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Management of Bladder Pain Syndrome

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Management of Bladder Pain Syndrome

This is the first edition of this guideline.

Executive summary of recommendations

Initial presentation and assessment

What initial clinical assessment should be performed?

Bladder pain syndrome (BPS) is a chronic pain syndrome and the principles of management of chronic pain should be used for the initial assessment of this condition. C

A thorough medical history should be taken and physical examination performed. ✓

What baseline investigations should be performed?

A bladder diary (frequency volume chart) should be completed. ✓

A food diary may be used to identify if specific foods cause a flare-up of symptoms. ✓

Urine should be tested to rule out a urinary tract infection as this is a prerequisite for diagnosis of BPS. Investigations for urinary ureaplasma and chlamydia can be considered in symptomatic patients with negative urine cultures and pyuria. C

In those with a suspicion of urological malignancy, urine cytology should be tested. Cystoscopy and referral to urology should be initiated in accordance with local protocols. C

Diagnosis of BPS

What are the differential diagnoses?

BPS is a diagnosis of exclusion and other conditions should be excluded. D

What investigations are used to diagnose BPS?

Bladder biopsies and hydrodistention are not recommended for the diagnosis of BPS. Cystoscopy does not confirm or exclude the diagnosis of BPS, but is required to diagnose/exclude other conditions that mimic BPS. ✓

Potassium sensitivity test, urodynamic assessment and urinary biomarkers should not be used in the diagnosis of BPS. Urodynamic tests may be considered if there is coexisting BPS and overactive bladder (and/or stress urinary incontinence and/or voiding dysfunction) that are not responsive to treatment. C

How can we classify the severity of BPS?

Clinicians should use a validated symptom score to assess baseline severity of BPS and assess response to treatment. B

The use of visual analogue scales for pain should be considered to assess severity of pain in BPS. D

What is the effect of BPS on quality of life (QoL)?

Patients with BPS can have low self-esteem, sexual dysfunction and reduced QoL. C

Patients with BPS may have other coexistent conditions impacting on their QoL. D

What is the initial management? (see Appendix IV)

Conservative treatments

Dietary modification can be beneficial and avoidance of caffeine, alcohol, and acidic foods and drinks should be considered. D

Stress management may be recommended and regular exercise can be beneficial. D

Analgesia is recommended for the symptom of pelvic or bladder pain. ✓

There are limited data on the benefits of acupuncture. D

Pharmacological treatments

Oral amitriptyline or cimetidine may be considered when first-line conservative treatments have failed. Cimetidine is not licensed to treat BPS and should only be commenced by a clinician specialised to treat this condition. B

Intravesical treatments

If conservative and oral treatments have been unsuccessful, other therapies may be added or substituted using an individualised approach. This will depend on the experience and expertise of the clinical team involved, and onward referral to a specialist centre with expertise in chronic pain management and access to professionals from other specialties to provide a multidisciplinary approach to care may be appropriate. Options include:

Intravesical lidocaine. B

Intravesical hyaluronic acid. B

Intravesical injection of botulinum toxin A (Botox). B

Intravesical dimethyl sulfoxide (DMSO). C

Intravesical heparin. D

Intravesical chondroitin sulfate. D

Further treatment options

Further options should only be considered after referral to a pain clinic and discussion at a multidisciplinary team (MDT) meeting. ✓

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, may be considered after conservative, oral and/or intravesical treatments have failed, in a multidisciplinary setting. D

Oral cyclosporin A may be considered after conservative, other oral, intravesical and neuromodulation treatments have failed. D

Cystoscopy with or without hydrodistension may be considered if conservative and oral treatments have failed. D

Major surgery may be considered as last-line treatment in refractory BPS. D

Treatments that are not recommended

Oral hydroxyzine does not appear to be an effective treatment for BPS. B

Oral pentosan polysulfate does not appear to be an effective treatment for BPS. A

Long-term antibiotics, intravesical resiniferatoxin, intravesical Bacillus Calmette–Guérin, high-pressure long-duration hydrodistension and long-term oral glucocorticoids are therapies that are not recommended for BPS. ✓

Further management (see Appendix IV)

Who should manage BPS?

History, urinalysis and physical examination should be carried out in primary care. ✓

Who should be referred to secondary care?

Patients who fail to respond to conservative treatment should be referred to secondary care. ✓

What is the role of the MDT – physiotherapist, pain team, clinical psychologist?

Referral to a physiotherapist should be considered as BPS symptoms may be improved with physical therapy. B

Consider referring patients with refractory BPS for psychological support or counselling if it is impacting on their QoL or the patient requests a referral. ✓

Patients with refractory BPS should be referred to an MDT in order to explore alternative treatment options. Those patients who may benefit from neuromodulation should be referred to an MDT before treatment is commenced. ✓

What is the role of support groups?

Patients should be given written information about patient organisations that provide evidence-based information. ✓

Long-term management and prognosis

What should be the duration of follow-up?

Patients should be followed up periodically in secondary care 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. ✓

