IC/BPS Fact Sheet ic-network.com

You are not alone!

An estimated 3 to 8 million women and 1 to 4 million men in the USA have symptoms of IC, including frequency, urgency, pressure and/or pain. One of the most common pelvic pain conditions in the world, it may be called interstitial cystitis, bladder pain syndrome or hypersensitive bladder syndrome. Some call IC a chronic abdominal and pelvic pain syndrome (CAPPS) or a urologic chronic pelvic pain syndrome (UCPPS).

IC can begin after an injury or trauma though, for many, there is no obvious cause.

Many IC patients have damage to their bladder lining which allows urine to penetrate deep into the bladder wall where it irritates nerves and causes mast cells to release histamine. This drives symptoms of frequency, urgency and/or pain as the bladder fills.

Pelvic floor muscles often contribute to bladder symptoms & pelvic pain.

Many IC patients have tight pelvic floor muscles and painful trigger points. Pelvic floor dysfunction (PFD) can make it difficult to empty your bladder, have a bowel movement and enjoy sexual intimacy. A pelvic floor assessment is now part of the diagnostic process and most IC clinics now provide referrals for physical therapy to help restore proper muscle tone and function.

Interstitial cystitis (IC/BPS) patients often struggle with other health conditions.

Irritable bowel syndrome, vulvodynia, prostatodynia, endometriosis, anxiety disorder, fibromyalgia and TMJ are common related conditions to IC. Researchers suspect that neurosensitization is part of the problem. Many treatments and self-help strategies are designed to calm the nerves in the bladder, pelvis and throughout the body.

About the Interstitial Cystitis Network - www.ic-network.com - 1.800.928.7496

The Interstitial Cystitis Network is a “social advocacy” health education company dedicated to improving the lives of men, women and children suffering from bladder and pelvic pain disorders. We provide critical support to those struggling with IC/BPS, ketamine cystitis, eosinophilic cystitis, radiation cystitis, chronic prostatitis, pelvic floor dysfunction, pudendal neuralgia and other pelvic pain conditions.

To learn more about IC, the ICN and our patient magazine “The IC Optimist”, please visit our website: www.ic-network.com.

The New AUA Treatment Protocol For IC/BPS

The American Urology Association (AUA) offers a six step treatment protocol that can help you find relief. Patients are encouraged to begin with the easiest and less risky interventions in Step One and then, as needed, slowly proceed through the steps until relief is found. Treatments are organized with respect to risk of side effects and cost. Many patients manage their symptoms by just using Step One and Step Two strategies. Hunner's lesions may require prompt, direct lesion treatment as found in Step Three.

Step One: First-Line Treatments

- Adequate water intake. Urine should be a pale, clear yellow. Dark yellow or cloudy urine is concentrated and irritating.
- Diet modification to avoid foods that trigger bladder irritation, such as: coffee, soda, citrus, cranberry, etc.
- Heat or cold packs over the bladder or perineum.
- Over-the-counter products: calcium glycerophosphate (Prelief®), phenazopyridine (Azo Urinary Pain Relief Tablets®) and supplements (CystoProtek®, CystaQ®, Desert Harvest Aloe®, Cysto Renew®).
- Meditation, guided imagery, pelvic floor relaxation and bladder training.
- Good stress management skills and, if needed, support from psychological professionals.
- Treatment of other sources of pain and discomfort, such as: constipation, IBS, endometriosis, panic, anxiety, depression and vulvodynia symptoms.
- Avoidance of activities which can worsen symptoms temporarily, such as: wearing tight clothing, sexual intercourse and Kegel exercises.

Step Two: Second-Line Treatments

- Pelvic Floor Physical Therapy - Physical therapy can reduce muscle tension and release tight muscle trigger points. Kegel exercises are NOT recommended because they increase muscle tension.
- Pain Management - The AUA suggests that pain be evaluated at every clinical appointment. They encourage the use of multimodal pain relieving modalities (i.e. physical therapy, urinary analgesics, narcotic and non-narcotic medication, as needed). Patients with intractable pain or more complex presentations may require referral to outside pain specialists.
- Oral Medications - *Amitriptyline* (Elavil®), *Cimetidine* (Tagamet®), *Hydroxyzine* (Vistaril®, Atarax®), *Pentosan polysulfate* (Elmiron®)
- Bladder Instillations - *DMSO* (aka RIMSO-50®), *Heparin* and/or *Lidocaine* (aka Rescue Instillations).

Step Three: Third-Line Treatments

- Hydrodistention with cystoscopy may be considered if first and second line treatments have provided no relief. The AUA ONLY recommends low-pressure (60-80 cm H2O), short duration (less than 10 minutes) procedures.
- Hunner's lesions should be treated with fulguration and/or triamcinolone injection.

Step Four: Fourth-Line Treatments

- Neuromodulation (sacral, pudendal) - The non-surgical, more affordable method (Urgent PC®) is often attempted before the more invasive, costly surgical method (Interstim®).
- Botulinum Toxin (BTX-A) injections

Step Five: Fifth-Line Treatments

- Cyclosporine A

Step Six: Sixth-Line Treatments

- Surgical intervention, such as urinary diversion, substitution cystoplasty or cystectomy. Pain can be persistent even after cystectomy, especially in non-ulcer IC/BPS

Discontinued Treatments:

- Long-term oral antibiotics
- Intravesical Bacillus Calmette Guerin (BCG) & Resiniferatoxin (RTX)
- High pressure, long duration hydrodistentions
- Systemic glucocorticoids