



GLOBAL INTERSTITIAL CYSTITIS  
BLADDER PAIN SOCIETY

Volume 7 Issue 11 || November 2025

# GIBS NEWSLETTER

## How Guidelines Changed IC/BPS Practice Patterns

### Latest Updates

11th Annual Congress on  
IC/BPS - GIBS 2026

Date : 22<sup>nd</sup> & 23<sup>rd</sup> August 2026

Venue : Jaipur

Theme: Beyond the Bladder: Decoding  
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Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS) is a chronic urological condition characterized by pelvic pain, urinary urgency, and frequency in the absence of identifiable pathology. Over the past decade, advances in scientific understanding and increasing patient heterogeneity have necessitated revisions in diagnostic criteria and therapeutic strategies. Recent guideline updates from the American Urological Association (AUA, 2022) and the Global Interstitial Cystitis Bladder Pain Syndrome Society (GIBS, 2024) have significantly reshaped clinical practice patterns in the diagnosis and management of IC/BPS [1,2]. This article examines these guidelines comparatively to highlight how they have influenced a paradigm shift in IC/BPS care.

A key change introduced by both guidelines is the emphasis on symptom-based diagnosis with fewer mandatory investigations. The AUA defines IC/BPS as a chronic pain condition associated with the urinary bladder lasting more than six weeks, in the absence of infection or other identifiable causes [3]. It discourages overreliance on invasive procedures and emphasizes a careful clinical history, physical examination, and selected laboratory tests. The GIBS guideline, while aligning with these core principles, recommends mandatory ultrasound evaluation and cystoscopy to rule out alternative pelvic pathology, thereby aiming to improve diagnostic accuracy in resource-limited settings [4]. It also places greater emphasis on excluding gynecological, gastrointestinal, and neurologic mimics, reflecting a more integrative approach.

Phenotyping of IC/BPS patients has been formalized by the AUA guideline into three major categories: those with Hunner lesions (bladder-centric disease), those with pelvic

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floor dysfunction, and those with systemic or widespread pain conditions [5-7]. This stratification helps tailor therapy more precisely. GIBS also supports individualized treatment based on symptom patterns but lacks a strict phenotype classification; instead, it relies heavily on detailed clinical history, menstrual and sexual health evaluation, and examination findings [2]. Pain management strategies reflect a notable evolution. Both guidelines endorse multimodal, non-opioid-based approaches. The AUA recommends stress management, behavioral therapy, and manual physical therapy, cautioning against pelvic floor strengthening exercises [8-14]. GIBS introduces a structured application of the WHO analgesic ladder for chronic pelvic pain, beginning with non-steroidal anti-inflammatory drugs and progressing to adjuvants like amitriptyline, gabapentin, and pregabalin [2]. Additionally, GIBS incorporates cognitive behavioral therapy (CBT), myofascial release techniques, and guided nerve blocks, offering a broader and often more practical framework suited to multidisciplinary settings.

In terms of pharmacologic therapy, both guidelines recommend tricyclic antidepressants, antihistamines, and pentosan polysulfate sodium (PPS) as first-line oral agents. However, the AUA highlights the emerging concern regarding PPS-associated maculopathy, advising caution [13]. GIBS, while supporting PPS, expands its pharmacologic armamentarium to include skeletal muscle relaxants and urinary alkalizers, recognizing the multifactorial nature of IC/BPS symptoms [2].

Intravesical therapies have also been redefined. The AUA supports the use of DMSO, heparin, and lidocaine based on moderate to low levels of evidence [14-18]. It does not recommend intravesical BCG or prolonged high-pressure bladder distention. GIBS endorses these core agents and additionally outlines multiple evidence-informed “cocktail” instillation protocols combining anesthetics, anti-inflammatories, and corticosteroids, which have become popular in real-world clinical practice [2]. These cocktails are presented with attention to safety and patient tolerability, particularly in contexts where single-agent efficacy is limited.

Both guidelines now explicitly recommend against the use of long-term antibiotics, systemic corticosteroids, and high-pressure hydrodistention-interventions that were once commonly used despite limited benefit and considerable risk [1,2]. These consensus-based exclusions further reflect a shift toward evidence-aligned and patient-centered care.

In conclusion, the AUA and GIBS guidelines represent a significant advancement in the clinical management of IC/BPS. While the AUA provides a robust, evidence-rated framework emphasizing stratification and standardized care, the GIBS guideline offers a flexible, practical model adaptable to diverse clinical settings. Together, these guidelines underscore a shift from invasive, generalized treatment protocols to patient-specific, stepwise, and multidisciplinary management approaches, enhancing therapeutic outcomes and quality of life for patients with IC/BPS.



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## **Latest Webinar Updates**

### **Mastering the Voiding Diary - From Basics to Clinical Application**

Organizing Chair - Dr. William Ong, Malaysia

 **5th December, 2025**

 **7:30PM - 8:30PM IST**

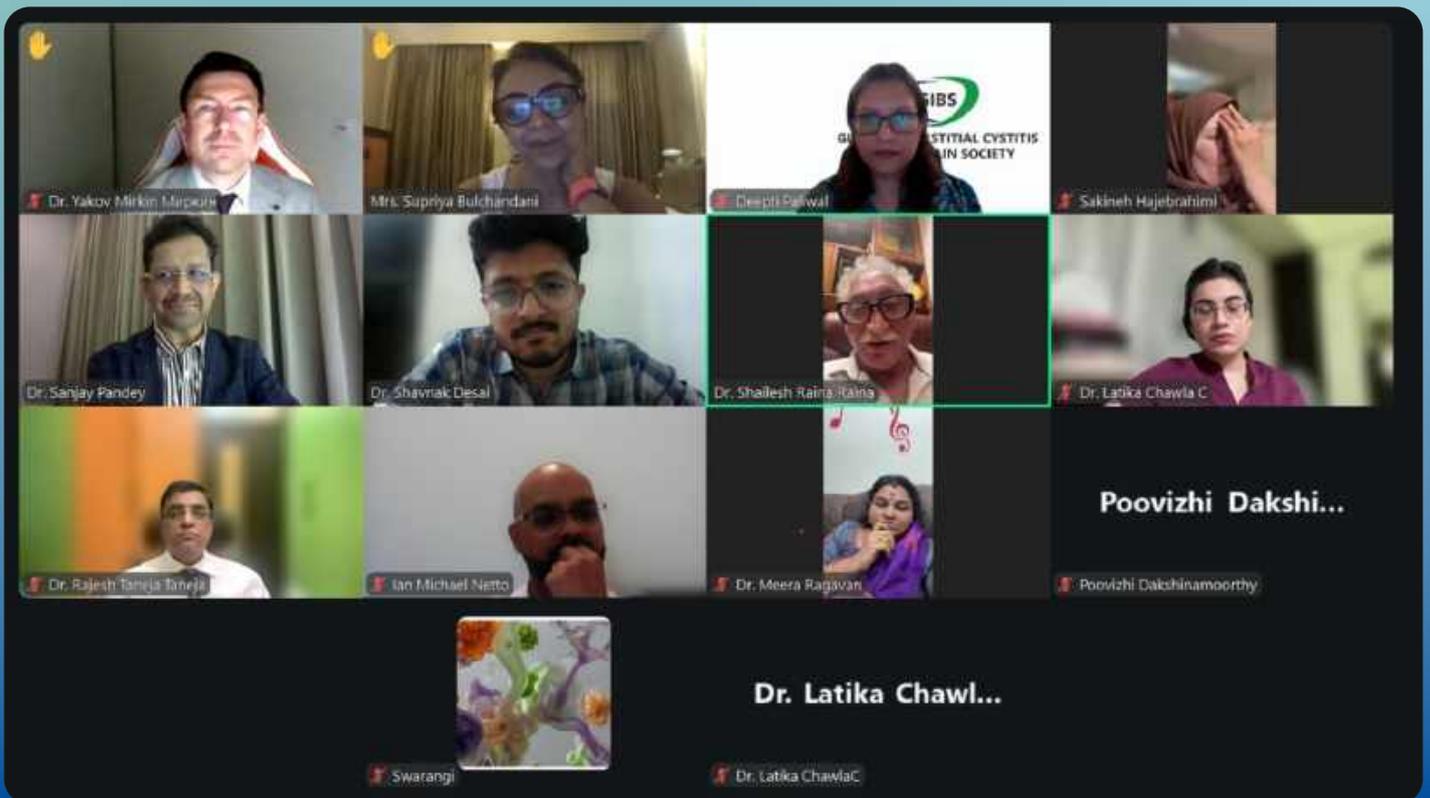
**PLATFORM**

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# Moments & Insights from Our Recent Webinar

The Global Interstitial Cystitis Bladder Pain Society (GIBS), in collaboration with the Orphan Diseases Foundation (ODF), organized its Periodic Case-Based Discussion on **17th October 2025**. The session featured an insightful talk by **Dr. Latika Chawla** on “**Beyond the Bladder – Twin to Quadruplets,**” chaired by **Dr. Meera Ragavan** and **Dr. Rajesh Taneja**. Engaging case discussions presented by **Dr. Poovizhi** and **Dr. Shavnak Desai**, with expert contributions from renowned clinicians across specialties.



ANNOUNCING



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# GIBS 2026

**11<sup>TH</sup> ANNUAL CONGRESS ON IC/BPS**  
**22<sup>ND</sup> - 23<sup>RD</sup> AUGUST 2026**

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