

Interstitial Cystitis

Interstitial cystitis is a poorly understood chronic pain syndrome occurring almost exclusively in females with some association with voiding dysfunction. There is no definitive test for interstitial cystitis (IC). IC can not be confirmed on any test. Rather, some other more well understood pathologies of the bladder are generally excluded by performing certain studies. For example, cystoscopy and urodynamics are commonly performed when a patient presents for some of the common signs and symptoms of interstitial cystitis. With cystoscopy and urodynamics one cannot confirm or refute the diagnosis of interstitial cystitis but one can exclude some of the other more well understood pathologies such as bladder cancer and neurogenic bladder. Generally, the diagnosis of IC is arrived at gradually over time with continuing interaction between the patient and the treating urologist.

Common presenting signs and symptoms of IC include recurrent urinary tract infections, pelvic pain, burning with urination, frequency of urination, night time frequency of urination, pain with intercourse, and a sense of incomplete bladder emptying. A very common clinical scenario for a patient who ultimately arrives at a diagnosis of IC is that they have been treated with mixed results for recurrent urinary tract infections and that sometimes the urinary cultures are positive and sometimes these cultures are negative. Commonly, in such a situation the patient may have some pelvic pain or pain with intercourse. Another common presenting scenario for IC is that a patient has unexplained, chronic pelvic pain and urinary frequency. Commonly, IC patients also experience significant bladder pressure.

There is no single test to confirm a diagnosis of IC. In fact, there is not even a series of tests or studies which can definitively diagnose IC. Rather, some more well understood bladder pathologies are looked for by performing studies such as cystoscopy, cystoscopy with a biopsy, urodynamics testing, a CT scan of the abdomen and pelvis for pain or blood in the urine, and perhaps an MRI of the pelvis to rule out urethral diverticulum or VCUG to rule out vesicoureteral reflux. After some or all these studies are performed and no other bladder pathologies can be identified to explain the symptoms a patient and urologist may move toward a diagnosis of IC.

Another common pathway for arriving at a diagnosis of IC is to elect to treat for a presumptive diagnosis of IC and if the patient responds to a certain treatment protocol his or her response to the treatment may be highly suggestive of IC. There are multiple possible treatment plans or methods for IC. There is no treatment or management plan that can eliminate IC. The management options for IC, at best, can make the problem more manageable. For example, if a patient is presumed to have IC and the patient suffers from bladder pain associated with urinary frequency, then decreasing the urinary frequency may reduce the overall amount of pain the patient is experiencing but it will not

eliminate the pain. Some of the management plans available for interstitial cystitis include treating urinary frequency with anticholinergic medications such as Ditropan, Detrol, Sanctura, or Oxytrol patch. These anticholinergic medications can reduce bladder frequency by decreasing bladder contractions. Reducing urinary frequency can improve the clinical situation with IC. These anticholinergic medications can be used in combination with other medications. A commonly used treatment plan for IC includes triple drug therapy with Elmiron, Ativan, and Ditropan. In addition to using an anticholinergic such as Ditropan or Detrol the use of Elmiron can improve the lining of the bladder and decrease pain. The overall response can be improved by adding an anti-anxiety medication such as Ativan.

Other management options for IC include cystoscopy with urethral dilation or cystoscopy hydrodistention or a combination of cystoscopy with urethral dilation and hydrodistention. Urethral dilation may help improve bladder emptying and decrease urinary frequency. Hydrodistention of the bladder is expanding the bladder to a larger volume than is normally experienced by the patient the bladder to a larger than normal bladder volume under anesthesia (i.e., stretching the bladder wall,) can sometimes reduce pain and urinary frequency with IC. During such an endoscopic intervention, a bladder biopsy may be performed if desired.

Sometimes medications can be instilled into the bladder that can temporarily relieve the symptoms of IC. This type of treatment is performed in the office by placing a bladder catheter through the urethra and instilling medication into the bladder through the catheter. A commonly used medication for this treatment is called DMSO. DMSO is a mixture of steroids and other agents that for reasons that are not clearly understood seem to reduce inflammation of the bladder wall.

An initial assessment of the patients symptoms is important in trying to arrive at a diagnosis of interstitial cystitis and this initial assessment can be facilitated by completing an IC symptom survey. (See attached). This survey is also available at our web site (usadelaware.com) or at <http://www.orthoelmiron.com>.