What is BPS and how should it be managed in real life clinical practice?

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What is "bladder pain syndrome (BPS)"? This report published in this month's *CUAJ* describes the long-term clinical results of pentosan polysulfate sodium (PPS) for BPS.[1] No one had even heard of this diagnostic entity until 2008, when the syndrome was first proposed by the European Society for the Study of Painful Bladder Syndrome/Interstitial Cystitis.[2] This same group previously proposed and championed the term "painful bladder syndrome (PBS)" for what we all believed was the same condition. Prior to that time, most of us called this syndrome "interstitial cystitis (IC)."[3] Many still do. Based on the years that these authors reported their results, I strongly suspect that they were treating patients that they diagnosed with IC, not PBS or BPS. While the research community struggles with nomenclature, there is no doubt that women with pelvic pain perceived to be bladder related and concomitant urinary storage symptoms are difficult to manage. The literature surrounding the only oral medication approved for this condition (approved for IC not BPS, a term not recognized by any regulatory organization) clearly shows that the benefits of PPS compared to placebo are at best modest in the short term,[3] however the longer the duration of exposure, the greater the predicted response rate.[4]

Some problems and limitations with this study include that it was retrospective, patients who discontinued PPS prior to 3 months were not included, other treatments were not documented and the primary outcome measure was global response assessment which has not be validated for long-term studies and is likely very inaccurate after 3 months. The strengths of this study were that it provides real-life clinical observations on the safety and efficacy of this treatment in Canadian urology outpatients. And what were those observations? The results corroborated that of a large multicentre, long-term, prospective study that clearly showed that response increased with duration of therapy.[4] However, is PPS an appropriate long-term monotherapy? Despite the suggestion from this study that it is, many patients did not achieve the desired beneficial response and it is very likely that many of those that did had other forms of specific and nonspecific IC directed therapy.

So how do these results affect clinical practice? To start with, PPS is an appropriate intervention, but duration of therapy remains a key point in efficacy considerations. Many of these patients are not a homogenous group, but present with various but identifiable clinical phenotypes that predict different responses to different therapies. We have addressed this issue by describing the UPOINT (urinary, psychosocial, organ-specific, infection, neurologic/systemic, and tenderness domains) phenotypic classification system for patients with chronic urologic pain syndromes,[5] including IC/PBS/BPS,[6] that differentiates patients according to their clinical phenotype, allowing individually directed therapy according to the various phenotype classifications diagnosed. Multimodal therapy is the key to better management of this condition, no matter whether you call it IC, PBS or BPS.

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