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ABSTRACT COLLECTION

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2 - A Phenotype-Based Framework for Earlier Targeted Intervention in IC/BPS: Integrating International Guidelines and Contemporary Evidence

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BACKGROUND

Interstitial cystitis/bladder pain syndrome (IC/BPS) remains a heterogeneous condition with substantial variability in diagnostic and therapeutic recommendations among international guidelines. Recent advances in phenotyping have improved understanding of clinically distinct disease subgroups, particularly Hunner lesion (HL) disease, pelvic floor dysfunction, and bladder-centric phenotypes.

OBJECTIVE

To identify areas of consensus among contemporary AUA, EAU, and CUA guidelines and recent literature and to evaluate whether earlier phenotype identification may facilitate more targeted interventions, including early lesion-directed treatment for HL disease and phenotype-specific management for non-HL patients.

METHODS

We compared the American Urological Association (AUA, 2022), European Association of Urology (EAU, 2025), and Canadian Urological Association (CUA, 2025) guidelines to identify key discrepancies and propose a practical phenotype-based framework for everyday urologic practice. A structured narrative synthesis of the three guidelines was performed alongside selected peer-reviewed studies and expert consensus (PROSPERO CRD420251064829). Diagnostic pathways, the use of cystoscopy, and therapeutic strategies were analyzed; discrepancies were mapped; and harmonization strategies were developed through a phenotypic lens. To summarize the selection process for the studies included in our review of the phenotype-based diagnosis and management of IC/BPS, we used Covidence systematic review software (Veritas Health Innovation, Melbourne, Australia) to manage screening and extraction.

RESULTS

There are several differences among international guidelines (tab.1). Hunner lesion disease demonstrated the strongest evidence supporting early identification and lesion-directed treatment. Cystoscopy with hydrodistension may provide important phenotypic information by identifying occult HL, assessing bladder capacity, and guiding targeted management in selected patients. Pelvic floor-directed therapy demonstrated consistent benefit in patients with myofascial dysfunction. For non-Hunner disease, increasing evidence supports phenotype-directed interventions, including intravesical botulinum toxin A in selected bladder-centric patients. Across guidelines and contemporary literature, treatment success appeared more closely associated with phenotype identification than with strict adherence to stepwise treatment escalation.

CONCLUSIONS

A phenotype-based framework may help reconcile differences among international guidelines and support more individualized IC/BPS management (tab.2). Early identification of Hunner lesion disease and timely implementation of phenotype-directed therapies represent the most consistent areas of agreement across contemporary guidelines and literature.

Table 1. Key Differences Among Major International Guidelines for IC/BPS

Topic	AUA (2022)	EAU (2025)	CUA (2025)
Phenotyping approach	Individualized, non-tiered; no formal phenotype framework	Supports ESSIC classification	Explicit phenotype-based management
Role of cystoscopy	Selective; complex/refractory cases	Earlier use; identifies Hunner lesions	Older age, refractory disease, suspected Hunner lesions
Glomerulations	Discouraged as diagnostic criterion	Nonspecific	Not defining phenotype
Hunner lesions	Supports lesion-directed therapy	Early targeted treatment	Preferred targeted therapy
Intravesical DMSO	Supported	Variable emphasis	Supported
GAG therapy	Not endorsed	Supported	Supported
Botulinum toxin A	Later escalation	Earlier consideration	Conditional
Neuromodulation	Later pathway	Earlier use	Conditional
Central sensitization	Limited emphasis	Limited emphasis	Limited emphasis
Overall philosophy	Individualized	Stratified	Phenotype-guided multimodal

Table 2. Proposed Practical Phenotype-Based Framework

Phenotype	Clinical hallmarks	Diagnostic priorities	First considerations	Rescue options
Hunner lesion	Severe bladder pain, reduced capacity	Early cystoscopy ± biopsy	Fulguration + steroid injections, continue with DMSO+Kenalog	CyA, BoNT-A, neuromodulation
Bladder-centric non-Hunner	Filling pain, urgency/frequency	Early Cystoscopy when indicated	DMSO? GAG, earlier BoNT-A	Repeat BoNT-A
Pelvic floor dysfunction	Tenderness, trigger points	Focused pelvic exam	PFPT, myofascial release	Neuromodulation, injections
Systemic/central sensitization	Widespread pain, IBS, sleep dysfunction	Assess overlapping syndromes	Neuromodulators, CBT	Pain specialist

3 - Association of Neutrophil-to-Lymphocyte Ratio with Cystoscopic Inflammatory Phenotypes in Interstitial Cystitis/Bladder Pain Syndrome

Presenter: Nurşah SARIDUMAN

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INTRODUCTION

Interstitial cystitis/bladder pain syndrome (IC/BPS) is characterized by heterogeneous cystoscopic phenotypes. We evaluated whether neutrophil-to-lymphocyte ratio (NLR), other inflammatory indices, and symptom/problem scores were associated with Hunner lesions and the combined Hunner lesion–glomerulation (CHG) phenotype.

MATERIAL METHODS

This retrospective single-center study included 120 female patients diagnosed with IC/BPS between 2010 and 2025. Patients were categorized according to cystoscopic findings, while non-lesion IC/BPS was defined clinically using validated symptom/problem indices. Demographic characteristics, smoking status, cystoscopic phenotype, symptom/problem scores, and inflammatory indices, including NLR, systemic inflammatory response index (SIRI), and pan-immune-inflammation value (PIV), were recorded. Group comparisons were performed using Mann–Whitney U tests. ROC was used to assess NLR discrimination; logistic regression, adjusted for age and smoking, assessed phenotype associations.

RESULTS

Hunner lesions were detected in 31 patients (25.8%), and CHG was present in 12 (10.0%). NLR was higher in Hunner-positive than Hunner-negative patients (2.40 ± 1.04 vs 1.87 ± 0.88 , $p=0.004$), and in CHG-positive than CHG-negative patients (2.64 ± 1.25 vs 1.94 ± 0.89 , $p=0.022$). SIRI, PIV, and symptom/problem scores did not differ. NLR moderately discriminated Hunner lesions and CHG (AUC: 0.676 and 0.701). In multivariate analysis, NLR independently predicted Hunner lesions (OR: 2.049, 95%CI: 1.259–3.333; $p=0.004$) and CHG (OR: 1.923, 95%CI: 1.095–3.377; $p=0.023$).

CONCLUSION

NLR may represent a simple, non-invasive inflammatory marker associated with cystoscopic phenotypes in IC/BPS.

Table Multivariate logistic regression models for the prediction of Hunner lesion presence and the combined Hunner lesion–glomerulation phenotype

Predictor	Hunner lesion OR	Hunner lesion 95% CI	Hunner lesion p-value	CHG OR	CHG 95% CI	CHG p-value
NLR	2.05	1.26–3.33	0.004	1.92	1.10–3.38	0.023
Age	1.04	1.00–1.08	0.074	1.03	0.98–1.09	0.192
Smoking status	1.27	0.56–2.87	0.572	1.44	0.53–3.91	0.474

Abbreviations: CHG, combined Hunner lesion–glomerulation phenotype; NLR, neutrophil-to-lymphocyte ratio; OR, odds ratio; CI, confidence interval.

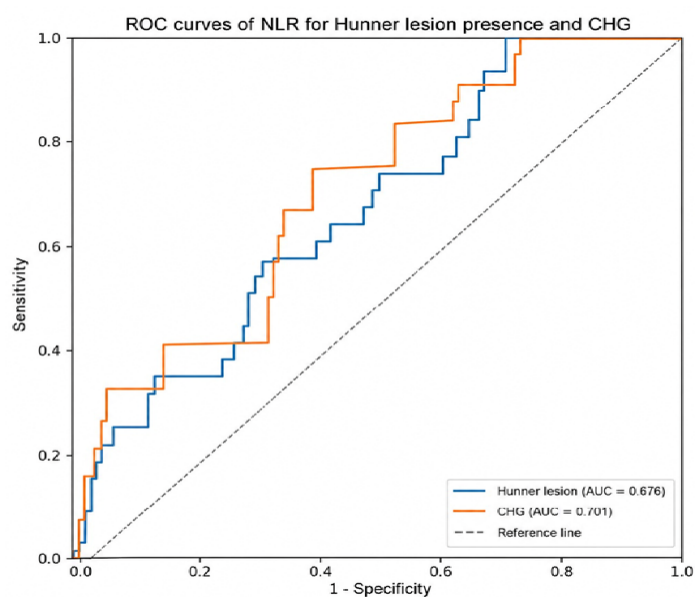


Figure Receiver operating characteristic (ROC) curve analysis of NLR for predicting Hunner lesion and CHG presence.

5 - International Declaration of the IC/BPS Patient Advocate Network: A Call for Urgent, Coordinated, and Courageous Action

Presenter: Laura SANTURRI

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INTRODUCTION AND AIM OF THE STUDY

Despite a substantial increase in scientific publications on interstitial cystitis/bladder pain syndrome (IC/BPS) over the past two decades, patients continue to face an unknown etiology, prolonged diagnostic delays, limited treatments, and significant quality of life impairment. This study aims to present findings from a patient-led literature review and the resulting international declaration calling for systemic reform in IC/BPS research and care.

MATERIALS AND METHODS

An international coalition of 10 IC/BPS patient advocacy organizations representing patients across North America, Europe, the Middle East, and Asia conducted a comprehensive, multi-year review of the scientific literature on IC/BPS published between 2010 and 2025. More than 700 publications were identified and analyzed, including randomized controlled trials, meta-analyses, and multicenter studies. Findings were synthesized to evaluate research quality, international coordination, and translational impact on patient outcomes.

RESULTS

The review identified persistent structural barriers to progress: fragmented research without international coordination, inconsistent terminology and diagnostic definitions, heterogeneous patient populations grouped under an overly broad diagnostic label, small sample sizes, and weak or inconsistent methodologies. Additional systemic challenges include declining specialist expertise, insufficient medical education, chronic underfunding, and conceptual confusion from diagnostic frameworks conflating bladder-specific pathology with other pelvic or systemic pain conditions.

INTERPRETATION OF RESULTS

These findings demonstrate that current research paradigms are structurally incapable of producing cumulative, translational progress. The persistent inconclusiveness of IC/BPS research is not due to disease complexity alone but reflects systemic failures in coordination, standardization, and investment that must be addressed at an institutional level.

CONCLUSIONS

An international declaration calls for coordinated initiatives, internationally standardized definitions and protocols, mandatory phenotyping, root cause investigation, meaningful patient inclusion in scientific processes, investment in specialist training, improved treatment access, and recognition of the full psychosocial burden of IC/BPS. Incremental approaches have failed; coordinated global reform is urgently needed.

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7 - Right-Sizing Urology's Role in IC/BPS: Expert Consultation, "I See" Communication, and Shared Care

Presenter: Laura SANTURRI

Laura Santurri ⁽¹⁾ - Tony Buffington ⁽²⁾ - Philip Hanno ⁽³⁾

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BACKGROUND

Interstitial Cystitis/Bladder Pain Syndrome/ (IC/BPS) is increasingly recognized as a heterogeneous chronic condition rather than a single bladder disease. Although urologists remain essential for diagnosis, red-flag evaluation, phenotype recognition, cystoscopy when indicated, and treatment of bladder-predominant disease, many patients require longitudinal chronic-care support that extends beyond episodic specialty visits.

OBJECTIVE

To propose a patient-centered shared-care model that right-sizes the urologist's role in IC/BPS while preserving expert consultation and urology-specific treatment.

APPROACH

Contemporary evidence on IC/BPS phenotypes, urologic workforce constraints, chronic-care delivery, and patient-reported experiences of disbelief and dismissal was synthesized into a practical care framework for BPS/IC.

PROPOSED FRAMEWORK

A high-value urology consultation for IC/BPS should include 6 elements: validation of symptoms; exclusion of infection, hematuria-related disease, stones, malignancy, retention, neurologic disease, and other confusable conditions; selective use of cystoscopy or urodynamics when diagnosis is uncertain, red flags are present, Hunner lesions are suspected, or findings will guide treatment; treatment of Hunner lesions or other bladder-predominant/procedural phenotypes; a written shared-care plan for longitudinal management; and explicit return-to-urology triggers. Because IC is pronounced "I see," this phrase can also serve as a communication mnemonic: "I see that your symptoms are real, I see how much they affect your life, and I see a path forward." This validates the patient without implying that any single mechanism has been proven to be the cause.

CONCLUSION

Right-sizing urology's role in IC/BPS is not a retreat from care. It is a sustainable model in which urologists provide expert consultation and urology-specific care while helping patients enter the longitudinal care setting most likely to support recovery, adaptation, and self-management.

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Symptom prevalences of moderate or quite a bit severity (R2) in women with different apical pelvic organ prolapse before and 2 years after vaginal mesh-supported sacrospinous ligament fixation								
	Apical stage 1				Apical stage 2-4			
	Preop. N = 109	2 years postop. N = 86	p	Cure rates	Preop. N =137	2 years postop. N = 73	P	Cure rates
Symptoms of overactive bladder								

Daytime urinary frequency	50,5 %	7,0 %	< 0,01	86 %	46 %	12,3 %	< 0,01	73 %
Urgency	50,5 %	8,1 %	< 0,01	84 %	44,5 %	19,2 %	< 0,01	57 %
Urinary urgency incontinence	40,4 %	8,8 %	< 0,01	78 %	34,3 %	11,0 %	< 0,01	68 %
nocturia	56,9 %	17,6 %	< 0,01	69 %	42,3 %	19,2 %	< 0,01	55 %
Pelvic pain symptoms of different locations								
Lower abdomen or genital area	21,1 %	5,9 %	< 0,01	72 %	23,4 %	4,1 %	< 0,01	82 %
Lower back most days	46,8 %	22,5 %	< 0,01	52 %	31,4 %	11,0 %	< 0,01	65 %
Abdominal or lower back when straining	12,8 %	2,9 %	< 0,01	77 %	8,8 %	2,7 %	< 0,01	69 %
Passing stool	25,7 %	13,7 %	< 0,01	47 %	24,1 %	9,6 %	< 0,01	60 %

Table 1: Cure defined as

9 - Transition in Surgical Management of Benign Prostatic Hyperplasia in a Tertiary Centre: From TURP to Contemporary Minimally Invasive and Laser Therapies

Presenter: Pranavi CHALLAPALLI

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INTRODUCTION

Transurethral resection of the prostate (TURP) has been the gold standard surgical treatment for benign prostatic hyperplasia (BPH). However, minimally invasive surgical therapies (MIST) and laser-based approaches are increasingly adopted. We evaluated the evolution of BPH surgical practice at our tertiary centre and compared perioperative outcomes.

MATERIALS AND METHODS

A retrospective review was performed of 296 patients between September 2023 and April 2026. Procedures included TURP (193), UroLift (28), iTIND (10), Rezūm (27), and HoLEP (38). Total institutional procedural volume during this period was TURP (410), HoLEP (72), iTIND (16), Rezūm (35), and UroLift (32). Outcomes included length of stay (LOS), complications, symptom outcomes, and reintervention.

RESULTS

A progressive shift away from TURP toward MIST and laser therapies was observed. Day-case management was achieved in all iTIND and Rezūm cases and 96.4% of UroLift procedures. HoLEP achieved comparable LOS despite treating significantly larger prostates than TURP (mean 121.4cc vs 56.7cc); 73% of HoLEP patients were discharged on postoperative day 1 compared with 51.8% following TURP.

Functional outcomes improved markedly following HoLEP (IPSS 22.5→4.5; QoL 4.47→1.23), compared with after TURP (IPSS 20.3→14). TURP showed higher perioperative morbidity, including urosepsis (4.1%), haematuria (4.7%), and TWOC failure (19.7%), compared with HoLEP (2.6%). Reintervention rates within one year were highest in UroLift (14.3%), Rezūm (7.4%) compared to TURP (0.5%), HoLEP (2.6%) and iTIND (0%).

Urinary incontinence occurred in 7.3% of TURP patients and 10.2% of HoLEP patients (when performed by multiple training surgeons) and 2% with a single main surgeon, compared to UroLift (3.6%), iTIND (10%), and Rezūm (0%).

CONCLUSION

Our institutional experience demonstrates a shift toward MIST and laser-based surgery. While MIST offers excellent recovery profiles, HoLEP delivered durable functional improvement and favourable perioperative outcomes in a more complex patient population, supporting its expanding role in contemporary BPH management.

10 - Women with Urinary Urgency and Chronic Pelvic Pain – Prevalences of Pelvic Organ Prolapse and Bladder Pain Syndrome / Interstitial Cystitis

Presenter: Bernhard LIEDL

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INTRODUCTION AND AIM OF THE STUDY

Urinary urgency and chronic pelvic pain are co-occurring key symptoms in women with Bladder Pain Syndrome/Interstitial Cystitis (BPS/IC), but also in women with Pelvic Organ Prolapse (POP). As BPS/IC occurs 9 times more often in women than in men (1) and therapy options and effectiveness differs widely, the goal was to investigate the prevalences and potential coexistence of symptom origins.

MATERIALS AND METHODS

The study protocol of the prospective cross-sectional cohort-study was accepted by the ethical committee of the Bayerische Landesärztekammer (number 22002). 51 women were included at a mean age of 64.3 years, all presenting with urinary urgency and CPP of at least 6 months. Symptom questionnaires and the Pelvic-Organ-Prolapse-Quantifity (POP-Q) test were used in all women. An additional urethrocystoscopy was performed in 23 cases.

RESULTS

In the analysed cohort 64.7% showed a POP stage 2 or higher and the prevalence of POP stage 1 was 31.4%, while only two women had POP stage 0. Therefore, the total prevalence of POP of any severity was 96.2%. Comparing symptom patterns of urinary urgency and CPP, there was no significant difference in severity or distribution between the POP stages 1 versus stage 2-4. In 52.2% of the 23 urothrocystoscopies signs of IC, such as glomerulations or inflammation were found, while no Hunner's ulcers were detected.

INTERPRETATION OF RESULTS

The majority of the study population showed a POP, which is also typical in the posterior fornix syndrome, and has therefore a potentially curable symptom origin. As not in all cases an urethrocystoscopy was performed, the exact number with potential origin coexistence of IC and POP remains unclear.

CONCLUSIONS

As many women with urinary urgency and CPP have some stage of POP, the vaginal assessment including the POP-Q test is essential to exclude POP.

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