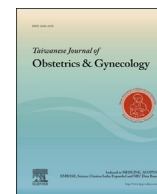




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Research Letter

The coexistence of interstitial cystitis and overactive bladder in a patient with lower urinary tract symptoms



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The definition of interstitial cystitis (IC) has evolved to include painful bladder syndrome (PBS) in the past few years. IC is a syndrome characterized by “the complaint of suprapubic pain related to bladder filling, accompanied by other symptoms such as increased day- and nighttime frequency, in the absence of proven urinary infection or other obvious pathology” [1]. However, the signs and symptoms of IC/PBS early in the course of disease may be intermittent and variable, making IC/PBS difficult to recognize [2].

Overactive bladder (OAB), which was recently defined by the International Continence Society as “urinary urgency, usually accompanied by frequency and nocturia, with or without urinary urgency incontinence, in the absence of urinary tract infection or other obvious pathology” [3], is one of several disorders that have the same cluster of symptoms as IC/PBS. Therefore, it is sometimes not easy to differentiate IC and OAB on the basis of clinical presentation alone.

However, the conventional therapies used for each diagnosis address different pathophysiological mechanisms [4,5]. It is crucial to establish the correct diagnosis prior to embarking on any extended treatment protocol. Many clinicians have used the presence of urodynamic detrusor overactivity (DO) as a criterion to exclude the diagnosis of IC [6]. However, recent studies and surveys suggest the possibility that two conditions may exist concurrently [7]. Investigators have suggested that some patients diagnosed with OAB, particularly those refractory to treatment with antimuscarinics, may have IC [8–11].

We report a patient with refractory OAB who also had cystoscopic findings of IC. The purpose of this study was to investigate the possibility that the two conditions may occur concurrently. The findings indicate that some patients refractory to one of the two therapies require further evaluation and treatment.

A 35-year-old woman, gravida 3, para 3, presented with urinary frequency, urgency, and urgency incontinence, which had plagued her for several years. She had undergone a Cesarean section for her third baby 7 years ago, and experienced these symptoms shortly after the operation. In the past 2 years, she also noticed a dull lower abdominal pain accompanied with a bearing-down sensation. She tried several medications prescribed by other doctors including Solifenacin (Vesicare; Astellas Pharma, Lederdorp, Netherlands, Europe), and Tolterodine (Detrusitol; Pfizer Pharma, Winchester, Kentucky, USA), but symptoms persisted and she decided to visit our hospital.

A pelvic examination revealed a normal-sized uterus with adhesion to the right abdominal wall. The patient reported mild tenderness while the uterus was being lifted. The frequency–volume chart revealed she had to void a volume of 70–150 mL every 30–60 minutes. Sometimes she also experienced urine incontinence when she rushed to the bathroom. The urinalysis report was normal, except for the presence of a few red blood cells (RBC 2–5 in HPF). The urodynamic study revealed phasic and terminal DO. Frequent and involuntary detrusor contractions occurred during filling cystometry (Fig. 1), accompanied with urine incontinence. The first desire to void was at 18 mL, and her cystometric capacity was only 60 mL. Owing to the patient's poor response to antimuscarinic drugs, we arranged diagnostic laparoscopy and cystoscopy. We noticed bladder adhesion to the lower segment of the uterus during the laparoscopic examination (Fig. 2), and adhesion lysis was performed. Cystoscopy showed diffuse (grade III) glomerulations and marked terminal hematuria (Fig. 3).

Thereafter, the patient received cyclic hyaluronic acid bladder instillation therapy (4 weekly intravesical instillations of 40 mg of hyaluronic acid followed by 5 monthly instillations), with concomitant antimuscarinics (Oxbo extended-release, 5 mg QD

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Patient: (2012/08/10 11:00:43 AM)
 Birth Date: 1976/09/29
 Patient #: 2257375H

Sex: F
 Age: 35

Complaint:
 Diagnosis:
 Record #:

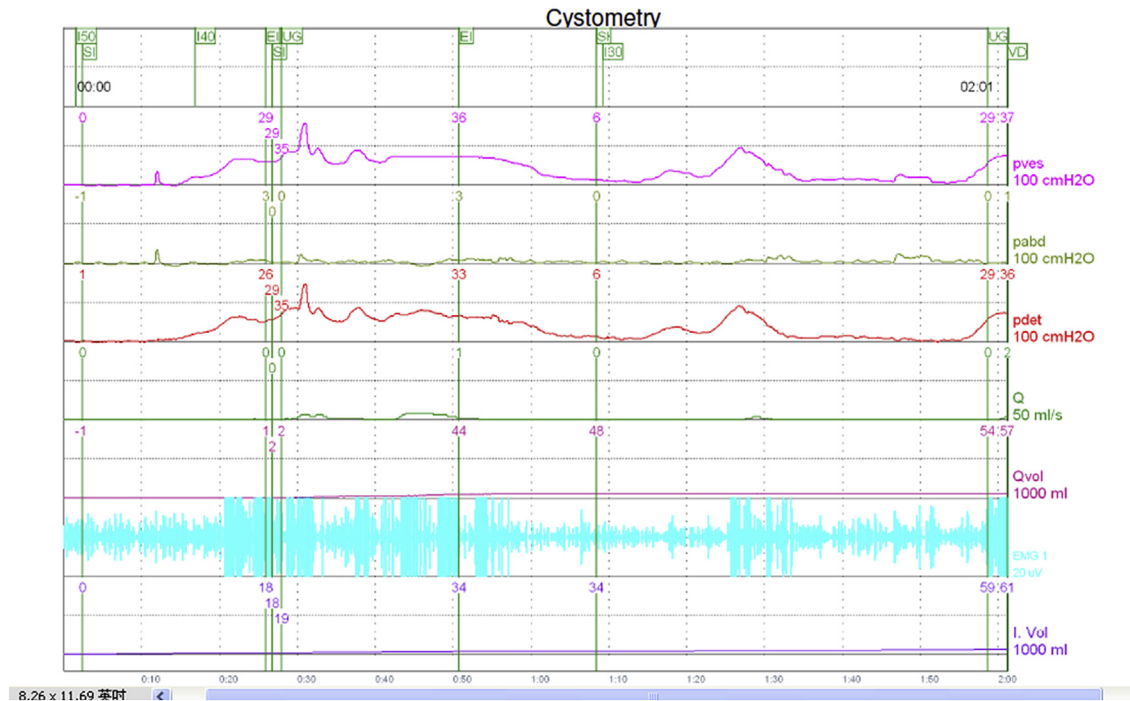


Fig. 1. Phasic and terminal detrusor overactivity on filling cystometry.

use) at our outpatient department. Her irritative voiding symptoms dramatically improved from voiding every 30 minutes to once every 1–2 hours. She was very satisfied with the decrease in urine incontinence. Furthermore, the lower abdominal pain also subsided dramatically after the therapy.

In this study, we present a case of an underdiagnosis in which no effective treatment had been found by previous clinicians, and who was ultimately diagnosed with IC and OAB as well as pelvic adhesion. Concomitant cystoscopy and laparoscopy, as well as a comprehensive urodynamic study, led to the final diagnosis and

enhanced the complete treatment. The patient is currently in a stable condition and is receiving multiple treatments.

Female lower urinary tract symptoms are categorized into different syndromes based on combinations of symptoms [1,3]. OAB and PBS were formally defined in 2002 by the International Continence Society [1]. Both have the symptoms of frequency, urgency, and nocturia, but the core symptoms are different. Suprapubic pain accompanied with bladder filling is the hallmark symptom of PBS. By contrast, urgency with or without urgency incontinence is considered to be the core symptom of OAB. For most typical patients, symptomatic diagnosis and empirical treatment are adequate. But for patients with atypical symptoms or nonresponders, it is important to verify the symptoms using specific methods, such as urodynamic study for detection of DO, or cystoscopy for evaluation of IC signs. Under such circumstances, clinicians can establish a second diagnosis and develop alternative treatment strategies.

For decades, IC/PBS and OAB/DO were thought to exclude one another in differential diagnosis because the underlying pathophysiologies are different. The National Institute of Digestive and Kidney Diseases formulated strict criteria for diagnosis of IC in 1988, encompassing the inclusion and exclusion criteria that describe the syndrome and identify a relatively homogeneous patient population [12]. Therefore, many clinicians have used the presence of DO as a criterion to exclude the diagnosis of IC [6], but there is no widespread consensus on its use [7]. However, in many OAB studies, bladder pain and/or IC are exclusionary criteria and pain has rarely been measured in OAB patients [13–15].

Nonetheless, it is still possible that a patient may have the two conditions concurrently. For example, several investigators had suggested that the prevalence of IC in patients with DO that does not respond to treatment with anticholinergic medications is high

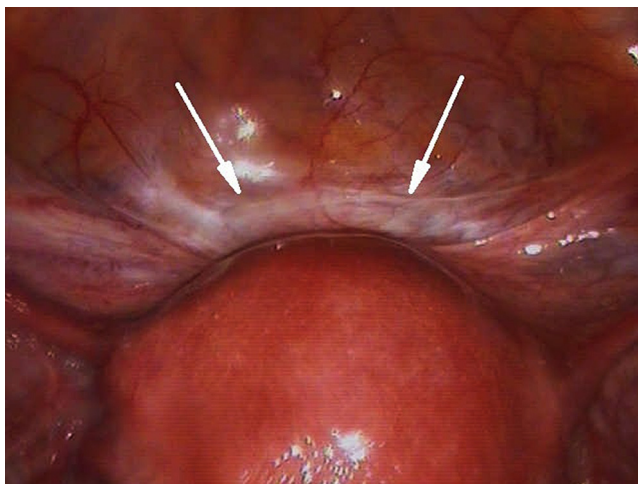


Fig. 2. Bladder adhesion to the lower segment of the uterus due to previous cesarean section (white arrows).

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