Update – urologie psychosomatique

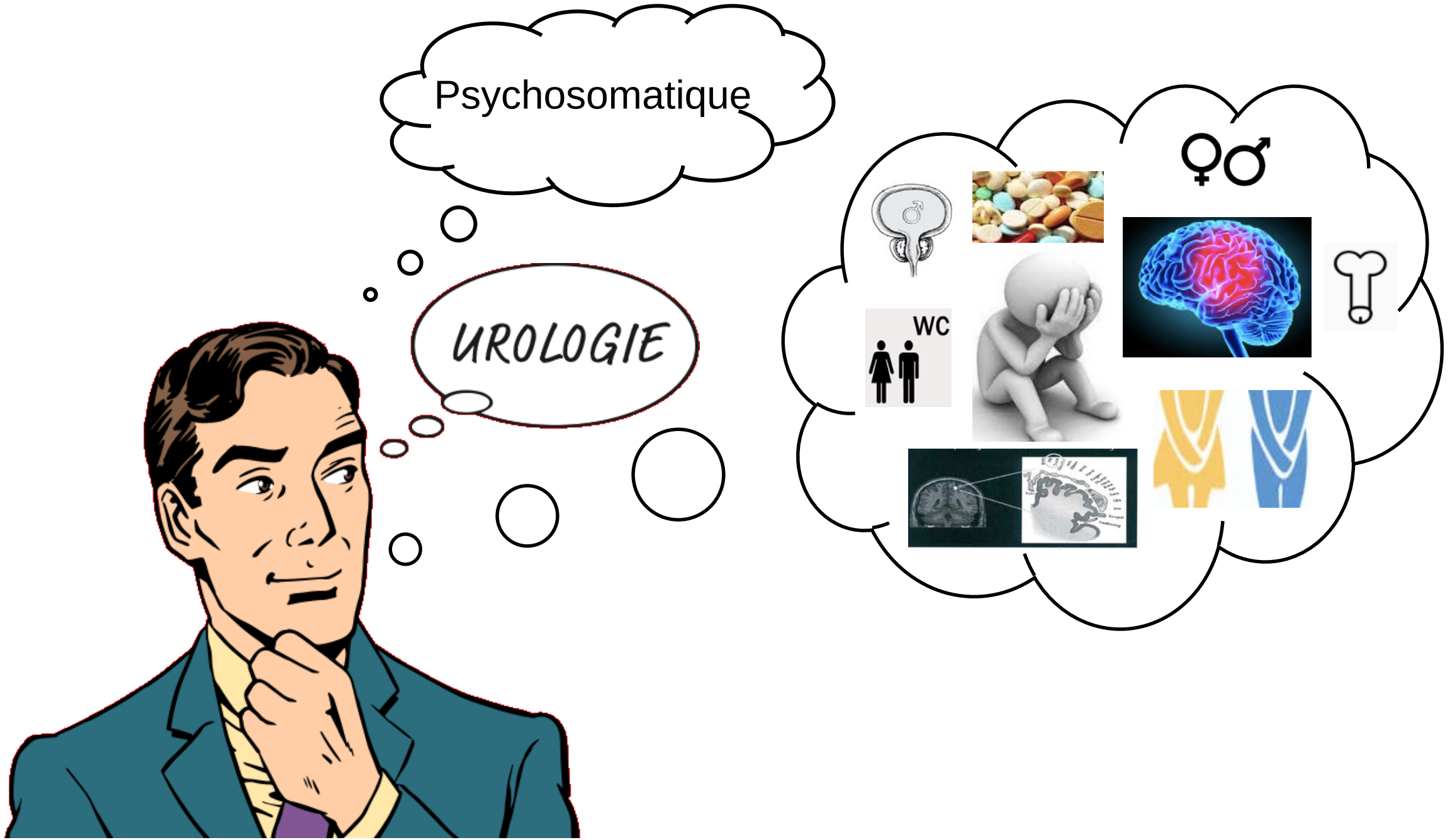
SSMIG Congrès d‘automne, Montreux, 20.09.2018

Présentation Dr. med. N. Bischoff / Modération Dr. med. A. Gonthier

Contenu de l‘atelier

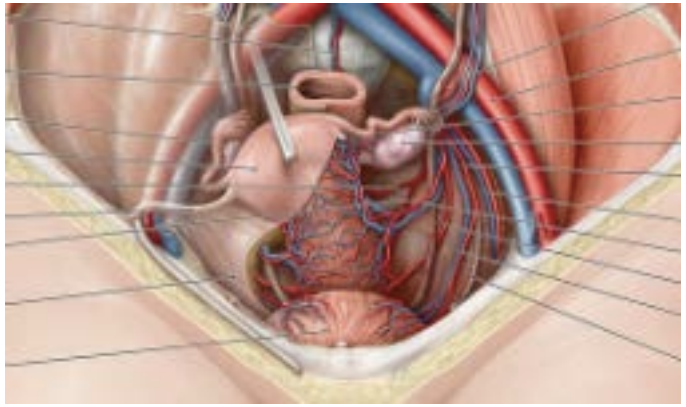
- Accueil / Présentation
- Recueil des questions et définition des objectifs
- Cas 1
- Cas 2
- Cas 3
- Synthèse / Take home messages
- Liens utiles
- Feedback

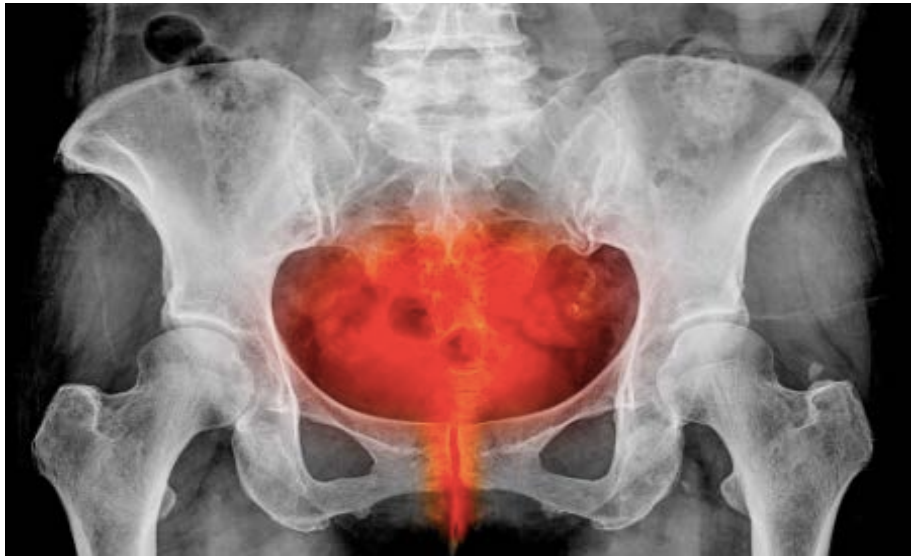
Bienvenue – Willkommen - Benvenuti


Psychosomatique
UROLOGIE
WC

Cas n°1

Syndrome de la vessie douloureuse – Bladder Pain Syndrome IC/BPS





Cas n°1 - Théorie

- Syndrome de la douleur chronique pelvienne – CPPS -> UCPPS
- Syndrome de la vessie douloureuse ou cystite interstitielle -> Bladder Pain Syndrome IC/BPS
- IC/BPS comme “functional somatic syndrome“ FSS
- Pas de classification et de nomenclature internationale standardisées
- Symptomes -> Douleur, pression, inconfort dans la zone de la vessie accompagnés par LUTS, pas d‘infection ou d‘autres causes.
- Typiquement – aller souvent aux WC pour réduire la douleur, DD OAB pour diminuer l‘incontinence
- BPS est un diagnostic clinique – diagnostic par exclusion
- SGU / EAU / AUA Guidelines

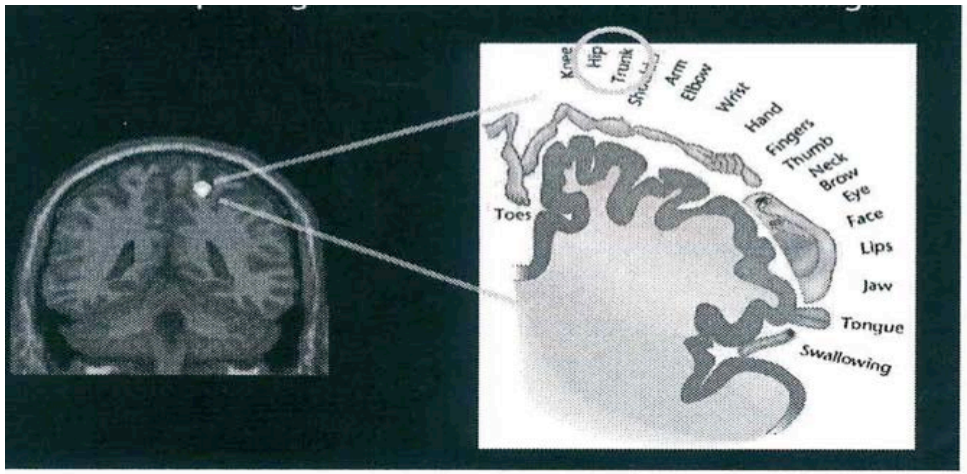
The Journal of Urology
Volume 193, Issue 1, January 2015, Pages 131-137

Adult Urology

Infection/Inflammation

Increased Brain Gray Matter in the Primary Somatosensory Cortex is Associated with Increased Pain and Mood Disturbance in Patients with Interstitial Cystitis/Painful Bladder Syndrome

Anson E. Kairys [a], Tobias Schmidt-Wilcke [b], Tudor Puiu [a], Eric Ichesco [a] ✉, Jennifer S. Labus [c], Katherine Martucci [d], Melissa A. Farmer [e], Timothy J. Ness [f, †], Georg Deutsch [f], Emeran A. Mayer [c], Sean Mackey [d], A. Vania Apkarian [e], Kenneth Maravilla [g, ‡], Daniel J. Clauw [a], Richard E. Harris [a]



Journal of Psychosomatic Research 77 (2014) 510–515

Contents lists available at ScienceDirect

Journal of Psychosomatic Research

Bladder pain syndrome/interstitial cystitis as a functional somatic syndrome

John W. Warren

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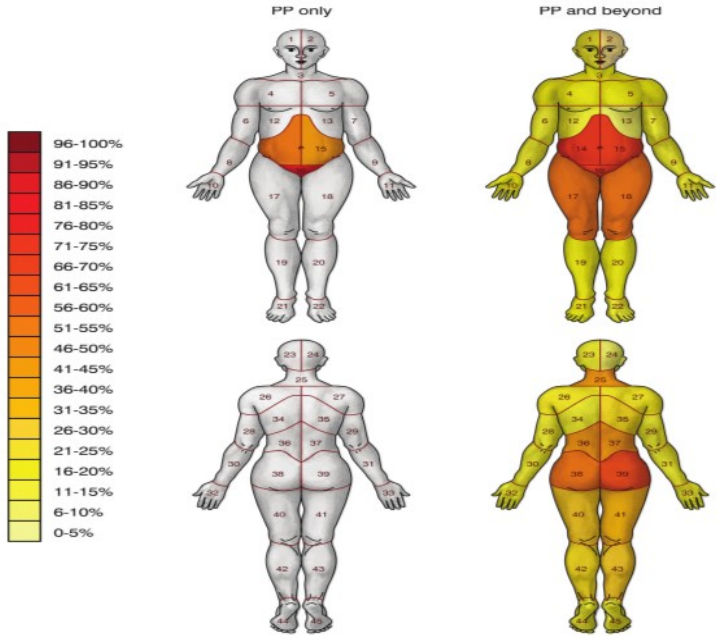
Clinical and Psychological Parameters Associated with Pain Pattern Phenotypes in Women with Interstitial Cystitis/Bladder Pain Syndrome

J. Curtis Nickel,* Dean A. Tripp and the International Interstitial Cystitis Study Group†

From the Departments of Urology (JCN), Psychology and Anesthesiology, Queen's University, Kingston, Ontario, Canada

RESULTS

Analysis was done in 193 female patients with IC/BPS and body pain mapping data available, including 36 (18.7%) with the PP only phenotype and 157 (81.3%) with the PP beyond phenotype. The figure shows pain maps of the 2 distinct phenotypes. The PP beyond and PP only groups did not differ in mean patient age (48.9 vs 50.6 years, p = 0.530) or in the average number of years since diagnosis (7.2 vs 6.7, p = 0.673).



Pain location reports of female patients diagnosed with IC/BPS differentiated by PP only and PP beyond phenotypes. Anterior and posterior body maps show body areas numbered sequentially (*1* to *45*) with some areas (*14* to *16*) considered PP only phenotype.

IC/BPS

An unpleasant sensation (pain, pressure, discomfort) perceived to be related to the urinary bladder, associated with lower urinary tract symptoms of more than six weeks duration, in the absence of infection or other identifiable causes

BASIC ASSESSMENT

- History
- Frequency/Volume Chart
- Post-void residual
- Physical examination
- Urinalysis, culture
- Cytology if smoking hx
- Symptom questionnaire
- Pain evaluation

Confirmed or Uncomplicated IC/BPS

Signs/Symptoms of Complicated IC/BPS

- Incontinence/OAB
- GI signs/symptoms Microscopic/gross hematuria/sterile pyuria
- Gynecologic signs/symptoms

CONSIDER:

- Urine cytology
- Imaging
- Cystoscopy
- Urodynamics
- Laparoscopy
- Specialist referral (urologic or non-urologic as appropriate)

Dx Urinary Tract Infection

TREAT & REASSESS

CLINICAL MANAGEMENT PRINCIPLES

- Treatments are ordered from most to least conservative; surgical treatment is appropriate only after other treatment options have been found to be ineffective (except for treatment of Hunner's lesions if detected)
- Initial treatment level depends on symptom severity, clinician judgment, and patient preferences
- Multiple, simultaneous treatments may be considered if in best interests of patient
- Ineffective treatments should be stopped
- Pain management should be considered throughout course of therapy with goal of maximizing function and minimizing pain and side effects
- Diagnosis should be reconsidered if no improvement within clinically-meaningful time-frame

FIRST-LINE TREATMENTS

- General Relaxation/ Stress Management
- Pain Management
- Patient Education
- Self-care/Behavioral Modification

SECOND-LINE TREATMENTS

- Appropriate manual physical therapy techniques
- Oral: amitriptyline, cimetidine, hydroxyzine, PPS
- Intravesical: DMSO, Heparin, Lidocaine
- Pain Management

THIRD-LINE TREATMENTS

- Cystoscopy under anesthesia w/ hydrodistention
- Pain Management
- Tx of Hunner's lesions if found

FOURTH-LINE TREATMENTS

- Intradetrusor botulinum toxin A
- Neuromodulation
- Pain Management

FIFTH-LINE TREATMENTS

- Cyclosporine A
- Pain Management

SIXTH-LINE TREATMENTS

- Diversion w/ or w/out cystectomy
- Pain Management
- Substitution cystoplasty

Note: For patients with end-stage structurally small bladders, diversion is indicated at any time clinician and patient believe appropriate.

RESEARCH TRIALS

Patient enrollment as appropriate at any point in treatment process

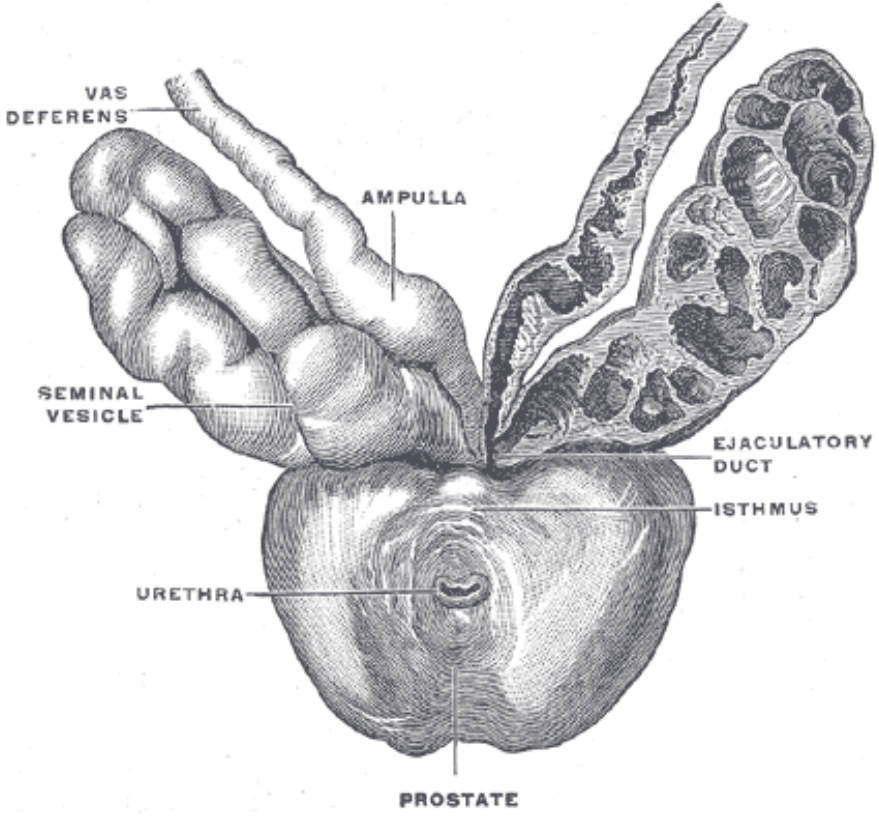
The evidence supporting the use of Neuromodulation, Cyclosporine A, and BTX for IC/BPS is limited by many factors including study quality, small sample sizes, and lack of durable follow up. None of these therapies have been approved by the U.S. Food and Drug Administration for this indication. The panel believes that none of these interventions can be recommended for generalized use for this disorder, but rather should be limited to practitioners with experience managing this syndrome and willingness to provide long term care of these patients post intervention.

Cas n°1 – Pratique / Discussion

- Comment on évalue la suicidalité dans la discussion ?
- Education des patients
- Gestion des douleurs
- Paindrawing / Algopeg pour prendre en compte le FSS, hypersensitivité
- Exercice de relaxation (par exemple Inselhealth)
- Dessiner l‘anatomie

Cas n°2

La prostatite chronique - Chronic Prostatitis CP/CPPS



Cas n°2 - Théorie

- DD Male IC/BPS
- CP appartient au CPPS – UCPPS
- COPCs – “chronic overlapping pain conditions“ comorbides avec CP
- Douleurs et symptomes de mauvaise vidange de la vessie
- Composants myofaciaux
- **Synonyme:** prostatite chronique abactérielle, myalgie du plancher pelvien, syndrome de douleurs chroniques du bassin (chronic pelvic pain syndrome), syndrome non inflammatoire des douleurs du bassin, prostatodynie, syndrome urogénital végétatif, complexe anogénital.
- Problèmes de l‘érection et de la sexualité

Thomas M. Kessler, BJUI Associate Editor – Functional Urology Neuro-Urology, Spinal Cord Injury Center & Research, University of Zuerich, Balgrist University Hospital, Zuerich, Switzerland, BJU 2017

Editorial

BJUI
BJU International

Biomarkers in chronic pelvic pain syndrome: did we find the Holy Grail?

Journal of Psychosomatic Research 102 (2017) 29–33

Contents lists available at ScienceDirect

Journal of Psychosomatic Research

journal homepage: www.elsevier.com/locate/jpsychores

Chronic prostatitis and comorbid non-urological overlapping pain conditions: A co-twin control study

Marianna Gasperi[a,b], John N. Krieger[c], Christopher Forsberg[d], Jack Goldberg[c,d], Dedra Buchwald[e], Niloofar Afari[a,b,*]

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[b] VA Center of Excellence for Stress and Mental Health, San Diego, CA, USA
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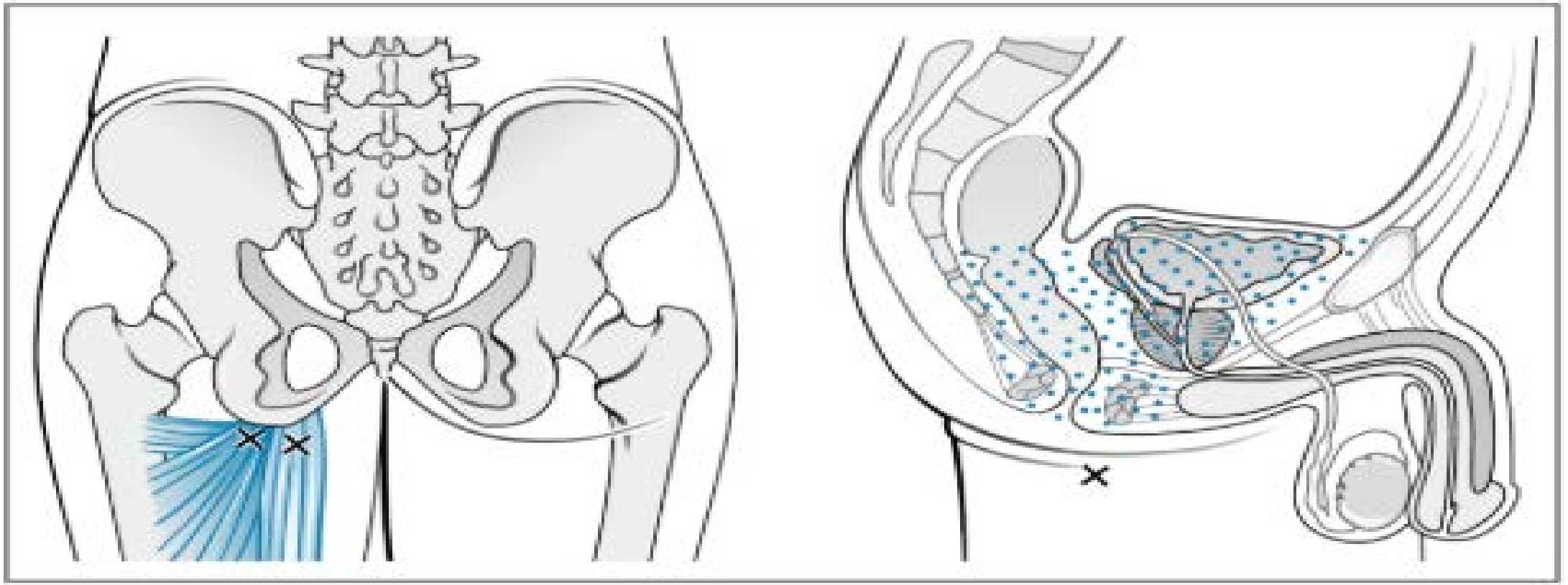
Triggerpoints (x) du départ crânien des adducteurs (Travell u. Simons, 1992)



◆ ARTICLE ORIGINAL

Progrès en Urologie (2006), 16, 324-327

La prostate, symbole de la vulnérabilité masculine : une enquête qualitative AFU-IPSOS

Yves BARDON (1), Emmanuel CHARTIER-KASTLER (2), Jean-Luc MOREAU (2), Jean-Louis DAVIN (2), Jean-Pierre MIGNARD (2), Christian COULANGE (2) et les membres du Conseil d'Administration de l'Association Française d'Urologie

(1) Ancien élève de l'Ecole Normale Supérieure, Ipsos Qualitative Research Developer, (2) Membre du bureau de l'AFU

Principes de l‘anamnèse sexuelle

(Bosinski 2002)

- partie intégrante de l’entretien médical
- aussi précise que possible et aussi vaste que nécessaire
- pas blessante
- doit être acquise
- élément essentiel pour la détection d’autres troubles
- peut constituer la première étape d’une thérapie sexuelle réussie

Situations dans lesquelles des questions sur la sexualité devraient être posées...

(Buddenberg 2005)

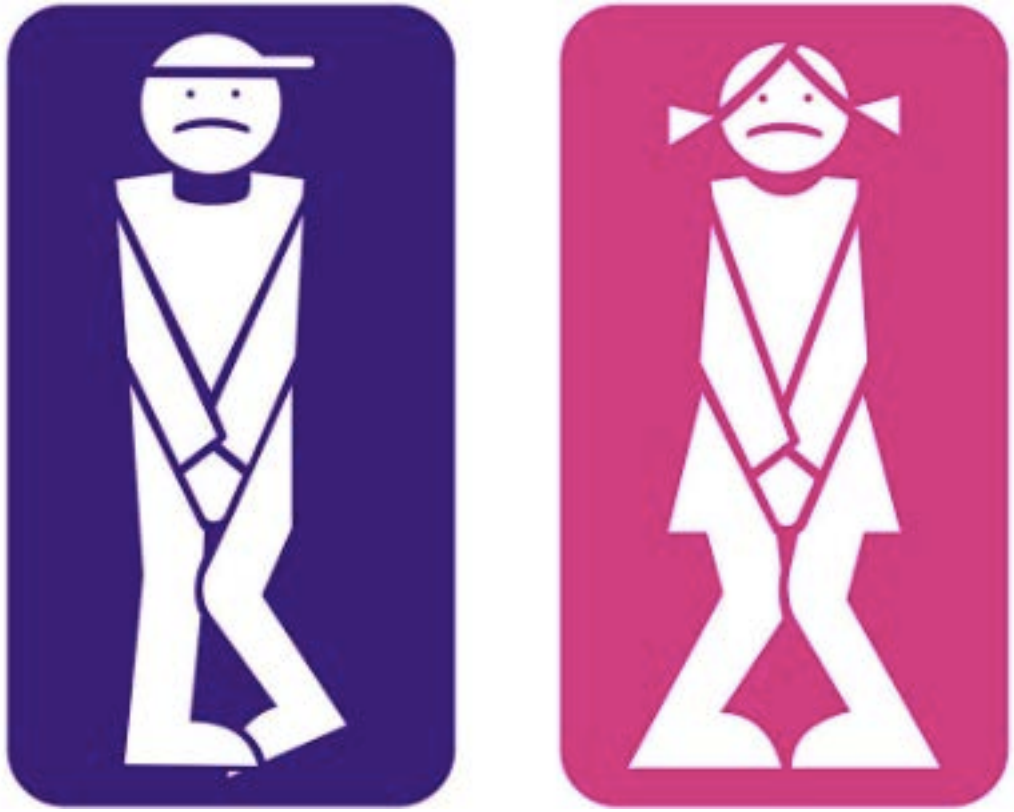
- Puberté et adolescence
- Au début ou durant une relation de couple
- Durant la grossesse, après la naissance ou durant la ménopause
- En cas de conflits de couple et familiaux
- En cas de maladies chroniques
- Avant ou après des opérations gynécologiques
- En cas d‘infections sexuellement transmissibles ou maladies touchant les organes génitaux
- En cas de traitement médicamenteux à long terme, qui compte les troubles sexuels parmi ses effets indésirables
- En cas de troubles fonctionnels, particulièrement au niveau du petit bassin
- En cas de maladies psychiques

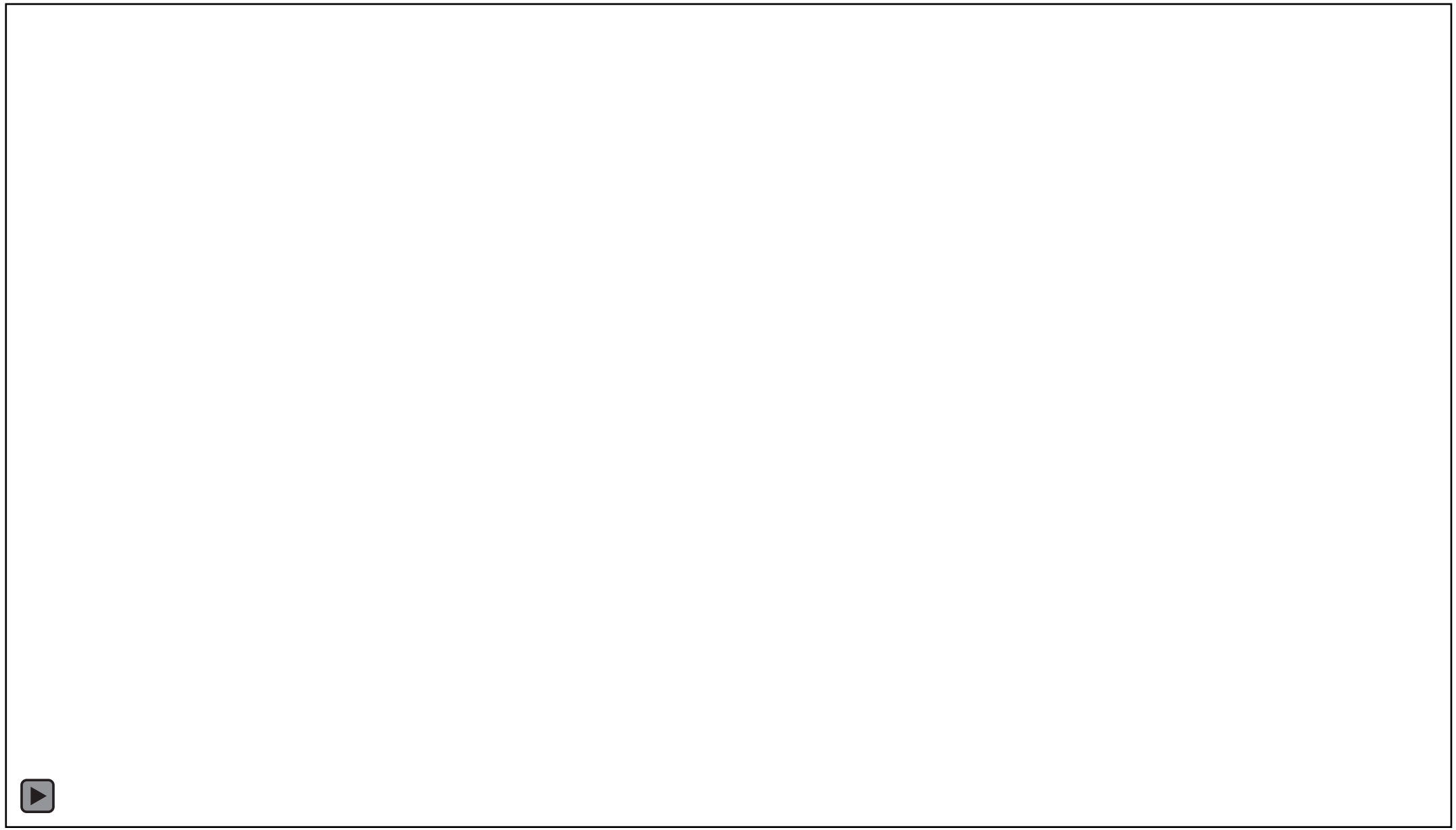
Cas n°2 – Pratique / Discussion

- Quand et comment faire l‘anamnèse sur la sexualité?
- Exercices, jeux de rôles

Cas n°3

Incontinence de la vessie

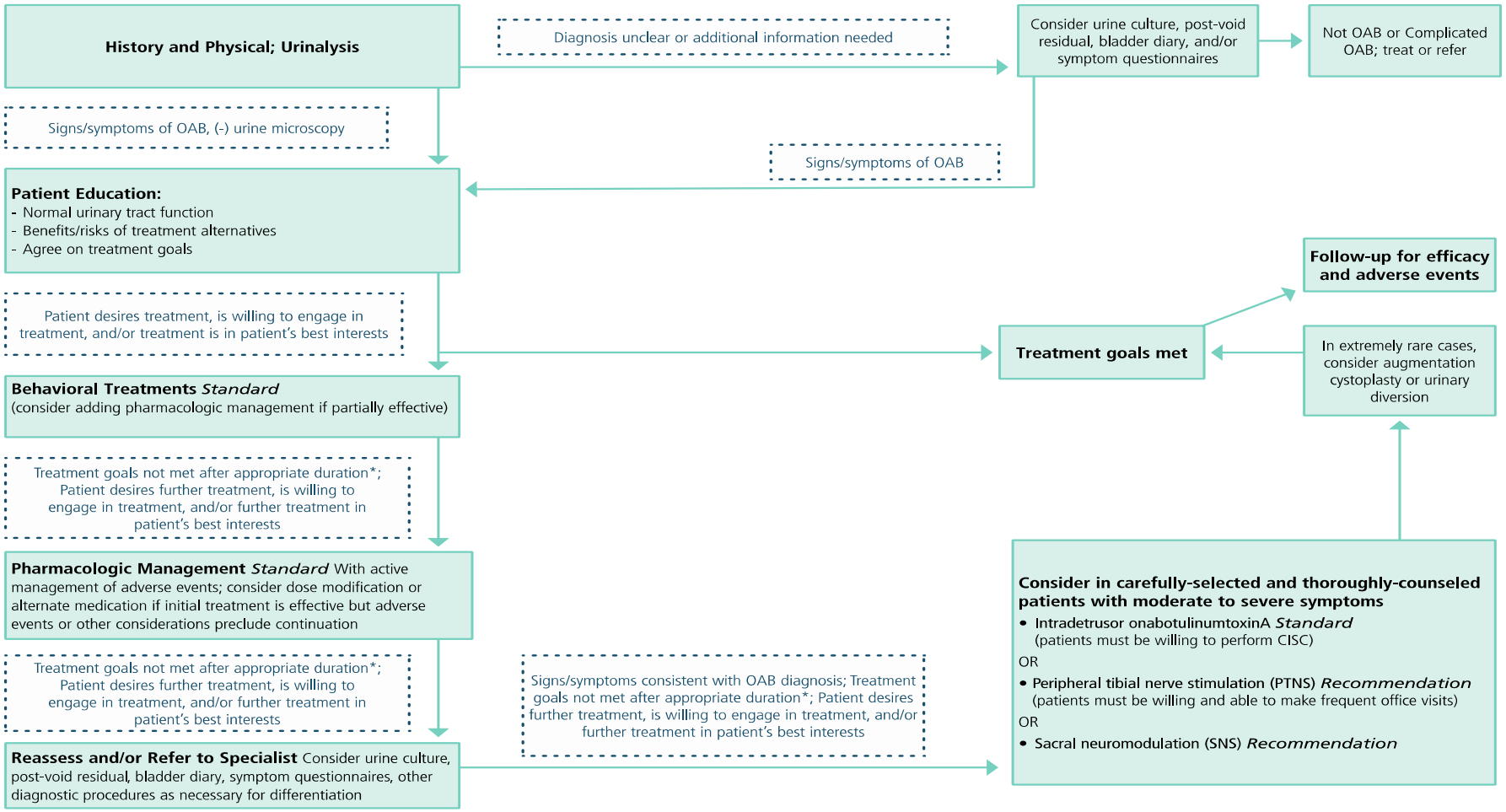




Cas n°3 - Théorie

- Comment questionner sur l‘incontinence?
- Incontinence de type urgence
- Overactive Bladder OAB = Syndrome
- Exclusion de l‘infection, urolithiasis, obstacles à l‘écoulement

Diagnosis & Treatment Algorithm: AUA/SUFU Guideline on Non-Neurogenic Overactive Bladder in Adults



Cas n°3 – Pratique / Discussion

- Dessiner l‘anatomie urologique à des fins éducatives
- Education des patients sur le fonctionnement normal du système urologique
- Questionner l‘incontinence

Take home message 1

Elargir l‘horizon...

-> Interroger sur les autres syndromes somatiques fonctionnels (FSS Functional Somatic Syndrome)

-> Du symptome au syndrome pour établir la thérapie adéquate

Take home message 2

Ne pas avoir peur des questions “en dessous de la ceinture“.

-> l‘anamnèse sexuelle doit être faite pour toutes les maladies chroniques!

Take home message 3

liaison et empathie

versus

diagnostic et spécialiste

Liens utiles

- https://www.sappm.ch/
- http://www.urologie.insel.ch/
- http://www.neurologie.insel.ch/de/unser-angebot/psychosomatische-medizin/
- http://www.pelvisuisse.ch
- http://www.urologyhealth.org/urologic-conditions/interstitial-cystitis
- http://www.painful-bladder.org/
- http://www.ic-network.com/patient-resources/diet/diet-introduction/

Feedback / Discussion

Je vous remercie de votre participation et de votre attention!

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SAVE THE DATE!