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GLOBAL INTERSTITIAL CYSTITIS, BLADDER PAIN SOCIETY

NEWSLETTER

Initial assessment of Interstitial Cystitis / Bladder Pain Syndrome (IC/BPS)

IC/BPS is of unknown etiology with difficulty to reach a diagnose. It has often been described as two separate disorders: "IC," a chronic inflammatory disorder and "BPS," often lacking an inflammatory component [1].

Diagnosis is symptom driven and with no definitive marker till date for interstitial cystitis (2). I agree with the recently published literature, that "there is worldwide confusion in diagnosis and treatment of IC patients and most of them not receiving individualized tailored treatment" [3].

What is the most striking symptom that a patient wants relief from?

Filling Pain as opposed to dysuria, is the most striking symptom, and mostly exists in the absence of demonstrable pathology of the viscera or associated nerves. Patients with chronic pain experience a greater impairment in quality of life than healthy controls.

Our aim with this article is to help in initial evaluation for early diagnosis of IC/BPS.

Evaluation:

1. **A careful history** related to bladder must be elicited. Most patients with IC/BPS have symptom complexes as shown in Table.1. Symptomatology is illustrated in Table.2.

The Pelvic Pain Urgency and Frequency (PUF) symptom scale is a simple tool of 8 questions which helps in diagnosis of IC/BPS. It is a self-administered questionnaire and measures both the presence and severity of symptoms of IC and the degree to which women are bothered with the symptoms. It helps to distinguish IC/BPS from other condition of chronic pelvic pain [4].

Other validated symptom scales are IC Symptom and Problem Index and the Genitourinary Pain Index. They assess the severity and monitor clinical progress after diagnosis. They do not help to distinguish IC/BPS from other conditions [5].

The O'Leary-Sant Interstitial Cystitis Symptom Index (ICSI) is effective in screening [6] and outcome measure [7]. It has four domains examining urinary urgency, frequency, nocturia, and pain.

A modified clinical scoring system has been developed by Taneja et al, which in addition to the above four domains, include sexual dysfunction in male and female and psychological impact [8].

Overlapping Conditions with IC/BPS

- Depression
- Pelvic floor dysfunction & Myofascial pain (87 %)(9)
- Irritable bowel syndrome
- Vulvodynia (48%)(10)
- Fibromyalgia,
- Chronic fatigue syndrome,
- Anxiety disorders,
- Sjögren's syndrome, Endometriosis,
- Migraines, and Temporomandibular joint disorder

Symptomatology

- Pain perceived to be related to bladder (ref to Table.3)
- Urinary urgency & frequency
- Dyspareunia
- Premenstrual flares (points more towards endometriosis and helps to exclude IC/BPS)
- Multiple triggering factors - diet, stress, after certain activities (eg, exercise, sexual intercourse, prolonged sitting)
- Failed response to treatment for other suspected diseases, e.g. endometriosis, overactive bladder, refractory UTI,etc
- High scores on PUF scale

GIBS Definition of IC/ BPS

Pain or discomfort in lower abdomen and /or urogenital area

- Of more than 3 months duration
- Which is usually worst on full bladder
- Along with one or more lower urinary tract irritative symptoms like frequency, urgency, nocturia
- With or without standard stigmata on cystoscopy
- Provided another discernible pathology likely to cause these symptoms has

2. **Focussed Physical Examination (Table.4)** to rule out alternate diagnoses including pelvic prolapse, urethral diverticulum, inguinal hernia, uterine/cervical mass, prostate mass, and eroded/exposed vaginal mesh. Severe tenderness may make it impossible to perform an adequate pelvic or rectal examination. In this situation, for patients who meet diagnostic criteria for IC/BPS, clinicians may choose to begin empiric treatment and to defer full examination until symptoms have improved to the point where examination is possible [11].

Physical examination findings

Variable tenderness of the abdominal wall, hip girdle, pelvic floor, bladder base, and urethra

- Suprapubic tenderness
- Anterior vaginal wall/ bladder base tenderness
- Levator muscle spasm
- Rectal spasm
- Allodynia

3. **Bladder diary / Voiding diary:** frequent, low-volume (←300 mL) voiding pattern is characteristic of IC/BPS. Patients with IC/BPS give a history of frequent voiding to maintain low bladder volumes to avoid discomfort & pain.
4. **Urine analysis & urine culture:** mostly normal in IC/BPS, but normal urine analysis does not rule out IC/BPS. The important thing is that urine does not contain any signs of infection like pus cells, leukocyte esterase or nitrite. Presence of any of them indicates UTI and raises caution against the diagnosis of IC /BPS. Presence of microscopic hematuria indicates urine cytology to exclude urothelial carcinoma [13].
5. **Post void residual volume:** by ultrasound or placing a catheter in the bladder (usually avoided as it may cause more pain). Urinary retention could suggest bladder outlet obstruction or neurologic dysfunction.
6. **Use of routine cystoscopy:** for evaluation of IC/BPS is controversial. Some societies such as American urological association recommends its use in select cases. Cystoscopy has been incorporated as part of diagnostic workup in GIBS and is a mandatory diagnostic tool. Canadian Urological Association guidelines recommends cystoscopy in all patients [13]. Further discussion is beyond the scope of this article [11,12].
7. **Intravesical anaesthetic bladder challenge / lignocaine sensitivity test:** and hydrodistension are optional tests, included in case of doubt [13].

Conclusion:

One should have a high clinical suspicion while investigating and treating patients with chronic pelvic pain. Most patients with IC/BPS have visited many doctors and received multiple treatments, without much relief. Therefore, it is important to spend time with them and individualize their management. A multidisciplinary clinic approach is ideal for treating these patients.

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