Recent update in guidelines

IC/BPS

Department of Urology
Pusan National University Hospital
Hyeon Woo Kim, MD, PhD

2023 EAU Guideline

Chronic Pelvic Pain

Summary of Changes

- The 2023 edition of the Chronic Pelvic Pain Guidelines is a reprint of the 2022 version. The Guideline will be updated in full for 2024.

2022 AUA Guideline

Diagnosis and Treatment of IC/BPS

Published 2011; **Amended 2014**; **Amended 2022**

Appendix 1

2014

BASIC ASSESSMENT

- History
- Frequency/Volume Chart
- Post-void residual
- Physical examination
- Urinalysis, culture
- Cytology if smoking hx
- Symptom questionnaire
- Pain evaluation

Confirmed or Uncomplicated IC/BPS

FIRST-LINE TREATMENTS

- General Relaxation/ Stress Management
- Pain Management
- Patient Education
- Self-care/Behavioral Modification

RESEARCH TRIALS

Patient enrollment as appropriate at any point in treatment process

Signs/Symptoms of Complicated IC/BPS

- Incontinence/OAB
- GI signs/symptoms Microscopic/gross hematuria/sterile pyuria
- Gynecologic signs/symptoms

CONSIDER:

- Urine cytology
- Imaging
- Cystoscopy
- Urodynamics
- Laparoscopy
- Specialist referral (urologic or non-urologic as appropriate)

Dx Urinary Tract Infection

TREAT & REASSESS

SECOND-LINE TREATMENTS

- Appropriate manual physical therapy techniques
- Oral: amitriptyline, cimetidine, hydroxyzine, PPS
- Intravesical: DMSO, Heparin, Lidocaine
- Pain Management

THIRD-LINE TREATMENTS

- Cystoscopy under anesthesia w/ hydrodistention
- Pain Management
- Tx of Hunner's lesions if found

FOURTH-LINE TREATMENTS

- Intradetrusor botulinum toxin A
- Neuromodulation
- Pain Management

FIFTH-LINE TREATMENTS

- Cyclosporine A
- Pain Management

SIXTH-LINE TREATMENTS

- Diversion w/ or w/out cystectomy
- Pain Management
- Substitution cystoplasty

Note: For patients with end-stage structurally small bladders, diversion is indicated at any time clinician and patient believe appropriate.

CLINICAL MANAGEMENT PRINCIPLES

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- Ineffective treatments should be stopped
- Pain management should be considered throughout course of therapy with goal of maximizing function and minimizing pain and side effects
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The evidence supporting the use of Neuromodulation, Cyclosporine A, and BTX for IC/BPS is limited by many factors including study quality, small sample sizes, and lack of durable follow up. None of these therapies have been approved by the U.S. Food and Drug Administration for this indication. The panel believes that none of these interventions can be recommended for generalized use for this disorder, but rather should be limited to practitioners with experience managing this syndrome and willingness to provide long term care of these patients post intervention.

2022

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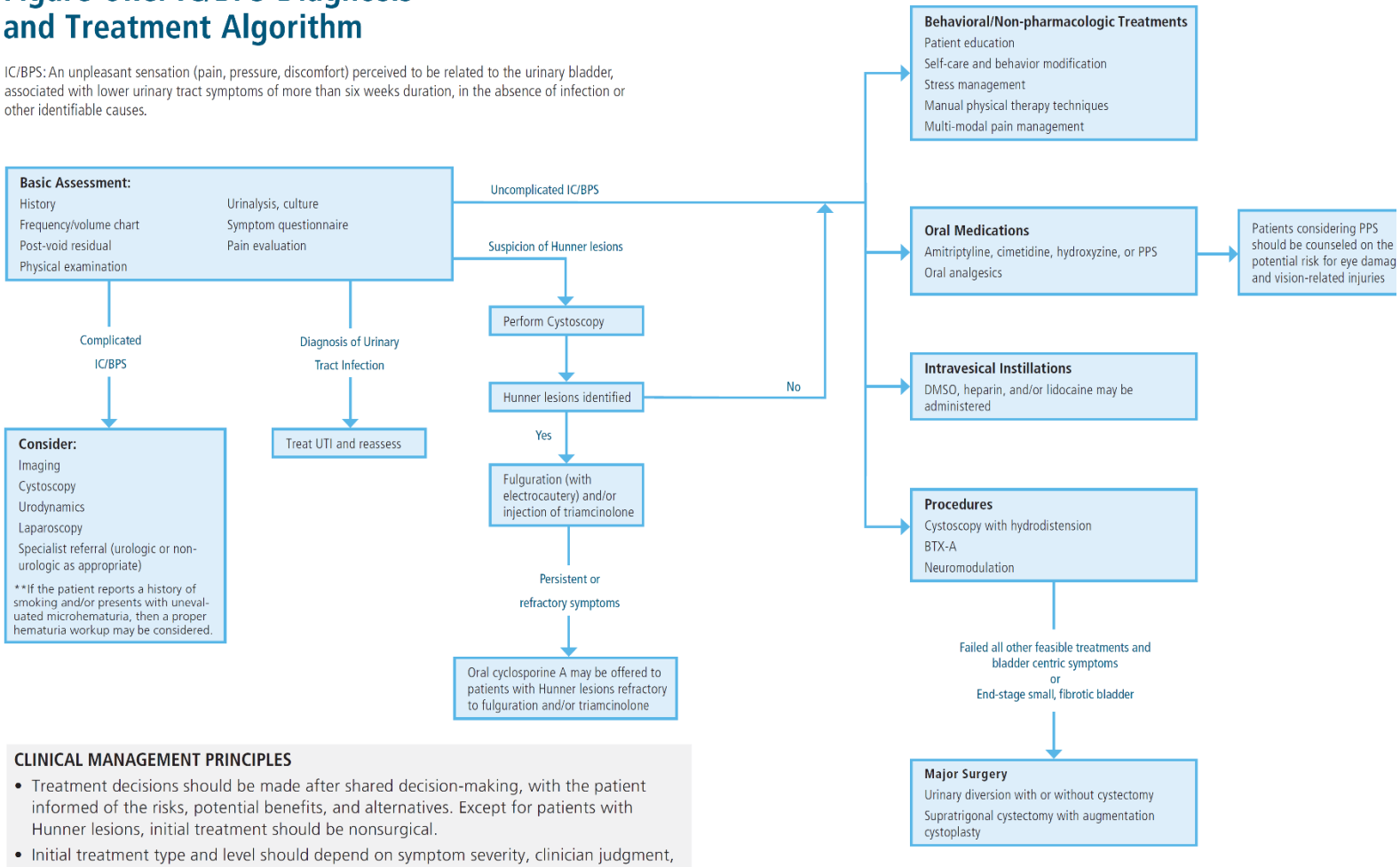

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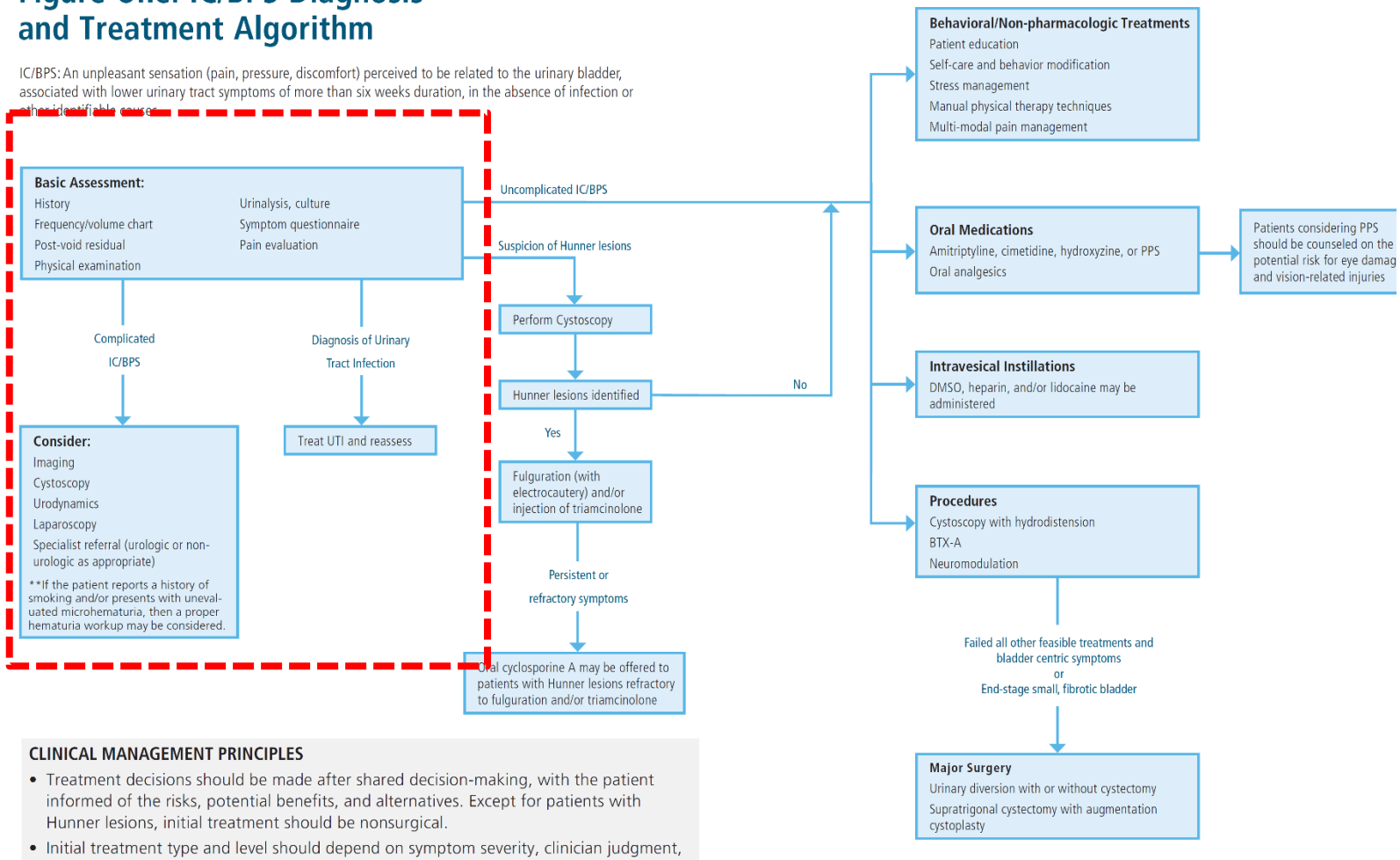

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TREAT & REASSESS

2022

Basic Assessment:

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Post-void residual
Physical examination
Urinalysis, culture
Symptom questionnaire
Pain evaluation

Complicated IC/BPS

Consider:

Imaging
Cystoscopy
Urodynamics
Laparoscopy
Specialist referral (urologic or non-urologic as appropriate)

**If the patient reports a history of smoking and/or presents with unevaluated microhematuria, then a proper hematuria workup may be considered.

Diagnosis of Urinary Tract Infection

Treat UTI and reassess

2014

2022

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- Post-void residual
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TREAT & REASSESS

Similar

Basic Assessment:

History
Frequency/volume chart
Post-void residual
Urinalysis, culture
Symptom questionnaire
Pain evaluation

Diagnosis of Urinary Tract Infection

Treat UTI and reassess

Consider:

Imaging
Cystoscopy
Urodynamics
Laparoscopy
Specialist referral (urologic or non-urologic as appropriate)

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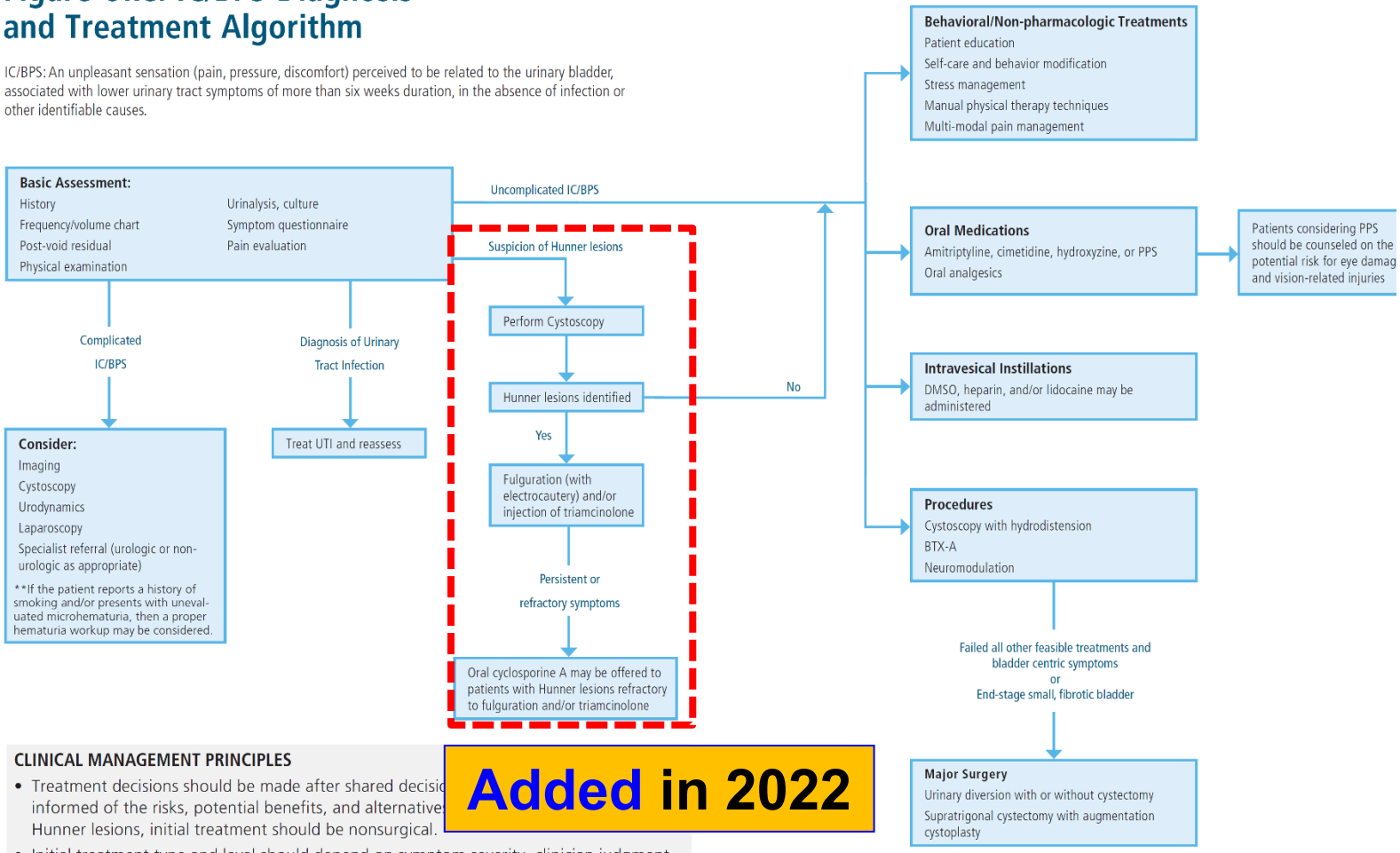

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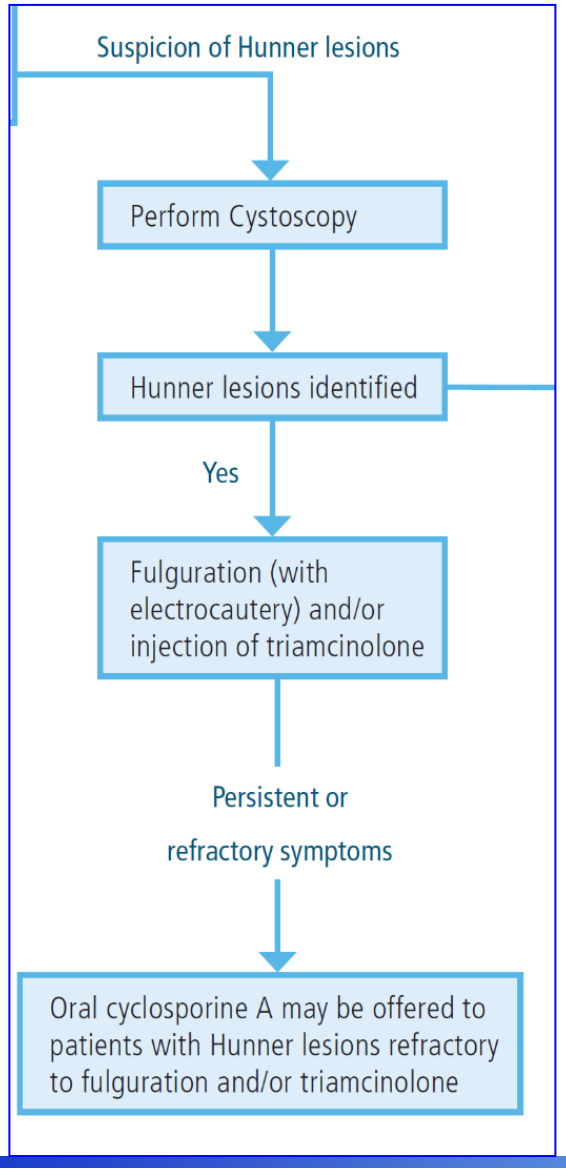


Guideline Statement 4

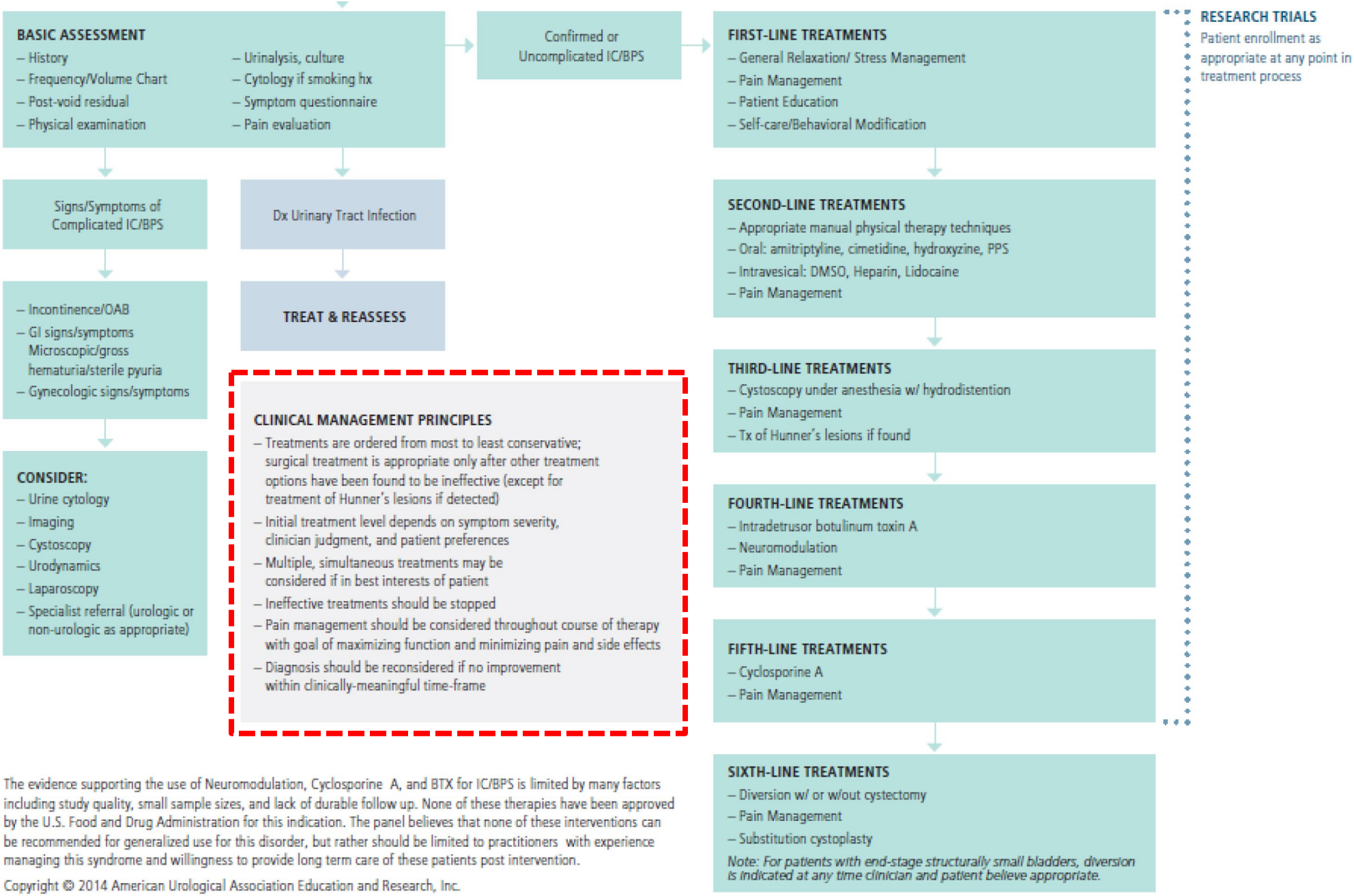
Cystoscopy should be performed in patients for whom Hunner lesions are suspected. *Expert Opinion*

- Men or women over the age of 50 are more likely to have Hunner lesions on cystoscopy, thus it is reasonable to offer cystoscopy to IC/BPS patients over the age of 50.
- Cystoscopy should also be considered in those who fail conventional therapies but have never had a cystoscopy before in order to evaluate for the presence or absence of Hunner lesions.
- If Hunner lesions are found on cystoscopy, triamcinolone injection and/or fulguration can be performed.
- For those who fail triamcinolone and/or fulguration, oral Cyclosporine A (CyA)and/or other multi-modal therapies may be offered

Management Approach

Appendix 1

2014



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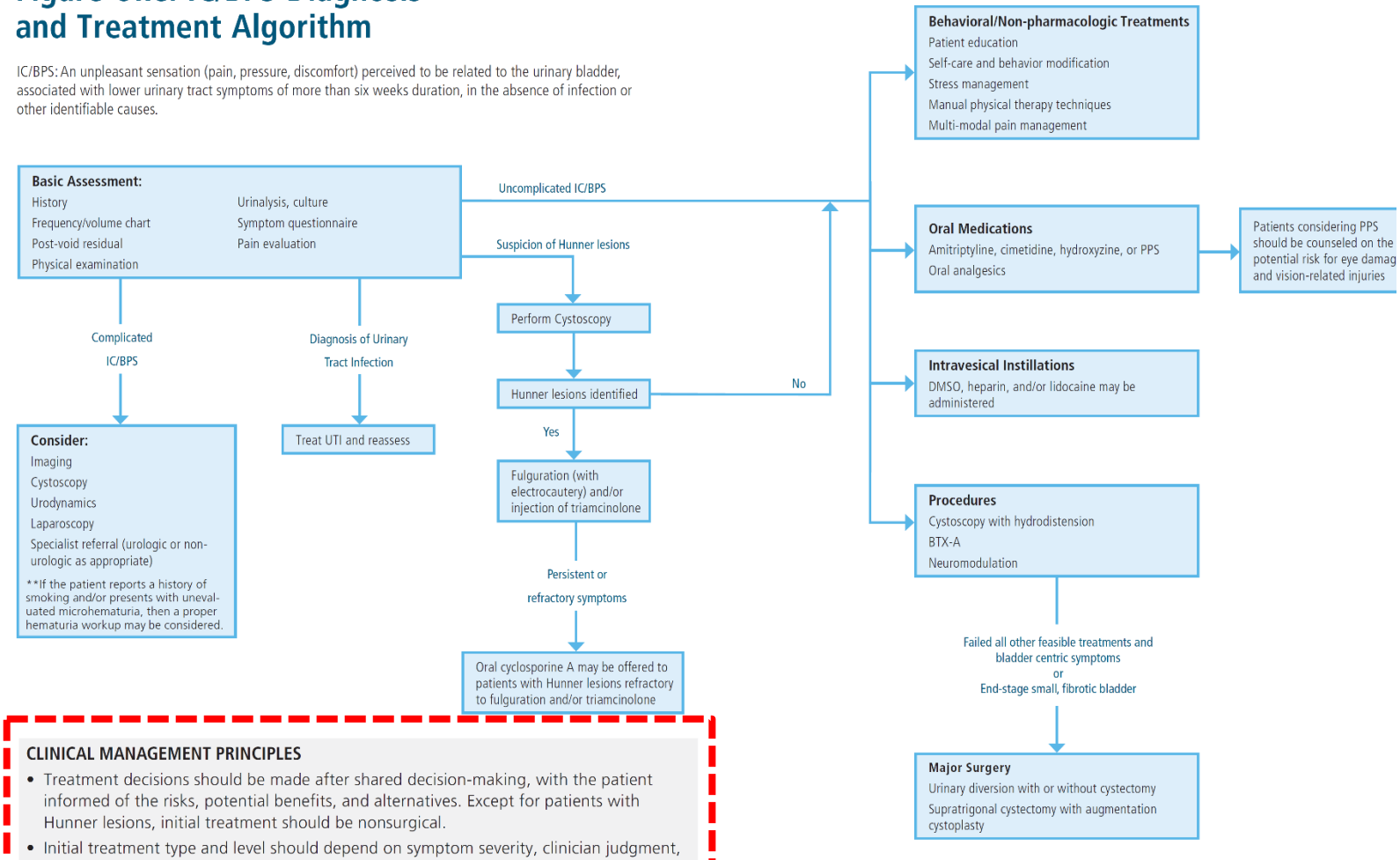

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Similar

Emphasized

Guideline Statement 5

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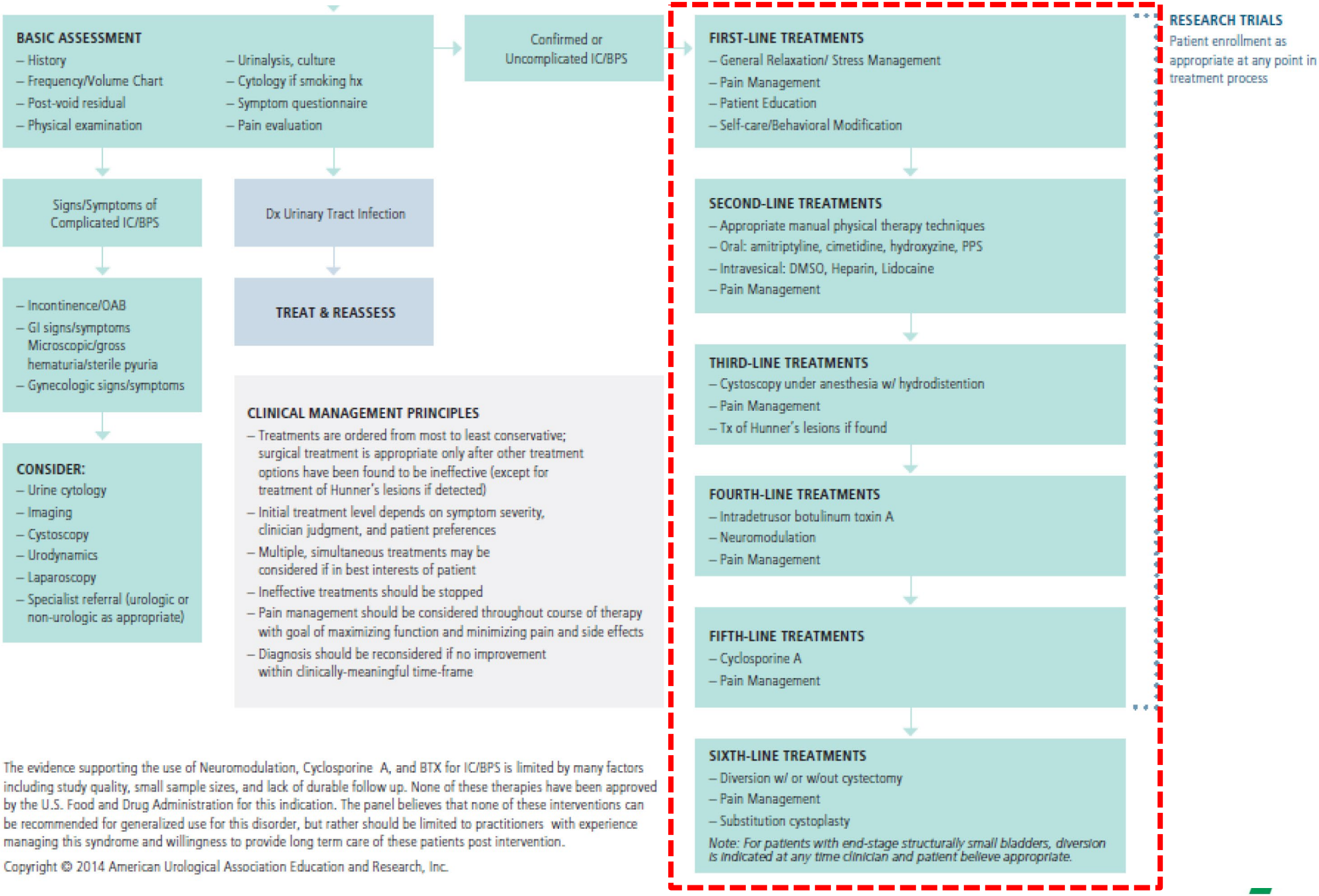
Treatment Categories for IC/BPS

Appendix 1

2014



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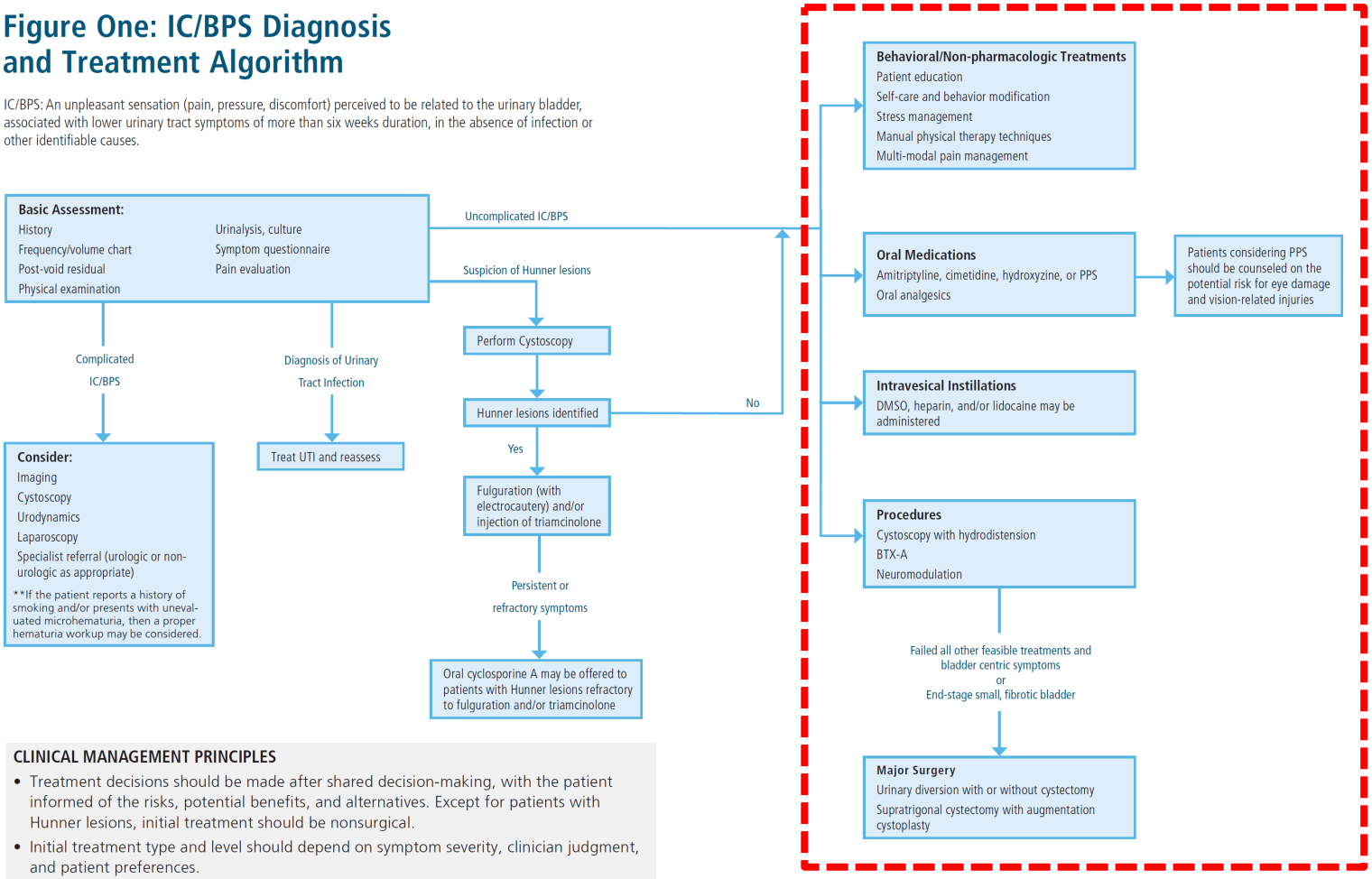

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2014

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2022

Behavioral/Non-pharmacologic Treatments
Patient education
Self-care and behavior modification
Stress management
Manual physical therapy techniques
Multi-modal pain management

Oral Medications
Amitriptyline, cimetidine, hydroxyzine, or PPS
Oral analgesics

→ Patients considering PPS should be counseled on the potential risk for eye damage and vision-related injuries

Intravesical Instillations
DMSO, heparin, and/or lidocaine may be administered

Procedures
Cystoscopy with hydrodistension
BTX-A
Neuromodulation

Failed all other feasible treatments and bladder centric symptoms
or
End-stage small, fibrotic bladder

Major Surgery
Urinary diversion with or without cystectomy
Supratrigonal cystectomy with augmentation cystoplasty

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Changed

2022

- In contrast to the prior versions of this guideline, this update no longer divides treatments into first-line through sixth-line tiers.
- Clinicians do not need to proceed in a linear algorithm or a hierarchy from first-line to sixth-line treatments described in the previous guideline.
- Instead, treatment is categorized into behavioral/nonpharmacologic, oral medicines, bladder instillations, procedures, and major surgery.
- Except for patients with Hunner lesions, initial treatment should be nonsurgical.
- Concurrent, multi-modal therapies may be offered.
- The Panel made this change in order to emphasize that shared decision-making, individual patient factors and clinical judgment are the most important factors in treatment choice.

Behavioral/Non-pharmacologic Treatments (1)

Guideline Statement 9

Patients should be educated about normal bladder function, what is known and not known about IC/BPS, the benefits versus risks/burdens of the available treatment alternatives, the fact that no single treatment has been found effective for the majority of patients, and the fact that acceptable symptom control may require trials of multiple therapeutic options (including combination therapy) before it is achieved. *Clinical Principle*

Guideline Statement 10

Self-care practices and behavioral modifications that can improve symptoms should be discussed and implemented as feasible. *Clinical Principle*

Guideline Statement 11

Patients should be encouraged to implement stress management practices to improve coping techniques and manage stress-induced symptom exacerbations. *Clinical Principle*

Behavioral/Non-pharmacologic Treatments (2)

Guideline Statement 12

Appropriate manual physical therapy techniques (e.g., maneuvers that resolve pelvic, abdominal and/or hip muscular trigger points, lengthen muscle contractures, and release painful scars and other connective tissue restrictions), if appropriately trained clinicians are available, should be offered to patients who present with pelvic floor tenderness. Pelvic floor strengthening exercises (e.g., Kegel exercises) should be avoided. ***Standard (Evidence Strength: Grade A)***

Oral Medications

Guideline Statement 13

Clinicians may prescribe pharmacologic pain management agents (e.g., urinary analgesics, acetaminophen, NSAIDs, opioid/non-opioid medications) after counseling patients on the risks and benefits. Pharmacological pain management principles for IC/BPS should be similar to those for management of other chronic pain conditions. *Clinical Principle*

Guideline Statement 14

Amitriptyline, cimetidine, hydroxyzine, or pentosane polysulfate may be administered as second-line oral medications (listed in alphabetical order; no hierarchy is implied). *Option (Evidence Strength: Grades B, B, C, and B)*

Guideline Statement 15

Clinicians should counsel patients who are considering pentosan polysulfate sodium on the potential risk for macular damage and vision-related injuries. *Clinical Principle*

Guideline Statement 16

Oral cyclosporine A may be offered particularly for patients with Hunner lesions refractory to fulguration and/or triamcinolone. *Option (Evidence Strength: Grade C)*

Intravesical Instillations

Guideline Statement 17

DMSO, heparin, and/or lidocaine may be administered as second-line intravesical treatments (listed in alphabetical order; no hierarchy is implied). ***Option (Evidence Strength: Grades C, C, and B)***

Procedures

Guideline Statement 18

Cystoscopy under anesthesia with short-duration, low-pressure hydrodistension may be undertaken as a treatment option. *Option (Evidence Strength: Grade C)*

Guideline Statement 19

If Hunner lesions are present, then fulguration (with electrocautery) and/or injection of triamcinolone should be performed. *Recommendation (Evidence Strength: Grade C)*

Guideline Statement 20

Intradetrusor onabotulinumtoxin A may be administered if other treatments have not provided adequate improvement in symptoms and quality of life. Patients must be willing to accept the possibility that intermittent self-catheterization may be necessary. *Option (Evidence Strength: Grade C)*

Guideline Statement 21

A trial of neuromodulation may be performed if other treatments have not provided adequate symptom control and quality of life improvement. If a trial of nerve stimulation is successful, then the permanent neurostimulation device may be implanted. *Option (Evidence Strength: Grade C)*

Major Surgery

Guideline Statement 22

Major surgery (substitution cystoplasty, urinary diversion with or without cystectomy) may be undertaken in carefully selected patients with bladder-centric symptoms, or in the rare instance when there is an end-stage small fibrotic bladder, for whom all other therapies have failed to provide adequate symptom control and quality of life improvement. *Option (Evidence Strength: Grade C)*

Treatments that Should Not be Offered

Guideline Statement 23

Long-term oral antibiotic administration should not be offered. *Standard (Evidence Strength: Grade B)*

Guideline Statement 24

Intravesical instillation of bacillus Calmette-Guerin should not be offered outside of investigational study settings. *Standard (Evidence Strength: Grade B)*


thank you !