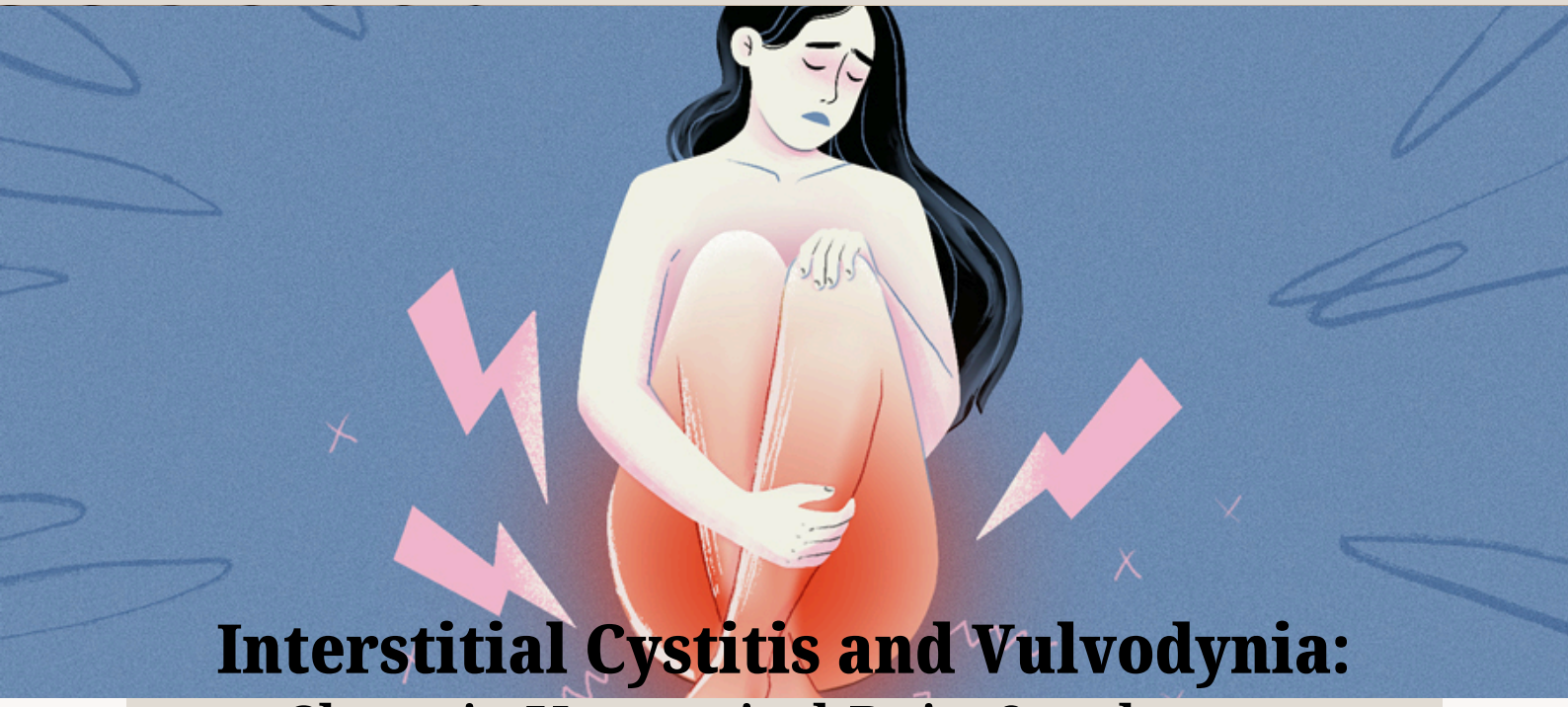
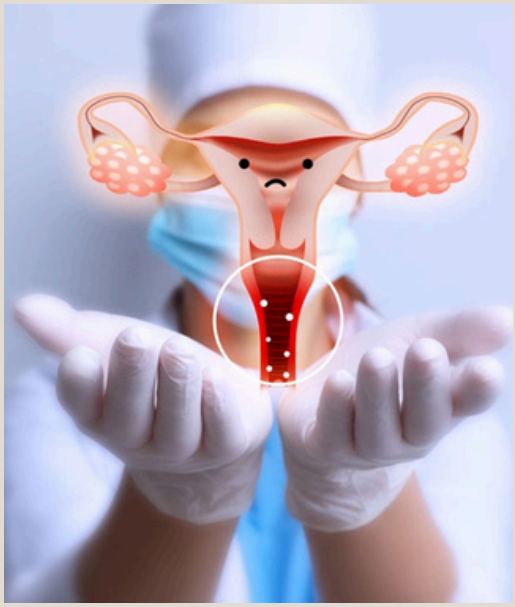
VOLUME 6
ISSUE 3

GIBS NEWSLETTER

JUNE 2024



Interstitial Cystitis and Vulvodynia: Chronic Urogenital Pain Syndrome



Once suspected only as a diagnosis of exclusion, IC has now found its own clinic-pathological identity owing to better definitions and diagnostic criteria. It is known that the symptoms of IC overlap with many other uro-gynecological conditions. Vulvodynia is one such enigmatic condition that very often coexists with IC. The definition of vulvodynia has evolved from the original 2003 International Society for the Study of Vulvovaginal Disease (ISSVD) definition that identified vulvar discomfort as possibly “idiopathic” to the recent one in 2015 that acknowledges the complexity of its presentation and the “potentially associated” factors whose identification is necessary for a complete management plan.(1)

A review published by Jean et al stated that the prevalence of spontaneous and provoked vulvodynia is in 23.4% and 74.5% of all IC cases. In this study, vulvodynia was localised in 38 (80.9%) and generalised in 8 (17%) cases. This number is significantly higher than that reported in the general population (7-16%) (2) Similarly, patients with vulvodynia are two to three times more likely to also have one or more other chronic pain conditions like IC. (3)

In this newsletter you will find:

Article on IC & Vulvodynia, Latest updates on GIBS activities, Become a Lifetime Member, Be the NEXT Author.

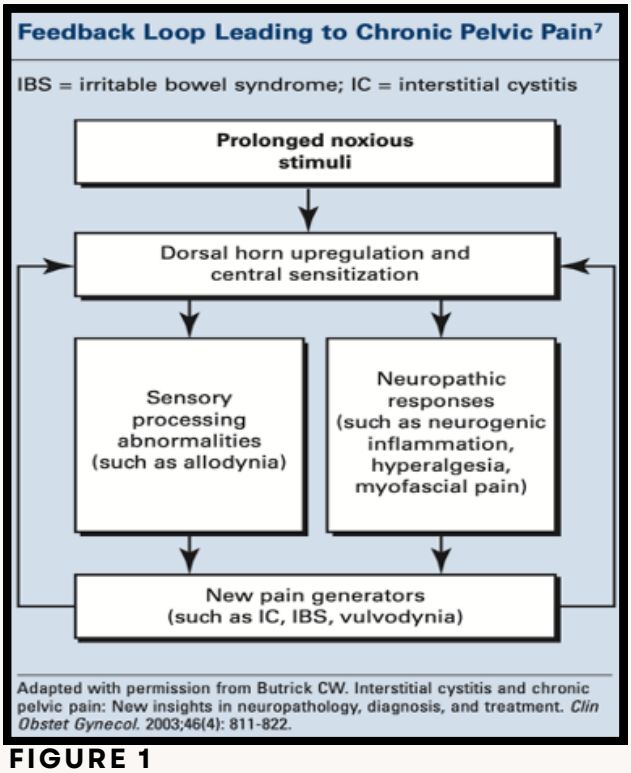
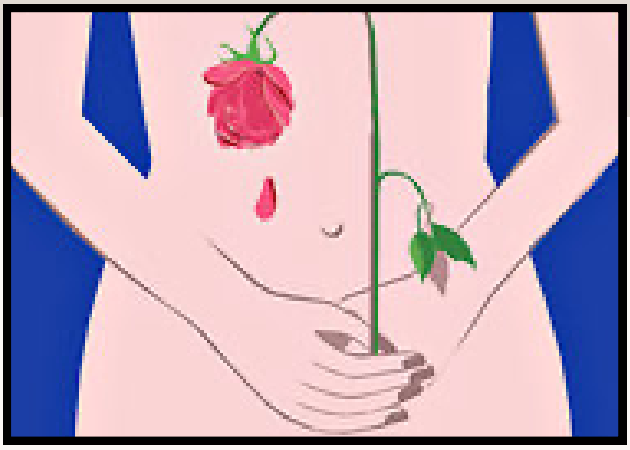


FIGURE 1

Etiopathogenesis

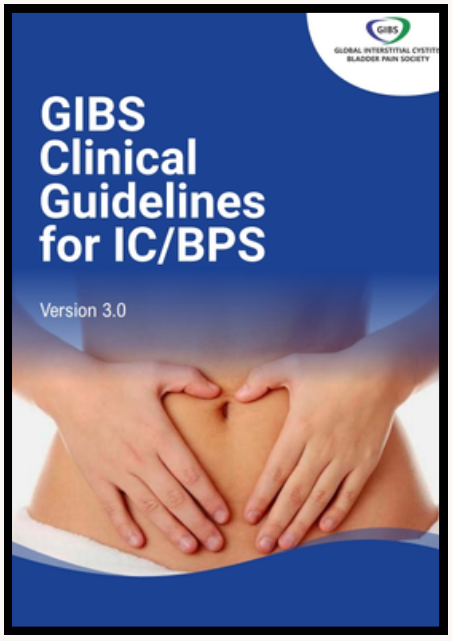
IC and vulvodynia have common embryological and neuroanatomical origins. The female urinary and reproductive systems arise from the urogenital sinus and are innervated by the same sacral nerve pathways. Both local (end organ) and central nervous system (CNS) related pain pathways (as demonstrated by functional MRI scans) **(Figure 1)** have been identified in IC and vulvodynia. (3) It has been postulated that changes in the sex steroid milieu like that during oestrogen surge, may cause perimenstrual and periovulatory symptom exacerbation/ flares in both vulval and bladder pain. (4)

Oral contraceptive (OCP) use has also been linked as a causative factor in female sexual dysfunction and pain when taken over a period of 2 years, though newer OCPs (containing drosperinone and gestodene) do not seem to cause these symptoms. (5)



Diagnosis

Patients presenting with vulvodynia should be screened for urinary symptoms (pain, urgency, and frequency) to rule out IC as a contributor to the pain and vice- versa. The goal is to diagnose and treat the pain as well as underlying cause. Even if symptoms appear to be gynaecologic in origin, the source of the pain may be in the bladder, or the two conditions may occur concomitantly.



The Global Interstitial Bladder Pain Society (GIBS) has defined the diagnostic criteria for IC.

ACCESS THE GUIDELINE ON GIBS WEBSITE

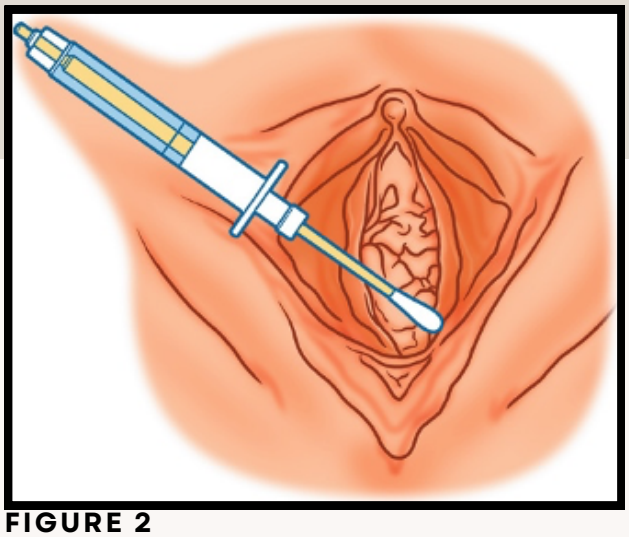


FIGURE 2

A detailed medical history followed by a thorough physical examination form the cornerstone in management of these conditions. (6). The assessment of Vulvodynia involves its diagnosis, classification and evaluation of potentially associated factors. The q tip test is considered as a standard for examining vulvodynia. **(Figure 2)** Pressure is systematically applied to different parts of the vulva (vestibule, clitoris, etc.) to assess the degree, location and characteristics of pain which is then plotted on a Visual Analogue Scale (0 to 10) (7)

THE FOLLOWING DESCRIPTORS ARE IDENTIFIED DURING EVALUATION:

A. Localized (eg: vestibulodynia, clitorodynia) or generalized or mixed (localized and generalized) pain **(Figure 3)**

B. Provoked (eg, insertional, contact) or spontaneous or mixed (provoked and spontaneous)

C. Onset (primary or secondary)

D. Temporal pattern (intermittent, persistent, constant, immediate, delayed) (1)

Most patients with vulvodynia have poor vaginal health. Hence the assessment of vulvodynia must be completed with a Vaginal Health Index score (VHIS). Overall elasticity, fluid secretion characteristics, vaginal pH range, epithelial mucosa, and moisture form the 5 components of VHIS.

It is measured on a scale of 1 (none), 2 (poor), 3 (fair), 4 (good) and 5 (excellent). A total VHIS score of less than 15 is considered to indicate poor vaginal health. (7). These women report higher rates of hypertonic pelvic floor dysfunction (HTPFD), Irritable bowel syndrome(IBS), chronic fatigue syndromes, temporal mandibular joint and muscle disease (TMD) and myalgia. Hence, the examination must also include assessment of these conditions.

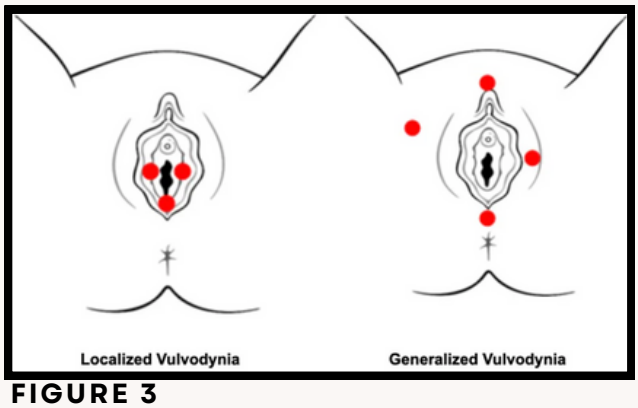


FIGURE 3

Clinical Management

Women suffering with IC and vulvodynia often have common symptoms making diagnosis and treatment challenging. Chronic urogenital pain syndromes have a huge impact on quality of life and sexual dysfunction. Studies suggest that the pathophysiological similarities of both these syndromes also evoke a similar response to treatment.

SOME OF THE STRATEGIES USED IN PATIENTS WITH BOTH IC AND VULVODYNIA ARE(4):

1. Behavioural modification/ Cognitive behavioural therapy (CBT): Stress often exacerbates symptoms hence stress relaxation strategies and self-care measures play a significant role in management.

2. Physical therapy (PT): Women with IC and Vulvodynia often have trigger points /bands in the pelvic floor muscles, lower back, abdomen and lower limbs. Kegel exercises used commonly by gynaecologists are NOT recommended as they may in fact exaggerate the pain. Internal and external myofascial release by an expert physical therapist along with soft tissue mobilization by stretching and biofeedback form the mainstay of PT in these women.

3. Medical therapy: Tricyclic antidepressants (amitriptyline and nortriptyline) are effective in peripheral and central neuropathic pain, but their anticholinergic side effects restrict their long-term use. Anticonvulsants such as gabapentin and pregabalin are especially helpful in patients with generalised anxiety disorder. Though gabapentin improves pain in vulvodynia both as mono and adjuvant therapy, its role in IC needs further evaluation. Mast cell modulators eg: Hydrazine and montelukast are effective in both IC and vulvodynia.

TAKE HOME MESSAGE

IC and vulvodynia are complex multifactorial syndromes. A strong association between VVD and IC exists, and further research is needed to determine whether they are a part of a larger chronic urogenital pain syndrome. (8) As clinicians, it is imperative to identify overlapping symptoms and extract relevant history. An interdisciplinary customised treatment plan must be offered to these patients that will in turn positively impact their QOL.

Be the NEXT Author!

Please send your contributions to info@gibsociety.com

References

1.Bornstein J, Goldstein AT, Stockdale CK, Bergeron S, Pukall C, Zolnoun D, Coady D, International Society for the Study of Vulvovaginal Disease (ISSVD). 2015 ISSVD, ISSWSH, and IPPS consensus terminology and classification of persistent vulvar pain and vulvodynia. The journal of sexual medicine. 2016 Apr;13(4):607-12.

2. Gardella B, Porru D, Nappi RE, Daccò MD, Chiesa A, Spinillo A. Interstitial cystitis is associated with vulvodynia and sexual dysfunction–a case-control study. The journal of sexual medicine. 2011 Jun;8(6):1726-34.

3. Siegel JF, Sand PK, Sasso K. Vulvodynia & pelvic pain? Think interstitial cystitis. The Nurse Practitioner. 2008 Oct 1;33(10):40-5

4.Fariello JY, Moldwin RM. Similarities between interstitial cystitis/bladder pain syndrome and vulvodynia: implications for patient management. Translational andrology and urology. 2015 Dec;4(6):643

5. Jean-Jasmin M.L. Lee, Lian Leng Low, Seng Bin Ang, Oral Contraception and Female Sexual Dysfunction in Reproductive Women, Sexual Medicine Reviews, Volume 5, Issue 1, January 2017, Pages 31–44, https://doi.org/10.1016/j.sxmr.2016.06.001

6. GIBS clinical guidelines for IC/BPS version 1.0. Accessed 5 June 2020. https://gibsociety.com/wp-content/uploads/2017/11/ GIBS-Guidelines.pdf

7. Okui N, Okui M, Gambacciani M. Examining vaginal and vulvar health and sexual dysfunction in patients with interstitial cystitis (UNICORN-1 study). International Urogynecology Journal. 2022 Sep;33(9):2493-9.

8. Bosio S, Perossini S, Torella M, Braga A, Salvatore S, Serati M, Frigerio M, Manodoro S. The association between vulvodynia and interstitial cystitis/bladder pain syndrome: A systematic review. International Journal of Gynecology & Obstetrics. 2024 Apr 24.

The Author

Dr. Latika Chawla

Gynecologist and Endoscopic Surgeon,
Endometriosis Specialist,
Mumbai, India.
GIBS Executive Member

FOR ANY ASSISTANCE CONTACT US

info@gibsociety.com
+91 8169746459
www.gibsociety.com

GLOBAL INTERSTITIAL CYSTITIS
BLADDER PAIN SOCIETY

August
24th & 25th, 2024

GIBS 2024

9th Annual Congress on IC/BPS

CONTAINING THE BLADDER BLAZE

Pride Plaza Hotel,
Aerocity, New Delhi, India

SCAN FOR MORE INFORMATION

GLOBAL INTERSTITIAL CYSTITIS
BLADDER PAIN SOCIETY

August
24th & 25th, 2024

GIBS 2024

9th Annual Congress on IC/BPS

CONTAINING THE BLADDER BLAZE

INTERNATIONAL STALWARTS

DR. BARY BERGHMANS
Pelvic Physiotherapist

DR. SAJJAD RAHNAMA'I
Urologist

DR. BHOJRAJ LUITEL
Urologist

DR. SAKINEH HAJEBRAHIMI
Urologist

DR. GEORGE KASYAN
Urologist

DR. SANDOR LOVASZ
Urologist

DR. GOPAL BADLANI
Urologist

DR. SENDER HERSCHORN
Urologist

DR. MANISH PRADHAN
Urologist

DR. SITI NUR MASYITHAH MAAROF
Urologist

DR. NG POH YIN
Urogynecologist

DR. WARREN LO HWA LOON
Urologist

DR. OLGA PLEKHANOVA
Urologist

DR. WILLIAM ONG
Urologist

DR. PAWAN RAJ CHALISE
Urologist

DR. YADGAR SHWANI
Urologist

DR. POONGKODI NAGAPPAN
Urologist

GLOBAL INTERSTITIAL CYSTITIS
BLADDER PAIN SOCIETY

August
24th & 25th, 2024

GIBS 2024

9th Annual Congress on IC/BPS

CONTAINING THE BLADDER BLAZE

SCIENTIFIC PROGRAM TOPICS

1. **How do we manage IC/BPS in our Country – Across the Globe ?**
(Canada, Iran, Malaysia, Nepal, Russia, Iraq)

2. **Phenotyping in IC/BPS**
Evolution, Recent concepts, Treatments linked to Phenotypes

3. **AI in IC/BPS**
Diagnosis & HL, Phenotyping, Treatments

4. **IC/BPS as Pelvic Pain**
Gynecologists view, Laparoscopy, Pelvic Floor, Pudendal Neuralgia & MRN, Neuromuscular Disorder, NGS in Pelvic Pain

5. **Having Brain in Bladder**
Brain to Bladder - Neuroanotomy & Bladder to Brain - In the clinic

6. **Newer Modalities in treatment of IC/BPS,**
Oral Agents, Intravesical Agents, Botox, Stem Cell Therapy, Physical Therapy - SWT, PRP

7. **Hunner's Lesions (HL)**
Etiopathogenesis, Cystoscopic appearance, Treatments, Dietary Influences

8. **More attractions –** Competitive papers session
Case Based Panel Discussions, Quiz.

'Ask the Experts'

SCAN FOR MORE INFORMATION

Pride Plaza Hotel,
Aerocity, New Delhi, India

GLOBAL INTERSTITIAL CYSTITIS
BLADDER PAIN SOCIETY

August
24th & 25th, 2024

GIBS 2024

9th Annual Congress on IC/BPS

CONTAINING THE BLADDER BLAZE

REGISTRATION DETAILS

Scan To Register

Submit Your Abstract

Become a Lifetime Member

Categories	NATIONAL DELEGATES		
	Till 31st May	1st June – 15th Aug	16th August Onwards (Onspot)
GIBS Lifetime Members	~~INR 5000~~	INR 8000	INR 13000
Non Members	~~INR 10000~~	INR 15000	INR 20000
PG/AHP*	~~INR 3500~~	INR 6000	INR 10000

Categories	INTERNATIONAL DELEGATES		
	Till 31st May	1st June – 15th Aug	16th August Onwards (Onspot)
GIBS Lifetime Members	~~USD 75~~	USD 100	USD 150
Non Members	~~USD 150~~	USD 200	USD 250
PG/AHP*	~~USD 60~~	USD 80	USD 125

*AHP - ALLIED HEALTH PROFESSIONALS

BOOK YOUR STAY WITH GIBS

PRIDE PLAZA HOTEL - 5* HOTEL
AEROCITY, NEW DELHI, INDIA

**Exclusive Subsidized rates for GIBS Delegates

CONTACT FOR MORE DETAILS info@gibsociety.com +91-8779515840