CHRONIC PELVIC PAIN

BACKGROUND

- Chronic pelvic pain (CPP) is defined as the presence of intermittent or constant pain in the lower abdomen or pelvis for > 6 months, not associated exclusively with menstruation or intercourse and not associated with pregnancy.
- CPP is a common condition affecting approximately 1 in 6 women. It has a significant impact on the lives of women and carries a heavy social and economic burden.

CAUSES OF CHRONIC PELVIC PAIN

- There is frequently more than one component to chronic pelvic pain. Assessment should be holistic and aim to identify contributory factors rather than assign causality to a single pathology.
- Aim to identify and treat some of the contributory factors to decrease the overall pain burden, even if some aspects are left untreated or unidentified.
- Women commonly seek help for their CPP because they want to be able to understand it, even if it can't be completely cured.

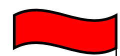
Gynaecological	Non-Gynaecological
Endometriosis	Irritable bowel syndrome (IBS)
Adenomyosis	Interstitial cystitis
Chronic PID	Musculoskeletal pain
Fibroids	Neuropathic/nerve entrapment
Pelvic organ prolapse	Lower back pain
Adhesions (prev surgery, endometriosis or infection)	Psychological – depression, anxiety, somatisation
Gynae malignancies	**Rare – hernias, retroperitoneal tumours**

HISTORY

Women should be encouraged to tell their story and made to feel they have been listened to and believed!
Discuss the multifactorial nature of CPP and encourage women to keep a pain diary over 2-3 cycles.
Full gynae history including specific questions on the following:

- Pattern of pain – menstrual association/cyclical
- Dysmenorrhoea and Dyspareunia
- Ovulation pain
- Bowel symptoms (endometriosis - dyschesia, PR bleeding during period, IBS – bloating, relief on defecation, a/w diet)
- Urinary symptoms
- Effect of movement and posture on pain
- History of sexual abuse/ domestic violence
- Psychological and social issues
- Impact of pain on work/life/sleep etc
- Ideas, concerns and expectations

RED FLAG SYMPTOMS



PR bleeding
New bowel symptoms AND >50 yrs old
New pain after menopause
Pelvic mass
Suicidal intention
Excessive weight loss
Irregular vaginal bleeding >40 yrs old
Post coital bleeding

Pain that has a strong cyclical pattern is likely to be gynaecological in origin
Classic symptoms of endometriosis/adenomyosis – CPP, dysmenorrhoea, dyspareunia

EXAMINATION AND INVESTIGATIONS

PA and PV examination:
- Examine for focal tenderness, enlargement, tethering, or prolapse
- Localised trigger points may be identified in the abdominal wall and/or pelvic floor
- Sacroiliac joints or the symphysis pubis may be tender, suggestive of musculoskeletal cause
- Endometriosis - pelvis can be tender with a fixed retroverted uterus, enlarged ovaries or tender utero-sacral ligaments
- Adenomyosis - uterus is tender and boggy to palpate

Investigations:
- **STI screening** for all women, smear opportunistically if indicated
- **Pelvic USS** to identify ovarian, adnexal and/or uterine pathology – not useful to diagnose endometriosis unless endometrioma
- **CA125** – indicated in women reporting; bloating, early satiety, pelvic pain or urinary urgency on a regular basis (>12 times per month) or in women > 50 years with new IBS symptoms
- MRI and laparoscopy (gold standard for diagnosis of endometriosis) considered by hospital gynae

TREATMENT

- MDT integrated approach advised including counsellors, physio, GP
- Consider need for paracetamol/NSAIDs and Antineuropathic agents e.g. Amitriptyline/gabapentin
- Consider most likely diagnosis based on assessment (may be more than one cause)

ENDOMETRIOSIS/ADENOMYOSIS

Cyclical pelvic pain indicating possible endometriosis or Adenomyosis

Therapeutic trial of ovarian suppression for 3-6 months with:

- COCP
- Progestogens
- IUS (Mirena)

If no improvement after 3 months refer to hospital gynae

OTHER CAUSES

Gynaecological:
- Fibroids
- pelvic organ prolapse
- chronic PID

Treat as per local guidance

Musculoskeletal:
MDT approach with GP, physio

Psychological:
CBT/psychology/psychosexual counsellor as appropriate

IBS

Pain relived by defecation, altered bowel frequency, bloating, symptoms worse after food

- Lifestyle advice
- FODMAP diet
- Consider antispasmodics e.g. buscopan

GP/gastro input if no improvement or bowel red flags

REFER TO HOSPITAL GYNAECOLOGY

1. **Any red flag symptoms refer as 2WW**
2. **No/limited improvement in pain after 3 months** Gynae to consider GNRH analogues, diagnostic laparoscopy, surgical treatment
3. **Other complex gynae pathology** (large ovarian cysts, large fibroids, interstitial cystitis)

Patient support:
Endometriosis UK
www.endometriosis-uk.org
IBS Network
www.theibsnetwork.org
Pelvic Pain Support Network
www.pelvicpain.org.uk

REFERENCES

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