



# Global Year Against Pain in Women

## real women, real pain

### Chronic Pelvic Pain

Chronic pelvic pain (CPP) is a common, debilitating and complex condition whose etiology remains poorly understood. It can be associated with significant morbidity and loss of physical and sexual functioning

Patients are distressed by their continuing symptoms, by extensive and repeated investigations and often by the inability of the medical profession to diagnose and treat them effectively. Many patients describe frustration at their inability to get their pain taken seriously or by suggestions that the pain may be due to psychological causes.

#### Mechanisms and causes of pelvic pain

Chronic pelvic pain can be caused by gynecological conditions, such as endometriosis, adhesions, infection or rarely by tumor, and by non-gynecological causes which can be bowel-related, such as irritable bowel syndrome (IBS), or bladder-related, or musculoskeletal or neuropathic. Often the cause is obscure.

Multiple pelvic organs can be involved. For example, 30-50% women with pelvic pain have urinary frequency. IBS commonly co-exists with pelvic pain.

Three types of visceral hyperalgesia which may be relevant to the clinical presentation of patients with pelvic pain are described (1):

- 1) Visceral hyperalgesia: hyperalgesia of a viscus from inflammation and / or excess stimulation of the same viscera e.g. irritable bowel syndrome
- 2) Referred hyperalgesia from viscera: hyperalgesia of somatic tissues in the area of referred pain from viscera, e.g. trigger points in body wall tissues
- 3) Viscero-visceral hyperalgesia: hyperalgesia of a viscus rendered clinically manifest by a painful condition of another viscera e.g. exacerbation of urinary colic pain in patients with urinary calculus plus dysmenorrhea.

#### Epidemiology

- The prevalence of CPP in the community is high.
- In the USA, a 3-month period prevalence (excluding mid-cycle pain) of 15% was found in women aged 18-50 (2).
- In the UK, the annual prevalence in primary care was 38 / 1000, a rate similar to that reported for asthma or back pain (3).
- A prevalence of 25.4% was reported in New Zealand (4).
- Women complaining of chronic pelvic pain symptoms contribute to 15-20% of all consultations in the general gynecological clinic and up to 10% of all female attendances in general practice.
- Chronic pelvic pain is the indication for 10-15% of hysterectomies performed in the United States.
- Women with chronic pelvic pain were found to have undergone almost five times more surgeries and to have sought treatment for four times as many somatic conditions unrelated to chronic pelvic pain as compared with pain-free age-matched controls.

#### Evaluation of women with pelvic pain

- Consultation: Assessment of women with chronic pelvic pain requires a systematic and comprehensive approach. The assessment is a prime opportunity to establish rapport with the patient and initiates the concept that the clinician and the patient are working together to manage symptoms.
- Examination: General observation of the patient, especially of their posture, is important. Scars can be a source of pain. Abdominal wall trigger points can be identified by palpation. Vaginal examination gives the opportunity to assess the gynecological organs and the tone of the pelvic floor musculature.
- Investigation: Trans-vaginal ultrasound scanning, laparoscopy and MRI scanning are the commonest investigations performed. More than 40% of laparoscopies are performed for the diagnosis of chronic pelvic pain. This investigation is not without risk and is expensive.

### **Psychological factors:**

Psychological factors may both contribute to the experience and consequences of pelvic pain. One of the challenges is for the patient to agree that psychological factors may be important in understanding her pain condition and its management. A therapeutic relationship should be created in which the patient feels heard and understood and is able to ask questions about any concerns and beliefs that she may have.

Women with CPP may have high levels of anxiety and depression and fear serious undiagnosed disease. Sexual dysfunction and relationship distress can result. Specific interventions such as Kegel's exercises, use of graded dilators, advice on lubrication, advice on intercourse positions and sensate focus exercises can be useful.

A number of controlled studies have shown that women with chronic pelvic pain have a higher incidence of previous sexual and physical abuse (5). Questions should be asked about any previous unwanted or unpleasant sexual experiences in a supportive and open environment. If a history of sexual or physical abuse is affecting current functioning, psychotherapy may be appropriate.

### **Treatment**

Treatment has traditionally focused on identifying pathology and utilizing medical, hormonal and surgical interventions to alleviate the pain. Hormonal therapy and surgery can help some patients with pelvic pain, adenomyosis and endometriosis, but unfortunately not all. Core stability exercises and pelvic floor musculature rehabilitation can be beneficial. Drugs used for neuropathic pain have been shown to reduce pelvic pain in a small group of patients unresponsive to weak opioids (6).

As medical understanding of the complexity of CPP has advanced to incorporate the psychosocial aspects of pain, the consensus has shifted to employing a multidisciplinary approach to management acknowledging that pain involves complex interactions between psychological, neurological and physiological mechanisms (7).

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