EAU GUIDELINES ON CHRONIC PELVIC PAIN

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Introduction

The EAU Guideline for Chronic Pelvic Pain plays an important role in the process of consolidation and improvement of care for patients with abdominal and pelvic pain. From both literature and daily practice it has become clear that abdominal and pelvic pain are areas still under development. The EAU Guideline aims to expand the awareness of caregivers in the field of abdominal and pelvic pain, and to assist those who treat patients with abdominal and pelvic pain in their daily practice. The guideline is a useful instrument not only for urologists, but also for gynaecologists, surgeons, physiotherapists, psychologists and pain doctors.

This pocket version aims to synthesise the important clinical messages described in the full text and is presented as a series of 'graded action based recommendations', which follow the standard for levels of evidence used by the EAU (see Introduction chapter of the EAU Guidelines book ISBN 978-90-79754-98-4).

Chronic pelvic pain syndromes

Classification

Much debate over the classification of chronic pelvic pain (CPP) has occurred, is ongoing and will continue in the future. Classification involves three aspects of defining a condition: phenotyping, terminology and taxonomy.

Definition of CPP

Chronic pelvic pain is chronic or persistent pain perceived* in structures related to the pelvis of either men or women. It is often associated with negative cognitive, behavioural, sexual and emotional consequences as well as with symptoms suggestive of lower urinary tract, sexual, bowel, pelvic floor or gynaecological dysfunction.
(*Perceived indicates that the patient and clinician, to the best of their ability from the history, examination and investigations (where appropriate) has localised the pain as being perceived in the specified anatomical pelvic area.)

Definition of CPPS

Chronic pelvic pain syndrome is the occurrence of CPP when there is no proven infection or other obvious local pathology that may account for the pain. It is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. CPPS is a subdivision of CPP.

Table 1: Classification of chronic pelvic pain syndromes

Axis I Region		Axis II System	Axis III End-organ as pain syndrome as identified from Hx, Ex and Ix	
Chronic pelvic pain	Specific disease associated pelvic pain OR Pelvic pain syndrome	Urological	Prostate	
			Bladder	
			Scrotal Testicular Epididymal	
			Penile Urethral	
			Postvasectomy	
		Gynaecological	Vulvar Vestibular Clitoral	
			Endometriosis associated	
			CPPS with cyclical exacerbations	
			Dysmenorrhoea	
		Gastrointestinal	Irritable bowel	
			Chronic anal	
			Intermittent chronic anal	
		Peripheral nerves	Pudendal pain syndrome	
		Sexological	Dyspareunia	
			Pelvic pain with sexual dysfunction	
		Psychological	Any pelvic organ	
		Musculo-skeletal	Pelvic floor muscle Abdominal muscle Spinal	
			Coccyx	

Hx = History; Ex= Examination; Ix = Investigation; PTSD = post-traumatic stress disorder.

	Axis IV Referral character-istics	Axis V Temporal characteristics	Axis VI Character	Axis VII Associated symptoms	Axis VIII Psychological symptoms
	Suprapubic Inguinal Urethral Penile/clitoral Perineal Rectal Back Buttocks Thighs	ONSET Acute Chronic ONGOING Sporadic Cyclical Continuous TIME Filling Emptying Immediate post Late post TRIGGER Provoked Spontaneous	Aching Burning Stabbing Electric	UROLOGICAL Frequency Nocturia Hesitance Dysfunctional flow Urge Incontinence GYNAECOLOGICAL Menstrual Menopause GASTROINTESTINAL Constipation Diarrhoea Bloatedness Urge Incontinence NEUROLOGICAL Dysaesthesia Hyperaesthesia Allodynia Hyperalegesie SEXOLOGICAL Satisfaction Female dyspareunia Sexual avoidance Erectile dysfunction Medication MUSCLE Function impairment Fasciculation CUTANEOUS Trophic changes Sensory changes	ANXIETY About pain or putative cause of pain Catastrophic thinking about pain DEPRESSION Attributed to pain or impact of pain Attributed to other causes Unattributed PTSD SYMPTOMS Re-experiencing Avoidance

Table 2: Urological pain syndromes

Urological Pain Syndromes	
Abdominal and Pelvic Pain Syndromes	
Prostate pain syndrome	PPS is the occurrence of persistent or recurrent episodic pain (which is convincingly reproduced by prostate palpation). There is no proven infection or other obvious local pathology. PPS is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction. The term "chronic prostatitis" continues to be equated with that of PPS. In the authors' and others' opinion, this is an inappropriate term, although it is recognised that it has a long history of use. The National Institutes of Health (NIH) consensus includes infection (types I and II), which the authors feel should not be considered under PPS, but as specific disease-associated pelvic pain.
Bladder pain syndrome	BPS is the occurrence of persistent or recurrent pain perceived in the urinary bladder region, accompanied by at least one other symptom, such as pain worsening with bladder filling and day-time and/or night-time urinary frequency. There is no proven infection or other obvious local pathology. BPS is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction. BPS is believed to represent a heterogeneous spectrum of disorders. There may be specific types of inflammation as a feature in subsets of patients. Localisation of the pain can be difficult by examination, and consequently, another localising symptom is required. Cystoscopy with hydrodistension and biopsy may be indicated to define phenotypes.

Scrotal pain syndrome	Scrotal pain syndrome is the occurrence of persistent or recurrent episodic pain localised within the organs of the scrotum, and may be associated with symptoms suggestive of urinary tract or sexual dysfunction. There is no proven infection or other obvious local pathology. Scrotal pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction. Scrotal pain syndrome is a generic term and is used when the site of the pain is not clearly testicular or epididymal. The pain is not in the skin of the scrotum as such, but perceived within its contents, in a similar way to idiopathic chest pain.
Testicular pain syndrome	Testicular pain syndrome is the occurrence of persistent or recurrent episodic pain perceived in the testes, and may be associated with symptoms suggestive of urinary tract or sexual dysfunction. There is no proven infection or other obvious local pathology. Testicular pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction.
Epididymal pain syndrome	Epididymal pain syndrome is the occurrence of persistent or recurrent episodic pain perceived in the epididymis, and may be associated with symptoms suggestive of urinary tract or sexual dysfunction. There is no proven infection or other obvious local pathology. Epididymal pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction.
Penile pain syndrome	Penile pain syndrome is the occurrence of pain within the penis that is not primarily in the urethra, in the absence of proven infection or other obvious local pathology. Penile pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction.

Urethral pain syndrome	Urethral pain syndrome is the occurrence of chronic or recurrent episodic pain perceived in the urethra, in the absence of proven infection or other obvious local pathology. Urethral pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. Urethral pain syndrome may occur in men and women.
Postvasectomy scrotal pain syndrome	Postvasectomy scrotal pain syndrome is a scrotal pain syndrome that follows vasectomy. Postvasectomy scrotal pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction. Postvasectomy pain may be as frequent as 1% following vasectomy, possibly more frequent. The mechanisms are poorly understood and it is for that reason considered a special form of scrotal pain syndrome.
Gynaecological Pain Syndromes: external genitalia	
Vulvar pain syndrome	Vulvar pain syndrome is the occurrence of persistent or recurrent episodic vulvar pain. There is no proven infection or other local obvious pathology. It is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. Although pain perceived in the vulva was subsumed under sexual disorders in the DSM-IV-R manual for classifying psychiatric disorders, there is no scientific basis for this classification, and pain perceived in the vulva is best understood as a pain problem that usually has psychological consequences.

	There is no evidence for its classification as a psychiatric disorder. The International Society for the Study of Vulvovaginal Disease (ISSVD) has used the term vulvodynia, where we use the term vulvar pain syndrome. According to the ISSVD, vulvodynia is vulvar pain that is not accounted for by any physical findings. The ISSVD has defined vulvodynia as "vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder". If physical findings are present, the patient is said to have vulvar pain due to a specified cause. The ISSVD has subdivided vulvodynia based on pain location and temporal characteristics of the pain (e.g.,provoked or unprovoked). The following definitions are based on that approach.
Generalised vulvar pain syndrome	Generalised vulvar pain syndrome refers to a vulvar pain syndrome in which the pain/burning cannot be consistently and precisely localised by point-pressure mapping via probing with a cotton-tipped applicator or similar instrument. Rather, the pain is diffuse and affects all parts of the vulva. The vulvar vestibule (the part that lies between the labia minora into which the urethral meatus and vaginal introitus open) may be involved but the discomfort is not limited to the vestibule. This pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences.
Localised vulvar pain syndrome	Localised vulvar pain syndrome refers to pain that can be consistently and precisely localised by point-pressure mapping to one or more portions of the vulva. Clinically, the pain usually occurs as a result of provocation (touch, pressure or friction). Localised vulvar pain syndrome can be subdivided into vestibular pain syndrome and clitoral pain syndrome.
Vestibular pain syndrome	Vestibular pain syndrome refers to pain that can be localised by point-pressure mapping to the vestibule or is well perceived in the area of the vestibule.
Clitoral pain syndrome	Clitoral pain syndrome refers to pain that can be localised by point-pressure mapping to the clitoris or is well perceived in the area of the clitoris.

Gynaecological system: internal pelvic pain syndromes	
Endometriosis-associated pain syndrome	Endometriosis-associated pain syndrome is chronic or recurrent pelvic pain in patients with laparoscopically confirmed endometriosis, and the term is used when the symptoms persist despite adequate endometriosis treatment. It is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. Many patients have pain above and beyond the endometriotic lesions; this term is used to cover that group of patients. Endometriosis may be an incidental finding, is not always painful, and the degree of disease seen laparoscopically does not correlate with severity of symptoms. As with other patients, they often have more than one end-organ involved.
CPPS with cyclical exacerbations	CPPS with cyclical exacerbations covers the non-gynaecological organ pain that frequently shows cyclical exacerbations (e.g., IBS or BPS) as well as pain similar to that associated with endometriosis/adenomyosis but where no pathology is identified. This condition is different from dysmenorrhoea, in which pain is only present with menstruation.
Dysmenorrhoea	Dysmenorrhoea is pain with menstruation that is not associated with well-defined pathology. Dysmenorrhoea needs to be considered as a chronic pain syndrome if it is persistent and associated with negative cognitive, behavioural, sexual or emotional consequences.
Gastrointestinal Pelvic Pain Syndromes	
Irritable bowel syndrome	IBS is the occurrence of chronic or recurrent episodic pain perceived in the bowel, in the absence of proven infection or other obvious local pathology. Bowel dysfunction is frequent. IBS is often associated with worry and preoccupation about bowel function, and negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract or gynaecological dysfunction.

	The above classification is based upon the Rome III Criteria: 3 months of continuous or recurring symptoms of abdominal pain or irritation that may be relieved with a bowel movement, may be coupled with a change in frequency, or may be related to a change in stool consistency. Two or more of the following are present at least 25% of the time: change in stool frequency (> 3 bowel movements per day or < 3 per week); noticeable difference in stool form (hard, loose, watery or poorly formed stools); passage of mucus in stools; bloating or feeling of abdominal distension; or altered stool passage (e.g., sensation of incomplete evacuation, straining, or urgency). Extra-intestinal symptoms include: nausea, fatigue, full sensation after even a small meal, and vomiting.
Chronic anal pain syndrome	Chronic anal pain syndrome is the occurrence of chronic or recurrent episodic pain perceived in the anus, in the absence of proven infection or other obvious local pathology. Chronic anal pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction.
Intermittent chronic anal pain syndrome	Intermittent chronic anal pain syndrome refers to severe, brief, episodic pain that seems to arise in the rectum or anal canal and occurs at irregular intervals. This is unrelated to the need to or the process of defecation. It may be considered a subgroup of the chronic anal pain syndromes.
Musculoskeletal System	
Pelvic floor muscle pain syndrome	Pelvic floor muscle pain syndrome is the occurrence of persistent or recurrent episodic pelvic floor pain. There is no proven well-defined local pathology. It is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. This syndrome may be associated with overactivity of or trigger points within the pelvic floor muscles. Trigger points may also be found in several muscles, such as the abdominal, thigh and paraspinal muscles and even those not directly related to the pelvis.

Coccyx pain syndrome	Coccyx pain syndrome is the occurrence of chronic or recurrent episodic pain perceived in the region of the coccyx, in the absence of proven infection or other obvious local pathology. Coccyx pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction.

Epidemiology, Aetiology and Pathophysiology

Chronic visceral pain, pelvic pain and abdominal aspects of pelvic pain

Recommendations: Chronic Pelvic Pain (CPP) and mechanisms	**GR**
All of those involved in the management of CPP should have knowledge of peripheral and central pain mechanisms.	A
The early assessment of patients with CPP should involve: • investigations aimed at specific disease-associated pelvic pain • assessment of functional, emotional, behavioural, sexual and other quality of life issues, such as effect on work and socialisation.	A
CPPS patients should be managed in a multispecialty and multidisciplinary environment with consideration of all their symptoms.	A

Diagnostic Evaluation

History and physical examination

History is very important for the evaluation of patients with CPP. Pain syndromes are symptomatic diagnoses, which are derived from a history of pain perceived in the region of the pelvis, and absence of other pathology, for a minimum of three

out of the past six months. This implies that specific disease-associated pelvic pain caused by bacterial infection, cancer, primary anatomical or functional disease of the pelvic organs, and neurogenic disease must be ruled out. The clinical examination often serves to confirm or refute the initial impressions gained from a good history. The examination should be aimed at specific questions where the outcome of the examination may change management. As well as a local examination, a general musculoskeletal and neurological examination should be considered an integral part of the assessment and be undertaken, if appropriate.

Figure 1: Diagnosing chronic pelvic pain

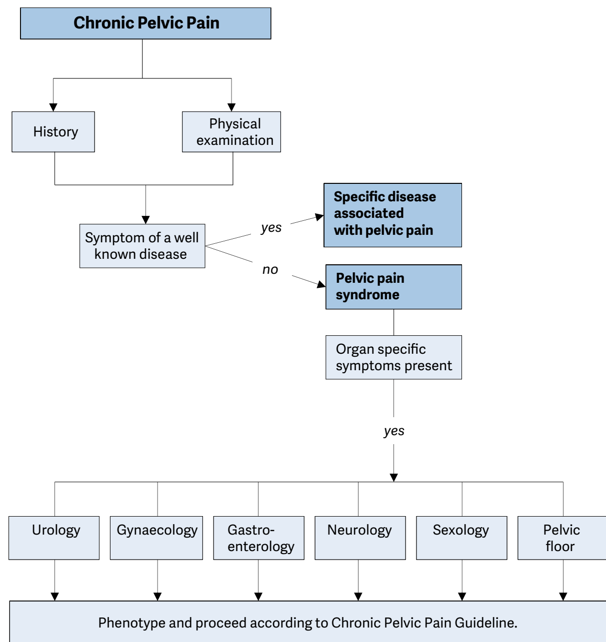

Figure 2: Phenotyping of pelvic pain

Phenotyping	Assessment
Urology	Urinary flow, micturition diary, cystoscopy, ultrasound, uroflowmetry,
Psychology	Anxiety about pain, depression and loss of function, history of negative sexual experiences
Organ specific	Ask for gynaecological, gastro-intestinal, ano-rectal, sexological complaints Gynaecological examination, rectal examination
Infection	Semen culture and urine culture, vaginal swab, stool culture
Neurological	Ask for neurological complaints (sensory loss, dysaesthesia). Neurological testing during physical examination: sensory problems, sacral reflexes and muscular function.
Tender muscle	Palpation of the pelvic floor muscles, the abdominal muscles and the gluteal muscles

Recommendations for diagnostic evaluation

Recommendations for the management of prostate pain syndrome (PPS)	GR
Adapt diagnostic procedures to the patient. Specific diseases with similar symptoms must be excluded.	A
Use a validated symptom and quality of life (QoL) scoring instrument, such as the NIH-CPSI, for initial assessment and follow-up.	B
Assess prostate pain syndrome associated negative cognitive, behavioural, sexual, or emotional consequences, as well as symptoms of lower urinary tract and sexual dysfunctions.	B

CPSI = Chronic Prostatitis Symptom Index.

Recommendations for the management of bladder pain syndrome (BPS)	**GR**
Patients with bladder pain should undergo general anaesthetic rigid cystoscopy in accordance with ESSIC guidelines	A
After primary exclusion of specific diseases, patients with symptoms according to the above definition should be diagnosed with BPS by subtype and phenotype.	A
Assess BPS associated non-bladder diseases systematically.	A
Assess BPS associated negative cognitive, behavioural, sexual, or emotional consequences.	A
Use a validated symptom and quality of life (QoL) scoring instrument for initial assessment and follow-up.	B

ESSIC = International Society for the Study of BPS.

Recommendations for the management of gynaecological aspects of CPP	**GR**
All women with pelvic pain should have a full gynaecological history and evaluation, including laparoscopy is recommended to rule out a treatable cause (e.g. endometriosis).	A

Recommendations for the management of anorectal pain syndrome	**GR**
Functional testing is recommended in patients with anorectal pain.	A

Recommendations for the management of pudendal neuralgia	**GR**
Rule out confusable diseases.	A
If a peripheral nerve pain syndrome is suspected, early referral should occur to an expert in the field, working within a multidisciplinary team environment.	B
Imaging and neurophysiology helps diagnosis but image and nerve locator guided local anaesthetic injection is preferable.	B

Recommendations for the management of sexological aspects in CPP	**GR**
Patients presenting with symptoms suggestive for chronic pelvic pain syndrome, should be screened for abuse, without suggesting a causal relation with the pain.	B
The biopsychosocial model should be applied in the evaluation of the effect of chronic pelvic pain syndrome on the sexual function of the patient.	B
The biopsychosocial model should be incorporated in research in the role of chronic pelvic pain in sexual dysfunction.	B

Recommendations for the management of psychological aspects of CPP	**GR**
Psychological distress is common in pelvic pain in women, but should be interpreted in the context of pain.	A
Ask the patient what they think is the cause of their pain to allow the opportunity to inform and reassure as appropriate.	B

Recommendations for the management of pelvic floor function	**GR**
Use ICS classification on pelvic floor muscle function and dysfunction.	A
In patients with chronic pelvic pain syndrome it is recommended to actively look for the presence of myofascial trigger points.	B

ICS = International Continence Society.

Management

The philosophy for the management of chronic pelvic pain is based on a biopsychosocial model. This is a holistic approach with the patients' active involvement. Single interventions rarely work in isolation and need to be considered within a broader personalised management strategy. The management strategy may well have elements of self-management. Pharmacological and non-pharmacological interventions should be considered with a clear understanding of the potential outcomes and end points. These may well include: psychology, physiotherapy, drugs and more invasive interventions. Providing information that is personalised and responsive to the patient's problems, conveying belief and concern, is a powerful way to allay anxiety. Additional written information or direction to reliable sources is useful; practitioners tend to rely on locally produced material or pharmaceutical products of variable quality while endorsing the need for independent materials for patients.

Recommendations for the management of PPS	**GR**
Offer multimodal and phenotypically directed treatment options for PPS.	A
Single use of antimicrobial therapy (quinolones or tetracyclines) is recommended in treatment-naïve patients over a minimum of 6 weeks with a duration of PPS < 1 year.	A
Alpha-blockers are recommended for patients with a duration of PPS < 1 year.	A
High-dose pentosan polysulphate is recommended in PPS.	A
NSAIDs are recommended for use in PPS, but long-term side-effects have to be considered.	B
For PPS with significant psychological distress, psychological treatment focused on PPS is recommended.	B

NSAIDs = Non-steroidal anti-inflamatory drugs.

Recommendations for the management of BPS	**GR**
Offer subtype and phenotype-oriented therapy for the treatment of BPS.	A
Multimodal behavioural, physical and psychological techniques should always be considered alongside oral or invasive treatments of BPS.	A
Administer amitriptyline for use in BPS.	A
Offer oral pentosanpolysulphate sodium for the treatment of BPS.	A
Treatment with oral pentosanpolysulphate sodium plus subcutaneous heparin is recommended especially in low responders to pentosanpolysulphate sodium alone.	A
Administer intravesical lidocaine plus sodium bicarbonate prior to more invasive methods.	A
Administer intravesical pentosanpolysulphate sodium before more invasive treatment alone or combined with oral pentosanpolysulphate sodium.	A
Administer submucosal injection of BTX-A plus hydrodistension if intravesical instillation therapies have failed.	A
All ablative organ surgery should be the last resort for experienced and BPS knowledgeable surgeons only.	A
Offer intravesical hyaluronic acid before more invasive measures.	B
Offer intravesical chondroitin sulphate before more invasive measures.	B
Offer transurethral resection (or coagulation or laser) of bladder lesions, but in BPS type 3 C only.	B
Offer neuromodulation before more invasive interventions.	B
Offer dietary advice.	C

Offer intravesical heparin before more invasive measures alone or in combination treatment.	C
Offer intravesical bladder wall and trigonal injection of BTX-A if intravesical instillation therapies have failed.	C
Corticosteroids are not recommended for long-term treatment.	C
Bladder distension is not recommended as a treatment of BPS.	C

BCG = Bacillus Calmette Guérin.

Recommendations for the management of scrotal pain syndrome	**GR**
Start with general treatment options for chronic pelvic pain.	A
Inform about the risk of postvasectomy pain when counselling patients planned for vasectomy.	A
To reduce the risk of scrotal pain, open instead of laparoscopic inguinal hernia repair is recommended.	A
It is recommended that during inguinal hernia repair all the nerves in the spermatic cord are identified.	A
For patients who are treated surgically, microsurgical denervation of the spermatic cord is recommended.	A
We recommend that orchiectomy should not be done, unless all other therapies, including pain management assessment, have failed.	C

Recommendations for the management of urethral pain syndrome	**GR**
Start with general treatment options for chronic pelvic pain.	A
It is recommended that patients with urethral pain syndrome are treated in a multidisciplinary and multimodal programme.	B
When patients are distressed, it is recommended to refer them for pain-relevant psychological treatment to improve function and quality of life.	B

Recommendations for the management of gynaecological aspects of CPP	**GR**
Provide therapeutic options such as hormonal therapy or surgery in well-defined disease states.	B
Provide a multidisciplinary approach to pain management in persistent disease states.	B

Recommendations for the management of functional anorectal pain	**GR**
Biofeedback treatment is recommended in patients with pelvic pain and dyssynergic defecation.	A
Offer botulinum toxin A and electrogalvanic stimulation in the chronic anal pain syndrome.	B
Offer percutaneous tibial nerve stimulation in the chronic anal pain syndrome.	B
Offer sacral neuromodulation in the chronic anal pain syndrome.	C
Offer inhaled salbutamol in the intermittent chronic anal pain syndrome.	C

Recommendations for the management of pudendal neuralgia	**GR**
Neuropathic pain guidelines are well established. Standard approaches to management of neuropathic pain should be utilised.	A

Recommendations for the management of sexological aspects in CPP	**GR**
Offer behavioural strategies to the patient and his/her partner to cope with sexual dysfunctions.	B
Training of the pelvic floor muscles is recommended to improve quality of life and sexual function.	B

Recommendations for the management of pelvic floor functions	**GR**
Apply pelvic floor muscle treatment as first line treatment in patients with chronic pelvic pain syndrome.	A
In patients with an overactive pelvic floor, biofeedback is recommended as therapy adjuvant to muscle exercises.	A
When myofascial trigger points are found, treatment by pressure or needling is recommended.	A

Recommendations for the management of chronic/ non-acute urogenital pain by opioids	**GR**
All other reasonable treatments must have been tried and failed.	A
The decision to instigate long-term opioid therapy should be made by an appropriately trained specialist in consultation with another physician (including the patient and their family doctor).	A
Where there is a history or suspicion of drug abuse, a psychiatrist or psychologist with an interest in pain management and drug addiction should be involved.	A

This short booklet is based on the more comprehensive EAU Guidelines (ISBN 978-90-79754-98-4), available to all members of the European Association of Urology at their website, http://www.uroweb.org