Chronic Pelvic Pain

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Objectives

- Define chronic pelvic pain
- Identify the prevalence and common etiologies of chronic pelvic pain
- Describe the symptoms & physical exam findings associated with chronic pelvic pain
- Discuss the steps in the evaluation & management options for chronic pelvic pain
- Discuss the psychosocial issues associated with chronic pelvic pain

Definition

Chronic Pelvic Pain (CPP) is non-cyclical pain in the pelvis lasting 6 months or more, severe enough to cause functional disability or require medical attention; pain located below the umbilicus in the region of the anterior abdominal wall, lumbosacral back or buttocks

- ACOG

Chronic Pelvic Pain (CPP)

- Difficult to diagnose
- Difficult to treat
- Difficult to cure

Frustration for patient and physician

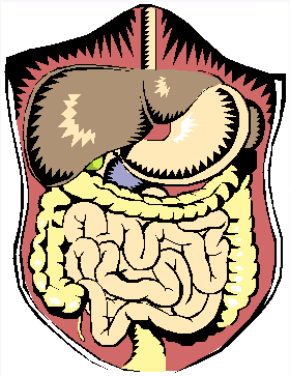
Incidence

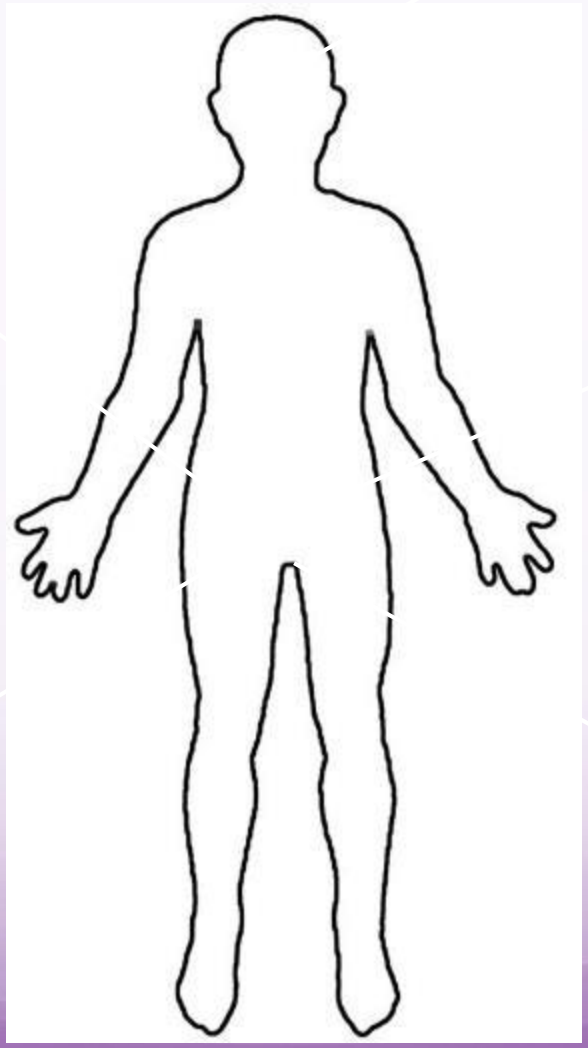
- Affects 6-25% of women of reproductive age globally
  - One study found 15% of US women
- Accounts for 20% of all laparoscopies
- Accounts for 12-16% of hysterectomies
- Medical costs of $3 billion annually

Etiology

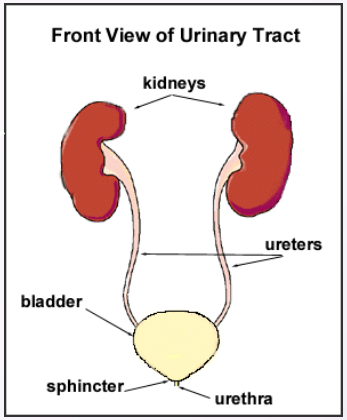
Psychological

Gastrointestinal

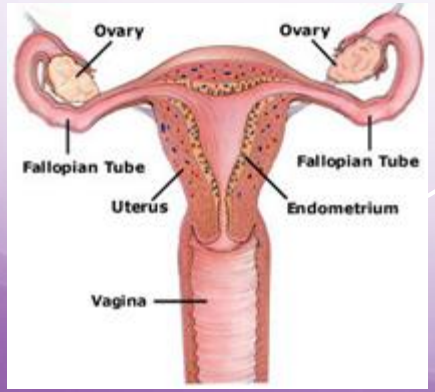




Urological



Gynecological



Musculoskeletal

Demographics

- Age, race, ethnicity, education, and SES do not differ between those with and those without
- Higher incident in single, separated or divorced women
- 40-50% of women have a history of abuse

Etiology:
UK Primary Care Database

Diagnosis Distribution	
Gastrointestinal	37.7%
Urinary	30.8%
Gynecological	20.2%

- 25-50% of women had more than one diagnosis
- Severity and consistency of pain increased with multisystem symptoms
- Most common diagnoses
  - endometriosis
  - adhesive disease
  - irritable bowel syndrome
  - interstitial cystitis

Diagnosis

A COMPLETE and DETAILED HISTORY is the key to formulating a diagnosis

Case

- JR is a 42 year old female who comes to you as a new patient. She reports years of pelvic pain that has worsened in the last 6 months.

Let’s take a history

Details of Pain

- Duration of Pain
- Nature of the Pain
  - Sharp, stabbing, throbbing, aching, dull?
- Specific Location of Pain
  - Associated with radiation to other areas?
- Modifying Factors
- Timing of the Pain
  - Intermittent or constant?
  - Temporal relationship with menses?
  - Temporal relationship with intercourse?
  - Predictable or spontaneous onset?
- Detailed medical and surgical history
  - Specifically abdominal, pelvic, back surgery

Gynecologic Review of Systems

- Associated with menses?
- Association with sexual activity? (Be specific)
- New sexual partners and/or practices?
- Symptoms of vaginal dryness or atrophy?
- Other changes with menses?
- Use of contraception?
- Detailed childbirth history?
- History of pelvic infections
- History of gyn surgeries

Gastrointestinal Review of Systems

- Regularity of bowel movements?
- Diarrhea/constipation/flatus?
- Relief with defecation?
- History of hemorrhoids/fissures/polyps?
- Blood in stool, melena, mucus?
- Nausea, emesis or change in appetite?
- Bloating?
- Weight loss?

Urological Review of Systems

- Pain with urination?
- History of frequent/recurrent UTI?
- Hematuria?
- Urgency or urinary incontinence?
- Difficulty voiding?
- History of nephrolithiasis?

Musculoskeletal Review of Systems

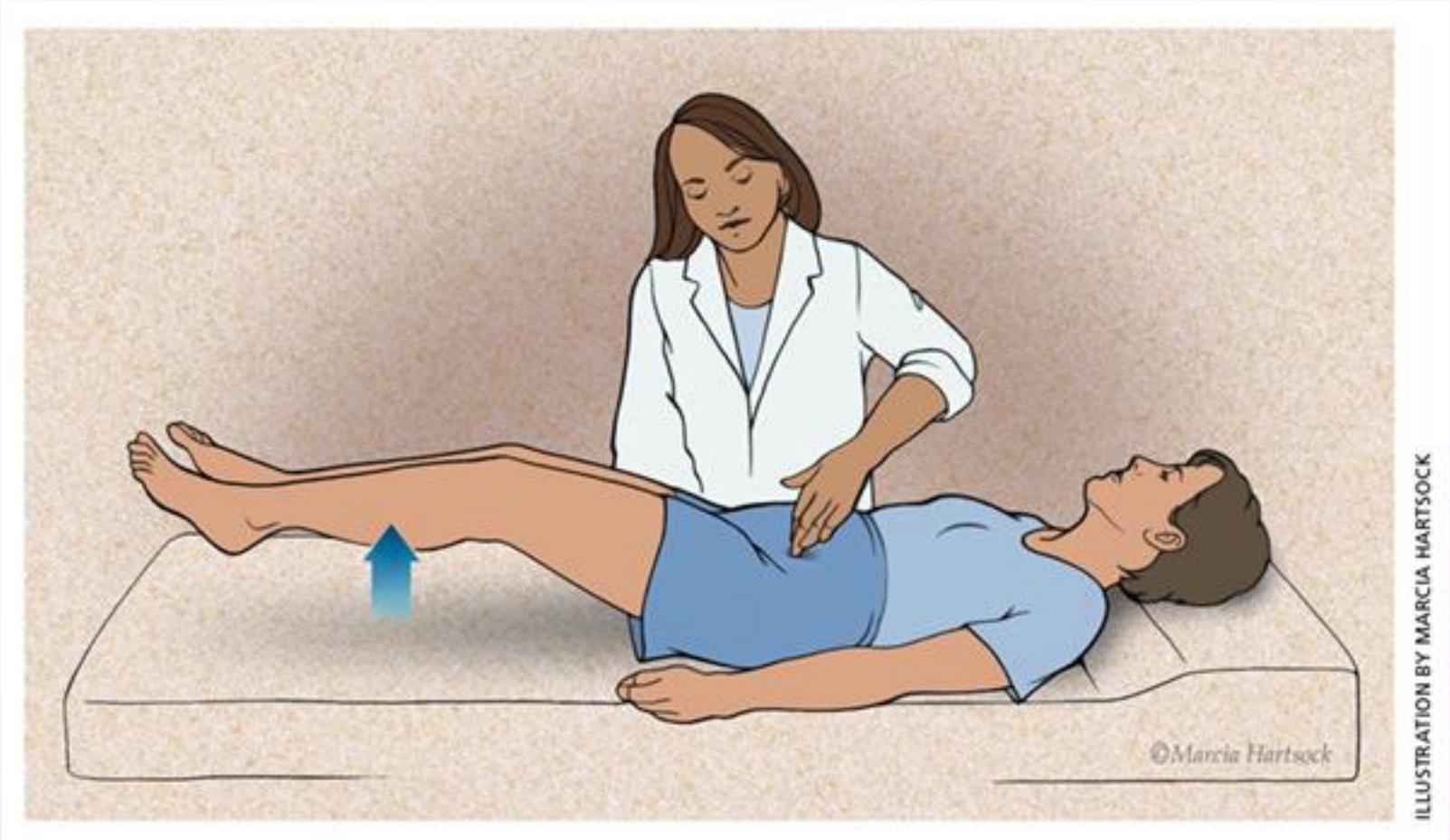
- History of trauma
- Association with back pain?
- Other chronic pain?
- Association with position or activity?
- Any abdominal wall complaints or surgery?

Psychological Review of Systems

- Current or prior psychiatric illness?
- History of verbal, physical or sexual abuse?
- Onset or exacerbation associated with life stressors?
- Familial or spousal support?

Physical Exam

- Consider evaluation of
  - Abdomen
  - Abdominal Wall
  - Pelvic floor muscles
  - Vulva
  - Vagina
  - Urethra
  - Cervix
  - Viscera – bimanual exam
  - Rectum
  - Coccyx
  - Low back



The Carnett test for patients with pelvic pain. The patient raises both legs off the table while supine. Raising only the head while in the supine position can serve the same purpose. The examiner places a finger on the painful abdominal site to determine whether the pain increases during the maneuver when the rectus abdominis muscles are contracted. The assumption is that it potentially increases myofascial pain such as trigger points, entrapped nerve, hernia, or myositis, whereas true visceral sources of pain may be less tender when abdominal muscles are tensed.

Gynecologic Conditions

- Endometriosis
- Adhesions – >90% of surgeries lead to these
- Adenomyosis – relationship unclear
- Leiomyomas – CPP in 15% vs 3% without
- PID – as many as 30% develop CPP
- Less common: malignancy, pelvic congestion

Endometriosis

- Most common gyn cause of CPP
  - Typically women age 25-35
  - Common association with infertility
  - Family history increases risk
- Presence of endometrial glands outside the uterus
- 20-80% who have surgery are dx with this
- Path severity  degree of pain
- Co-existence of other pain syndromes is higher

Endometriosis: Signs and Symptoms

History

- Dysmenorrhea
- Dyspareunia
- Infertility
- Vaginal spotting
- Painful defecation
- Pelvic heaviness
- Asymptomatic

Exam Findings

- Visible lesions on cervix or vagina
- Tender nodules in the cul-de-sac, uterosacral ligaments or rectovaginal septum
- Pain with uterine movement
- Tender adnexal masses
- Fixation (retroversion) of uterus
- Rectal mass
- Can have normal findings!

Endometriosis Treatment

- First line: NSAIDs, combined contraceptives (continuous)
  - Improve sx in 70-80%
- Second line: progestins (depo, norethindrone acetate, LNg IUD) GnRH agonists (lupron), danazol
- Others: aromatase inhibitors, surgical resection, nerve transection

Gastrointestinal Conditions

Level A

- Colon Cancer
- Constipation
- Inflammatory Bowel Disease
- Irritable Bowel Syndrome

Level B

None

Level C

- Colitis
- Chronic Intermittent Bowel Obstruction
- Diverticular Disease

Source: ACOG Practice Bulletin #51, March 2004

Irritable Bowel Syndrome

- Rome IV: Recurrent abdominal pain at least one day per week for >3 months with 2/3: related to defecation, change in stool frequency, change in stool form
- Prevalence
  - 12% of US population
  - 2W:1M
  - Peak ages 30s-40s
  - Associated with chronic fatigue syndrome, GERD, MDD, GAD
  - Symptoms of IBS in 50-80% with CPP
- Symptoms
  - Cramping with variable intensity and periodic exacerbations
  - Generally improvement with defecation
  - Mucus (50%)
  - Not IBS: nocturnal diarrhea, bloody stools, greasy stools

Irritable Bowel Syndrome

- Treatment
  - Dietary changes
    - Avoid gas-producing foods (beans, onoins, raisins, bananas, etc)
    - Lactose avoidance if intolerance
    - Low FODMAP
    - For some, gluten avoidance
    - Consider fiber
  - Increase exercise
  - Medications
    - Bowel function: PEG, anti-diarrheals
    - Antispasmodics
    - TCA

Urologic Conditions

Level A

- Bladder Carcinoma
- Interstitial Cystitis
- Radiation Cystitis
- Urethral Syndrome

Level B

- Detrusor Dyssynergia
- Urethral Diverticulum

Level C

- Chronic Urinary Tract Infection
- Recurrent Acute Cystitis
- Recurrent Acute Urethritis
- Stone/urolithiasis
- Urethral Caruncle

Source: ACOG Practice Bulletin #51, March 2004

Interstitial Cystitis

- IC/BPS (bladder pain syndrome) is an unpleasant sensation perceived to be related to the urinary bladder assoc with lower urinary sx for >6 weeks in absence of other identifiable causes
- More common in women
- Most common feature: increase in discomfort with filling, relief with voiding
- Exam with widespread tenderness of abd wall, hip girdle, buttocks, thighs and pelvic floor and bladder base/urethra
- UA/UC and postvoid residual to exclude others. Cystoscopy not required but can support
- Treatment isn't curative. Behavior modification needed. PT can be helpful. Medications with +/-

Musculoskeletal Conditions

Level A

- Abdominal Wall Myofascial Pain (Trigger Points)
- Chronic Back Pain
- Poor Posture
- Fibromyalgia
- Neuralgia of pelvic nerves
- Pelvic Floor Myalgia
- Peripartum Pelvic Pain Syndrome

Level B

- Herniated Disk
- Low Back Pain
- Neoplasia of spinal cord or sacral nerve

Level C

- Lumbar Spine Compression
- Degenerative Joint Disease
- Hernia
- Muscular Strains and Sprains
- Rectus Tendon Strains
- Spondylosis

Source: ACOG Practice Bulletin #51, March 2004

Pelvic Floor Dysfunction

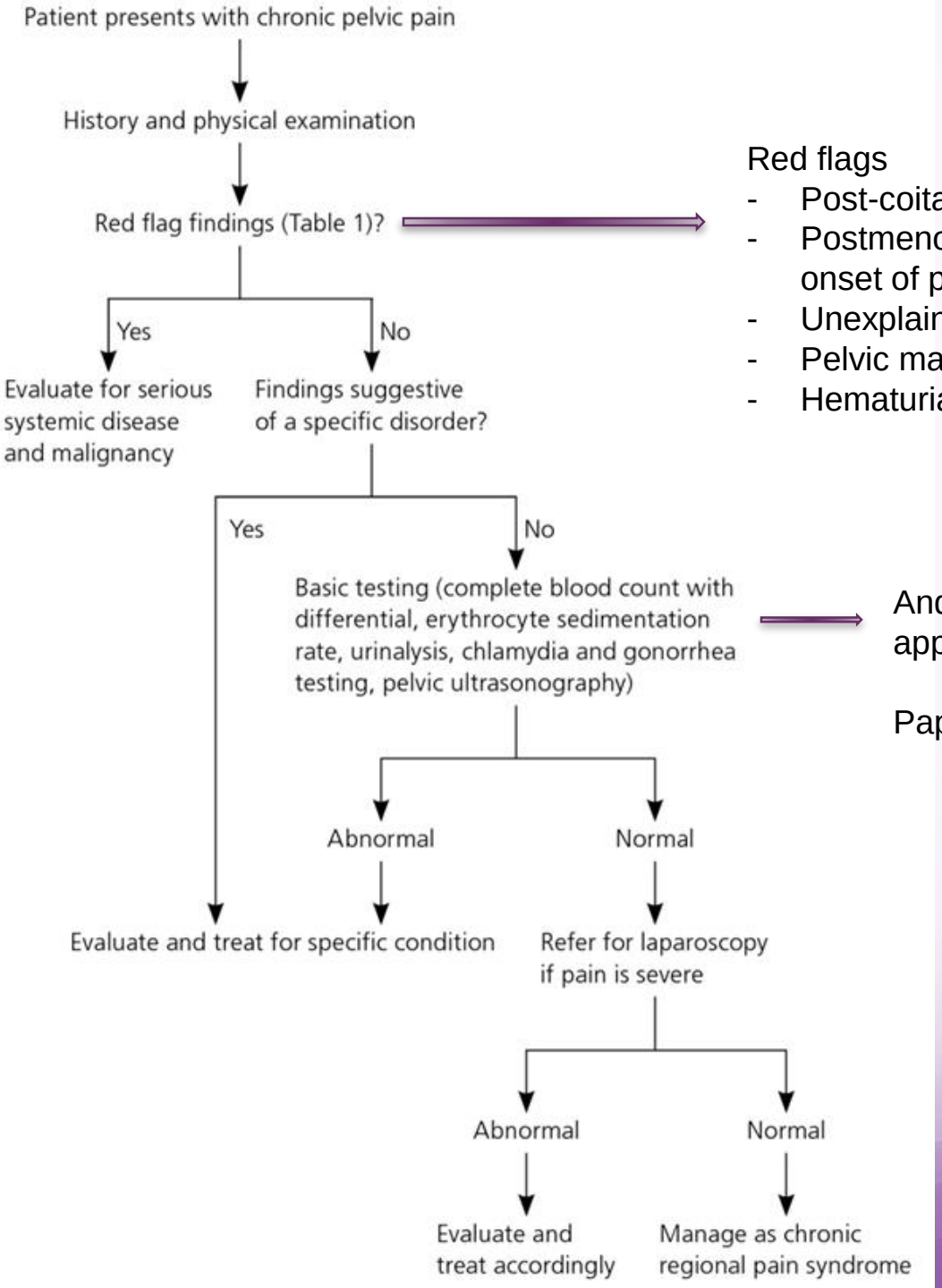
- ***Description:*** Spasm and strain of pelvic floor muscles
  - Levator Ani Muscles
  - Coccygeus Muscle
  - Piriformis Muscle

- ***Symptoms:*** Chronic pelvic pain symptoms; pain in buttocks and down back of leg, dyspareunia

- ***Treatment:*** Biofeedback, Pelvic Floor Physical Therapy, TENS (Transcutaneous Electrical Nerve Stimulation) units, antianxiolytic therapy, cooperation from sexual partner

Psychological Associations

- 40 – 50% of women with CPP have a history of abuse
- Psychosomatic factors play a prominent role in CPP
- Psychotropic medications and various modes of psychotherapy appear to be helpful as both primary and adjunct therapy for treatment of CPP– Multidisciplinary pain clinic
- Approach patient in a gentle, non-judgmental manner
  - Do not want to imply that “pain is all in her head”



Red flags

- Post-coital bleeding
- Postmenopausal bleeding or onset of pain
- Unexplained weight loss
- Pelvic mass
- Hematuria

And UPT when appropriate!

Pap smear if not UTD

Treatment

- “Curative treatment is elusive, and evidence-based therapies are limited.”
- Engage in a biopsychosocial approach
  - Behavioral therapy is an integral part of treatment
- Treat any identifiable disease process
- Pelvic floor physical therapy may be helpful
- In select cases, surgery may be appropriate
  - Hysterectomy is a last resort; improvement only in 1/2

Agent	Pain type	Comment
Acetaminophen	Somatic	Evidence based on arthritic pain
Gabapentin (Neurontin), pregabalin (Lyrica)	Neuropathic	Evidence supports use for general neuropathic pain, with low number needed to treat; limited studies on chronic pelvic pain
Gabapentin plus amitriptyline	Neuropathic	Small study in women with chronic pelvic pain showed combination was more effective than amitriptyline alone
Nonsteroidal anti-inflammatory drugs	Inflammatory	Good evidence of benefit for dysmenorrhea; Cochrane review indicates lack of effectiveness for endometriosis
Opioids	Chronic, non-malignant	Controversial for long-term use

Agent	Pain Type	Comment
Oral contraceptives, progestogens, gonadotropin-releasing hormone agonists	Cyclic	Good evidence of benefit for endometriosis; limited evidence for noncyclic pelvic pain
Selective serotonin reuptake inhibitors	Pain with underlying depression	Good evidence of benefit for depression; insufficient evidence for pain
Tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors	Neuropathic	Most evidence based on neuropathic pain; few studies specifically on chronic pelvic pain

Pearls of Chronic Pelvic Pain

- CPP requires patience, understanding and collaboration from patient and physician
- Obtaining a thorough history is key
- Diagnosis is often multifactorial
- Treatment is multifactorial