It Hurts Down There:
Managing CPRP

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Practice point...

Chronic pelvic region pain (CPRP) refers to pain that lasts more than three to six months, rising from, or perceived to be, in the pelvic region of the body.

Point #1

The pelvic region consists of visceral organs of the urinary, reproductive and gastrointestinal systems. It also consists of the genitals, the pelvic floor and regional muscles, the lumbosacral spine, the pelvis and the hips.

The area is richly innervated by somatic nerves (*e.g.*, pudendal, spinal and ilio-inguinal nerves), as well as the visceral autonomic nerves.

Management

Appropriate management requires health-care practitioners to become transdisciplinary (grow beyond the normal constraints of their scope of practice) and to function as part of a multidisciplinary team.

Point #2

The pelvic region has been the province of the gynecologists, urologists and gastroenterologists, but often with a very specialty-oriented perspective. Most are not well schooled in issues related to pain pathophysiology.

Other specialists interested in the area are: physiatrists, back specialists, neurologists, psychiatrist, psychologists and various pain specialists. However, they are not schooled in specific evaluation including physical examination of the visceral systems of the pelvis.

Pelvic pain FYI...

Disease related treatments could include anti-fungals for yeast infection, hormonal manipulation and surgical interventions for endometriosis and bladder instillations for interstitial cystitis.

Point #3

The Wasser Pain Management Centre has developed a system of managing pain that can be summarized as "the four pillars of pain management" (Table 1).

Pillar One:

General and pain assessment

There are many symptoms and issues to be explored in CPRP. These include:

- Vulvar, vaginal or clitoral pain
- Painful sexual activity including painful intercourse
- Alteration in sex drive and sexual performance
- Urinary urgency, frequency and painful urination
- Constipation, diarrhea and anorectal pain
- Issues related to childbearing and infertility
- Back, tailbone, internal pelvic, buttock and lower abdominal and inguinal pain
- Current and past medications and treatment
- Risk assessment for use of strong pain medication including a comprehensive assessment of drug and alcohol use and physical, sexual and psychologic trauma
- Psychologic evaluation

Table 1

The four pillars of pain management

Pillar 1:
General and pain assessment

Pillar 2:
Understand and treat the underlying disease

Pillar 3:
Make a pain diagnosis and treat it

Pillar 4:
Treat comorbid symptoms, conditions and complications

Pelvic pain FYI...

An understanding of the types and mechanisms of pain, leads to the proper setting of the appropriate pain treatment paradigms.

Point #4

The history must be comprehensive and detailed enough to diagnose CPRP. Physical examination of the genito-urinary and gastrointestinal systems must include:

- a genital examination,
- an internal pelvic and rectal examination,
- a musculoskeletal and neurologic system check,
- a sensory and light touch examination of the vulva, urethra and clitoris, as well as of the pelvic floor,
- A Q-tip test of the introitus (necessary to determine pain on contact).

Internal exam must look for tender muscles as well as organs. Appro-priate imaging and tests such as diagnostic laparoscopy and cytoscopy and biopsy may be necessary.

Pillar Two:
Understanding and treating the underlying disease

Some of underlying diseases include:

- Vulvar vestibulitis with contact pain of the introitus or opening
- Dysesthetic vulvodynia with burning resting pain
- Interstitial cystitis with urgency, frequency and painful urination
- Yeast infection
- Lichen sclerosis
- Endometriosis
- Chronic endometriosis
- Pudendal neuralgia
- Ilio-inguinal and genito-femoral nerve lesion
- Post surgical pain (hernia, hysterectomy, bladder surgery)
- Pain related to adhesion
- Irritable bowel disorder
- Inflammatory bowel disease
- Hip and back disease

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Pelvic pain FYI...

The pharmacologic treatment of nociceptive pain (acetylsalicylic, non-steroid anti-inflammatory drugs and cyclooxygenase-2s and opiate) is quite different from the path of treatments of neuropathic pain (tricylics, anti-epileptics, topical anaesthetics, tramadol, opiates and possibly cannabinoids). Botulinum toxin A may have a role in both.

Point #5

Pillar Three:
Making a Pain Diagnosis and Treating It

Pain may be classified as nociceptive (inflammatory substances stimulating normal nerve endings) leading to peripheral and eventually to central sensitization. Otherwise, pain can be classified as neuropathic (due to a lesion of the peripheral or central nervous system), leading to sensitized peripheral and eventually to central neurons.

Each of these would require different kinds of therapies. Among the axes of pain diagnosis, pain can be mild, moderate or severe. It can be acute or chronic or non-cancer and cancer (Figure 2).

Pelvic pain may initially be nociceptive, but with chronicity. Furthermore, from surgery pelvic pain can develop neuropathic features.

Table 2
Parameters in deciding upon treatment

Acute	Mild	Neuropathic
Cancer	Pain	Non-cancer
Nociceptive	Severe	Chronic

Point #6

Pillar Four :
Treating comorbid symptoms, conditions and complications

In pelvic region pain, this can mean addressing sleep anxiety, depression, sexual function and complications of treatment and addiction issues.

Particular attention must be paid to complications of therapy. Thus, doctors who are treating chronic pelvic region pain need to take a comprehensive and caring view of the patient.