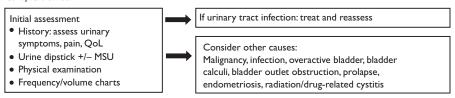
Appendix IV: Proposed treatment algorithm for BPS

BPS; Pain/pressure/discomfort in the pelvis/bladder, associated with urinary symptoms (frequency, urgency, nocturia, bladder filling pain) lasting at least 6weeks, with no identifiable cause.



First-line treatments:

- Conservative: analgesia, stress relief, dietary modification, exercise, physical therapy, support groups
- If treatment fails refer to secondary care

Second-line treatments:

- Oral amitriptyline, cimetidine
- If treatment fails refer to an MDT, pain team +/- clinical psychologist

Third-line treatments:

• Intravesical DMSO, heparin, botulinum toxin A, lidocaine, chondroitin sulfate, hyaluronic acid

Fourth-line treatments

- Neuromodulation posterior tibial nerve or sacral nerve stimulation
- Oral cyclosporin A

Fifth-line treatments:

- Cystoscopy and hydrodistension
- If Hunner lesions are noted or if major surgery is considered refer to a tertiary centre

Treatments that are not recommended: Long-term antibiotics, intravesical resiniferatoxin, intravesical BCG, intravesical PPS, high-pressure long-duration hydrodistension and long-term oral glucocorticoids.

Abbreviations: BCG Bacillus Calmette–Guérin; **BPS** bladder pain syndrome; **DMSO** dimethyl sulfoxide; **MDT** multidisciplinary team; **MSU** midstream specimen of urine; **QoL** quality of life; **PPS** pentosan polysulfate.

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All RCOG guidance developers are asked to declare any conflicts of interest. A statement summarising any conflicts of interest for this guideline is available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg70/.

The final version is the responsibility of the Guidelines Committee of the RCOG.

The review process will commence in 2019, unless otherwise indicated.

DISCLAIMER

The Royal College of Obstetricians and Gynaecologists produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient and the diagnostic and treatment options available.

This means that RCOG Guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.