Mycobacterium tuberculosis. Gomes et al noted in a cohort of IC/BPS patients that up to 40% of patients with IC/BPS had microscopic hematuria (only 2/60 gross hematuria). In their study, None of the cases were reported to be linked to a potentially lethal urologic condition;[17] however, bladder cancer must be ruled out if hematuria (microscopic or gross) is found, and patients should be appropriately investigated with cystoscopy and upper tract imaging.

The Interstitial Cystitis Symptom Index (ICSI), the Interstitial Cystitis Problem Index (ICPI), and the Genitourinary Pain Index (GUPI) are self-administered symptom questionnaires for IC/BPS that have been evaluated to varying degrees.[18-21] Clinicians should be aware that while the surveys can be useful as diagnostic aids, none have enough specificity to be used as a stand-alone diagnostic instrument. The questionnaires may be used to establish a baseline in terms of symptom severity and monitor response to therapeutic intervention.

The role of a cystoscopy includes ruling out bladder malignancy (or other pathology) in patients with risk factors (e.g., hematuria), identifying Hunner lesions (HLs), assessing the impact of bladder filling on symptoms of pain, objectively evaluating the "functional" bladder capacity, facilitating a suitable pelvic examination, and providing reassurance to the patient. Taking into account all these factors, particularly the fact that HL diagnosis requires direct visualization, the authors recommend routine flexible cystoscopic evaluation in all patients suspected of IC/BPS. Treatment should not be delayed while awaiting cystoscopy in patients with symptoms of IC/BPS.[22]

Older individuals are more likely to have HLs; they may be found in 4% of patients <50 years old, in 20% of patients 50–70 years old, and as high as 55% for those over the age of 70.[23] Reduced urodynamic and anesthetic capacity, as well as more severe symptoms, are linked to HLs.[23-27] It is only after a formal hydrodistension performed under anesthesia that the classic findings of glomerulations can be accurately identified. Evidence, however, indicates that glomerulations are neither specific nor sensitive to IC/BPS.[28]

It is uncommon for bladder cancer to manifest with symptoms that are consistent with IC/BPS. According to Tissot et al, 1% of 600 patients who were referred with an IC/BPS diagnosis also had bladder cancer. All but two of the six cancer patients had microscopic hematuria or positive cytology. The majority were over 60 years of age.[29] Bladder biopsy should be carried out in settings where malignancy is suspected.

Urodynamic studies may be used in certain patients with IC/BPS when the diagnosis is unclear or to guide more invasive treatment options, but are not required for the diagnosis. There are no standard urodynamic criteria for the diagnosis of IC/BPS.

Clinical phenotyping

The concept of clinical phenotyping in urologic chronic pelvic pain was first popularized by Nickel et al among IC/BPS patients when they introduced their UPOINT phenotyping tool in 2009.[30] The NIH-funded Multidisciplinary Approach to Pelvic Pain (MAPP) Network then further explored clinical phenotyping through a comprehensive and thorough characterization of IC/BPS phenotypes[31] further highlighting the importance of this approach.

IC/BPS patients represent such a heterogenous patient population that identifying the clinical phenotype of the patient in front of you is vital. HL patients, for example, will require their own treatment algorithm. Patients with tenderness on pelvic floor examination — the pelvic floor phenotype — will benefit most from pelvic floor physiotherapy. The widespread pain phenotype will often exhibit one or multiple chronic overlapping pain conditions (COPCs), such as fibromyalgia, chronic fatigue syndrome, or irritable bowel syndrome, in addition to their bladder pain, and can be challenging to manage.

The best diagnostic tool at our disposal is still the history and physical exam. Recognizing the importance of clinical phenotyping may represent one of the more impactful advancements in terms of treatment of IC/BPS patients to date and should be sought at every encounter. Practitioners should strive for a phenotype-directed approach to treatment; incorporating phenotypes into clinical trial design is regarded as the key to identifying improved treatment options.

METHODOLOGY

The goal of this guideline was to address high-priority questions in the realm of IC/BPS and to aid practitioners in developing an up-to-date clinical approach to the management of IC/BPS. The panel compiled a list of priority questions to be addressed in a systematic manner using the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) methodology[32] and evidence-to-decision (EtD) framework.[33] Each question was developed using a PICO (population, intervention, comparison, outcome) format. The detailed PICO format questions are listed in Supplementary Table 1 (available at *cuaj.ca*). The