Report of the ESSIC Annual Meeting 2007 in Munster, Germany

Participants

Full and Associate Members

Anganuthu Arunkalaivanan (UK), Kirsten Bouchelouche (Denmark), Pierre Bouchelouche (Denmark), Mauro Cervigny (Italy), Suzy Elneil (UK), Magnus Fall (Sweden), Phil Hanno (USA), Joop van de Merwe (the Netherlands), Jørgen Nordling (president, Denmark), Arndt van Ophoven (chairman of the meeting, Germany), Benedikte Richter (Denmark), Rajesh Taneja (India), Claus Riedl (Austria), Andrey Zeitcev (Russia)

Non-members

Alex Aguilera (Bioniche, Spain), Arnd Carrette (Allergan, Germany), Arsen Davidyants (Russia), Karin Greeske (Astellas, Germany), Elke Hessdörfer (Germany), Irina Korsunskaya (Russia), John Kusek (NIDDK/NIH, USA), Birgit Löffler (invited speaker, Germany), Maren Möller (Pohl-Boskamp, Germany), Lowell Parssons (USA), Frank Perabo (Astellas, Germany), Gerben Terpstra (Astellas, the Netherlands), Frank Ückert (Germany, invited speaker)

Notice of absence has been received from: Paul Irwin (UK) and Paulo Oliveira (Portugal)

Excused by the board: JJ Wyndaele

Scientific Presentations Thursday 3 May 2007

Presented by the underlined author

Pushkar D, Zeitcev A, Korsunskaya I, Rasner P.
Practical significance of endovesical electromotive drug administration in the multimodality treatment of BPS/IC.

Zaitcev AV, Pushkar DU, Djakov VV, Galchikov IV.
Our experience with Ho:YAG laser ablation in the complex treatment of patients with recurrent cystitis and BPS/IC.

A novel neuromuscular electrostimulation treatment for interstitial cystitis patients.

Zaitcev A, Mazaev A, Davidyants A, Farmanov R.
Use of hyperbaric oxygenation in the treatment of patients with BPS/IC.

Van Ophoven A, Rossbach G, Hertle L.
Hyperbaric oxygen therapy (HBO) for the treatment of BPS/IC: a randomized, sham-controlled, double-blind trial.

Van Dijck J, De Wachter S, Wyndaele JJ.
Comparison between cystoscopic data and histological data in patients with BPS-IC.

Taneja R.
Intravesical lignocain as a diagnostic test for interstitial cystitis.

Abstract handouts were available.
PRESENTATIONS FRIDAY 4 MAY 2007

Jørgen Nordling. Review on last year
Review on ESSIC presentations, discussions and reactions from patient organization on the ESSIC consensus 2006 at the NIDDK/NIH Meeting, Bethesda, USA, October 2006 and the 2nd ICICJ in Kyoto, Japan, March 2007.

"Urge is a sacred word that needs in the definition."

Jørgen Nordling. How to define urgency.
Oxford dictionary: urgency asks for immediate action; urge is a strong desire.

Frank Ückert. Introduction & background regarding ESSIC database.
Topics: pseudonymisation and anonymisation; security concept; AJAX
Next steps: 1) what does everybody want to do with it (the database); 2) what are the prophits for both parties?

Birgit Löffler. Microbiological exclusion of confusable diseases.
Ureaplasma urealyticum, Mycoplasma hominis and Mycoplasma genitalium are the most frequent causes of “hidden” urinary tract infection (UTI). Culture is slow!!
Risk factors for UTI with Corynebacterium urealyticum are UTIs with other micro-organisms, immunosuppression and catheters.
Risk factors for Candida infections: diabetes mellitus, use of antibiotics and catheters.

The diagnosis of infection with herpes simplex virus (HSV) and human papilloma virus is mainly on the basis of the clinical presentation. Further confirmation is possible with PCR, EM and serology.
There are two types of HSV, type 1 and 2. The usual type is type 2. HSV2 infection is recognized by typical skin lesions.
For the diagnosis of Mycoplasma and Chlamydia infection an urethral swab is done. For Mycoplasma the urine can be tested as well. Chlamydia grows intracellularly, so for recognition cells are needed.

How can infections with these microorganisms be ruled out as the cause of “bladder pain syndrome”?
- Corynebacterium is not cultured from midstream urine.
- consult a microbiologist
- procedure: do normal culture with midstream urine. If negative, test for Mycoplasma and Ureaplasma (comment Phil Hanno: “tests are as often positive in IC as in controls”; to exclude UTI as the cause of “BPS” he prescribes at least 1 course with antibiotics).
Comment Rajesh Taneja: microscopy of the sediment of the first urine in the morning is helpful.
Comment Suzy Elneil: cytology is very helpful.
- infection with Corynebacterium increases the urine pH.

Sequence:
1. urethral swab
2. dipstick midstream urine
3. microscopy
4. PCR for Chlamydia (comment Phil Hanno: need further studies: it would be usefull if positive in 1-2%). QUESTION FOR DATABASE STUDY
DISCUSSION ON THE DATABASE

Goals of the database
1. validation of the ESSIC definition and evaluation of BPS;
2. where is the pain perceived? (patients without pain are also entered into the database);
3. how is the composition of the group as far as pain, urgency, frequency are concerned? (x% BPS, y% OAB, z% confusable disease)

Entry criterium: patients with pelvic pain OR urgency OR frequency not explained by bacterial infection.

Include in the database:
- symptoms (questionnaires)
- history
- physical examination
- laboratory tests
- cystoscopy

Patients to be included in the database

IN

If chief complaints of, or positive answer to question: do you have …..
- pelvic pain
- urgency
- frequency
and no obvious UTI (negative dip stick)

NOT INCLUDED

Obvious other causes of the symptoms e.g. radiation cystitis, chronic bacterial infection, pelvic trauma, pelvic cancer.
Previously diagnosed confusable disease.

Questions

General
- date of information
- time relationship to instrumentation

Pro memori: ask J. Warren

Ad 1. Pelvic pain, pressure or discomfort
- do you have pain with sex?
- where do you perceive the pain? (picture for patients to mark their pain)

Type of pain?
- time chronology
- pain associated with bladder filling or bladder emptying? better or worse?

Degree of pain (VAS scale)
Is it perceived as pain, pressure or discomfort?

Ad 2. Urgency
- Blaivis classification
- do you have urgency (a sudden compelling desire to urinate)?
- is it all the time, or frequently?
- is it for fear of leakage?
- is it for fear of pressure?
- do you leak?
- when does the urgency start?

Ad 3 Frequency
- 24 hr voiding diary (Jean-Jacques Wyndaele diary: 1 day is enough)
- when did it start?
- frequency problem perception VAS-scale (0=no problem; 10=worst thinkable problem)

Ad 4 UTI
No questions

Workgroups
1. Symptoms including questions for inclusion (chairman Phil Hanno, Jørgen Nordling, Lowell Parssons)
2. History (Suzy Elneil)
3. Physical examination (Mauro Cervigni, Jean-Jacques Wyndaele for men)
4. Laboratory tests and urodynamics (Pierre Bouchelouche and Jørgen Nordling)
5. Cystoscopy and morphology (Magnus Fall and Kirsten Bouchelouche)

Ad 1. Symptoms including questions for inclusion

Ad 2. History
- demographics: personal data, education
- duration of symptoms, specified symptoms
- previous treatment
- pregnancy history
- past medical history
- associated diseases
- triggering patterns (start, stop)
- menstrual cycle
- abuse
- smoking
- IC in family members
- sexually transmitted diseases

Ad 3. Physical examination


- Trigger points
- Vulvar hypersensitivity
- Pelvic floor reflexes specified
- anal reflex etc.
- rolling test (rolling of perineal skin is painful: tests pudendal neuropathy/entrapment)

Entry criteria: if the work load would be too much, it is possible to document this in only every 3rd or 5th patient. This way of selection is non-biased.

Ad 4. Laboratory tests and urodynamics

Laboratory tests
- blood test: PSA in men > 40 years
- urine: dipstick, culture, special cultures

Urodynamics
- cystometry (if done)
- KCl test (comment Jørgen Nordling: may be useful for the decision on GAG-therapy)

Ad 5. Cystoscopy and morphology

Comments by Magnus Fall: a more detailed description must be documented; Hunner’s lesion: document location and findings with photo’s. A separate project would be a central assessment review of biopsies by experienced pathologists. Fundung ?

Method of mast cell counts. Comment Kirsten Bouchelouche: use 3 different staining methods

Documentation of patient data

Patients enter the database on the basis of the symptom of pelvic pain or urgency or frequency if a bacterial infection as the cause of the symptom(s) is excluded.

Patient data collection is completed when a confusable disease is diagnosed.
We can decide to keep certain patient groups in the database for further follow-up, e.g. patients with nonbacterial prostatitis or endometriosis (controversial reason for pain; out if responding to endometriosis treatment). Pelvic pain related to the menstrual cycle: laparoscopy is a standard procedure. OAB is completed after urodynamics.

The most important question is which of the collected data can predict the final classification as non-BPS and BPS: these data play a role for the diagnosis of BPS.

A possible easy to perform method for analysis is logistic discriminant analysis.

Treatment
- Result of initial treatment: global response assessment after 1 month + O’Leary-Sant + ICS score for OAB (?)

Urgency
What urgency questionnaires do exist? Make a choice (action of Suzy Elneil)