A review of the 23rd Congress of the European Association of Urology, 26-29 March 2008, Milan, Italy

by Jane Meijlink

The 23rd congress of the EAU was an unprecedented success with some 14,000 participants, thereby surpassing the record set in Berlin 2007. Delegates came from 84 countries worldwide, including a huge delegation from China. As EAU Secretary-General Professor Per-Anders Abrahamsson told delegates: the EAU may be based in Europe, but it is now fast becoming a urological society with global influence. One of the highlights of EAU 2008 was the opening ceremony with a truly memorable classical concert by Milan’s world-famous La Scala orchestra and opera singers. However, with a strong emphasis on oncology evident this year, there were relatively few offerings in the field of painful bladder syndrome/interstitial cystitis in the scientific programme in Milan.

IPBF booth in Milan

Once again this year, there was considerable interest in collecting information on PBS/IC from our booth by EAU delegates. While the IPBF CDs were very popular since they are lightweight and take up little space for travellers, hundreds of brochures and leaflets were also distributed during the three exhibition days. This indicates that there is still a great need for information on PBS/IC worldwide. Several hundred people from all corners of the earth signed up for our newsletter.

Our booth at the EAU congress is an important opportunity to gain feedback from clinicians working at the grass roots in countries around the world. It was evident that the situation has not really changed since last year where treatment is concerned: many treatment options are still unavailable and/or unaffordable, except by patients with the financial means to order drugs from abroad. The result is: patients around the world with inadequate treatment and physicians frustrated because they feel they cannot offer their patients the best treatment options. It is alarming to hear that the disease is still virtually unknown and undiagnosed in some countries and the name not even officially registered, making it difficult for those patients who are insured to obtain reimbursement of treatment costs. However, many patients have no medical insurance at all.

A number of doctors came to our booth to ask how to set up a patient support group. It is clear to physicians that patients learn to cope better if they have contact with each other and can help each other. This can sometimes have a very therapeutic effect. The IPBF has developed a simple 4 page booklet with brief information on the main aspects of IC that can be used as a basis for patient information in any language or for a patient website. This can be found on the IPBF website:
We also have a basic leaflet as well as the popular, much more detailed brochure on PBS/IC: Diagnosis & Treatment. These resources can provide useful basic information for a new group to create its own information in its own language.

The IPBF would like to take this opportunity of thanking the EAU for kindly giving our charity a complimentary booth.

**Historical exhibition**

Every year the EAU has a fascinating history exhibition. This year was no exception with the exhibition: “Urine, an important business” featuring, for example, chamber pots, latrines and urinals; urination in art and culture; urine as a commercial item used as a key ingredient for cleaning, bleaching, tanning and dyeing; and urine used medicinally. Urine was indeed big business!

Historic items on display included the splitting underwear for ladies shown here, that many IC patients might find handy today, if perhaps a little chilly in cold weather! These splitting drawers allowed women to urinate in the street by just opening their legs.

*(With thanks to the EAU for permission to use this photograph)*

**ESU Course 7 on chronic pelvic pain syndromes (CPPS) with special focus on chronic prostatitis (CP) and painful bladder syndrome/interstitial cystitis (PBS/IC)**

This course, chaired by Prof. J-J Wyndaele with speakers Prof. J. Curtis Nickel and Prof. D. Prezioso, can be found on the official webcasts, with audio and slides, at [www.uroweb.org/webcastseaumilan2008](http://www.uroweb.org/webcastseaumilan2008).

The course included the following sections:

- CPPS: anatomical considerations, pathophysiological mechanisms, confusable diseases, the phenomenon of chronic pain.
- Chronic prostatitis: definition, classification and etiology, diagnostic work up and treatment.
- Painful bladder syndrome/interstitial cystitis: definition, classification and etiology, diagnostic work up and treatment.
- Other locations: scrotal pain and urethral pain.

Neuro-urology is continually developing with information changing and increasing from year to year. One focus of attention is the possible relationship and/or interaction between the different pelvic organs. Prof. Wyndaele spoke in details about the innervation of the lower urinary and bowel tracts. The bladder and the bowel comes from the same embryologic structure, are anatomically close together, share some striated muscles and partly use the same innervation.

It is now becoming apparent that in some patients visceral pain can become chronic and maybe even permanent after a period of 6 months. The initial event (infection or trauma) appears to set up a pain experience that persists long after the initial stimulus has gone. Persistent pain can lead to sensitization and changes in both the
peripheral nervous system and the CNS. It may lead to altered central mechanisms in the processing of pain.

Prof. Curtis Nickel stressed the terrible quality of life of patients with prostatitis and the phenomenal social economic costs. Like IC, it is still only possible to ameliorate the symptoms of patients with chronic prostatitis. There is no way of curing the disorder. He mentioned the NIH/NIDDK MAPP project (Multi-disciplinary approach to the study of chronic pelvic pain), a 5-year research project to start later this year that will examine all the chronic pelvic pain syndromes from an holistic point of view. The primary goals of the multicentre, multidisciplinary MAPP research project are to advance understanding of disease phenotypes, underlying pathophysiology, natural history, and biologic, genetic and behavioural risk factors for urologic chronic pelvic pain syndromes.

It was emphasized by Prof. Wyndaele in his discussion of diagnosis & treatment that it is advisable to reassess an IC patient after 5 years since you may find some other disorder that has been overlooked that could be causing the symptoms (intraurethral wall diverticulum, chronic urethritis, obstruction etc). His overview of diagnostic investigations and treatment can be found on the webcast.

A diagnostic test that is being used experimentally in North America is the anaesthetic test using alkalized lidocaine that is also used for treatment. Prof. Curtis Nickel explained that for diagnostic purposes it allows them to determine whether the pelvic pain is actually coming from the bladder since when it is instilled into the bladder it anaesthetizes the bladder. Furthermore, once the bladder pain is under control, it allows better examination of pelvic structures. In addition it allows for a degree of hydrostatic bladder dilation, enough to determine if bladder capacity increases and whether or not there are glomerulations and/or Hunner's ulcers. Their randomized placebo controlled trial demonstrated that daily instillations of alkalized lidocaine results in pain relief for 3 and even as long as 10 days after the last treatment (a time when the acute effect has worn off), suggesting that some form of bladder desensitization may be occurring. They are now working to make this a home-based patient controlled therapy.

Note: Instilling lidocaine by itself into the bladder results in non-absorption and no anaesthetic effect. However, instilling bicarbonate after the lidocaine results in absorption and anaesthesia. (See also abstracts below).

Prof. Preciozo went through the definition and classification of pain for the benefit of participants. While these can be found in the webcast on the internet, it may be useful to reproduce them here for quick reference:

The definition of pain according to the International Association for the Study of Pain (IASP) is as follows:

“Pain is an unpleasant sensory and emotional experience associated with either actual or potential tissue damage, or described in terms of such damage”

Classification of pain as given by Prof. Prezioso:

- **Nociceptive**: linked with noxious stimuli or physiological, it is associated with tissue damage or inflammation, so is also called inflammatory pain
- **Neuropathic**: results from a lesion to the peripheral or central nervous systems
- **Acute**: occurs after traumas, operations or lesions of a nerve, and it is often recurrent
- **Chronic**: pain occurs continuously for at least 3 months; it inhibits feelings, emotions, thinking and reactions; social interactions and work are restricted to the extent that mobility and physiological functions are inhibited
- **Visceral**: can be produced by stimuli different from that necessary to produce somatic pain. Injury is not required for visceral pain: it can be induced by organ distension, traction on the mesentery, ischemia and chemicals. Also, visceral pain is associated with emotional and autonomic responses not seen with somatic pain
- **Somatic**: is produced by a defined injury, is not associated with emotional and autonomic responses.

Much more about pain and its classification can be found on the very interesting IASP website: [www.iasp-pain.org](http://www.iasp-pain.org)

It was emphasized during the course that in all the chronic pelvic pain syndromes, persistent pain can be a major cause of depression and anxiety. While not psychosomatic disorders, these syndromes may have psychosomatic consequences, according to Prof. Wyndaele. Prof. Prezioso felt that it was regrettable that Europe lacks the support of pain psychologists available in the USA for example, as mentioned by Prof Curtis Nickel. This means that the urologist often has to play the role of psychologist for which he may have no training and for which he may have inadequate time to spend with the patient. Multidisciplinary clinics, including pain psychologists to help the patients cope with chronic pain, are desirable but still the exception rather than the rule.

*Editorial comment*: Much attention has been focused in recent years on pelvic pain syndromes and hopefully we will see new and better pain drugs being developed in the coming years. However, in the case of PBS/IC, it is important to ensure that such intensive focus on the pain aspect as we are currently seeing does not lead to the other two important symptoms (urge/urgency and frequency) being pushed into the background with the risk of being forgotten. Nor should we forget that some of these patients do not experience pain. They may have pressure or discomfort but do not perceive this to be pain or describe it as such.

**Webcasts**
All the ESU courses can be found on the webcasts as well as a number of the scientific sessions. This is a wonderful education opportunity for everyone worldwide and the EAU is to be congratulated.

**Abstracts**
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**UROGYNAECOLOGIC FEATURES OF PATIENTS WITH INTERSTITIAL CYSTITIS/PAINFUL BLADDER SYNDROME**
Gardella B, Porru D, Ferdeghini F, Martinotti Gabellotti E, Nappi RE, Rovereto B, Spinillo A.
This study has already been published online in European Urology, 2008 February 6. (PMID 18276064).
This study compared clinical gynaecologic characteristics including localized and generalized vulvodynia and sexual activity in 47 women diagnosed with IC/PBS compared with 47 negative controls. The rates of vaginal candida, trichomas, vaginosis, cervical Human Papillomavirus infections and squamous intraepithelial neoplasia were similar in both groups. However, prevalence of both localized and generalized vulvodynia was 85.1% in the group of patients and 6.4% in the control group. There was significant impairment of sexual function in the women with IC/PBS compared with controls. Pain during sexual intercourse was described as unbearable by 15 women with IC/PBS and 2 controls. It is therefore considered that a multidisciplinary approach to these patients involving a gynaecologist is advisable.

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EFFECTS OF ENDOVESICAL HYALURONIC ACID/CHONDROITIN SULFATE IN THE TREATMENT OF INTERSTITIAL CYSTITIS/PAINFUL BLADDER SYNDROME
Porru D, Cervigni M, Nasta L, Gardella B, Lo Voi R, Anghileri A, Spinillo A, Rovereto B.
This pilot study at two centres with 27 patients with symptoms of IC/PBS was based on the assumption that a more viscous compound than the existing hyaluronic acid (HA) formulation would be more effective in helping to restore a defective glycosaminoglycan (GAG) layer. In addition it was hypothesized that a solution containing a combination of HA and chondroitin sulfate (CS) might produce additional benefits for IC/PBS patients than the use of the single components. It was concluded that this combination appears to be safe, effective and potentially sustainable. No significant side effects were recorded.

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IMMEDIATE AND SUSTAINED RELIEF FROM THE SYMPTOMS OF INTERSTITIAL CYSTITIS/PAINFUL BLADDER SYNDROME (IC/PBS) WITH INTRAVESICAL ALKALIZED LIDOCAINE (PSD597); RESULTS OF A PHASE II MULTI-CENTRE PLACEBO-CONTROLLED TRIAL
Nickel JC, Henry RA, Wyllie MG
The aim of this randomized placebo-controlled trial was to assess the immediate and sustained relief of symptoms, as well as the safety and pharmacokinetics in 102 IC/PBS patients following a course of treatment with intravesical alkalized lidocaine (PSD597) or placebo on 5 consecutive days, followed by 10 days follow-up. Patients were offered a second 5-day open label course of treatment on a voluntary basis from the 15th day. Significant improvements were seen and 86% of patients opted to receive a second course of treatment at day 15. Of these patients, 63% and 56% reported moderate or marked improvement in Global Response Assessment at days 22 and 29 respectively. The improvement concerned pain, frequency and urgency. This suggests that benefit may increase with repeated doses. This drug was found to be safe, well-tolerated and with none of the side effects that are often experienced with oral drugs. It was concluded that this treatment is effective for acute treatment of IC/PBS symptoms, with improvement maintained beyond the end of treatment.

The International Painful Bladder Foundation does not engage in the practice of medicine. It is not a medical authority nor does it claim to have medical knowledge. Information provided in IPBF emails, newsletters and website is not medical advice. The IPBF recommends patients to consult their own physician before undergoing any course of treatment or medication.

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