a modest benefit over placebo. Adverse reactions are uncommon and include gastrointestinal symptoms, headache, and alopecia. Pentosan polysulfate has weak anticoagulant effects and perhaps should be avoided by patients with coagulation abnormalities.

Anecdotal reports suggest that successful therapy for one FSS is accompanied by diminished symptoms of other FSSs. As has been noted here, IC/BPS often is associated with one or several FSSs. Thus, it seems reasonable to hope that, to the extent that accompanying FSSs are treated successfully, the symptoms of IC/BPS will be relieved as well.

If several months of these therapies in combination do not relieve symptoms adequately, the patient should be referred to a urologist or urogynecologist who has access to additional modalities. Cystoscopy under anesthesia allows distention of the bladder with water, a procedure that provides ~40% of patients with several months of relief and can be repeated. For those few patients with a Hunner's lesion, fulguration may offer relief. Bladder instillation of solutions containing lidocaine or dimethyl sulfoxide can be administered. Physicians experienced in the care of IC/BPS patients have used anticonvulsants, narcotics, and cyclosporine as components of therapy. Pain specialists can be of assistance. Sacral neuromodulation with a temporary percutaneous electrode can be tested and, if effective, can then be performed with an implanted device. In a very small number of patients with recalcitrant symptoms, surgeries, including cystoplasty, partial or total cystectomy, and urinary diversion, may provide relief.