Chronic Pelvic Pain

Background
1. Definition
   o Non-cyclic pain below the umbilicus lasting > 6 mo causing functional
disability or leading to medical care
   o Excluded pain related to Pregnancy, Dysmenorrhea, dyspareunia

Pathophysiology
1. Pathology of disease
   o No diagnosis in 61% of cases
   o Top 4 diagnoses
     • Endometriosis
     • Adhesions
     • Irritable bowel syndrome
     • Interstitial cystitis
2. Prevalence
   o 4-43% of women worldwide, 15% in US, 24% in UK
   o Difficult to assess due to lack of consistent definition
3. Risk factors
   o Drug or alcohol abuse
   o Miscarriage
   o Heavy menstrual flow
   o PID
   o Previous cesarean section
   o Pelvic pathology
   o Physical or sexual abuse
   o Psychological comorbidity

Diagnostics
1. History and physical forms
   o Available at International Pelvic Pain Society
     www.pelvicpain.org/resources/handpform.aspx
2. History
   o Pain characteristics
     • Timing, quality, duration, modifying factors
   o Pain associations
     • Menses, sexual activity, urination, defecation
   o Red flags
     • Unexplained weight loss, hematochezia, postmenopausal bleeding,
       postcoital bleeding
   o Sexual, physical, substance abuse history
   o OB/GYN history
   o Pelvic infections, surgery, pelvic radiation treatment
3. Physical exam
   o Palpation for local pain, nodularity, organ mobility
     • Back
     • Abdomen
- Vulva, vagina, cervix, uterus, adnexa, pelvis
- Rectum
  - Psychiatric assessment

4. Diagnostic testing
  - Based on suspected etiology
  - Cancer screening appropriate for patient's age
  - Primary considerations (SOR:C)²
    - Pregnancy testing
    - Cervical culture and pap smear
    - Urinalysis, urine culture
    - Transvaginal ultrasound
  - Secondary considerations
    - Colonoscopy
    - Hysteroscopy
    - Laparoscopy
    - Cystoscopy
    - Referral to sub-specialist

**Differential Diagnosis**:¹

1. Gynecologic
   - Endometriosis
   - Chronic PID
   - Gynecologic malignancies
   - Pelvic congestion syndrome (pelvic varicosities)
   - Adhesions
   - Uterine fibroids
   - Adenomyosis
   - Ovarian cysts
   - Atypical dysmenorrhea or ovulatory pain
   - Intrauterine device
   - Cervical or endometrial polyps
   - Symptomatic pelvic relaxation
   - Ovarian ovulatory pain

2. Gastrointestinal
   - Irritable bowel syndrome
   - Constipation
   - Inflammatory bowel disease (Crohn's dz, ulcerative colitis)
   - Colon cancer
   - Celiac disease
   - Colitis
   - Diverticulitis
   - Chronic intermittent bowel obstruction

3. Genitourinary
   - Interstitial Cystitis
   - Bladder adenocarcinoma
   - Radiation cystitis
   - Chronic urethritis
4. Musculoskeletal
   o Chronic coccygeal or back pain
   o Fibromyalgia
   o Abdominal wall myofascial pain
   o Abdominal wall nerve entrapment
   o Faulty or poor posture (Scoliosis)
   o Neuralgia pf pelvic nerves
   o Pelvic floor myalgias
   o Peripartum pelvic pain syndrome
   o Low back pain
   o Herniated disc dz / degenerative disc dz
   o Neoplasia of spinal cord or sacral nerve
   o Spondylosis / spondylolisthesis
   o Hernias
   o Degenerative joint dz (osteoarthritis)
   o Compression fx of lombar vertebrae
   o Muscle strain/sprain
   o Rectus tendon strain

5. Psychological
   o Somatoform disorder
   o Depression
   o Bipolar disorder

Therapeutics
1. Guided by history, physical exam, diagnostics
2. If all evaluation is normal, consider
   o Empiric treatment with NSAIDs (SOR:A)¹
   o Daily progestin (high-dose) - pelvic congestion syndrome (SOR:A)¹
   o Psychotherapy (SOR:A)¹
   o Neurontin with/without amitriptyline²
     o Botulism toxin injections into pelvic floor muscles²
3. Multidisciplinary approach - physical, dietary, social, psychological (SOR:B)¹
   o Physical therapy
   o Sacral nerve stimulation
   o Abdominal trigger point injections
   o Acupuncture/pressure
   o Magnet therapy
   o Vitamin B1 or magnesium - dysmenorrhea
   o Hysterectomy
4. Anti-depressants may improve chronic pain (SOR:C)¹
5. Opioid analgesics may improve chronic pain but may not improve functional or psychological status (SOR:C)¹

Follow Up
1. Encourage regular follow-up visits vs. visits just for pain
Prognosis
1. 25% of patients may completely recover\textsuperscript{5}
2. Successful treatment facilitated by personal care, listening, explaining, reassuring and commitment to help\textsuperscript{6}

Prevention
1. Prevention, screening and treatment of chlamydia and gonococcal cervicitis may prevent the development of chronic pelvic pain

Patient Education
1. Handout from the American Academy of Family Physicians

References

Author: Deborah E. Miller, MD, Wright State University FMR, OH

Editor: Chandrika Iyer, MD, St. John FMRP, Detroit, MI