Management of Bladder Pain Syndrome

Reference No.: UHDB/Gynae/02:23/B6

Contents

1. Introduction

Chronic pelvic pain is a very distressing symptom, Bladder pain syndrome (BPS) can be a cause of chronic pelvic pain. BPS is defined by the American Urological Association (AUA) as an unpleasant sensation (pain, pressure, discomfort) perceived to be related to the urinary bladder, associated with lower urinary tract symptoms of more than 6 weeks duration, in the absence of infection or other identifiable causes.

BPS has also been found to have symptoms associated with decline in cognition, behavioral changes and sexual dysfunction (EAU).

BPS was previously known as Interstitial cystitis and painful bladder syndrome, but the current recommendation is the term bladder pain syndrome. BSUG/RCOG

It is a chronic condition with uncertain etiology as such is a diagnosis of exclusion.

2. Purpose

This guideline covers the assessment and management of bladder pain syndrome.

3. Abbreviations

AUA	-	American Urological Association
BPS	-	Bladder Pain Syndrome
BSUG	-	British Society of Urogynecology
EAU	-	European Association of Urology
MDT	-	Multidisciplinary Team
NICE	-	National Institute for Health and Care Excellence
PPS	-	Pentosan Polysulfate Sodium
RCOG	-	Royal College of Obstetrics and Gynaecology
UTI	-	Urinary Tract Infection

4. Assessment at Urogynaecology Outpatient by Named Consultant Unit

A detailed history and a thorough physical examination should be done using the specialized gynecology template in the outpatient clinic. BPS is a diagnosis of exclusion; it is important to rule out other possible causes of bladder pain. The location of the pain, and relationship to bladder filling and emptying should be established. Other important findings

in the history include previous urinary tract infections (UTIs), sexually transmitted infections (STIs), bladder disease and previous pelvic surgeries. It is also important rule out other causes of chronic pelvic pain such as endometriosis, irritable bowel syndrome, fibromyalgia and chronic fatigue syndrome. Physical examination should include an abdominal examination looking for evidence of urinary retention, hernias and painful trigger points. A pelvic examination should be done to rule out atrophic changes, prolapse, vaginitis and trigger point tenderness over the urethra, vestibular glands, vulvar skin or bladder. Features of dermatosis, including vulvar or vestibular disease, should be looked for. Superficial and deep vaginal tenderness should be noted on speculum examination and bimanual palpation. A pelvic examination is also helpful to rule out abdominal, cervical and adnexal pathology. All patients with BPS should have at least a 3-day bladder diary and food diary.

Urine Testing
It is recommended at the first assessment to undertake a urine dipstick test in all women presenting with chronic pelvic pain, to detect the presence of blood, glucose, protein, leucocytes and nitrites in the urine, which in turn may suggest a urinary tract infection. Women symptomatic for UTI with a positive urine dip test should have a mid-stream urine samplesent for microbiology, culture and analysis for antibiotic sensitivities. Investigations for urinary ureaplasma and chlamydia can be considered in symptomatic patients with negative urine cultures and pyuria. BSUG/RCOG

Urodynamic studies
During urodynamic studies, pain on bladder filling, a reduced first sensation to void and reduced bladder capacity are consistent with BPS; however, there are no urodynamic criteria that are diagnostic for BPS.

Cystoscopy
Cystoscopy does not confirm or exclude the diagnosis of BPS but is required to diagnose/exclude other conditions that mimic BPS. Cystoscopy without hydrodistension is expected to be normal (except for discomfort and reduced bladder capacity) in most patients with BPS. Characteristic cystoscopy findings in BPS include post distention glomerulations, reduced bladder capacity and bleeding.

5. Management Options

Women with bladder pain syndrome should have all the options of management enumerated and discussed in detail during the initial visit. The management of this condition requires a discussion with the woman on the benefits of conservative management, including lifestyle modification prior to offering pharmacologic or surgical options.

Conservative management
Dietary modification can be beneficial, and avoidance of caffeine, alcohol, and acidic foods and drinks should be considered. Stress management may be recommended, and regular exercise can be beneficial. Analgesia can be used in treatment of pelvic and bladder pain

Pharmacologic management
Oral amitriptyline or cimetidine may be considered when first-line conservative treatments have failed. Cimetidine is however not licensed to treat BPS. Multimodal therapy may be considered if single drugs are unsuccessful but should be commenced by consultants with special expertise and consideration of multidisciplinary input. BSUG/ RCOG 2016
Pentosan polysulfate sodium (ELMIRON®) is recommended as an option for treating bladder pain syndrome in women with moderate or severe pain and cystoscopy evidence of glomerulations or Hunner's lesions who haven't responded to other oral medications. Dosage is 100mg three times a day and should be reviewed and discontinued after 6 months if no response. Patients should have a baseline ophthalmic examination and annually thereafter as there is a rare complication of pigmentary maculopathy with long term use. If this occurs, treatment cessation should be discontinued. NICE 2019, MHRA

Intravesical treatments
If conservative and oral treatments have failed, intravesical treatments could be offered. These treatments include

- Intravesical Lidocaine
- Intravesical hyaluronic acid
- Intravesical injection of botulinum toxin A (Botox)
- Intravesical dimethyl sulfoxide (DMSO)
- Intravesical heparin
- Intravesical chondroitin sulfate

Further treatment options
In patients who conservative, pharmacologic and intravesical treatments have failed. A pain clinic referral should be made. An MDT meeting should be held, and possible further options of treatment after MDT include

- Cystoscopic fulguration and laser treatment, and transurethral resection of lesions can be considered if Hunner lesions are identified at cystoscopy
- Neuromodulation (nerve stimulation), in the form of posterior tibial or sacral neuromodulation
- Oral cyclosporin A may be considered after conservative, other oral, intravesical and neuromodulation treatments have failed
- Major surgery (Total cystectomy and urinary diversion in the form of supratrigonal cystectomy with bladder augmentation, bowel or supratrigonal cystectomy, and orthotopic neobladder formation) may be considered in refractory cases of BPS after MDT discussions.

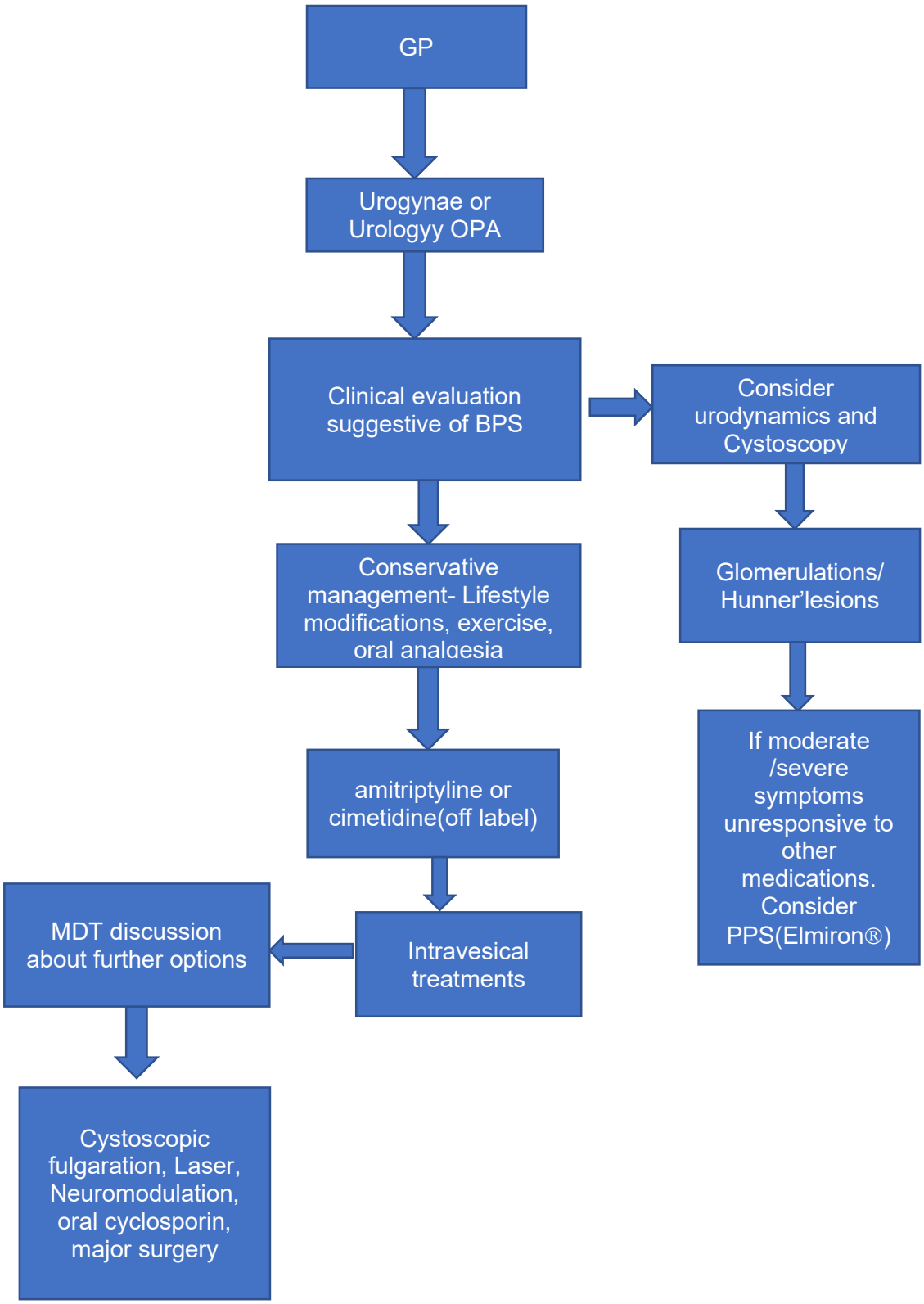
6. Follow-up

Patients should be followed up periodically with consideration for shared care between the pain team and urogynaecology until symptoms become controlled and then they can be followed in primary care if required**.**

7. Monitoring Compliance and Effectiveness

As per the Business Unit audit forward programme

Bladder Pain Syndrome Pathway



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