GUIDELINES ON NEUROGENIC LOWER URINARY TRACT DYSFUNCTION

(Text update March 2009)


Introduction
Before the 1980s, considerable morbidity was associated with renal failure in patients with neurogenic lower urinary tract dysfunction (NLUTD). Most patients with NLUTD require life-long care to maintain their quality of life (QoL) and maximise life-expectancy. Significant technological developments that have occurred over the last 30 years have helped to achieve these goals.

Methodology
Where possible, the Panel has used a three-tier system (A-C) to grade treatment recommendations and thus assist clinicians in determining the validity of a recommendation.

Terminology
The terminology used and the diagnostic procedures outlined follow the recommendations for the investigation of the lower urinary tract (LUT) published by the International Continence Society (ICS).
**Risk factors and epidemiology**

All central and peripheral neurological disorders carry a high risk of causing functional disturbances of the urinary tract.

**Classification**

Several classification systems have been proposed for NLUTD. The panel recommends a functional classification for motor function based on urodynamic and clinical findings (Figure 1).

Fig. 1: The EAU-Madersbacher classification system

Adapted from Madersbacher et al.
Timing of diagnosis and treatment
In both congenital and acquired NLUTD, early diagnosis and treatment are essential, as irreversible changes within the LUT may occur, even when the related neuropathological signs are normal. Also, remember that NLUTD can, by itself, be the presenting feature of neurological pathology.

Diagnosis
Patient assessment
Diagnosis of NLUTD should be based on a comprehensive assessment of neurological and non-neurological conditions. Initial assessment should include a detailed history, physical examination, and urinalysis.

History
An extensive general and specific history is mandatory and should concentrate on past and present symptoms and disorders of the urinary tract, bowel, and sexual and neurological function. Special attention should be paid to possible warning signs and symptoms (e.g. pain, infection, haematuria, fever) that warrant further investigation.

Physical examination
The neurological status should be described as completely as possible. All sensations and reflexes in the urogenital area must be tested, including detailed testing of the anal sphincter and pelvic floor functions (Figure 2). Availability of this clinical information is essential for the reliable interpretation of subsequent diagnostic investigations.
Fig. 2: The neurological status of a patient with NLUTD must be described as completely as possible (a - dermatomes, b - associated reflexes).

Fig. 2a - Dermatomes of spinal cord levels L2-S4.

Fig. 2b - Urogenital and other reflexes in lower spinal cord.
**Urodynamic tests**

A bladder diary should be recorded for at least 2-3 days. Uroflowmetry and ultrasound assessment of post-void residual should be repeated at least 2 or 3 times in patients able to void.

Invasive urodynamic studies comprise mandatory assessment tools to determine the exact type of NLUTD (Table 1).

<table>
<thead>
<tr>
<th>Table 1: Guidelines for urodynamics and uro-neurophysiology tests in NLUTD</th>
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<tbody>
<tr>
<td>Urodynamic investigation is necessary to document the (dys-)function of the LUT.</td>
<td>A</td>
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<tr>
<td>The recording of a bladder diary is advisable.</td>
<td>B</td>
</tr>
<tr>
<td>Non-invasive testing is mandatory before invasive urodynamics is planned.</td>
<td>A</td>
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<tr>
<td>Video-urodynamics is currently the preferred method for invasive urodynamics in patients with NLUTD. If this is not available, then a filling cystometry continuing into a pressure flow study should be performed.</td>
<td>A</td>
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<tr>
<td>For standard urodynamic testing, a physiological filling rate (see Table 1, e.g. not faster than 20 mL/min) and body-warm fluid must be used.</td>
<td>A</td>
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<tr>
<td>Specific uro-neurophysiological tests and provocative manoeuvres (e.g. fast filling cystometry with cooled saline [the ‘ice water test’], coughing, tapping, anal stretch) are elective procedures.</td>
<td>C</td>
</tr>
</tbody>
</table>
Filling cystometry is the only procedure that quantifies the filling function of the bladder. However, when filling cystometry is used alone, the results have limited significance.

Measurement of detrusor leak point pressure (DLPP) has limited diagnostic value; it is not recommended as a stand alone test.

Pressure flow studies: the function of the LUT must also be recorded during the voiding phase.

Video-urodynamics combines filling cystometry and pressure flow studies with radiological imaging. Currently, video-urodynamics is considered to provide the most comprehensive information evaluating NLUTD.

Electromyography (EMG) is a semi-quantitative measure of pelvic floor activity, which can be used to detect detrusor/sphincter dyssynergia (DSD) and pelvic floor relaxation disorders.

Table 2: Characteristic findings in NLUTD*

<table>
<thead>
<tr>
<th>Filling phase</th>
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<tr>
<td>• Increased, decreased, or absent bladder sensation</td>
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<tr>
<td>• Vegetative non-specific sensations</td>
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<tr>
<td>• Low bladder compliance</td>
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<tr>
<td>• High capacity bladder</td>
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<tr>
<td>• Detrusor overactivity, spontaneous or provoked</td>
</tr>
<tr>
<td>• Incompetent urethral closure mechanism</td>
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<table>
<thead>
<tr>
<th>Voiding phase</th>
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<tr>
<td>• Acontractile or underactive detrusor</td>
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</table>
• Bladder outlet obstruction
• DSD
• Non-relaxing urethral sphincter obstruction

These signs warrant further neurological evaluation, as LUTD may be the presenting symptom of a neurological disease.

*modified from ICS publication.

Treatment

Introduction

Treatment of NLUTD aims to protect the upper urinary tract, and improve continence, QoL and, whenever possible, LUT function.

In patients with a high detrusor pressure in the filling phase, the principal aim of treatment is conversion of an overactive, high-pressure bladder into a low-pressure reservoir; even if this should result in a high post-void residual. The patient’s QoL is a prime consideration when making any treatment decision.

Conservative treatment

Drug treatment for neurogenic detrusor overactivity (NDO)
Antimuscarinic agents are currently the most widely used treatment, although most of the available drugs have not been registered for the treatment of this patient population. Antimuscarinic agents can also be given intravesically.

Drug treatment for neurogenic detrusor underactivity

There is no evidence of effective drug treatment for detrusor underactivity.
Drug treatment to decrease bladder outlet resistance
Selective and non-selective alpha-blockers have been partially successful in decreasing bladder outlet resistance, residual urine and autonomic dysreflexia.

Catheterisation
Intermittent, self- or third-party, catheterisation (IC) is the gold standard for the management of NLUTD. Compared to clean IC, aseptic IC provides significant benefit in reducing the potential for contamination. On average, IC, using a 12-14 Fr catheter, is needed 4-6 times per day.

Indwelling transurethral IC and, to a lesser extent, suprapubic cystostomy should be avoided as they are risk factors for UTI and significant long-term complications. If indwelling catheters must be used, empirical evidence and expert opinion suggests silicone catheters provide advantages over latex catheters.

Assisted bladder emptying
Triggered reflex voiding is not recommended as there is a risk of pathologically elevated bladder pressures. Only in the case of absence, or surgically reduced, outlet obstruction it may be an option. Bladder compression techniques to expel urine (Crede) and voiding by abdominal straining (Valsalva manoeuvre) create high pressures and are potentially hazardous, and their use should be discouraged.
**Rehabilitation**
In selected patients, pelvic floor muscle exercises, pelvic floor electro-stimulation, and biofeedback might be beneficial.

**External appliances**
Social continence for the incontinent patient can be achieved using an appropriate method of urine collection.

**Minimally invasive treatment**
**Botulinum toxin A injections in the bladder**
Botulinum toxin A causes a long-lasting (approximately 9 months), reversible, chemical denervation.

**Intravesical vanilloid treatment**
Resiniferatoxin and capsaicin have limited clinical efficacy compared to botulinum toxin A injected in the detrusor.

**Bladder neck and urethral procedures**
Reduction of the bladder outlet resistance, to protect the upper urinary tract, can be achieved by sphincterotomy or chemical denervation of the sphincter using botulinum toxin A. Insertion of urethral stents is not recommended. Increasing bladder outlet resistance using bulking agents or urethral inserts, or alternative appliances is not recommended for long-term treatment.

**NDO and reflux**
Vesico-ureteral reflux should be managed by lowering intravesical pressure. If reflux is persistent, intervention using bulking agents or ureteral re-implantation can be considered.
**Surgical treatment**

**Overactive detrusor**
Bladder augmentation/clam cystoplasty is indicated for an overactive detrusor, when less invasive procedures have failed. Alternative options include: auto-augmentation (myectomy), dorsal rhizotomy, with or without sacral anterior root stimulation (SARS) (complete lesions), and neuro-modulation (incomplete lesions). Substitution, with either continent or incontinent diversion, is indicated for the small contracted non-compliant bladder.

**Fig. 3: Surgery for neurogenic detrusor overactivity**

<table>
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<tr>
<th>Surgery for neurogenic detrusor overactivity</th>
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<tr>
<td><strong>All lesions</strong></td>
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<tr>
<td>Botulinum Toxin A</td>
</tr>
<tr>
<td>Auto-Augmentation (optional)</td>
</tr>
<tr>
<td>Clam Cystoplasty</td>
</tr>
<tr>
<td>Enterocystoplasty</td>
</tr>
<tr>
<td>Incomplete lesion</td>
</tr>
<tr>
<td>Neuromodulation</td>
</tr>
<tr>
<td>Deafferentation</td>
</tr>
<tr>
<td>Complete lesion</td>
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<tr>
<td>Neurostimulation</td>
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**Underactive detrusor**
Sacral anterior root stimulation (complete lesions) and sacral neuromodulation (incomplete lesions) are effective in selected patients.

**Sphincter insufficiency (underactive urethra)**
The artificial urinary sphincter is the preferred tried and tested treatment.
Procedures to treat sphincter incompetence are suitable only when the detrusor activity is, or can be, controlled and there is no significant associated vesico-ureteral reflux.

**Quality of life**

QoL represents a very important aspect in the global management of the patient who has NLUTD. Restoration and maintenance of the patient’s QoL it as much as possible, should be one of the major aims of treatment. QoL should be integral to the evaluation of lower urinary tract symptoms in patients with NLUTD and also, when considering any type of treatment for neurogenic bladder dysfunction.

**Follow-up**

Meticulous follow-up and regular checks are essential. Individualised patient follow-up is imperative to safeguard QoL and life expectancy. The underlying pathology and the state of the urinary tract dictate the frequency of follow-up required.

<table>
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<tr>
<th>Table 3: Minimum follow-up required in patients with NLUTD*</th>
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<tbody>
<tr>
<td>Investigation</td>
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<tr>
<td>Urinalysis</td>
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<tr>
<td>Ultrasound of the upper urinary tract, bladder status, post void residual</td>
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<tr>
<td>Physical examination, blood biochemistry, and urine microbiology</td>
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</tbody>
</table>
(Video-) urodynamic investigations in patients without detrusor overactivity and with normal bladder compliance | Every 2 years | A
---|---|---
(Video-) urodynamic investigations in patients with detrusor overactivity, and/or low bladder compliance | At least once a year | A

The need for detailed special investigations must be determined on the basis of the patient’s risk profile (see above), but should, where indicated, include a video-urodynamic study, which should be carried out in an institution with neuro-urological expertise.

*Grades of recommendation assigned on basis of panel consensus.*

**Summary**

NLUTD is a multi-faceted pathology. Extensive investigation and a precise diagnosis are required before the clinician can initiate individualised therapy. Treatment must take into account the patient’s medical and physical condition and expectations with regard to his/her future social, physical, and medical situation.

This short booklet text is based on the more comprehensive EAU guidelines (ISBN 978-90-79754-09-0), available to all members of the European Association of Urology at their website, http://www.uroweb.org.