CONSENSUS DOCUMENT

Recommendations for the diagnosis and management of bladder pain syndrome. Spanish urological association consensus document


Working group for recommendations on the diagnosis and management of bladder pain syndrome. Conducted under the auspices of the Spanish Association of Urology

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KEYWORDS
Bladder pain syndrome; Consensus; Diagnosis; Disease management; Practical guide; Treatment

Abstract

Introduction: Bladder pain syndrome/interstitial cystitis (BPS/IC) and other bladder pathologies share common manifestations, such as the presence of michtional symptoms and a negative impact on the patient’s quality of life. To be properly diagnosed and clinically managed, it is important to distinguish between its clinical modalities and diagnostic criteria for adequate exclusion.

Objective: The purpose of this study was to standardize criteria for making decisions in BPS management, for its diagnosis, initial treatment and follow-up.

Material and method: A nominal group methodology was employed, using scientific evidence on BPS taken from a systematic (non-exhaustive) literature review for developing recommendations along with specialist expert opinions.

Results: The diagnosis of BPS should be made based on the patient’s clinical history, with emphasis on pain and michtional symptoms as well as excluding other pathologies with similar symptomatology. BPS treatment should be directed toward restoring normal bladder function, preventing symptom relapse and improving patients’ quality of life. It is therefore advisable to start with conservative treatment and to adopt less conservative treatments as the level of clinical severity increases. It is also recommended to abandon ineffective treatments and reconsider other therapeutic options.


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More information on the Task Force recommendations in the diagnosis and management of bladder pain syndrome is available in Appendix 1.

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Conclusions: Quickly identifying the pathology is important when trying to positively influence morbidity and care quality for these patients.
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Consenso de la Asociación Española de Urología en el diagnóstico y manejo del síndrome de dolor vesical

Resumen

Introducción: El síndrome de dolor vesical/cistitis intersticial (SDV/CI) y otras enfermedades vesicales comparten una sintomatología común, como la presencia de los síntomas miccionales y la repercusión negativa sobre la calidad de vida de los pacientes. Para su correcto diagnóstico y manejo clínico es importante distinguir entre sus diferentes modalidades clínicas y criterios diagnósticos de exclusión adecuados.

Objetivo: El propósito de este trabajo ha sido homogeneizar los criterios para la toma de decisiones en el manejo del SDV, tanto en su diagnóstico y tratamiento inicial como en su seguimiento.

Material y método: Se utilizó metodología de grupo nominal, utilizando para la elaboración de las recomendaciones las evidencias científicas sobre el SDV extraídas de una revisión sistemática (no exhaustiva) de la literatura, junto con el juicio experto de especialistas.

Resultados: El diagnóstico del SDV debe hacerse basándose en la historia clínica del paciente, prestando importancia al dolor y a los síntomas miccionales y a la exclusión de otras enfermedades de sintomatología parecida. El tratamiento del SDV debe dirigirse a la restauración de la función vesical normal, la prevención de recaídas de los síntomas y la mejora de la calidad de vida de los pacientes. Para ello es recomendable empezar con un tratamiento conservador y adoptar tratamientos menos conservadores conforme el nivel de gravedad clínica aumenta. También se recomienda abandonar tratamientos ineficaces y replantearse otras opciones terapéuticas.

Conclusiones: La rápida identificación de la enfermedad resulta importante para intentar influir positivamente en los indicadores de morbimidad y la calidad asistencial de estos pacientes.
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Introduction

For several years, efforts have been directed to standardize a definition and evaluation of bladder pain syndrome (BPS), also known as interstitial cystitis (IC). While IC represents a special type of chronic inflammation of the submucosa and bladder muscle tissues, the term BPS encompasses those patients suffering from pain in the bladder region.1,2 In the latest update of the guideline for chronic pelvic pain,3 the European Association of Urology [EAU], defined the BPS as a pelvic pain associated to the urinary bladder accompanied by at least one other urinary symptom, such as day or night urinary frequency, while the American Urological Association [AUA]4 decided on the definition given by the Society for Urodynamics and Female Urology, which defines the BPS as "the unpleasant sensation (pain, pressure, discomfort) perceived in relation to the urinary bladder and accompanied by lower urinary tract symptoms, for more than 6 weeks and in the absence of infection or other identifiable cause".5 On the other hand, the International Society for the Study of BPS [ESSIC] has proposed a standard scheme of diagnostic criteria6 in order to facilitate comparison of different studies.

Some studies performed in the European context estimate a prevalence of 8–16 cases per 100,000 inhabitants.7-9 Subsequent studies indicate that the prevalence of IC/BPS in the United States could exceed 0.5% of the adult population, indicating that the incidence of IC/BPS would have been underestimated so far,10 although others point to an incidence (1.1/100,000),11 of clearly female predominance (5:1 or 10:1).12

The Spanish Association of Urology, in its efforts to develop documents for specialist help, designed to facilitate and improve the correct diagnosis and management of each disease process, decided to publish this consensus document on the management of BPS, based on the scientific evidence available and on the knowledge of experts who exercise their profession in the National Health System (NHS). This document adapts certain criteria and processes to the conditions of the NHS, thus providing added value in the most useful aspects of clinical practice.

The consensus document of diagnosis and management of SDV was developed with the following purposes: (1) standardize the criteria for decision making in the management of BPS, both in its diagnosis and initial treatment and follow-up; (2) highlight the importance of early identification of these patients; and (3) positively influence the morbidity indicators and the quality of care of these patients. It is addressed to any medical or health professional to diagnose...
and/or treat the disease: urologists, family physicians, gynecologists, nurses.

**Material and methods**

The development of recommendations of the consensus document was done following the guidelines of the Methodological manual of preparation of clinical practice guidelines of the NHS, of the Quality Plan of the Ministry of Health. A consensus methodology, nominal group type, was used, using scientific evidence available on BPS, from a systematic review of "not exhaustive" literature led by experts, which together with the opinion or considered point of view of the specialists, depending on their experience in routine clinical practice, made it possible to develop the consensus document whose main recommendations are presented in this paper.

The expert team was organized into 3 groups: a scientific committee (SC) consisting of 3 urologists, a recommendation developing group (RDG) consisting of members of the SC and 3 more urologists and a recommendation validating group (RVG), with another 21 experts in urology, all of them managed by a coordinator. The SC oversaw the quality and suitability of the processes and the methodology of consensus, as well as the identification of the thematic framework of contents to be validated. The RDG was responsible for the evaluation and selection of contents from the literature review, for discussing them, and making recommendations. The RVG was established to validate in a broader and more representative way the recommendations made by the RDG.

The RDG developed an advisory subject index asking the clinical questions to be answered, which, together with a framework protocol defining the characteristics and limits of the search, as well as the prioritization criteria, led to the review of the literature. The Patients Interventions Controls Outcomes (PICO) method was applied to those points of the advisory thematic index that were considered appropriate, facilitating the development of well-structured clinical questions. In the literature search, consensus documents, literature reviews, and guidelines published in the last 5 years were prioritized. After searching, critical reading and synthesis of contents were conducted, on which the recommendations of the RDG would be based. Finally, the consensus document included those recommendations agreed between the RDG and the RVG (Figs. 1 and 2).

The recommendations were categorized with the level of evidence (LE) and grade of recommendation (GR) referred to in the original or, failing this, with the categorization of the LE and GR of the criteria of the system Centre for Evidence-Based Medicine (Oxford) in the modified version by Sackett. We established as formal recommendation of the process, those that reach an agreement above 70% among RVG members in terms of usefulness (U) and applicability (A); the final percentage of agreement obtained is shown along with the formulation of the recommendation. The first-round recommendations were assessed by 19 experts, while the second-round ratings were assessed by a total of 23 experts.

**Results**

**Definition and characteristics of the bladder pain syndrome**

The panel of experts agreed to define the BPS as "the unpleasant sensation (pain, pressure, discomfort) perceived..."
in relation to the filling of the urinary bladder and accompanied by at least another symptom of the lower urinary tract, either daytime or nighttime, such as increased urinary frequency and in the absence of infection or another identifiable cause. The arbitrariness of criteria involved in the BPS makes it advisable to accept a range between 3 and 6 months to establish the diagnosis and initiate a consistent therapeutic approach.

The BPS involves no identification of injury to justify inflammatory activity and endocrine-neurological disorder. In fact, we found no pathogenesis associated with infections in relation to the BPS (LE: 2a). There is evidence that the BPS is often associated with several non-bladder syndromes, such as irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, vulvodynia, depression, panic disorders, migraine, Sjögren’s syndrome, temporomandibular joint disorder, allergy, asthma, systemic lupus erythematosus, and inflammatory bowel disease (LE: 2b).

Urinary levels of nitric oxide and induced nitric oxide synthase activity were observed significantly increased in patients with an ulcerative BPS form, and they decrease with treatment; this pattern does not occur in patients with non-ulcerative BPS (LE: 3).

The lack of universal markers complicates BPS classification. The ESSIC suggested a normalized Scheme to recognize differences in different subtypes of BPS and make easier the comparison between the cohorts of various studies. This classification uses 2 characters: degree of severity of the lesions found in the cystoscopy with hydrodistention (X = not performed, 1 = normal, 2 = glomerulations, 3 = Hunner lesion) and degree of severity of histological findings in bladder biopsy (X = not performed, A = normal, B = not conclusive, C = positive for inflammatory infiltrates, detrusor mastocytosis, granulation tissue, or intrafascicular fibrosis).

**Initial evaluation of patients with bladder pain syndrome**

The panel considered that, apart from the clinical symptoms, we should assess the impact that these might have on the normal activity and quality of life of these patients, keeping vigilant about the potential impact on the emotional sphere of the patient and the possible emergence of depressive symptoms (LE/GR: 2a/B, U: 94.7%, A: 84.2%).

The diagnosis of BPS is fundamentally exclusion, so in the initial evaluation it is recommended to focus on ruling out other conditions that may have similar symptoms such as vaginitis, urethritis, inflammation of the prostate, urethral diverticulum, or another potential pain or infection source (LE/GR: 2a/B, U: 100%, A: 100%).

In general, performing a basic evaluation that includes a careful history, physical examination with abdominal and pelvic exam, and laboratory tests (urinalysis and urine culture) is recommended, documenting the symptoms and signs that characterize the BPS and exclude other disorders (LE/GR: 4/C, U: 100%, A: 100%).

**Diagnosis**

Table 1 shows recommendations for diagnostic evaluation of BPS included in the guideline of the EAU. In addition, the panel of experts believes that after establishing the diagnosis by excluding BPS, it can be useful, for the purposes of analysis and research, to determine the subtype and the phenotype (LE/GR: 4/C, U: 101.3%, A: 87.3%).

The BPS type 3C cannot be differentiated from the non-ulcer form by non-invasive means (LE: 2a, EAU, 2012). The main indication of cystoscopy is to describe the presence of glomerulations or lesions with the appearance of Hunner’s ulcer, which appear as red spots of the mucosa, showing small radial vessels from a pale scar in the center (LE/GR: 3/B, U: 89.5%, A: 94.7%).

Consideration of the permeability test with potassium chloride as a diagnostic test produces discrepancies in terms of its power of discrimination. If performed, the method published by Daha et al. is recommended. Although it does not provide specific diagnosis, this is a comfortable, quick test, not expensive, and it is the only truly functional test possible in clinical practice that can reveal a deficit in the glycosaminoglycan barrier.

The use of questionnaires is useful in assessing the impact of the BPS on the quality of life. The guideline of the AUA recommends that tools such as the questionnaire Index of symptoms of interstitial cystitis and the questionnaire Pelvic Pain and Urgency/Frequency are used to establish a standardized base profile of symptoms for further evaluation of treatment response (LE/GR: 1B/A, U: 89.5%, A: 78.9%). The ESSIC recommends using the questionnaire Bladder Pain/Interstitial Cystitis Symptom Score as a tool for screening and symptomatic evaluation of patients with BPS.

Table 1. Diagnostic assessment.

<table>
<thead>
<tr>
<th>Recommendations on diagnostic assessment</th>
<th>LE/GR</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>When diagnosing BPS by exclusion, it is recommended to adapt diagnostic procedures to each patient, in order to exclude specific diseases with high clinical similarity</td>
<td>4/C</td>
<td>U: 94.7%</td>
</tr>
<tr>
<td>The systematic assessment of BPS associated to non-bladder diseases should be considered as a priority of the specialist physician</td>
<td>4/C</td>
<td>U: 100%</td>
</tr>
<tr>
<td>The systematic assessment of BPS associated to cognitive or behavioral disorders, either sexual or emotional, should be considered as a priority of the specialist physician</td>
<td>4/C</td>
<td>U: 94.7%</td>
</tr>
</tbody>
</table>
BPS, although at present there is no validated Spanish version. In any case, parametric symptoms score and quality of life should be established in the first evaluation, as basal reference in the clinical and therapeutic follow-up of the patient.\(^1\) (LE/GR: 4/C; U: 100%; A: 94.7%).

The urodynamic study should be conducted regardless of whether a stable or overactive bladder occurs. Since in men differential diagnosis obliges to rule out intravesical obstruction, we recommend performing a flowmetry in all of them and flow pressure studies, at a maximum of 20 ml/s\(^19\). (LE/GR: 3/C; U: 91.3%; A: 78.3%). Videourodynamic scan may be, in some cases, useful also during the initial diagnosis.

In the case of refractory BPS, the register of a bladder activity diary is also useful, including the frequency and volume of each urination as well as the eventualities that accompany each voiding episode, using the urgency perception scale (UPS).\(^1\) (LE/GR: 3/C; U: 89.5%; A: 89.5%).

The panel of experts participating in this consensus document considers that the minimum necessary set of diagnostic tests for the diagnosis of BPS are urine culture, cystoscopy, and cytology. In turn, there are other diagnostic tests that can be useful, depending on the results of the above: bladder biopsy, urodynamic study, and pelvic MRI (only useful in the differential diagnosis of other pelvic pain syndromes, especially endometriosis).

**Treatment**

None of the currently available therapies is effective in all subtypes or phenotypes of BPS (LE: 4, EUA, 2012). According to Offiah et al.,\(^25\) the treatment, whatever it is, should focus on the restoration of normal bladder function, prevention of relapses of symptoms, and improvement of quality of life of patients (LE/GR: 4/C, U: 94.7% A: 94.7%). For this, the effectiveness of particular treatments should be evaluated, interrupting those ineffective after expiry of a clinically significant interval\(^1\) (LE/GR: 4/C, U: 100%; A: 94.7%) and reacting with therapeutic alternatives when the therapies used are not effective\(^25\) (LE/GR: 4/C, U: 100%; A: 100%).

**Initial approach**

In 2011, the guideline of the AUA recommended in its treatment guidelines to start treatment strategies with the most conservative therapies, leaving less conservative ones for cases where there is a lack of symptom control or inadequate level of response to ensure an acceptable quality of life.\(^4\) (LE/GR: 4/C, U: 100%; A: 100%).

Therefore, it is recommended that initial therapy is adapted to the level of clinical severity and the characteristics of each patient’s symptoms, as well as considering their preferences and communicate reasonable expectations of the results of the treatment.\(^4\) (LE/GR: 4/C, U: 100%; A: 89.5%).

The AUA considers advisable to consult both the therapeutic algorithm proposed in the review of its 2011 therapeutic guidelines and the recommendations in the patient education section, to homogenize both therapeutic decision making and information and education provided to the patient. The experts participating in this consensus chose that therapeutic algorithm for decision making in the treatment of BPS.\(^4\)

**Non-drug therapies and educational therapy**

Self-care practice and behavior modifications should be proposed and implemented as soon as possible\(^4\) (LE/GR: 4/C, U: 100%; A: 94.7%).

Currently, we have no available scientific data to justify special diets, although there are signs of change in the concentration of some metabolites and amino acids in patients with BPS.\(^26\) Therefore, the panel of experts at this consensus recommends avoiding foods that clearly cause an exacerbation of symptoms in each patient and in each case (LE/GR: 4/C, U: 94.7%, A: 100%), such as coffee or citrus fruits (bladder irritants).

Appropriate physical therapy techniques are also recommended to resolve points of pelvic, abdominal muscle activation, muscle contractions, or release of painful scars.\(^25\) However, usual forms of pelvic physiotherapy are not recommended (Kegel exercises) aimed at strengthening the pelvic floor, given the lack of appropriate knowledge\(^4\) (LE/GR: 4/C, U: 100%; A: 94.7%).

In the psychological intervention, the role of the doctor is crucial, whose therapeutic work is closely related to an orderly and empathic information to the patient to calm them, to act through history on the mental aspects of the pathogenesis of pain as much as possible\(^4\) (LE/GR: 4/C, U: 100% A: 94.7%).

Finally, voiding training is perceived useful in patients with BPS, with predominant symptoms of frequency and urgency, but without severe pain.\(^28,29\) By contrast, the expert panel was positioned mostly (69.6%) against considering bladder hydrodistention and subsequent training as a first treatment option.

**Drug therapy**

There is broad therapeutic arsenal for the treatment of pain in the BPS. The guideline of the EUA\(^7\) ranks treatments according to their degree of recommendation; includes among the drugs with grade of recommendation A hydroxyurea, amitriptyline, pentosanpolysulfate (oral) and sodium pentosanpolysulfate, dimethyl sulfoxide, and botulinum toxin A with hydrodistention (bladder); and among those with grade of recommendation B cimetidine and cyclosporin A (oral) and hyaluronic acid and chondroitin sulfate (bladder).

Unlike the treatments administered orally, bladder instillations, according to the panel of experts, often improve local conditions that cause the BPS/IC symptoms, above oral treatments, which are only symptomatic. There is no scientific evidence to consolidate clear criteria to justify the frequency of instillations of glycosaminoglycans; some experts advocate a frequency of 24/48 h, on the basis of cell turnover; however, the most common form of administration and even the recommended one in the fact sheet is weekly.

The guideline of the AUA\(^1\) emphasizes that patients and doctors should be aware that pain relief at 100% is often not feasible.

Table 2 shows the different treatment options (both pharmacological and behavioral or interventions), the grade of supporting evidence and grade of recommendation assigned
Table 2  Level of evidence and recommendation of various therapeutic options according to treatment guidelines.

<table>
<thead>
<tr>
<th>Therapeutic interventions</th>
<th>LE/GR EAU</th>
<th>LE/GR ICI</th>
<th>LE/GR AUA</th>
<th>LE/GR JPG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conservative treatment</strong></td>
<td></td>
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<tr>
<td>Behavioral therapy</td>
<td>3/B</td>
<td>3/C</td>
<td>CP</td>
<td>B</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>3/B</td>
<td>3/C</td>
<td>CP</td>
<td>C</td>
</tr>
<tr>
<td>Relaxation and psychotherapy</td>
<td>3/B</td>
<td>4/C</td>
<td>CP</td>
<td>B</td>
</tr>
<tr>
<td>Diet</td>
<td>3/C</td>
<td>4/C</td>
<td>CP</td>
<td>B</td>
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<tr>
<td><strong>Oral treatments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydroxyzine (anti-allergy)</td>
<td>1b/A</td>
<td>1/D</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Amitriptyline (tricyclic antidepressants)</td>
<td>1b/A</td>
<td>2/B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Cimetidine</td>
<td>2b/B</td>
<td>3/C</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Corticoids</td>
<td>3/C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pentosan polysulfate sodium</td>
<td>1a/A</td>
<td>1/D</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Cyclosporin A (immunosuppressants)</td>
<td>1b/B</td>
<td>3/C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Oxybutynin (anticholinergics)</td>
<td>3/C</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Gabapentin</td>
<td>3/C</td>
<td>4/C</td>
<td>–</td>
<td>–</td>
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<tr>
<td><strong>Intravesical treatments</strong></td>
<td></td>
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<tr>
<td>Dimethyl sulfoxide (DMSO)</td>
<td>1b/A</td>
<td>2/B</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>Intravesical heparin</td>
<td>3/C</td>
<td>2/B</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>Hyaluronic acid (HA)</td>
<td>2b/B</td>
<td>4/D</td>
<td>–</td>
<td>D</td>
</tr>
<tr>
<td>Chondroitin sulfate (CS)</td>
<td>2b/B</td>
<td>4/D</td>
<td>–</td>
<td>D</td>
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<tr>
<td>Capsaicin</td>
<td>1b/C</td>
<td>1/A</td>
<td>–</td>
<td>D</td>
</tr>
<tr>
<td>Resiniferatoxin</td>
<td>1b/C</td>
<td>1/A</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>Bacillus Calmette Guérin (BCG)</td>
<td>A</td>
<td>1/A</td>
<td>B</td>
<td>D/c</td>
</tr>
<tr>
<td>Lidocaine (local anesthetics)</td>
<td>1b/A</td>
<td>2/C</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Oxybutynin (anticholinergics)</td>
<td>3/C</td>
<td>4/D</td>
<td>–</td>
<td>C</td>
</tr>
<tr>
<td><strong>Other treatments</strong></td>
<td></td>
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<tr>
<td>Bladder hydrodistention</td>
<td>3/C</td>
<td>3/C</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>Neuromodulation</td>
<td>1b/B</td>
<td>3/C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Botulinum toxin (BTX-A) + hydrodistention</td>
<td>1b/A</td>
<td>4/D</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Botulinum toxin (BTX-A) + injection in trigone</td>
<td>3/C</td>
<td>4/D</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Transurethral resection (TUR)</td>
<td>3/C</td>
<td>3/C</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>Cystoplasty</td>
<td>3/A</td>
<td>3/C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Corticoids</td>
<td>3/C</td>
<td>–</td>
<td>C</td>
<td>–</td>
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in the review of the EAU guidelines of the International Consultation on Incontinence [ICI] for the year 2010, of the AUA (2011), and of the Japanese guideline (2009). The EAU guideline and the ICI use the categorization proposed by Sackett, while the AUA and the Japanese one categorize the evidence in A (high), B (moderate), or C (low), according to their scientific and methodological consistency. Table 3 shows new therapeutic alternatives proposed by the experts during the preparation of this work.

Assessment of treatment effectiveness
To evaluate the effectiveness of the treatment received, it is recommended to use the voiding diary and conduct a questionnaire evaluating symptoms, as well as a clinical interview (LE/GR: 4/C, U: 94.7%, A: 94.7%).

Discussion
In clinical practice of many diseases, specifically in the BPS approach, it is essential to standardize the criteria for decision-making and extend them to all the professionals who treat them. Because of the high prevalence of symptoms, the association with risk factors such as lack of exercise, a diet high in fiber, or history of recurrent urogenital infection and impaired quality of life and self-esteem of these patients, the development of clinical recommendations to help in caring for them is essential.

For this purpose, there have been some recommendations that provide support in diagnosis, initial treatment, and treatment follow-up. These recommendations, developed and reviewed by a large group of specialists, using methodology of nominal groups, reflect the agreement of a wide expert group; although due to the method chosen, the representativeness of view of some participants about the possible bias of the opinion of others could have been limited. This paper has also tried to collect clinically relevant evidence available regarding the BPS, but due to the characteristics and limitations of the systematic literature review, something new or an old outstanding reference could have been left out.
Conclusion

The panel of experts involved have agreed that, since nowadays the diagnosis of BPS is made by exclusion, it is necessary to focus on ruling out diseases with similar symptoms and help of a medical history and appropriate physical examination, as well as laboratory tests that rule out the presence of urinary tract infections and other urological diseases. In this sense, the experts agreed to show a better continuing education of physicians regarding how to perform specific physical examination in these patients, as well as how to interpret it and proceed. Also, testing such as cystoscopy and biopsy have been recommended in order to classify the BPS or to differentiate cases of refractory BPS of other diseases.

The recommendations regarding the treatment options available highlight the importance of behavioral therapies, as well as the patient–physician interaction with proper explanation and understanding of the problem, adapting patient expectations to the reality of the achievable therapeutic results. The summary collected from the arsenal of available drug treatments (oral and bladder) and other treatments, indicating in each case the degree of evidence and level of recommendation proposed by various treatment guidelines, may help in the decision making of those specialists that face cases of BPS.

Conflict of interest

Salvador Arlandis and José María Adot have worked as lecturers in symposia sponsored by Gebro Pharma, SA. The remaining authors declare no conflicts of interest.

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Appendix 1.

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