Text algorithm

Painful Bladder Syndrome, including IC (PBS/IC)

1. History / Initial Assessment

Men or women with bladder pain, with or without a sensation of urgency, often with urinary frequency and nocturia (especially if drinking a normal amount of fluids) and no abnormal gynecologic findings to explain the symptoms should be evaluated for PBS/IC. The initial assessment consists of a frequency/volume chart, focused physical exam, urinalysis, and urine culture. Cytology and cystoscopy are recommended if clinically indicated.

Patients with infection should be treated and reassessed. Those with recurrent urinary infection, abnormal urinary cytology, and haematuria are evaluated with appropriate imaging and endoscopic procedures, and only if findings are unable to explain the symptoms are they diagnosed with PBS/IC.

2. Initial Treatment

Patient education, dietary manipulation, nonprescription analgesics, and pelvic floor relaxation techniques comprise the initial management of PBS/IC. When these fail, or symptoms are severe and conservative management unlikely to succeed, oral medication or intravesical treatment can be prescribed.

3. Secondary Assessment

If initial oral or intravesical therapy fails, or before beginning such therapy, it is reasonable to consider further evaluation which can include urodynamics, pelvic imaging, and cystoscopy with bladder distention and possible bladder biopsy under anesthesia. Findings of bladder overactivity suggest a trial of antimuscarinic therapy. Findings of a Hunner's ulcer suggest therapy with transurethral fulguration or resection of the ulcer. Distention itself can have therapeutic benefit in up to one-third of patients, though benefits rarely persist for longer than a few months.

4. Refractory PBS/IC

Those patients with persistent, unacceptable symptoms despite oral and/or intravesical therapy are candidates for more aggressive modalities. These might include neuromodulation, pain clinic consultation, narcotic analgesia, and/or experimental treatment protocols. The last step in treatment is usually some type of surgical intervention aimed at increasing the functional capacity of the bladder or diverting the urine stream. Augmentation (substitution cystoplasty) and urinary diversion with or without cystectomy have been used as a last resort with good results in selected patients.

Reference: Proceedings of the 3rd International Consultation on Incontinence, June 26-29 2004. Editors: Paul Abrams, Linda Cardozo, Saad Khoury, Alan Wein.

Courtesy of Prof. Philip Hanno, 2004