OPEN ACCESS Freely available online

Medical & Surgical Urology

ISSN: 2168-9857

Short Communication

Closing the Divide in Third-Line OAB Therapy: Toward Unified Clinical Practice

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DESCRIPTION

Overactive Bladder syndrome (OAB), characterized by urgency, frequency, and nocturia, affects nearly 12% of the global population and significantly impairs quality of life. Despite being a well-recognized clinical condition with established treatment guidelines, the management of OAB particularly in advanced stages remains inconsistent. A recent international survey conducted among members of the International Continence Society (ICS) revealed that third-line treatment preferences for OAB vary markedly across specialties, especially between urology and urogynecology-trained physicians. These findings should prompt the medical community to reflect critically on how treatment access, provider training, and specialty biases shape care delivery and patient outcomes [1].

The study, which collected responses from 201 physicians globally, highlights the growing divide in clinical decision-making despite shared guidelines. Notably, botulinum toxin injections and Sacral Neuromodulation (SNM) emerged as the most favored third-line treatments, rated highly favorable by 46.2% and 29.9% of respondents respectively. However, the enthusiasm for SNM varied significantly depending on the physician's specialty only 15.4% of OB-GYN-trained urogynecologists favored SNM compared to nearly 49% of urology-trained subspecialists [2].

This divergence is troubling, not because it reflects a lack of knowledge, but because it likely stems from training exposure, familiarity with procedures, and access to resources. Fellowship-trained physicians were more likely to follow structured post-treatment follow-ups, typically seeing patients within four weeks an important benchmark for evaluating response and managing complications. Conversely, the availability of therapies such as Implantable Tibial Nerve Stimulation (ITNS) remained limited, with only 19.4% of respondents reporting access. The treatment landscape is clearly uneven [3].

What is most concerning is not the disparity in preference per se, but what underlies it. Physicians trained in urology are likely more comfortable performing SNM due to their surgical and procedural exposure. Meanwhile, OB-GYN-trained urogynecologists may be less familiar or comfortable with implantable devices, particularly SNM or ITNS. This difference in comfort level translates directly into what options are presented to patients. And herein lies the core issue: a patient's access to therapy may be inadvertently dictated by their doctor's background, rather than by what is best for their condition [4].

Moreover, the issue of availability remains a serious obstacle. Botulinum toxin is nearly universally accessible, except in a few regions such as Pakistan and Andorra. SNM, though widely used in high-resource settings, is still unavailable to nearly 20% of physicians surveyed. ITNS, the newest among the options, is only accessible to a fifth of practitioners. This disparity hints at deeper issues of healthcare inequity and uneven resource allocation, which need urgent addressing through global health partnerships, government support, and industry engagement [5-6].

Another area requiring attention is the standardization of patient counseling. Patients must be thoroughly educated about the benefits, risks, and expectations of each third-line therapy. Unfortunately, when provider preferences bias treatment discussions, patients may never learn about viable alternatives. An urologist may lean toward SNM, while a urogynecologist may prefer PTNS or defer more invasive interventions. Ideally, treatment decisions should follow a shared decision-making model grounded in clinical guidelines, not shaped by provider limitations [7-8].

What this study ultimately underscores is the need for harmonization. Clinical guidelines from bodies such as the AUA and SUFU exist precisely to standardize care across different provider backgrounds. Yet real-world practice suggests that these guidelines are filtered through the lens of specialty-based training and access. Bridging this gap requires a multipronged approach: expanding access to therapies, unifying training across disciplines, reinforcing guideline adherence, and promoting interdisciplinary dialogue. The solution is not to homogenize the practice of urology and urogynecology each brings valuable perspective to pelvic floor care. Instead, collaboration must be the cornerstone. Combined clinics, shared care models, and joint procedural training can foster mutual respect and

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Received: 20-Feb-2025, Manuscript No. MSU-25-38188; **Editor assigned:** 24-Feb-2025, PreQC No. MSU-25-38188 (PQ); **Reviewed:** 10-Mar-2025, QC No. MSU-25-38188; **Revised:** 17-Mar-2025, Manuscript No. MSU-25-38188(R); **Published:** 24-Mar-2025, DOI: 10.35841/2168-9857.25.14.384

Citation: Kardous B (2025). Closing the Divide in Third-Line OAB Therapy: Toward Unified Clinical Practice. Med Surg Urol.14:384.

understanding between specialties. Furthermore, research into newer, less invasive third-line treatments like ITNS should be accelerated to offer simpler, patient-friendly options that may reduce both provider and patient resistance [9-10].

CONCLUSION

In conclusion, the management of OAB has entered an era where multiple effective third-line therapies are available, yet inconsistency in usage and availability hinders optimal care. Specialty-based preferences, patient resistance, and training deficiencies act as barriers, but they are not insurmountable. The global continence community must now focus on standardizing access, improving training, and encouraging cross-specialty collaboration to ensure that every patient with OAB receives the most appropriate care regardless of geography or provider background. With unified clinical practice and shared commitment, we can move toward an era where treatment decisions are based on patient needs, not provider limitations.

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