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GLOBAL INTERSTITIAL CYSTITIS, BLADDER PAIN SOCIETY Newsletter

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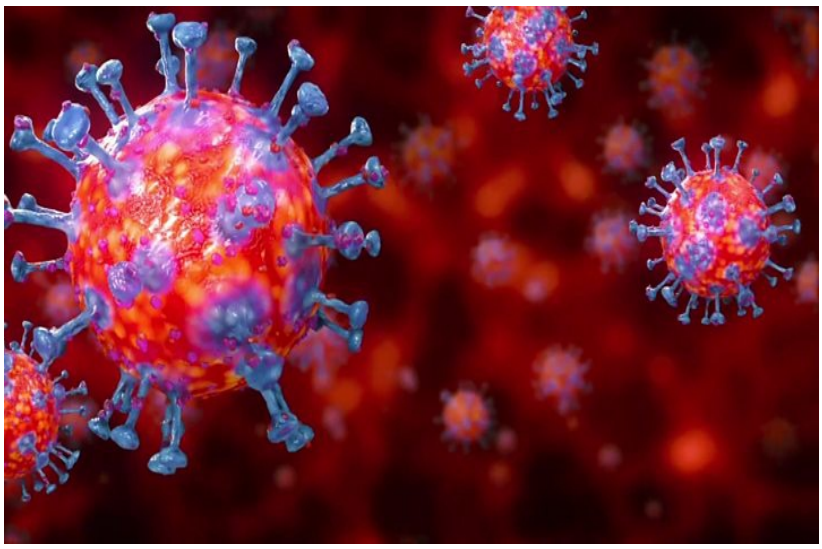
LESSONS LEARNED DURING COVID-19 PANDEMIC WHILE MANAGING BLADDER PAIN SYNDROME



INTRODUCTION

I am sure none of us could have imagined the global challenges the coronavirus (COVID-19) outbreak would create and bring the significant change in our daily routine from busy clinics and operating rooms to virtual consultation. It is likely that these changes will persist for some uncertain time. If so, what will we learn from this to improve our future practice in terms of management of Bladder Pain Syndrome/ Interstitial Cystitis (BPS/IC). Till now; none of recently issued guidelines [1,2] has touched this topic, as it might have been considered as non-urgent condition. While acute exacerbations could be really distressing for the patients and they still need to be supported through these difficult times. This write up is an attempt to guide individual healthcare professionals to continue managing these patients in these challenging times.

DIFFERENT PRESENTATIONS

The patients who approach you could be of two broad categories; either already diagnosed patients presenting with acute exacerbation (Category A)or undiagnosed patients where you suspect the presence of this disease (Category B). These two can be further subcategorised as

A1 - Relapse (already continuing treatment of BPS/IC with initial relief)

A2 - Recurrence (stopped treatment of BPS/IC after relief)

B1 - Nonspecific symptoms of urgency, frequency, discomfort for few weeks; not responding to usual antibiotics (occasionally even injectable once).*

B2 - Compelling feeling of incomplete evacuation of bladder.*

* Reason behind keeping these two subcategories is social media on internet, which many times prompt patients to make their own diagnosis and few patients specifically start their presenting complaints stating their self- made diagnosis in medical terms either as Recurrent UTI (B1) or Urinary Retention (B2).

Sometimes few family or general practitioners also contribute in their illusion by initialising treatment for the same diagnosis without complete evaluation and now patient approaches to you because of no relief despite extensive treatment for the same.

CHALLENGES

Ideally you should still follow the GIBS guideline for making a diagnosis of BPS/ IC, but considering the present scenario few challenges could be

1. Considering only urine routine and microscopy (RM) as mandatory to rule out Urinary Tract Infection (UTI) – now most of the sampling is from home with compromised collecting facilities. Therefore reliability of this test is questionable because of possibility of destruction of pus cells and other effects due to time lag resulting in false negative tests [3].

   Preferably ask for Urine culture and sensitivity along with RM, though there could again be chances of false positive test results due to contamination.

   Explanation: BPS/IC is a diagnosis of exclusion and its essential to rule out UTI; though in case of false positive results no response to antibiotics prescribed as per sensitivity results and repeat tests showing same organism and sensitivity can raise the suspicion of BPS/IC, provided clinical assessment is not suggestive of other pathology.

2. Non-availability of easy facility of Ultrasound (USG) or bladder scan to check PVR (Postvoid residual) and also patient's reluctance to go out, especially for category B2 – **Mention clearly in your prescription the requirement of the USG, even if patient denies or ask for some alternative.**

   A properly maintained frequency volume chart / Bladder diary can sometimes be helpful even to rule out voiding dysfunction apart from its other benefits. **Motivate patient to see online tutorials** eg. https://youtu.be/hfIOqIJ9bDI **to avoid mistake in filling the Bladder Diary** and giving excuse of not able to do so because of inability to recall what all you explained.

TIPS ON MANAGEMENT

Always follow GIBS Guidelines. In addition

1. To allow virtual consultation, always choose a proper channel like hospital call centre or a valid e-consultation app to maintain a record of appointments.
2. Ask patients to send all previous records of prescriptions and investigations online before your consultation even for face to face OPD visits to avoid touching her previous papers.
3. If possible ask them to also send you screenshot of their Aarogya Setu just before entering your room to rule out any recent exposure to active patient of COVID – 19. Avoid hospitalisation of these patients in common wards even for minor procedures like Bladder instillation.
4. Specifically ask for inclusion of any fresh bladder irritants in diet even from old patients (A1, A2) despite their strong belief that they are religiously following your advice of diet modification; as many new immunity boost ups are being marketed now a days.
5. Include Urine alkalizers while waiting for urine reports. Advice to use Baking soda from kitchen for immediate relief if delay in getting medication is expected.
6. Also advise the woman on self-care measures to avoid local irritation like Toileting techniques: sitting to void, feet flat on the floor, elbows leaning on thighs and relaxing. Double voiding techniques: When the patient has finished voiding, they count to 120, slightly lean forward and pass urine again or stand up move around a bit and sit down again. Avoid long intervals between passing urine. Drink at least 1.5L of fluid per day (preferably water; avoid those containing caffeine) Avoid using any feminine hygiene sprays and scented douches. Emptying bladder after sexual intercourse, as sexual relations can often trigger irritative LUTS even UTIs.

7 Consider antibiotics without recent urine reports on first visit, only if no history of recent consumption and severity of symptoms prevails like in presence of fever or other systemic symptoms.

8 Encourage all patients on bladder instillation to learn self-instillation to avoid many hospital visits.

9 Practise a good referral policy eg. take help of your psychiatry colleague for stress management, GI for bowel management etc.

10 Encourage them to join a social group of patients of BPS but make sure it promotes positive thinking.

11 Mention all details of your conversation including her denial for hospitalisation etc. in your prescription. You can even utilize the opportunity of recording your conversation on video/ phone call provided your appointment includes prior consent to do so.

12 Always provide a prescription on your letter head even for virtual consultation, whether hand written or typed.

13 Last but not least reassurance is the key requirement for managing these patient to alley their anxiety level in this difficult time, as we know anxiety and stress indirectly can result in worsening of condition.

DISCUSSION:

At the end, after going through this phase we will probably learn that a significant portion of what we do can be done remotely [4]. A previously published randomized trial in the International Urogynecology Journal also concludes that postoperative phone visits are not inferior to in-person visits in terms of patient satisfaction, complications and adverse events [5]. Another prospective study showed that scheduled postoperative phone visits reduce the number of patient -initiated calls and < 25% of patients calling needed to be seen in person [6]. We admit the therapeutic benefits of face to face visits in OPD, but offering care in a way that saves time, energy and money has its own advantages [7]. At least this strategy can be adopted for follow up to reduce distressing calls from A1 and A2 subcategories.

CONCLUSION:

This write up provides a framework for decision making, but I urge you to apply your own professional judgment to the situations you face.

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