pelvic floor training (PFE) in the treatment of urinary incontinence secondary to OAB?** | | | | |
| 36. PEF exercises are useful but less effective than in SUI. | 7 | 23.1 | 1 | Accepted |
| 37. PEF exercises are not indicated in all OAB patients. | 7 | 25.6 | 3 | Accepted |
| 38. PEF exercises indication depends on available resources. | 7 | 46.3 | 5 | Non-consensus |
| 39. PEF exercises are effective in motivated and monitored patients (led by trained nurses or physiotherapists). | 8 | 10.5 | 2 | Accepted |

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| **D. Is enough solution the present antimuscarinic drugs in the treatment of OAB?** | | | | |
| 40. Antimuscarinic drugs have a low adherence rates in the OAB treatment. | 7 | 31.6 | 2 | Accepted |
| 41. The price of some antimuscarinic drugs rebound in the OAB treatment adherence. | 7 | 13.2 | 1 | Accepted |
| 42. Antimuscarinics have a low efficiency in the OAB treatment. | 3 | 41.5 | 4 | Non-consensus |
| 43. Antimuscarinics not meet the expectations of patients with OAB. | 7 | 17.1 | 0 | Accepted |
| 44. In clinical consultancy, clinical management of antimuscarinic drugs is usually not suitable (change in the doses, association, posology). | 7 | 46.3 | 4 | Non-consensus |

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| **E. In routine clinical practice, Should be devised mechanisms for monitoring and adherence to treatment in OAB?** | | | | |
| 45. Information for the patient about chronic pattern of OAB and the treatment objective has to be improved. | 8 | 0.0 | 2 | Accepted |
| 46. It could be useful to have a quality writing material reporting clearly about key aspects of OAB (concept, diagnostic, treatment and recommendations). | 8 | 2.6 | 2 | Accepted |
| 47. Simultaneous indication of conservative treatment must be promote | 8 | 10.3 | 2 | Accepted |
| 48. The present use of antimuscarinics treatments in OAB must be optimized in order to use the lowest effective dose. | 8 | 10.3 | 2 | Accepted |
| 49. Patient follow-up must be strengthened through regular visits. | 8 | 25.6 | 3 | Accepted |
| 50. To involve to nurses or physiotherapists could be useful in order to improve the monitoring of OAB. | 8 | 15.4 | 2 | Accepted |
| 51. OAB patient involvement (Micturition diary, quality of life questionnaire) can improve the treatment results. | 8 | 7.9 | 2 | Accepted |

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| **BLOCK III: SURGICAL TREATMENT** | | | | |
|  | **Median** | **% Panelists against** | **Interquartile range** | **Result** |
| **A. Before starting a second-line of treatment of OAB, Do you consider necessary to measure the intensity/severity of symptoms and their impact on quality of life?** | | | | |
| 52. Before starting a second-line of treatment of OAB it is necessary to measure the intensity/severity of symptoms and their impact on quality of life. | 9 | 0.0 | 1 | Accepted |
| 53. 3-days micturition diary with urgency scale is one of the most useful tools for the assessment and monitoring of OAB. | 8 | 2.6 | 1 | Accepted |
| 54. Is necessary to employ specific questionnaires that assess the OAB symptomatology (with or without incontinence) and its impact on quality of life. | 8 | 10.3 | 2 | Accepted |
| 55. OABQ-SF is the most appropriate questionnaire for both the clinical assessment of OAB and the monitoring treatment | 7 | 28.2 | 2 | Accepted |

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| **B. Is there a precise definition for refractory overactive bladder (ROAB) indication?** | | | | |
| 56. If patient does not respond to conservative and antimuscarinic treatments and after using anticholinergic drugs at maximum doses, at least during 8 weeks, he is diagnosed with ROAB | 8 | 20.5 | 2 | Accepted |
| 57. The same treatment options for ROAB are considered in patients with manifest intolerance or contraindication to antimuscarinic drugs. | 8 | 12.8 | 1 | Accepted |
| 58. The employment of onabotulinumtoxin A and sacral neuromodulation, depending on the clinical criteria, the patient's willingness and availability of the center can be considered first-line treatments in ROAB | 8 | 17.9 | 2 | Accepted |
| 59. Onabotulinumtoxin A is considered as the treatment of choice in cases of refractory neurogenic bladder (refractory neurogenic detrusor overactivity) | 8 | 2.6 | 1 | Accepted |

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| **C. In routine clinical practice, Are antimuscarinic drugs associated with other second-line therapies in order to get best response?** | | | | |
| 60. In routine clinical practice antimuscarinics drugs linked to other second-line therapies allow to get better therapeutic response | 7 | 28.9 | 2 | Accepted |
| 61. A reversion of refractoriness to antimuscarinic drugs can be achieved after onabotulinumtoxin A treatment | 6 | 30.7 | 1 | Non-consensus |
| 62. The rescue therapy with antimuscarinic drugs (when a decrease of effect of onabotulinumtoxin A is observed when waiting for the next injection) allows to prolong the effect of onabotulinumtoxin A. | 7 | 30.8 | 3 | Accepted |
| 63. In OAB, intravesical instillation of oxybutynin can be taking into account when a decrease of the effect of onabotulinumtoxin A is observed. | 6 | 12.5 | 1 | Non-consensus |

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| **D. Do you consider highly useful the treatments with peripheral electrical stimulation, posterior tibial stimulation and neuromodulation?** | | | | |
| 64. There is not enough scientific evidence about peripheral electric stimulation usefulness in OAB. | 7 | 41.5 | 4 | Non-consensus |
| 65. Posterior tibial nerve stimulation is a simple procedure that could have a relevant role in patients with ROAB before passing to a treatment with onabotulinumtoxin A and/or sacral neuromodulation although there are few studies proving its effect at long term. | 7 | 30.8 | 2 | Accepted |
| 66. Sacral neuromodulation is a useful reversible technique for the treatment of OAB, although with high economic cost and technical difficulty (specific trial is required). | 8 | 10.3 | 2 | Accepted |

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| **E. In the cases in which OAB is associated to genital prolapse, Do you think that its surgical correction will enhance bladder overactivity?** | | | | |
| 67. Urodynamic study should be done before any surgical correction of pelvic organs prolapse (POP). | 8 | 28.2 | 3 | Accepted |
| 68. Symptomatic POP must be operated independently of detrusor overactivity is demonstrated. | 8 | 7.7 | 2 | Accepted |
| 69. Symptomatic high-grade POP is considered indicated for surgery | 9 | 0.0 | 1 | Accepted |
| 70. The temporary placement of a pessary can predict the possible resolution of bladder overactivity after POP correction. | 7 | 9.8 | 1 | Accepted |
| 71. Surgical intervention is absolutely justified if bladder overactivity is secondary to obstructive prolapse. | 9 | 10.3 | 1 | Accepted |

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| **BLOCK IV: ONABOTULINUMTOXIN A** | | | | |
|  | **Median** | **% Panelists against** | **Interquartile range** | **Result** |
| **A. Onabotulinumtoxin A injections into the detrusor muscle, Are they an effective and safe alternative in the treatment of drug refractory OAB?** | | | | |
| 72. Onabotulinumtoxin A injections into the detrusor muscle is an effective and safe alternative in the treatment of OAB refractory to anticholinergics. | 9 | 0 | 1 | Accepted |
| 73. Onabotulinumtoxin A injections into the detrusor muscle may increase the incidence of urinary infections and postvoid residual urine conditioning the need for clean intermittent catheterization. | 8 | 12.8 | 2 | Accepted |
| 74. Onabotulinumtoxin A injections into the detrusor muscle in OAB refractory to anticholinergics is effective and safe at doses of 200 U . | 8 | 15.4 | 2 | Accepted |
| 75. The use of onabotulinumtoxin A into the bladder is not recommendable if bladder accommodation is reduced by fibrosis, because efficacy is lower. | 8 | 22 | 1 | Accepted |

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| **B. Do you consider necessary to establish reference centers in the treatment of refractory OAB with onabotulinumtoxin A or neuromodulation?** | | | | |
| 76. It is not necessary to establish reference centers for the treatment of refractory OAB. | 8 | 12.2 | 2 | Accepted |
| 77. It is recommendable that sacral neuromodulation is performed in reference centers. | 8 | 7.7 | 2 | Accepted |
| 78. Scarcity of reference centers for neuromodulation can cause undertreatment of refractory OAB. | 7 | 39 | 5 | Non-consensus |

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| **C. Is there a consensus on what diagnostic test should be performed before injecting onabotulinumtoxin A into the detrusor?** | | | | |
| 79. There is no consensus list of essential and recommended tests previous to onabotulinumtoxin A injection | 7 | 46.3 | 4 | Non-consensus |
| 80. Urodynamic study is an essential test before toxin injection. | 8 | 12.2 | 2 | Accepted |
| 81. Postvoid residual urine measurement is an essential test before toxin injection. | 8 | 5.1 | 2 | Accepted |
| 82. Micturition diary with urgency scale is necessary before injection in order to assess the efficacy after the treatment. | 8 | 5.1 | 2 | Accepted |
| 83. Urine sediment and culture are essential tests before treatment. | 9 | 5.1 | 1 | Accepted |
| 84. Free flowmetry is a recommended test, but not essential. | 7 | 18.9 | 1 | Accepted |
| 85. Cystoscopy, cytology and ultrasound are recommended tests, but not essentials. | 7 | 28.2 | 3 | Accepted |

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| **D. Can injection of onabotulinumtoxin A into the detrusor be repeated without losing effectiveness?** | | | | |
| 86. Repeated injection of onabotulinumtoxin A has been shown safe | 8 | 2.6 | 1 | Accepted |
| 87. Repeated injection of onabotulinumtoxin A maintains its effectiveness over time | 8 | 20.5 | 2 | Accepted |
| 88. The adherence to treatments with onabotulinumtoxin A decreases after repeated injections | 7 | 17.1 | 0 | Accepted |
| 89. Repeated injection of onabotulinumtoxin A may increase the postvoid residual urine | 7 | 39 | 4 | Non-consensus |

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| **E. The treatment with onabotulinumtoxin A, Is it cost effective compared to other therapies?** | | | | |
| 90. The cost-effectiveness of the treatment of OAB caused by detrusor neurogenic overactivity with onabotulinumtoxin is higher than treatments with anticholinergic drugs. | 7 | 28.2 | 3 | Accepted |
| 91. The cost-effectiveness of the treatment of OAB with onabotulinumtoxin A is higher than sacral neuromodulation, in the short-mean term. | 8 | 15.4 | 2 | Accepted |
| 92. The cost-effectiveness of sacral neuromodulation for the treatment of OAB can be higher than onabotulinumtoxin A in long-term | 7 | 17.1 | 1 | Accepted |
| 93. The cost-effectiveness of the treatment of OAB with onabotulinumtoxin A is higher than anticholinergic drugs | 7 | 25.6 | 3 | Accepted |