

# Diagnosis and Management of Interstitial Cystitis



Susan Barr, MD

## KEYWORDS

- Interstitial cystitis • Painful bladder syndrome • Bladder pain • Diagnosis of IC
- Treatment of IC

## KEY POINTS

- Interstitial cystitis is a diagnosis of exclusion.
- Cystoscopy and hydrodistension can provide additional therapeutic benefit in addition to being diagnostic.
- Adding bladder training at the time of cystoscopy and hydrodistension may help prolong the therapeutic benefit.
- Treatment options include oral therapy, intravesical therapy, and surgical approaches.
- Re-evaluating with objective measure, such as validated questionnaire, is important in deciding when a treatment regimen is not working.
- Using a multidisciplinary approach is optimal.

## DIAGNOSIS

### *Patient History*

History is key to considering a potential diagnosis. As noted in the article in this issue by McLennan, symptoms may vary with age, but the typical patient with interstitial cystitis (IC) has urinary frequency, urgency, nocturia, and bladder or pelvic pain or pressure. The patient may start with only one of these symptoms and advance over time. Patients sometimes will describe a “peeing glass” sensation with voiding but also have improvement in pain after voiding. IC/painful bladder syndrome (PBS) is also a potential cause of sexual pain and should be on the differential when a patient presents with the complaint of dyspareunia. Thirty-five percent of the IC patients reported an effect on their sexual life.<sup>1</sup> Patients will typically describe dietary triggers. “Pain that worsened with certain food or drink and/or worsened with bladder filling and/or improved with urination” was described by 97% of IC/PBS patients.<sup>2</sup>

Pain often distinguishes IC from overactive bladder. Vulvar pain should differentiate vulvodynia from IC. Dysmenorrhea distinguishes endometriosis from IC.

---

The author has nothing to disclose.

Division of Urogynecology, Department of Obstetrics and Gynecology, University of Arkansas for Medical Sciences, 4301 West Markham, Slot 518, Little Rock, AR 72205, USA

*E-mail address:* [SABarr@uams.edu](mailto:SABarr@uams.edu)

Obstet Gynecol Clin N Am 41 (2014) 397–407

<http://dx.doi.org/10.1016/j.ogc.2014.04.001>

[obgyn.theclinics.com](http://obgyn.theclinics.com)

0889-8545/14/\$ – see front matter © 2014 Elsevier Inc. All rights reserved.

It becomes more difficult to diagnosis when a patient has more than one of these conditions.<sup>3</sup>

The practitioner should be aware that because there are most likely different pathways to developing IC, there are probable different initial clinical characteristics and varying optimal treatment paths.

### ***Physical Examination***

---

Examination should target the bladder but also focus on ruling out other causes of the patient's symptoms. Minimally, providers should order urinalysis and urine culture. During pelvic examination, particular attention should be paid to whether there is any bladder tenderness. Cytology and cystoscopy should be performed if clinically indicated, such as microscopic hematuria. Clinical experience suggests a very low likelihood of missing a stone or tumor by not performing a cystoscopy in a nonsmoker under the age of 40 with a clear urinalysis.<sup>4</sup>

### ***Imaging or Additional Testing***

---

Besides history and physical examination, there are other tests that can help a provider find an accurate diagnosis. Voiding diaries of patients with IC typically show increased frequency, nocturnal frequency, and lower mean voiding volume than an average patient and may correlate with cystoscopic findings.<sup>5</sup> Other options to screen for IC include validated questionnaires (such as PUF [pelvic pain and urgency/frequency] or O'Leary-Sant, **Figs. 1** and **2**), a potassium sensitivity test, or an anesthetic bladder challenge, which seems useful in excluding patients with pelvic pain originating from organs other than the urinary bladder.<sup>6</sup> Although urodynamics are not necessarily diagnostic, they may give a provider information regarding pain with filling of the bladder, presence of detrusor overactivity, and low compliance.<sup>7</sup> Urinary hexosamines have been found in various studies to be significantly increased, decreased, or the same in IC/bladder pain syndrome (BPS) patients compared with controls, and, therefore, at this time cannot be relied on to be a diagnostic marker or for monitoring the condition.<sup>4,8,9</sup> Cystoscopy with hydrodistension (HD) can be both diagnostic and therapeutic.

A cystoscopy with HD is performed by filling the bladder with normal saline to maximal capacity at a pressure of 80 mm Hg for 1 to 2 minutes, at which point the full bladder is drained and refilled to look for glomerulations.<sup>10</sup> It was first reported in 1930 and at one point was considered the best option for diagnosis, but more recently it has been questioned whether it is necessary. The procedure also offers a therapeutic benefit in up to one-third of patients,<sup>11</sup> but this appears short-lived.<sup>1</sup> To prolong the therapeutic benefit, the provider needs to consider adding bladder retraining to a patient's instructions after the procedure. Cystoscopy with HD followed by bladder training (BT) produced a statistically significantly better effect than HD alone in the treatment of patients with IC. BT guidelines involved asking patient to drink water or other fluids gradually, at a speed of 150 to 20 mL/h except at mealtimes and at night. It also asked them to perform self-scheduled voids with an aim to increase the time interval and voided volume. Recommendation was given to start every 2 hours and then increase by 15-minute intervals weekly.<sup>12</sup> Hsieh and colleagues<sup>1</sup> showed that HD followed by BT, when there was good compliance, was able to produce both a good efficacy and long-term benefits. BT seems to be important for long-term remission of symptoms for patients with IC undergoing treatment (**Figs. 3** and **4**).

### ***Summary***

---

Cystoscopy with HD was previously considered the best option. It is currently in question as to whether this is absolutely necessary, but to date there is not a better

Download English Version:

<https://daneshyari.com/en/article/3967787>

Download Persian Version:

<https://daneshyari.com/article/3967787>

[Daneshyari.com](https://daneshyari.com)