

Update on Chronic Pelvic Pain

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Chronic pelvic pain is defined as pelvic pain lasting longer than six months and interfering with normal activities.

Chronic pelvic pain affects 15% of North American women and is the indication for 15% to 40% of laparoscopic procedures and 12% of hysterectomies.¹ The average age of patients is between 27 and 29, and the average duration of symptoms is two and a half years.

Patients with chronic pelvic pain may have pathology in multiple organ systems (Table 1).

What causes chronic pelvic pain?

Pelvic pain of gynecologic origin may be cyclic or non-cyclic. The pain may initially be exacerbated by menses or intercourse.

Musculoskeletal causes of pelvic pain are often made worse by movement. These conditions are usually identified on physical examination. Myofascial pain may develop over time in response to pain caused by gynecologic pathology or as a direct result of faulty body mechanics or other etiologies.

Jenny's case

Jenny, 28, has a two-year history of right-sided pelvic pain. The pain was initially cyclic, but is now present on a daily basis. Bladder and bowel function are normal, aside from daytime frequency of micturition. The patient reports associated deep dyspareunia.



In the past, Jenny had a laparoscopy showing possible atypical pelvic endometriosis, which was cauterized without symptom improvement.

A trial of menstrual suppression resulted in recurrent breakthrough bleeding episodes. She is taking large doses of oxycodone and naproxen, and recently has been missing time from work due to her pain.

On examination, the patient demonstrated poor posture with tenderness over the right lumbar paraspinal muscles. Abdominal examination reveals a localized, right lower quadrant abdominal wall trigger point, with a positive rectus tension test. Pelvic exam shows localized right pelvic floor tenderness when the levator is contracted. Unidigital and bimanual exams show minimal tenderness in other pelvic structures.

For a followup on Jenny, see page 59.

Table 1

Etiologies of chronic pelvic pain

<u>Gynecologic</u>	<u>Musculoskeletal</u>	<u>Gastrointestinal</u>	<u>Urologic</u>	<u>Psychosocial</u>
Endometriosis	Myofascial pain	Irritable bowel	Interstitial cystitis	Abuse
Adenomyosis	Disc and joint disease	Inflammatory bowel disease	Urethral syndrome	Depression
Chronic pelvic infection	Hernia	Diverticular disease	Recurrent bacterial cystitis	Anxiety disorders
Pelvic adhesions	Nerve entrapment/neuropathic pain	Neoplasia	Calculi	Somatization
Pelvic mass	Fibromyalgia			

Gastrointestinal (GI) causes of chronic pelvic pain may be associated with episodic symptoms, such as alternating constipation and diarrhea, and abdominal bloating. The pain may migrate within the abdomen and may be associated with food. Pain is often relieved with decompression of the bowel.

Urologic causes of chronic pelvic pain include interstitial cystitis and urethral syndrome. Pain is typically suprapubic and often associated with deep dyspareunia. Frequency and nocturia are prominent symptoms. Pain is often worse with a full bladder.

While psychosocial and psychiatric disorders do not cause pelvic pain, they may influence the patient's pain perception. Identification and treatment of depression is an important part of chronic

pelvic pain management. Myofascial pain and interstitial cystitis are commonly misdiagnosed.

History and physical examination

The history and physical examination is critical in the evaluation of the patient. Determining the chronology of the development of chronic pelvic pain will give valuable information regarding diagnosis and potential therapy. While the history establishes a likely diagnosis, it also enables the physician to determine the level of functional impairment associated with the pain. Pelvic pain questionnaires may be useful (see Web box).

The physical exam is performed in a stepwise fashion, with the pelvic exam being performed last. Prior to the physical exam, it is important to establish with the patient that the goal should be to reproduce the pain if possible. The patient should confirm when any tenderness elicited during the exam is consistent with her pre-existing pain.

Initially, the patient is observed for disorders of gait and posture. Examination of the back and sacroiliac joints is then performed.

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Frequently Asked Questions

The abdominal wall is observed for herniae and scars, and is palpated for myofascial trigger points. Localized areas of tenderness are then tested with the rectus tension test (Carnett's test). The patient is placed in the lithotomy position and the vulva is examined for areas of tenderness. The minor vestibular glands are then palpated using a moistened Q-tip to look for vulvar vestibulitis. The speculum exam is then performed, and cultures may be obtained at that time, if indicated. Occasionally, endometriosis may be seen on speculum exam.

A single digit vaginal exam is then performed. The patient is asked to contract the levator muscles while the physician searches for areas of focal tenderness in the pelvic floor. Localized tenderness is indicative of tension or pelvic floor myalgia. The vaginal surfaces, fornices, and posterior pelvic structures are then palpated. Masses, nodules, and irregularity of the uterosacral ligaments may be identified. Once the digital exam is completed, a bimanual exam is performed which allows definition of pelvic structures. A rectal exam is also necessary to evaluate the rectovaginal septum, the uterosacral ligaments, and the rectum.

Following the history and physical examinations, most diagnoses will be apparent. Laboratory and imaging studies should be guided by the differential diagnosis. These may include cervical cultures, urinalysis, and imaging studies. Ultrasound, pelvic computerized tomography, and magnetic resonance imaging may be useful for suspected pelvic masses and adenomyosis.

What are the treatment options?

If gynecologic disease is suspected, a trial of medical treatment with birth control pills or non-

1. How does the examining physician differentiate abdominal wall myofascial pain from other causes of chronic pelvic pain?

The rectus tension test (Carnett's test) is used to determine if localized abdominal pain is confined to the abdominal wall. The patient is asked to elevate her head and shoulders while the point of tenderness is palpated. Rectus tension protects intra-abdominal structures, while the pain associated with an abdominal wall trigger point is the same or increased in intensity.

2. What medical therapies can be used?

If gynecologic chronic pain is suspected, then menstrual suppression is often helpful. Initially, this can be achieved with a monophasic birth control pill. Pain associated with endometriosis may respond to prolonged periods of amenorrhea. NSAIDs and coxibs are useful first-line analgesics.

3. What is the recommended management for patients with persistent or recurrent pelvic pain unresponsive to usual management strategies?

Once specific diagnoses have been managed, chronic pain is best assessed at a multidisciplinary pain clinic, using combination analgesic and pain-modulator therapy.

A followup on Jenny

Jenny elects to have her abdominal wall trigger point injected. Lidocaine hydrochloride, 1%, with adrenaline is injected into the area with immediate relief. On repeat pelvic examination, her pelvic floor tenderness is also relieved.

After two further injections two weeks apart, her pain, dyspareunia, and urinary frequency resolve. The patient is advised to consult a physical therapist for a core strengthening program.

steroidal anti-inflammatory drugs (NSAIDs) may be indicated. A trial of menstrual suppression may also be indicated. This suppression can be achieved with continuous birth control pill therapy using a monophasic, progesterone-dominant formulation. Second-line therapies for endometriosis, such as gonadotropin-releasing hormone analogs and danazol, may be initiated where there is a strong clinical suspicion of the disease, without the need for laparoscopic diagnosis.

Abdominal wall and pelvic floor trigger points may be injected with local anesthetic, dry-needled

or massaged. Myofascial pain is the most common diagnosis in patients who have non-gynecologic chronic pelvic pain.²

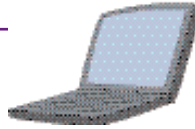
The initial management of chronic pelvic pain, if effective, will prevent patients from being subjected to unnecessary surgical procedures and reduce the risk of their progression to a chronic pain syndrome. **Dx**

References

1. Steege GF: Chronic pelvic pain—an integrated approach. First Edition. Saunders WB Co., 1998, p. 2.
2. Reiter RC, Gambone JC: Nongynecologic somatic pathology in women with chronic pelvic pain and negative laparoscopy. J Reprod Med 1991; 36(4):253-9.

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Myth **6** Alzheimer Disease is preventable.

Reality: Because there is no known cause for Alzheimer Disease, there is no conclusive evidence that Alzheimer Disease can be prevented. There is, however, a growing amount of evidence that lifestyle choices that keep mind and body fit may help reduce the risk. These choices include physical exercise, a healthy diet including fresh fruits, vegetables and fish, as well as keeping your brain active.