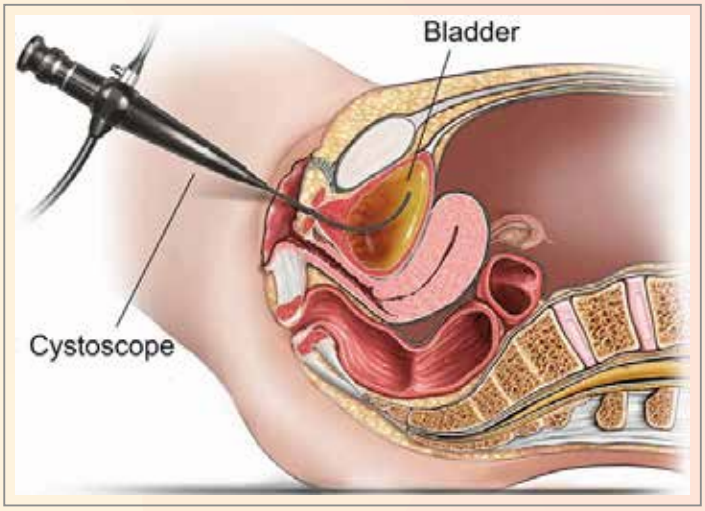
GLOBAL INTERSTITIAL CYSTITIS, BLADDER PAIN SOCIETY

NEWSLETTER

VOLUME 2, ISSUE 5 (AUGUST 2020)



THE ROLE OF CYSTOSCOPY IN BLADDER PAIN SYNDROME:

BPS can be defined as pain, pressure, or discomfort in the pelvis/bladder, associated with urinary symptoms (frequency, urgency, nocturia, bladder filling pain) lasting at least 6weeks (AUA), and with no identifiable cause.

Since 2008, the European Society for the Study of Interstitial Cystitis (ESSIC) establishes the diagnosis in basis of chronic (>6 months) pelvic pain, pressure or discomfort perceived to be related to the urinary bladder accompanied by at least one other urinary symptom such as persistent urge to void or urinary frequency, and establishes a list of confusable diseases that must be excluded. It indicates that the practice of cystoscopy under anaesthesia with HD with eventual biopsy is a diagnostic prerequisite.

Pain (including sensations of pressure and discomfort) is the hallmark symptom of IC/BPS. Pain involves the

urethra, vulva, vagina; including pain that is worsened with specific foods or drinks and/or worsened with bladder filling and/or improved with urination. Baseline voiding symptoms and pain levels should be obtained to measure subsequent treatment effects. Patients can be asked to complete a bladder diary and a food diary and urine should be tested to rule out a urinary tract infection.

Cystoscopy and/or urodynamics should be considered when the diagnosis is in doubt; these tests are not necessary for making the diagnosis in uncomplicated presentations.

Initial treatment type and level should depend on symptom severity, clinician judgment, and patient preferences.

Patients should be educated about normal bladder function, what is known and not known about IC/BPS, the benefits /burdens of the available treatment alternatives.

Patients should be encouraged to implement stress management practices and avoid certain food.

Cystoscopy under anaesthesia with short duration, low-pressure hydrodistension may be undertaken if conservative measures or oral (amitriptyline, cimetidine, hydroxyzine, or pentosan polysulfate) and intravesical (DMSO, heparin, or lidocaine) medications do not provide relief.

Cystourethroscopy enables the inside of the bladder and urethra to be visualised. It is an invasive but relatively low-risk procedure.

The choice between a rigid or flexible cystoscope and the anaesthetic used will depend upon the individual case and the preferences of the operator. Modern cystoscopes consist of at least three elements. First, an optical system for transmitting the image to a video monitor with maximum clarity and resolution. In a rigid endoscope this is done by a rod-lens system and in a flexible endoscope, by multifibre bundle of optical fibres. Another system of optical fibres is needed to transmit light into the bladder and an irrigating channel to flush away blood and dilate the bladder under direct vision. Most operating cystoscopes also have an outflow channel to carry debris away.

There are many indications where a direct visual inspection and targeted biopsies of the bladder and urethra are important in establishing a diagnosis.

Indications

- To investigate haematuria not related to urinary tract infection
- When a reduced bladder capacity or painful filling is found at cystometry
- To exclude bladder tumours and stones as a cause of recurrent or persistent urinary tract infection
- If a lower urinary tract fistula is suspected
- If interstitial cystitis is suspected
- Following failed incontinence surgery where the patient complains of voiding difficulty, irritative symptoms or persistent incontinence.

According to the criteria of the NIDDK, hydrodistension must take place under anaesthesia, at a pressure of 80 to 100 cmH2O, lasting 1 to 2 minutes and up to 2 times. To be considered positive Hunner's ulcers or glomerulations must be identified, which should be diffuse in at least three quadrants, with ten glomerulations per quadrant and these lesions should not be in the path of the cystoscope.

GIBS ON THE GO WEBINAR

GIBS has successfully conducted its 4th webinar on IC/BPS with

Association of Obs & Gyn Society of Bihar & Jharkhand
GIBS - AOGSBJ Live Webinar

Date: **17th July 2020**
Topic: **Female Pelvic Therapy & Wellness**
Participants: **360 Plus**

However, and despite the passing of the years, there is not a standard technical protocol. ESSIC and EAU guidelines did not mention the technique, and the AUA guidelines suggests that when carried out with therapeutic purposes it must be done under anaesthesia, at low pressure (60 to 80 cmH2O) and for less than 10 minutes.

Hunner's lesion is the most characteristic finding of this pathology. Hunner's lesion is a distinctive inflammatory lesion with characteristic central fragility, presenting a deep rupture through the mucosa and submucosa when bladder distention is provoked. It is defined as a circumscript, reddened mucosal area with small vessels radiating towards a central scar, with a fibrin deposit or coagulum attached to this area. However, this lesion is identified in less than 10% of patients with clinical diagnosis of IC/BPS

ESSIC classified IC/BPS combining cystoscopic and histological findings. Accepting as positive the glomerulations grade 2-3, Hunner's lesions or both, and including as positive biopsy findings inflammatory infiltration and/or granulation tissue and/or detrusor mastocytosis and/or intrafascicular fibrosis. IC/BPS subtypes are classified by the combination of a number for cystoscopic finds (1, 2, and 3 for normal, glomerulations or Hunner's injury respectively) and a letter for histopathological findings (A for normal biopsy, B for inconclusive and C for positive). If the cystoscopy or biopsies are not performed, the letter X is assigned.

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