

HOW DO YOU STRETCH A BLADDER?

Aims of Study

A subset of patients with painful bladder syndrome have interstitial cystitis (IC). Most of the diagnostic criteria for IC are standardised and it is accepted that cystoscopic assessment together with assessment of the response to short bladder distension (SBD) is required to make the diagnosis (Gillenwater JY, J Urol 1988 140(1) 203-6; Hanno P, J Urol 1999 161 (2) 553-7). Surprisingly however there is no published consensus on how this SBD should be performed. We became aware of a wide variability in practise amongst UK urologists and were concerned that this variability might compromise both accurate diagnosis and the collection of data on prevalence and outcome in IC. We aimed to survey the practice of consultant urologists in the UK before suggesting a standardised method.

Methods

A questionnaire was sent to all UK consultant urologists during summer 2002. Questions addressed the indications for SBD, detailed technique, perception of outcome, and awareness of evidence base.

Results

244 / 533 (46%) consultants replied. 87% of respondents use SBD. Of these, 40% use SBD for IC alone, 46% use SBD for both IC and for storage symptoms, 8% use SBD for storage symptoms alone. When doing a SBD, 70% of respondents distend the bladder only once, 20% twice and 5% three times. There was considerable variation in the duration of distension (overall range 1 – 20 minutes, single distenders mean (SD) = 5.4 (3) minutes, multiple distenders = 3.9 (2.7) minutes). The pressure used to distend the bladder ranged from 15 to 200cm of water (median = 100, mean (SD) = 99 (29)). Only 54% of respondents measured the bladder capacity before and after the distension, with an additional 34% measuring the capacity after the distension alone. We were intrigued to know how urologists recognise that the bladder is full. 82% judged this to be when the inflow stops and this was occasionally combined with subjective impression (e.g. restlessness under anaesthesia). 3% used a more objective method generally involving a tube on the cystoscope outflow. No respondent cited published evidence to support their practice though several cited anecdotal evidence.

Conclusions

SBD is widely used in the diagnosis of IC and in the management of IC / storage symptoms. There is wide variety in technique and little more than anecdotal evidence to support a particular practice. Since the IC literature requires precision, we propose a standardised method of SBD to allow generation of reliable incidence and outcome data.