GUIDELINES ON CHRONIC PELVIC PAIN

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Diagnosis and classification of CPP

Chronic (also known as persistent) pain occurs for at least 3 months. It is associated with changes in the central nervous system (CNS) that may maintain the perception of pain in the absence of acute injury. These changes may also magnify perception so that non-painful stimuli are perceived as painful (allodynia) and painful stimuli become more painful than expected (hyperalgesia). Core muscles, e.g. pelvic muscles, may become hyperalgesic with multiple trigger points. Other organs may also become sensitive, e.g. the uterus with dyspareunia and dysmenorrhoea, or the bowel with irritable bowel symptoms.

The changes within the CNS occur throughout the whole neuroaxis and as well as sensory changes result in both functional changes (e.g. irritable bowel symptoms) and structural changes (e.g. neurogenic oedema in some bladder pain syndromes). Central changes may also be responsible for some of the psychological consequences, which also modify pain mechanisms in their own right.

Basic investigations are carried out to exclude 'well-defined' pathologies. Negative results mean a 'well-defined' pathology is unlikely. Any further investigations are only done for specific indications, e.g. subdivision of a pain syndrome. The EAU guidelines avoid spurious diagnostic terms, which are associated with inappropriate investigations, treatments and patient expectations and, ultimately, a worse prognostic outlook.

The classification in Table 1 focuses on the urological pain syndromes. It recognises an overlap of mechanisms and symptoms between different conditions and their treatment by a multidisciplinary approach. A physician using the classification in Table 1 should start on the left of Table 1 and proceed to the right only if confidently able to confirm that pain has been perceived in the appropriate system and organ. It may often be impossible to define a condition further than 'pelvic pain syndrome'. Table 2 defines terminology used in CPP.

Figure 1 provides an algorithm for diagnosing and treating CPP. Follow steps 1 to 6 (Table 3) while referring to the correct columns in the algorithm (Fig. 1).

Table 1: Classification of chronic pelvic pain syndromes

Axis I Region		Axis II System	Axis III End organ as pain sundrome as identified from Hx, Ex and Ix		
Chronic pelvic pain	Pelvic pain syndrome	Urologic	Bladder pain syndrome	(See Table 5 on ESSIC classification)	
			Urethral pain syndrome		
			Prostate pain syndrome	Type A inflammatory	
				Type B non-inflammatory	
			Scrotal pain syndrome	Testicular pain syndrome	
				Epididymal pain syndrome	
				Post-vasectomy pain syndrome	
			Penile pain syndrome		
		Gynaecologic	Endometriosis associated pain syndrome		
			Vaginal pain syndrome		
			Vulvar pain syndrome	Generalised vulvar pain syndrome	
				Localised vulvar pain syndrome	Vestibular pain syndrome
					Clitoral pain syndrome
		Anorectal			
		Neurologic	e.g., Pudendal pain syndrome		
		Muscular			
	Non pelvic pain syndrome	e.g. Neurologic	e.g. Pudendal neuralgia		
		e.g. Urologic			

Hx = History; Ex = Examination; Ix = Investigation.

Axis IV Referral characteristics	Axis V Temporal characteristics	Axis VI Character	Axis VII Associated symptoms	Axis VIII Psychological symptoms
Suprapubic Inguinal Urethral Penile/clitoral Perineal Rectal Back Buttocks	ONSET Acute Chronic ONGOING Sporadic Cyclical Continuous TIME Filling Emptying Immediate post Late post PROVOKED	Aching Burning Stabbing Electric Other	URINARY Frequency Nocturia Hesitance Poor flow Pis en deux Urge Urgency Incontinance Other GYNAECOLOGICAL e.g Menstrual SEXUAL e.g. Female dyspareunia impotence Gastrointestinal MUSCULAR Hyperalgesia CUTANEOUS Allodynia	ANXIETY About pain or putative cause of pain Other DEPRESSION Attributed to pain/impact of pain Attributed to other causes or unattributed SHAME, GUILT related to disclosed or undisclosed sexual experience's PTSD SYMPTOMS Reexperiencing Avoidance Hyperarousal

Table 2: Definitions of chronic pelvic pain terminology	
Terminology	**Description**
Chronic pelvic pain	Non-malignant pain perceived in structures related to the pelvis of either men or women. In the case of documented nociceptive pain that becomes chronic, pain must have been continuous or recurrent for at least 6 months. If non-acute and central sensitization pain mechanisms are well documented, then the pain may be regarded as chronic, irrespective of the time period. In all cases, there often are associated negative cognitive, behavioural, sexual and emotional consequences.
Pelvic pain syndrome	Persistent or recurrent episodic pelvic pain associated with symptoms suggesting lower urinary tract, sexual, bowel or gynaecological dysfunction. No proven infection or other obvious pathology (adopted from ICS 2002 report).
Bladder pain syndrome	Suprapubic pain is related to bladder filling, accompanied by other symptoms such as increased daytime and night-time frequency. There is an absence of proven urinary infection or other obvious pathology. This term has been adopted from the ICS 2002 report, where the term painful bladder syndrome was used; the name has been changed to bladder pain syndrome to be consistent with other pain syndrome terminology. The European Society

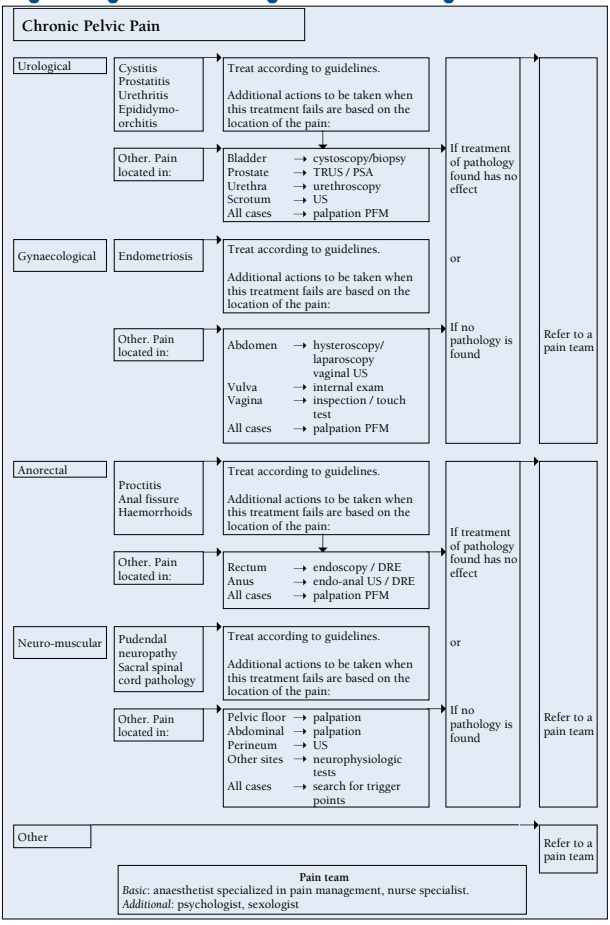
	for the Study of IC/PBS (ESSIC) publication places greater emphasis on the pain being perceived in the bladder.
Urethral pain syndrome	Recurrent episodic urethral pain, usually on voiding, with daytime frequency and nocturia. Absence of proven infection or other obvious pathology.
Penile pain syndrome	Pain within the penis that is not primarily in the urethra. Absence of proven infection or other obvious pathology.
Prostate pain syndrome	Persistent or recurrent episodic prostate pain, associated with symptoms suggestive of urinary tract and/or sexual dysfunction. No proven infection or other obvious pathology. Definition adapted from the National Institutes of Health (NIH) consensus definition and classification of prostatitis and includes conditions described as 'chronic pelvic pain syndrome'. Using the NIH classification system, prostate pain syndrome may be subdivided into type A (inflammatory) and type B (non-inflammatory).
Scrotal pain syndrome	Persistent or recurrent episodic scrotal pain associated with symptoms suggestive of urinary tract or sexual dysfunction. No proven epididymo-orchitis or other obvious pathology.

Testicular pain syndrome	Persistent or recurrent episodic pain localized to the testis on examination, which is associated with symptoms suggestive of urinary tract or sexual dysfunction. No proven epididymo-orchitis or other obvious pathology. This is a more specific definition than scrotal pain syndrome.
Post-vasectomy pain syndrome	Scrotal pain syndrome that follows vasectomy.
Epididymal pain syndrome	Persistent or recurrent episodic pain localized to the epididymis on examination. Associated with symptoms suggestive of urinary tract or sexual dysfunction. No proven epididymo-orchitis or other obvious pathology (a more specific definition than scrotal pain syndrome).
Endometriosis-associated pain syndrome	Chronic or recurrent pelvic pain where endometriosis is present but does not fully explain all the symptoms.
Vaginal pain syndrome	Persistent or recurrent episodic vaginal pain associated with symptoms suggestive of urinary tract or sexual dysfunction. No proven vaginal infection or other obvious pathology.
Vulvar pain syndrome	Persistent or recurrent episodic vulvar pain either related to the micturition cycle or associated with symptoms suggestive of urinary tract or sexual dysfunction. There is no proven infection or other obvious pathology.

Generalized vulvar pain syndrome	Vulval burning or pain that cannot be consistently and tightly localized by point (formally pressure 'mapping' by probing with a cotton-tipped applicator or similar dysaesthetic vulvodynia) instrument. The vulvar vestibule may be involved but the discomfort is not limited to the vestibule. Clinically, the pain may occur with or without provocation (touch, pressure or friction).
Localized vulvar pain syndrome	Pain consistently and tightly localized by point-pressure mapping to one or more portions of the vulva. Clinically, pain usually occurs as a result of provocation (touch, pressure or friction).
Vestibular pain syndrome	Pain localized by point-pressure mapping to one or more portions of the vulval (formerly vulval vestibulitis) vestibule.
Clitoral pain syndrome	Pain localized by point-pressure mapping to the clitoris.
Anorectal pain syndrome	Persistent or recurrent, episodic rectal pain with associated rectal trigger points/tenderness related to symptoms of bowel dysfunction. No proven infection or other obvious pathology.
Pudendal pain syndrome	Neuropathic-type pain arising in the distribution of the pudendal nerve with symptoms and signs of rectal, urinary tract or sexual dysfunction. No proven obvious pathology (This is not the same as the well-defined pudendal neuralgia).

Perineal pain syndrome	Persistent or recurrent, episodic, perineal pain either related to the micturition cycle or associated with symptoms suggestive of urinary tract or sexual dysfunction. No proven infection or other obvious pathology.
Pelvic floor muscle pain syndrome	Persistent or recurrent, episodic, pelvic floor pain with associated trigger points, which is either related to the micturition cycle or associated with symptoms suggestive of urinary tract, bowel or sexual dysfunction. No proven infection or other obvious pathology.

Fig. 1: Algorithm for diagnosis and management of CPP



DRE = digital rectal examination; US = ultrasound; PFM = pelvic floor muscles.

Table 3: Guide to using the algorithm in Fig. 1 for diagnosis and management of CPP

Step	Action	Algorithm
1	Start by considering the organ system where the symptoms appear to be primarily perceived.	First column
2	'Well-defined' conditions, such as cystitis, should be diagnosed and treated according to national or international guidelines.	Second column and upper part third column
3	When treatment has no effect on the pain, additional tests (e.g. cystoscopy or ultrasound) should be performed.	Lower part third column
4	When these tests reveal any pathology, this should be treated appropriately.	Fourth column
5	If treatment has no effect, the patient should be referred to a pain team.	Fifth column
6	If no well-defined condition is present or when no pathology is found by additional tests, the patient should also be referred to a pain team.	Fifth column

Prostate pain syndrome (PPS)

Based on a more general definition (see Table 2), the term prostate pain syndrome (PPS) is used instead of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) term chronic prostatitis/chronic pelvic pain syndrome. PPS is persistent discomfort or pain in the pelvic region with sterile specimen cultures and either significant or insignificant white blood cell counts in the prostate-specific specimens (ie, semen, expressed prostatic secretions, and urine collected after prostate massage). Because there are no clinically relevant diagnostic or therapeutic consequences arising from differentiating between inflammatory and noninflammatory subtypes, PPS can be regarded as one entity.

Diagnosis is based on a 3-month history of genitourinary pain and an absence of other lower urinary tract pathologies. It can be confirmed cost-effectively by the two-glass test or pre-post-massage test (PPMT), accurately identifying 96% of patients.

The unknown aetiology of PPS means treatment is often anecdotal. Most patients require multimodal treatment aimed at the main symptoms and considering comorbidities. Recent results from randomized controlled trials have led to some advances in the knowledge about different treatment options (Table 4).

Bladder pain syndrome/interstitial cystitis (BPS/IC)

This heterogeneous spectrum of disorders is still poorly defined. Inflammation is an important feature in only a subset of patients. BPS refers to pain perceived in the bladder region, while IC refers to a special type of chronic inflammation of the bladder.

Table 4: Treatment of prostate pain syndrome (PPS)

Drugs	LE	GR	Comment
α-blockers	-	-	Not effective according to recent large randomised controlled trial
Antimicrobial therapy	3	B	Give quinolones if previously untreated (naïve) only; reassess after 2–3 wk; duration 4–6 wk
Opioids	3	C	As part of multimodal therapy for treatment-refractory pain in collaboration with pain clinics
Non-steroidal anti-inflammatory drugs	1b	B	Long-term side-effects must be considered
5-α-reductase inhibitors	1b	B	If benign prostatic hyperplasia is present
Phytotherapy	1b-3	B	
Biofeedback, relaxation exercise, lifestyle changes, massage therapy, chiropractor therapy, acupuncture and meditation	2a-3	B	As supportive, second-line therapies

LE = level of evidence; GR = grade of recommendation; NIH-CPSI = NIH Prostatitis Symptom Index.

An extremely wide variety of diagnostic criteria have been used because of the difficulty in establishing different definitions such as the NIDDKK consensus criteria in the late 1980s. The European Society for the Study of IC/PBS (ESSIC) has recently suggested standardised diagnostic criteria to make it easier to compare different studies. It suggests BPS should be diagnosed on the basis of pain perceived in the urinary bladder, accompanied by at least one other symptom, such as daytime and/or night-time urinary frequency. Confusable diseases should be excluded as the cause of symptoms. Cystoscopy with hydrodistension and biopsy may be indicated (Table 5).

Table 5: ESSIC classification of BPS based on cystoscopy with hydrodistension and biopsies

	Cystoscopy with hydrodistension			
Biopsy	**Not done**	**Normal**	**Glomerulations (grade 2–3)**	**Hunner's lesions, with/without glomerulations**
• Not done	XX	1X	2X	3X
• Normal	XA	1A	2A	3A
• Inconclusive	XB	1B	2B	3B
• Positive*	XC	1C	2C	3C

** Histology showing inflammatory infiltrates and/or detrusor mastocytosis and/or granulation tissue and/or intrafascicular fibrosis.*

The diagnosis is made using symptoms, examination, urine analysis, and cystoscopy with hydrodistension and biopsy (Fig. 2). Patients present with characteristic pain and urinary frequency, which is sometimes extreme and always includes nocturia. Pain is the key symptom. It is related to the degree of bladder filling, typically increasing with increasing blad-

der content and located suprapubically, sometimes radiating to the groins, vagina, rectum or sacrum. Although pain is relieved by voiding, it soon returns.

The two main entities, classic (Hunner) and non-ulcer disease have different clinical presentations and age distribution. The two types respond differently to treatment and have different histopathological, immunological and neurobiological features. Recommendations for treating BPS/IC are listed in Tables 6 and 7.

Table 6: Medical treatment of BPS/IC

Drug	LE	GR	Comment
Analgesics	2b	C	Limited to cases awaiting further treatment
Hydroxyzine	1b	A	Standard treatment, even though limited efficacy shown in RCT
Amitriptyline	1b	A	Standard treatment
Pentosanpolysulphate sodium (PPS)	1a	A	Standard treatment; data contradictory
Cyclosporin A	1b	A	RCT showed superior to PPS, but with more adverse effects

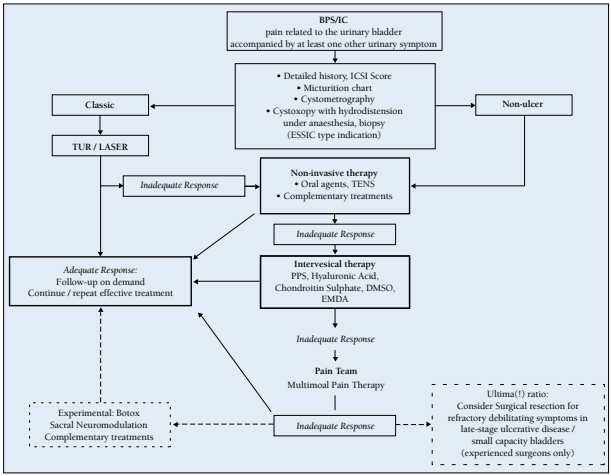
LE = level of evidence; GR = grade of recommendation; RCT = randomized controlled trial; IC = interstitial cystitis; PPS = pentosanpolysulphate sodium.

Table 7: Intravesical, interventional, alternative and surgical treatments of BPS/IC

Treatment	LE	GR	Comment
Intravesical PPS	1b	A	
Intravesical hyaluronic acid	2b	B	
Intravesical chondroitin sulphate	2b	B	
Intravesical DMSO	1b	A	
Bladder distension	3	C	
Electromotive drug administration	3	B	
Transurethral resection (coagulation and laser)	NA	NA	Hunner's lesions only. See full text.
Nerve blockade/epidural pain pumps	3	C	For crisis intervention; affects pain only
Bladder training	3	B	Patients with little pain
Manual and physical therapy	3	B	
Psychological therapy	3	B	
Surgical treatment	NA	NA	Very variable data, ultima ratio, experienced surgeons only. See full text.

LE = level of evidence; GR = grade of recommendation; PPS = pentosanpolysulphate sodium; DMSO = dimethyl sulphoxide; NA = type of evidence not applicable, since RCTs are unethical in such surgical procedures.

Fig. 2: Diagnosis and therapy flowchart for BPS/IC



Scrotal pain syndrome

A physical examination should always be done, including gentle palpation of each component of the scrotum and a digital rectal examination for prostate and pelvic floor muscle abnormalities. Scrotal ultrasound is of limited value in finding the cause of the pain. Scrotal pain can arise from trigger points in the pelvic floor or lower abdominal musculature.

Urethral pain syndrome

Urethral pain syndrome is a poorly defined entity. Signs are urethral tenderness or pain upon palpation and inflamed urethral mucosa found during endoscopy. Patients present with pain or discomfort during micturition in the absence of urinary infection. The 'absence of urinary infection' causes

diagnostic problems because the methods typically used to identify urinary infection are insensitive. There is no consensus on treatment. Management may require a multidisciplinary approach.

Pelvic pain in gynaecological practice

A full clinical history, examination and appropriate investigations (e.g. genital swabs, pelvic imaging and diagnostic laparoscopy) are necessary to identify any cause that can be treated. However, no cause will be found in 30% of patients. The commonest gynaecological pain conditions include dysmenorrhoea, pelvic infections and endometriosis. Pelvic infections usually respond to antibiotic therapy, but surgery may be necessary in long-term conditions. Gynaecological malignancies often present with symptoms similar to BPS.

Sexual dysfunction associated with pelvic pain may need special attention. Male sexual dysfunction is discussed in detail elsewhere in the EAU guidelines. Female sexual dysfunction is less easy to treat, but is affected by problems in the male partner. It is recommended that the female should be evaluated within the context of the couple in a sexual medicine clinic.

Neurogenic conditions

When CPP is not explained by local pelvic pathology, a neurological opinion should be sought to exclude any form of conus or sacral root pathology. Magnetic resonance imaging is the investigation of choice to show both neural tissue and surrounding structures. If all examinations and investigations fail to reveal an abnormality, consider a focal pain syndrome,

e.g. pudendal nerve entrapment. Treatment for each condition is individually tailored.

Pelvic floor function and dysfunction

The pelvic floor has three functions: support, contraction and relaxation. Pelvic floor dysfunction should be classified according to '*The standardisation of terminology of pelvic floor muscle function and dysfunction*', published by the International Continence Society (ICS). As in all ICS standardisation documents, classification is based on the triad of symptom, sign and condition. Symptoms are what the patient tells you; signs are found by physical examination. Palpation is used to assess the contraction and relaxation of the pelvic floor muscles. Based on the results, the function of the pelvic floor muscles is classified as normal, overactive, underactive or non-functioning. Overactive pelvic floor muscles can cause CPP.

Repeated or chronic muscular overload can activate trigger points in the muscle. Trigger points are defined as hyperirritable spots associated with a hypersensitive palpable nodule in a taut band. Pain arising from trigger points is aggravated by specific movements and alleviated by certain positions. Pain will be aggravated by pressure on the trigger point (e.g. pain related to sexual intercourse) and sustained or repeated contractions (e.g. pain related to voiding or defecation). On physical examination, trigger points can be palpated and compression will give local and referred pain. In patients with CPP, trigger points are often found in muscles related to the pelvis, such as the abdominal, gluteal and piriformis muscles.

Treatment of pelvic floor overactivity should be considered in CPP. Specialised physiotherapy can improve pelvic floor muscle function and co-ordination.

Psychological factors in CPP

Psychological factors affect the development and maintenance of persistent pelvic pain, adjustment to pain, and treatment outcome. Pain causes distress and the loss of valued activities. Patients also worry about damage, disease, and prolonged suffering. There is strong evidence for the involvement of cognitive and emotional processes in pain processing. There is no evidence base for the alternative, widespread model of somatisation/somatoform pain disorder. An absence of significant physical signs is not evidence for substantial psychological causation.

In women, anxiety, depression and sexual problems are common in CPP and should be assessed and treated. A history of sexual or physical abuse is fairly common, but this is a finding in other disorders and a causal link is unlikely. In men, depression is associated with urological symptoms and anxiety and depression may lead to withdrawal from normal activities; sexual problems are likely.

Psychological assessment (Table 8) is much easier if the clinician is able to liaise with a psychologist or equivalent expert. Asking direct questions about what the patient thinks is wrong or worrying him or her is more helpful than using an anxiety questionnaire. A patient who admits a depressed mood and attributes it to pain may respond to a psychologically based pain management. Disclosure of childhood physi-

cal and sexual abuse does not affect management of the pain. Any disclosure of current physical or sexual abuse should be referred immediately to the appropriate services. All treatment should be evaluated for its impact on quality of life. There are few psychological treatment studies. Female pelvic pain shows a significant rate of spontaneous symptom remission. Using both physical and psychosocial treatments is likely to produce the best results for both men and women (Table 9).

Table 8: Psychological factors in the assessment of CPP

Assessment	LE	GR	Comment
Anxiety about cause of pain:' ask, 'Are you worried about what might be causing your pain?'	1a	C	Studies of women only: men's anxieties not studied
Depression attributed to pain: ask, 'How has the pain affected your life?'; 'How does the pain make you feel emotionally?'	1a	C	Studies of women only: men's anxieties not studied
Multiple physical symptoms/general health	1a	C	
History of sexual or physical abuse	1a	C	Current/recent abuse may be more important

LE = level of evidence; GR = grade of recommendation.

Table 9: Physical and psychological treatment in the management of CPP

Treatment	LE	GR	Comment
Tension-reduction; relaxation, for pain reduction	1b	A	Relaxation +/- biofeedback +/- physical therapy; mainly male pelvic pain
Multidisciplinary pain management for well-being	(1a)	(A)	Pelvic pain patients treated with psychology-based pain management; few specific pelvic pain trials

LE = level of evidence; GR = grade of recommendation.

General treatment of CPP

There is little evidence for use of analgesics and co-analgesics in CPP. The recommendations provided here are derived from the literature on general chronic pain on the basis that CPP is probably modulated by mechanisms similar to those of somatic, visceral and neuropathic pain. Table 10 summarises general treatment.

Simple analgesics

Paracetamol is well tolerated with few side-effects. It can be an alternative to, or given with, NSAIDs. There is very little evidence, however, for the use of NSAIDs in CPP. Most analgesic studies have investigated dysmenorrhoea, in which NSAIDs were superior to placebo and possibly paracetamol.

Neuropathic analgesics and tricyclic antidepressants

If nerve injury or central sensitisation is possible, consider the algorithm in Fig. 3. Tricyclics are effective for neuropathic pain. There is limited evidence for selective serotonin reuptake inhibitors and insufficient evidence for other antidepressants.

Anticonvulsants

Anticonvulsants have been used in pain management for many years. They may be helpful in pain that may be neuropathic or in central sensitisation. Gabapentin is licensed in some countries for chronic neuropathic pain. Gabapentin has fewer serious side-effects compared to older anticonvulsants. Anticonvulsants have no place in acute pain.

Opioids

Opioid use in urogenital pain is poorly defined. Their use in neuropathic pain is unclear, although a meta-analysis suggests clinically important benefits.

Fig. 3: Guidelines for neuropathic analgesics

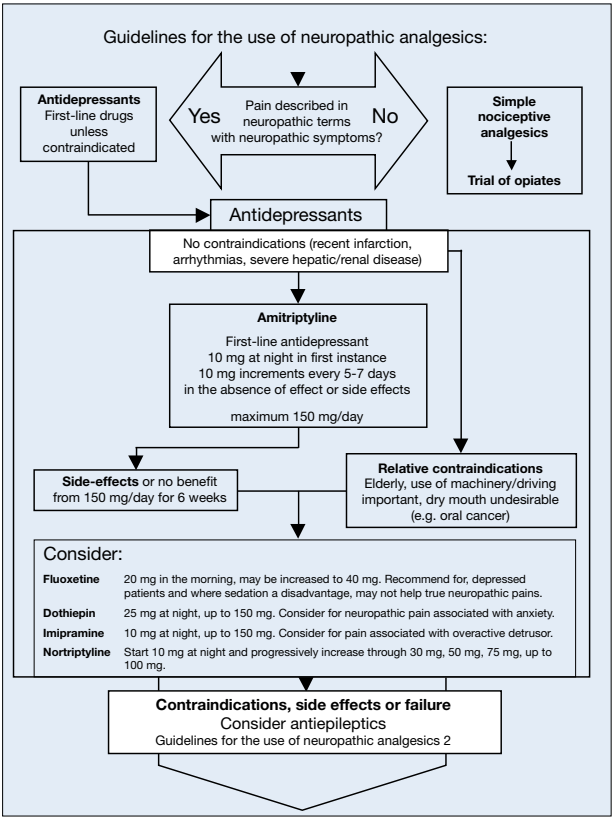


Table 10: Pharmacological treatment of CPP

Drug	Type of pain	LE	GR	Comment
Paracetamol	Somatic pain	1b	A	Benefit is limited and based on arthritic pain
COX2 antagonists		1b	A	Avoid in patients with cardiovascular risk factors
NSAIDs	Dysmenor-rhoea	1a	B	Better than placebo but unable to distinguish between different NSAIDs
Tricyclic antidepressants	Neuropathic pain	1a	A	
	Pelvic pain	3	C	Evidence suggests pelvic pain is similar to neuropathic pain
Anticonvulsants Gabapentin	Neuropathic pain	1a	A	
Opioids	Chronic non-malignant pain	1a	A	Limited long-term data; should only be used by clinicians experienced in their use
	Neuropathic pain	1a	A	Benefit is probably clinically significant. Caution with use, as above

LE = level of evidence; GR = grade of recommendation; COX = cyclo-oxygenase; NSAID = non-steroidal anti-inflammatory drug.

Nerve blocks

Neural blockade is usually carried out for diagnosis and/or management by a consultant in pain medicine with an anaesthetic background. Diagnostic blocks can be difficult to interpret because of the many mechanisms by which a block may act. All nerve blocks should be performed as safely as possible, using skilled support staff and monitoring and resuscitation equipment. The correct equipment must be used for the procedure, especially the correct block needles, nerve location devices and choice of imaging (i.e. X-ray image intensifier, ultrasound or computerised tomography).

Suprapubic transcutaneous electrical nerve stimulation (TENS)

In the largest study of suprapubic TENS in 60 patients (33 with classic IC, 27 with non-ulcer disease), 54% of patients with classic IC were helped by TENS. Less favourable results were obtained in non-ulcer IC. It is difficult to assess the efficacy of TENS in BPS/IC with accuracy. Controlled studies are difficult to design because high-intensity stimulation is being given at specific sites over a very long period of time.

Sacral neuromodulation in pelvic pain syndromes

Neuropathic pain and complex regional pain syndromes have been treated successfully with neurostimulation of dorsal columns and peripheral nerves. Neuromodulation may have a role in CPP.

Summary

Chronic pelvic pain encompasses a large number of clinical presentations and conditions. The aetiology and pathogenesis

is often obscure. Successful management requires a detailed history, careful physical examination supported by appropriate laboratory testing and a cautious attitude to treatment, moving from less harmful treatment to more invasive procedures according to established algorithms, contemplating surgery only when all other options have failed.

This short booklet text is based on the more comprehensive EAU guidelines (ISBN 978-90-79754-70-0), available to all members of the European Association of Urology at their website - http://www.uroweb.org/guidelines/online-guidelines/.