Editorial

Long-term care of patients with interstitial cystitis is appreciated

Interstitial cystitis/bladder pain syndrome (IC/BPS) is a syndrome of mystery in urology. IC/BPS is characterized by bladder pain associated with urgency to urinate frequent urination, nocturia, dysuria, and sterile urine. IC/BPS is diagnosed based on the findings of symptomatology and urological analysis including the identification of characteristic cystoscopic features after hydrodistention under anesthesia.1 In this issue of Urological Science, Wu et al2 followed up 54 patients with cystoscopic-confirmed IC/BPS for a median period of 30.6 months, of which 98.1% of patients had received multiple treatment regimens including oral medication, intravesical heparin instillations, and hydrodistention. Although only 14 patients had an increase of global response assessment by two points, the overall positive perception rate was 81.6%. The authors concluded that long-term, continual treatments for IC/BPS are appreciated by most patients.

In this study, the authors reported that all patients had pain and pressure over the bladder or pelvic region. However, in clinical experience, pain is only experienced in 33.5% of the patients with IC/BPS.3 It is possible that the authors did not include patients with bladder oversensitivity without pain for diagnostic cystoscopic hydrodistention. Although some of the patients might not experience pain at all, a small functional bladder capacity often raises an early suspicion about IC/BPS.4

The diagnosis of IC/BPS remains unclear and should be based on the exclusion of other diseases. Current treatment methods are based on the possible etiologies of IC/BPS, including (1) a postinfection autoimmune process, (2) mast cell activation induced by inflammation, toxins, or stress, (3) urothelial dysfunction and increased permeability of the urothelium, or (4) neurogenic inflammation. IC/BPS is also associated with a number of lifestyle and psychosocial correlates. This suggests that the treatment of patients with IC/BPS may benefit from a multifaceted approach of combining medical, psychological, and cognitive treatment in addition to controlling the dysfunctional epithelium.5

By far, administration of intravesical heparin and hyaluronic acid continue to remain as the treatment of choice for early IC/BPS based on the published reports.6–8 However, as commented by the authors, the placebo effect should be weighed and randomized, double-blind trials should be undertaken to demonstrate the actual therapeutic effects of these therapeutic modalities. Although the action mechanism of onabotulinumtoxinA injection for IC/BPS remains undetermined, positive response and long-term cure of IC/BPS have been reported recently.9 Combination therapies of hydrodistention, antihistamines, analgesics, and anticholinergics might be beneficial in addition to intravesical treatments. As the authors addressed, we seldom cure but we always care for patients with IC/BPS. With efforts in the early diagnosis and treatment, long-term therapy is needed for a better cure rate for IC/BPS.

Conflicts of interest statement

The authors declare that they have no financial or non-financial conflicts of interest related to the subject matter or materials discussed in the manuscript.

Source of funding

None.

References


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28 May 2012
Available online 15 March 2013