Conquering IC. Changing Lives.
Interstitial Cystitis Association

OFFICIAL AUA GUIDELINE – UPDATED MAY 2022!

The American Urological Association (AUA) clinical guideline for IC/BPS has been updated to be current with recent and new published researched. The purpose of this clinical guideline is to provide a clinical framework for the diagnosis and treatment of interstitial cystitis/bladder pain syndrome (IC/BPS), including discussion of treatments that should and should not be offered.

American Urological Association

The guideline helps to end the all-too-common misdiagnosis, underdiagnosis, mistreatment, and undertreatment, especially undertreatment of pain.

Empower yourself – share and discuss the guideline with your doctor to get the best possible treatment.

You can read the full guideline on the AUA website: https://www.auanet.org/guidelines/guidelines/diagnosis-and-treatment-interstitial-cystitis/bladder-pain-syndrome-(2022)

GUIDELINE STATEMENTS

Diagnosis

1. The basic assessment should include a careful history, physical examination, and laboratory examination to document symptoms and signs that characterize IC/BPS and exclude other disorders that could be the cause of the patient's symptoms. *Clinical Principle*
2. Baseline voiding symptoms and pain levels should be obtained in order to measure subsequent treatment effects. *Clinical Principle*
3. Cystoscopy and/or urodynamics should be considered when the diagnosis is in doubt; these tests are not necessary for making the diagnosis in uncomplicated presentations. *Expert Opinion*
4. Cystoscopy should be performed in patients in whom Hunner lesions are suspected. *Expert Opinion*

Management Approach

5. Treatment decisions should be made after shared decision-making, with the patient informed of the risks, potential benefits, and alternatives. Except for patients with Hunner lesions (S, initial treatment should typically be nonsurgical. *Expert Opinion*
6. Efficacy of treatment should be periodically reassessed, and ineffective treatments should be stopped. *Clinical Principle*
7. Multimodal pain management approaches (e.g., pharmacological, stress management, manual physical therapy if available) should be initiated. Pain management should be continually assessed for effectiveness because of its importance to quality of life. If pain management is inadequate, then consideration should be given to a multidisciplinary approach and the patient referred appropriately. *Clinical Principle*

8. The IC/BPS diagnosis should be reconsidered if no improvement occurs after multiple treatment approaches. *Clinical Principle*

Treatment Categories for IC/BPS

Behavioral/Non-pharmacologic Treatments

9. Patients should be educated about normal bladder function, what is known and not known about IC/ BPS, the benefits versus risks/burdens of the available treatment alternatives, the fact that no single treatment has been found effective for the majority of patients, and the fact that acceptable symptom control may require trials of multiple therapeutic options (including combination therapy) before it is achieved. *Clinical Principle*
10. Self-care practices and behavioral modifications that can improve symptoms should be discussed and implemented as feasible. *Clinical Principle*
11. Patients should be encouraged to implement stress management practices to improve coping techniques and manage stress-induced symptom exacerbations. *Clinical Principle*
12. Appropriate manual physical therapy techniques (e.g., maneuvers that resolve pelvic, abdominal and/or hip muscular trigger points, lengthen muscle contractures, and release painful scars and other connective tissue restrictions), if appropriately trained clinicians are available, should be offered to patients who present with pelvic floor tenderness. Pelvic floor strengthening exercises (e.g., Kegel exercises) should be avoided. *Standard (Evidence Strength: Grade A)*

Oral Medications

13. Clinicians may prescribe pharmacologic pain management agents (e.g., urinary analgesics, acetaminophen, NSAIDs, opioid/non-opioid medications) after counseling patients on the risks and benefits. Pharmacological pain management principles for IC/BPS should be similar to those for management of other chronic pain conditions. *Clinical Principle*
14. Amitriptyline, cimetidine, hydroxyzine, or pentosan polysulfate may be administered as oral medications (listed in alphabetical order; no hierarchy is implied) *Option (Evidence Strength: Grades B, B, C, and B)*
15. Clinicians should counsel patients who are considering pentosan polysulfate about the potential risk for macular damage and vision-related injuries. *Clinical Principle*
16. Oral cyclosporine A may be offered patients with Hunner lesions refractory to fulguration and/or triamcinolone. *Option (Evidence Strength: Grade C)*

Intravesical Instillations

17. DMSO, heparin, and/or lidocaine may be administered as intravesical treatments (listed in alphabetical order; no hierarchy is implied). *Option (Evidence Strength: Grades C, C, and B)*

Procedures

18. Cystoscopy under anesthesia with short-duration, low-pressure hydrodistension may be undertaken as a treatment option. *Option (Evidence Strength: Grade C)*

19. If Hunner lesions are present, then fulguration (with laser or electrocautery) and/or injection of triamcinolone should be performed. *Recommendation (Evidence Strength: Grade C)*
20. Intradetrusor onabotulinumtoxin A may be administered if other treatments have not provided adequate improvement in symptoms and quality of life. Patients must be willing to accept the possibility that post-treatment intermittent selfcatheterization may be necessary. *Option (Evidence Strength: Grade C)*
21. A trial of neuromodulation may be performed if other treatments have not provided adequate symptom control and quality of life improvement. If a trial of nerve stimulation is successful, then a permanent neurostimulation device may be implanted. *Option (Evidence Strength: Grade C)*

Major Surgery

22. Major surgery (e.g., substitution cystoplasty, urinary diversion with or without cystectomy) may be undertaken in carefully selected patients with bladder-centric symptoms, or in the rare instance when there is an end-stage small fibrotic bladder, for whom all other therapies have failed to provide adequate symptom control and quality of life improvement. *Option (Evidence Strength: Grade C)*

Treatments that Should Not be Offered

The treatments below appear to lack efficacy and/or appear to be accompanied by unacceptable adverse event profiles. See body of guideline for study details and rationales.

23. Long-term oral antibiotic administration should not be offered. *Standard (Evidence Strength: Grade B)*
24. Intravesical instillation of bacillus Calmette-Guerin should not be offered outside of investigational study settings. *Standard (Evidence Strength: Grade B)*
25. High-pressure, long-duration hydrodistension should not be offered. *Recommendation (Evidence Strength: Grade C)*
26. Systemic (oral) long-term glucocorticoid administration should not be offered. *Recommendation (Evidence Strength: Grade C)*