# Chronic Pelvic Pain

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# Aeitiology

- Often multi-factorial
- Identify contributing factors rather than assign to single pathology

- Physical factors
- Psychological factors
- Social factors

# Scope

- 1 in 10 gynaecological consultations
- Indication for 15 – 40% of laparoscopies
- Significant impact on life

# Causes

| Gynaecological | Urological | Gastrointestinal | Musculo-Skeletal | Psychological |
|---|---|---|---|---|
| Endometriosis | Interstitial Cystitis | IBS | Myofascial Pain | Depression |
| Salpingitis | Uretheral Syndrome | Chronic Appendicitis | Pelvic Floor Myalgia | Physical or Sexual Abuse |
| Adenomyosis | Chronic UTI | Constipation | Nerve Entrapment Syndrome | Sleep Disturbance |
| Adhesions | Bladder stones | Inflammatory Bowel Disease | Mechanical Back pain | Stress |
| PID | | | Disc Disease | Substance misuse |
| Ovarian Cysts | | | Hernias | |
| Residual Ovarian Syndrome | | | | |
| Pelvic Congestion Syndrome | | | | |
| Fibroids | | | | |

# Why Confusion?

- Uterus, cervix & adnexa share the same visceral innervation as the lower ileum, sigmoid colon and rectum.
- Signals travel via sympathetic nerves to spinal cord segments T10 through L1
- Not possible to distinguish pain between gynaecological and gastrointestinal origin

# Chronic Pelvic Pain

- Continuous or noncyclical pelvic pain of longer than 6 months duration
- Localizes to the anatomic pelvis, abdominal wall at or below the umbilicus, lumbosacral back, or the buttocks and
- Is of sufficient severity to cause functional disability or lead to medical care.
- Nearly 4% of women are thought to have ongoing CPP
- Presents in primary care as often as migraine or low-back pain
- 1 in 10 gynaecological consultations

# Chronic Pelvic Pain

- It forms the indication for 18% of all hysterectomies and 40% of gynecologic laparoscopies.
- Even the relationship of recurrent pain to menstruation or the presence of dyspareunia is only suggestive.
- Annually, 400,000 laparoscopies are performed on patients with endometriosis and chronic pelvic pain.
- Negative laparoscopic findings occur in 40% of patients.
- Important non-gynecologic causes must be considered in the differential diagnosis

# Dyspareunia – a Significant Factor?

- Patients with deep, internal, or thrust dyspareunia often express a feeling that some sort of internal collision is occurring during sexual activity.
- Any pelvic pathology may be responsible for this discomfort, but abnormalities such as endometriosis, pelvic adhesions, pelvic relaxation, malposition (retroversion), adnexal pathology and uterine fibroids are the most likely causes.
- IC may cause dyspareunia before it proceeds to chronic unremitting pain.
- IBS may also cause dyspareunia and pain at the apex of the vagina.

# Initial Assessment

- Adequate time for consultation
- Most patients need explanation for the pain
- Develop partnership between clinician & patient

- Meta-analysis of 3000 women shows integrated approach with multidisciplinary input has better outcome than standard surgical treatment

# History

- Chronological history of problem
- Pattern of pain
- Associated bladder or bowel symptoms
- Rule out IBS
- Sexual history
- Pain diary
- Impact on life
- Past treatments

# Pain Diary

- Monthly record of pain for 3 months
- Severity 1 – 10
- Aggravating and relieving factors
- Impact on life
- Association with bladder & bowel function, intercourse and lifestyle

# Examination

- May be deferred for next appointment
- Best findings when in pain

- General mobility & posture
- Back
- Abdomen
  - Scars, trigger points

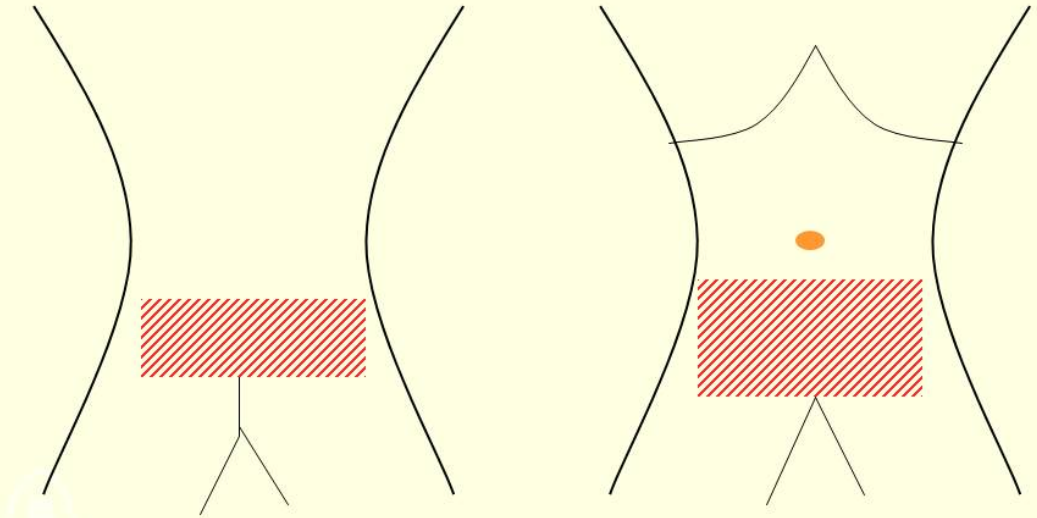
# Examination

- Vulva
- Single digit examination
- Bimanual examination
- Speculum examination

# Pain

## Gynaecological Pain : Localisation

- Below the umbilicus eventually radiating to the back



Philippe Koninckx

# Pain

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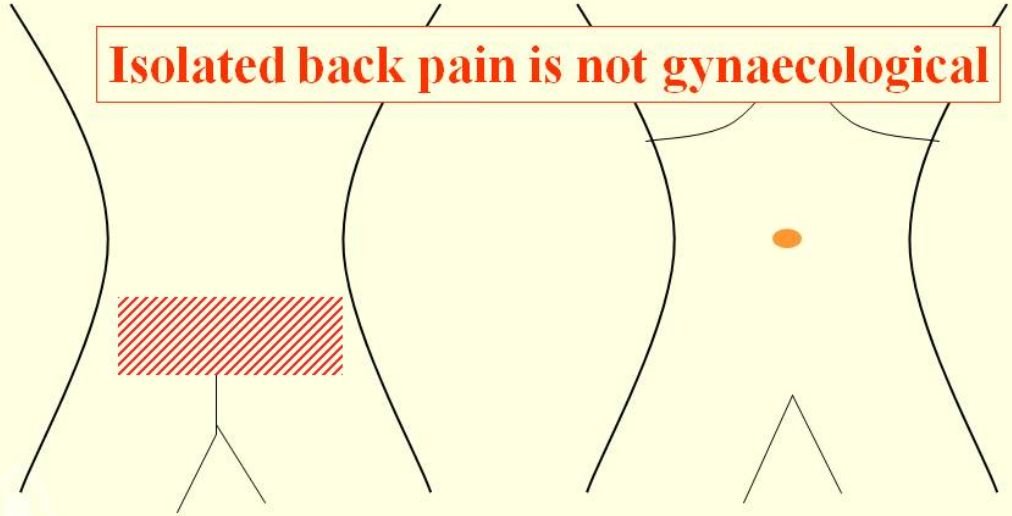


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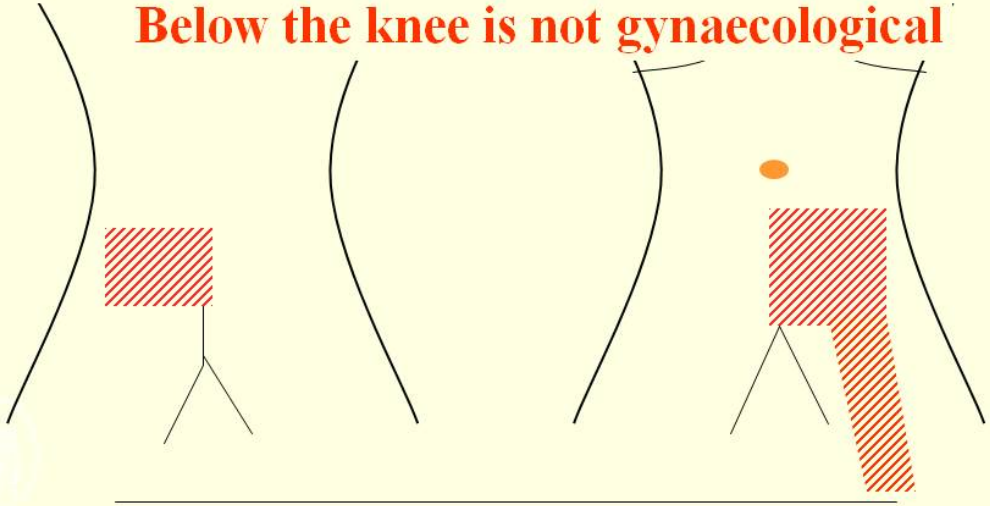
# Pain

## Gynaecological Pain : Radiation

- Below the umbilicus eventually radiating to the back
- Ovarian pain can be lateralised and radiates up to the knee, anterior medial side

**Below the knee is not gynaecological**



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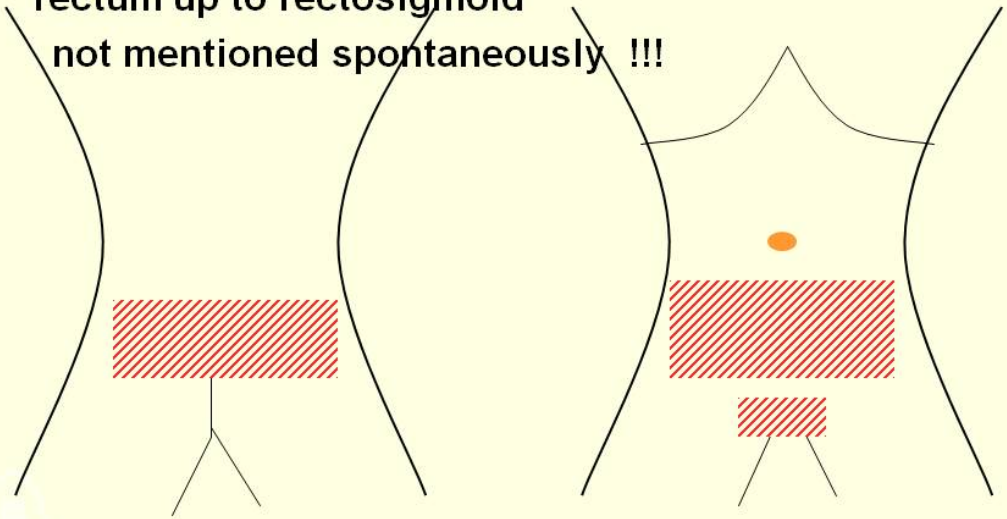
# Pain

## Gynaecological Pain : Radiation

- Perineal radiation is pathognomonic for bowel pain ie rectum up to rectosigmoid
  not mentioned spontaneously !!!



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# Psychological Assessment

- What is your main concern?

- Understanding of pain & expectations
- Pain impact
- Mood disorders
- Current stress

# Psychological Assessment

- Abuse history
- Support system
- Individual or couple counseling

- Important to identify the patient who'll need counseling

# Investigation

- Screen for infections
- Trans-vaginal Scan & MRI
  - Adnexal Mass
  - Adenomyosis
  - Fibroids
  - Poor mobility of uterus or ovaries
  - Uncertain role in endometriosis
- Laparoscopy (Gold Standard)

# Laparoscopy

- Standardized adequate laparoscopy
- Clear documentation with pictures
- If abnormality seen, 85% show endometriosis or adhesions

- Retrospective control trial of 100 women
  - 51% adhesions
  - 32% endometriosis
  - 14% adhesions in control group

# Common Causes of CPP

- Adhesions
- Endometriosis
- IBS
- Interstitial Cystitis

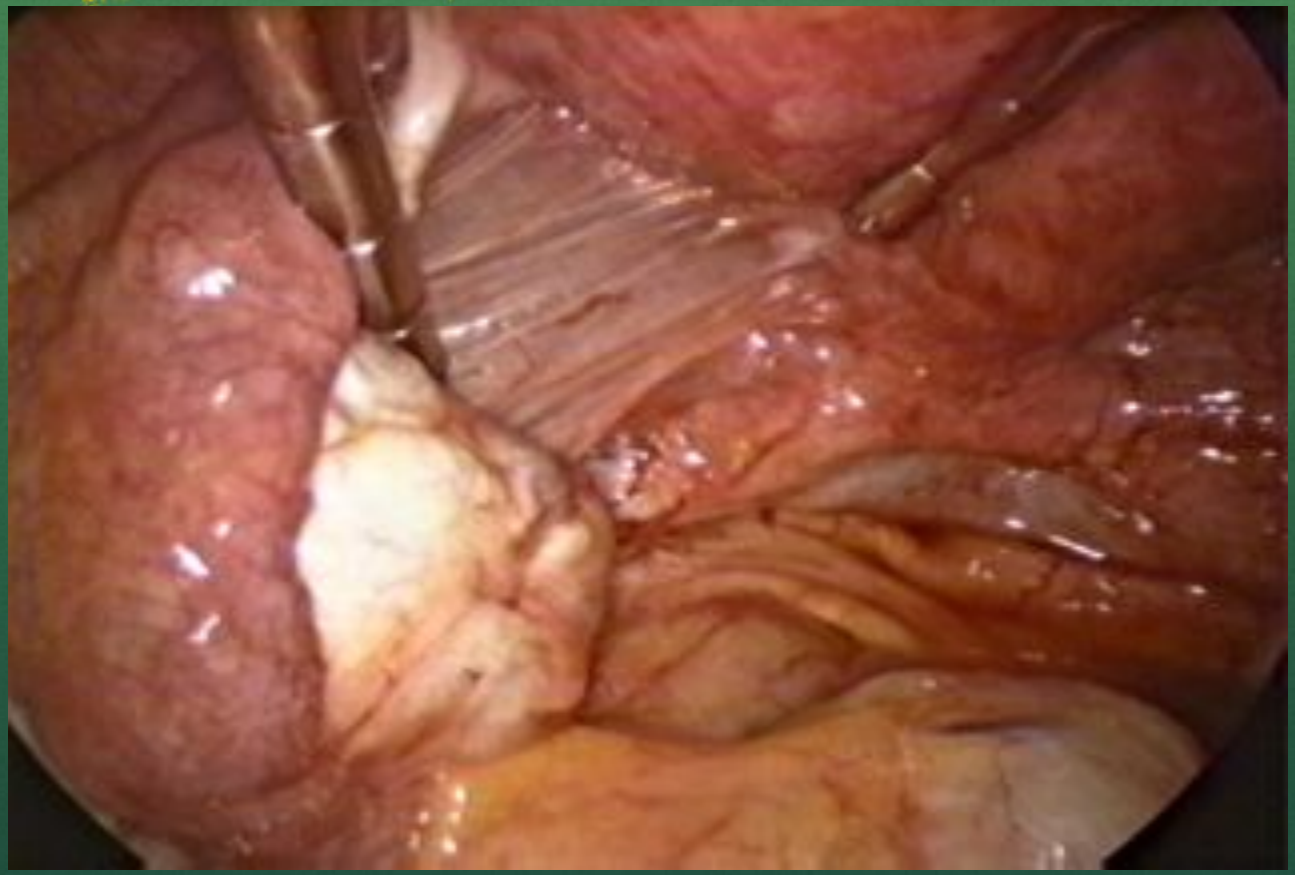
# Adhesions

- A study using conscious pain mapping during awake laparoscopy found that peritoneal adhesions and filmy adhesions that allowed for movement between 2 structures had the highest pain scores, while dense, fixed adhesions caused less pain.
- Pain is not cyclical and not accompanied by vaginal bleeding.
- Dyspareunia and symptoms suggestive of intermittent sub-acute bowel obstruction may be associated with adhesions.
- Adhesiolysis should be recommended with realistic expectations, and a multidisciplinary approach in a pain clinic may be worthwhile prior to attempting surgery.

# Adhesions

- In one study, cure or improvement was reported in two thirds of patients with chronic pelvic pain and nearly half of those with dysmenorrhea.
- In a randomized study, patients with severe adhesions involving the intestinal tract were shown to benefit from adhesiolysis.
- A recent study found adhesions deflecting the sigmoid colon to the pelvic sidewall in 38% of patients with chronic pelvic pain.
- Among patients without detectable endometriosis, 80% had a significant reduction in symptoms after adhesiolysis on an 18-month follow-up

# Adhesions



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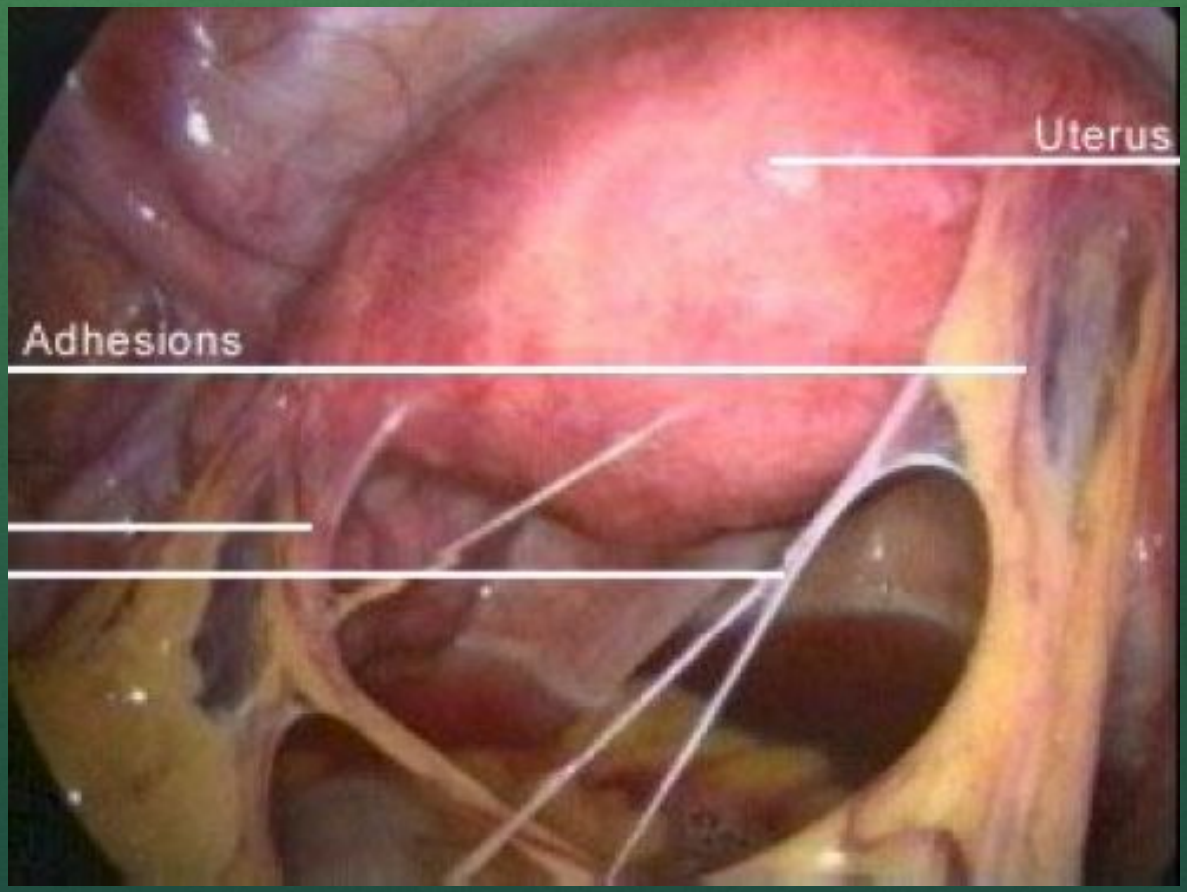

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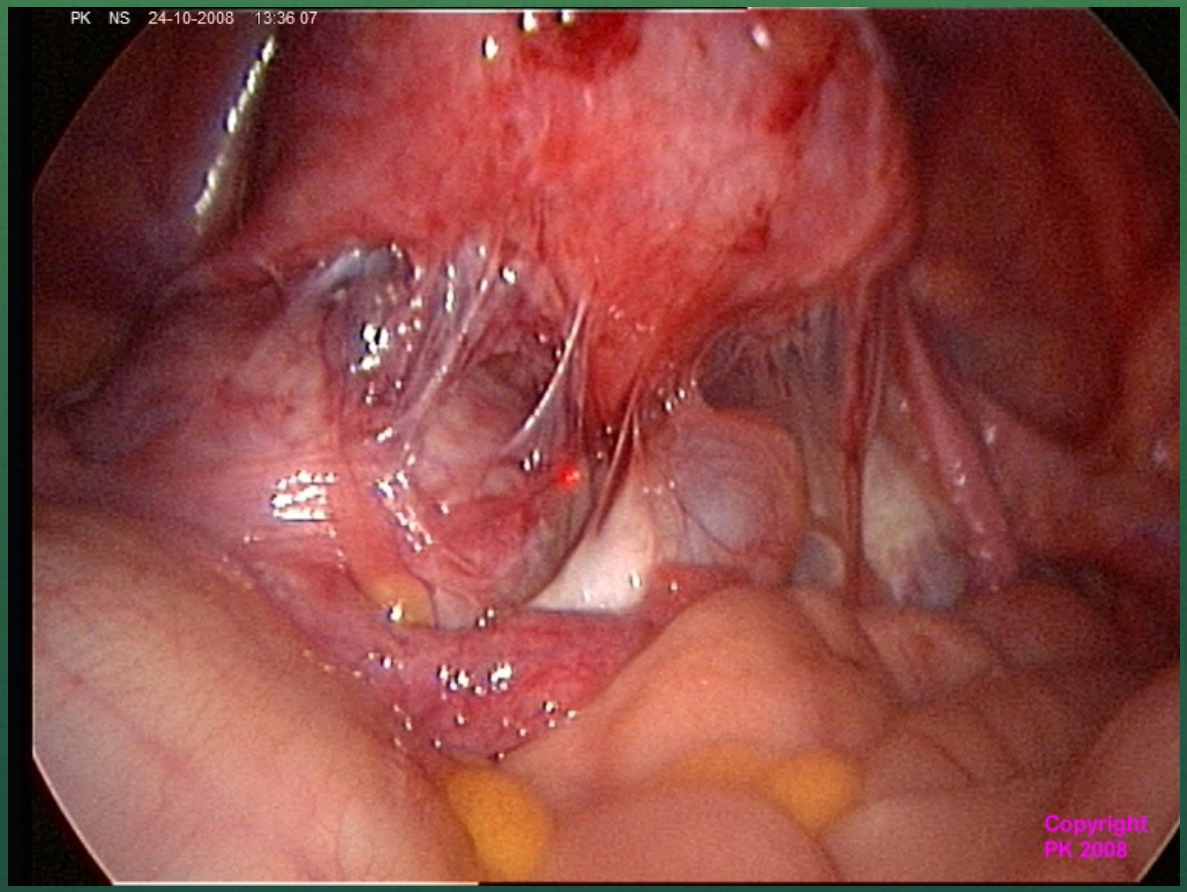


# Endometriosis

- Pain associated with endometriosis may worsen pre-menstrually or during menses.
- Patients experience generalized lower abdominal tenderness, and associated complaints include dysmenorrhea, dyschezia, and dyspareunia.
- Endometriotic deposits in both the utero-sacral ligaments and recto-vaginal septum contribute to pain during intercourse.
- Painful defecation is due to infiltration of the bowel wall by endometriotic deposits.

# Endometriosis

- Importantly, remember that the pain associated with endometriosis is not correlated with the presence or amount of visible endometriotic tissue.

- In fact, prevalence of endometriosis is the same in women with and without pain.

# Management

- Cyclical pain should be offered therapeutic trial using hormonal treatment for a period of 3 – 6 months before laparoscopy
  - COC
  - Progestogen
  - Mirena IUS
  - GnRHa
  - Amitriptyline
- Trial of anti-spasmodics for IBS, Diet modification
- Analgesia
- Pain team
- Operative Laparoscopy according to cause

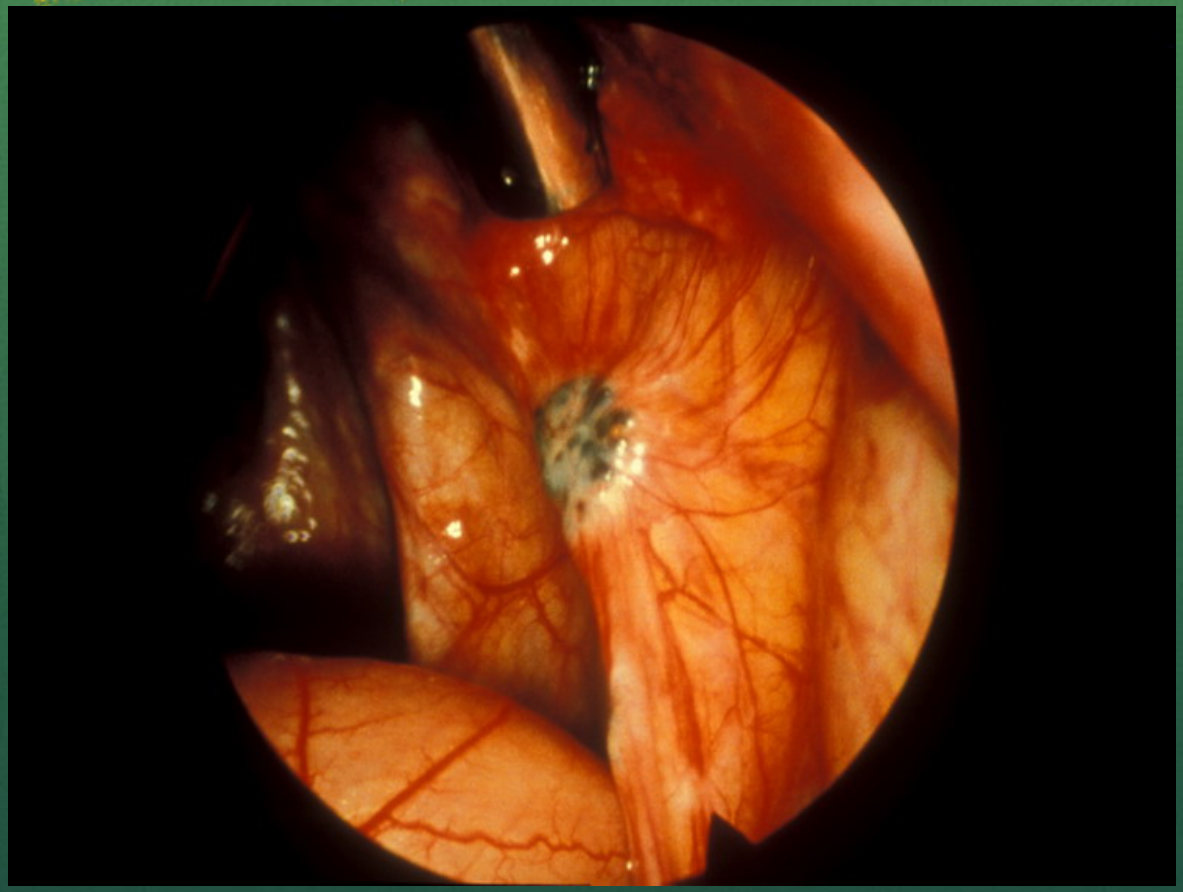
# Localisation & Appearance

- Common affected sites are pelvic organs and peritoneum.
- Extent of disease varies from few small lesions to large endometriotic cysts.
- Extensive fibrosis in utero-sacral ligaments and adhesion formation leading to distortion of anatomy
- Severity of disease does not co-relate with severity of symptoms

# Localisation & Appearance

- Powder burns
- Black, dark brown or bluish lesions
- Fibrosis
- Yellow-brown peritoneal discoloration

# Endometriosis



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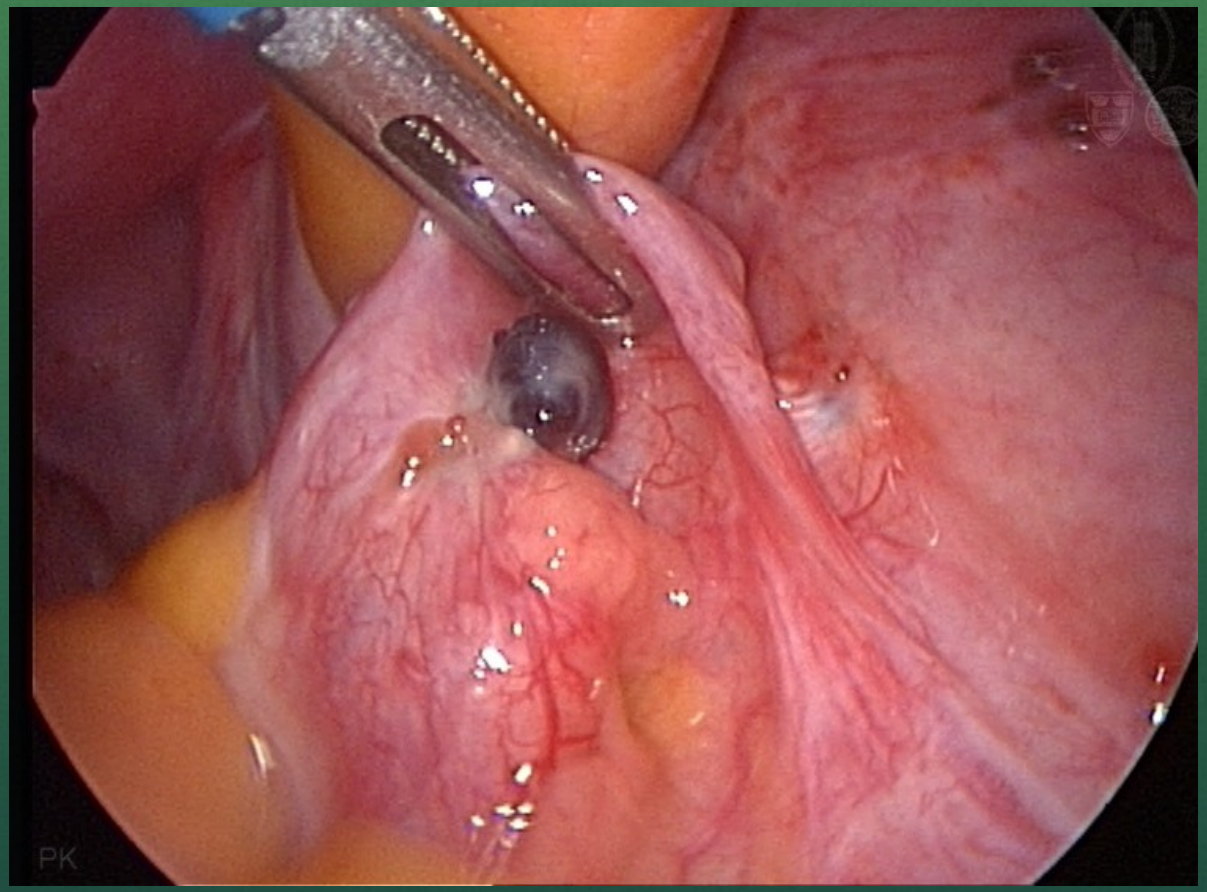
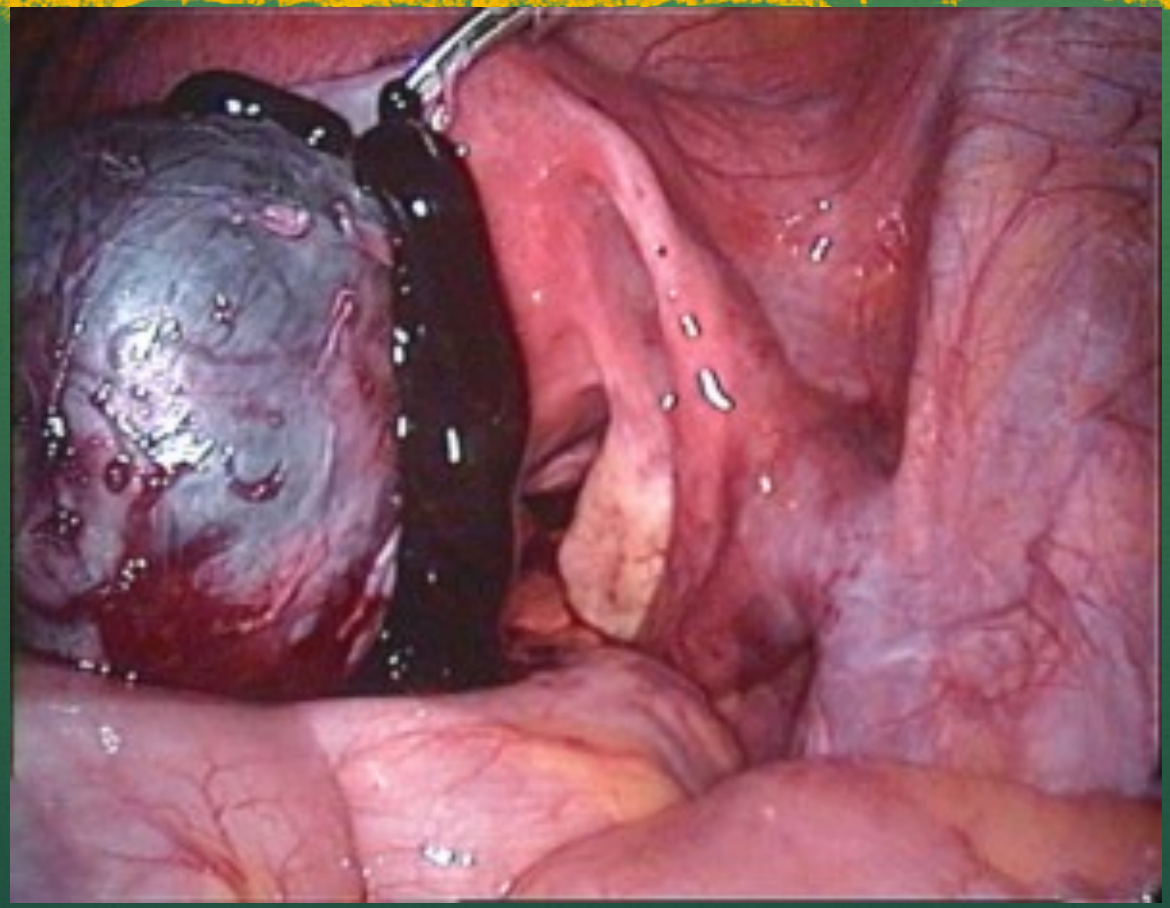


# Endometrioma



# Laparoscopy & Histology

- Gold standard
- Capture images or video
- No classification system co-relate with pain symptoms

- Visual inspection is adequate but histological confirmation of at-least one lesion is ideal
- CA125 has no value in diagnosis or prognosis

# Medical Management

- NSAIDS – inconclusive evidence
- Ovarian Suppression for 6 months reduces endometriosis-associated pain
  - Combined pill
  - Danazol
  - Medroxyprogesterone Acetate
  - LNG-IUS
  - GnRH analogues
- Recurrence is very common following hormonal treatment
- Duration of treatment depends on drug used, response and adverse effects
- Add-back therapy can be used if treatment used for long-term

# Surgical Management

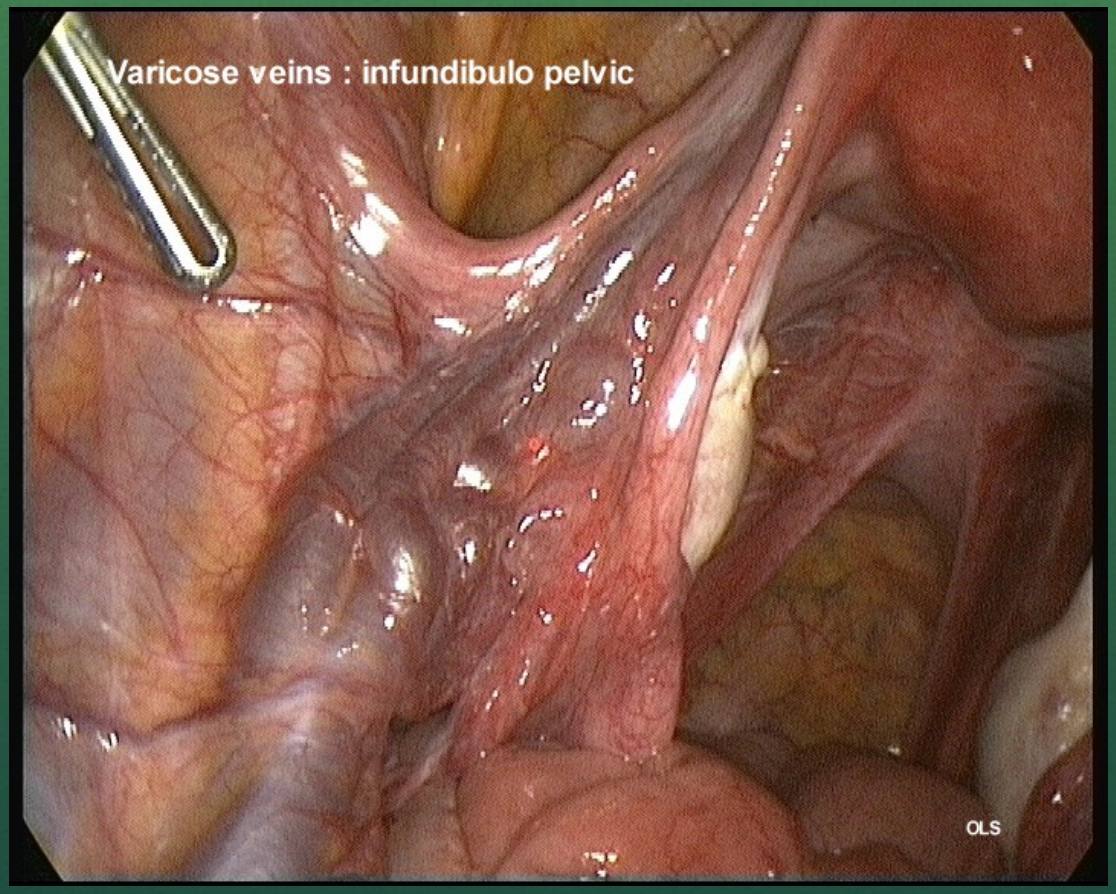
- Laparoscopy & excision of endometriosis
- At the same setting when diagnostic laparoscopy being performed
- Simple diathermy to lesion not sufficient

- LUNA – no evidence
- Pre-operative or post-operative hormonal treatment – no evidence
- Hysterectomy & bilateral oophorectomy
  - With or without HRT

# Pelvic Congestion Syndrome

- Probably is much more frequent than generally thought, but the diagnosis is diffcult to make.
- During laparoscopy this goes unnoticed if the laparoscopy not in anti-trendelenburg (head up) position.
- A ligature of the vein is sufficient, although generally these women end with an hysterectomy (which also cures the pelvic varices )

# Pelvic Congestion Syndrome



# IBS

- IBS is one of the most common functional intestinal disorders. It is defined as a group of functional disorders in which abdominal discomfort or pain is associated with defecation or a change in bowel habits.

- IBS also involves
  - features of disordered defecation.

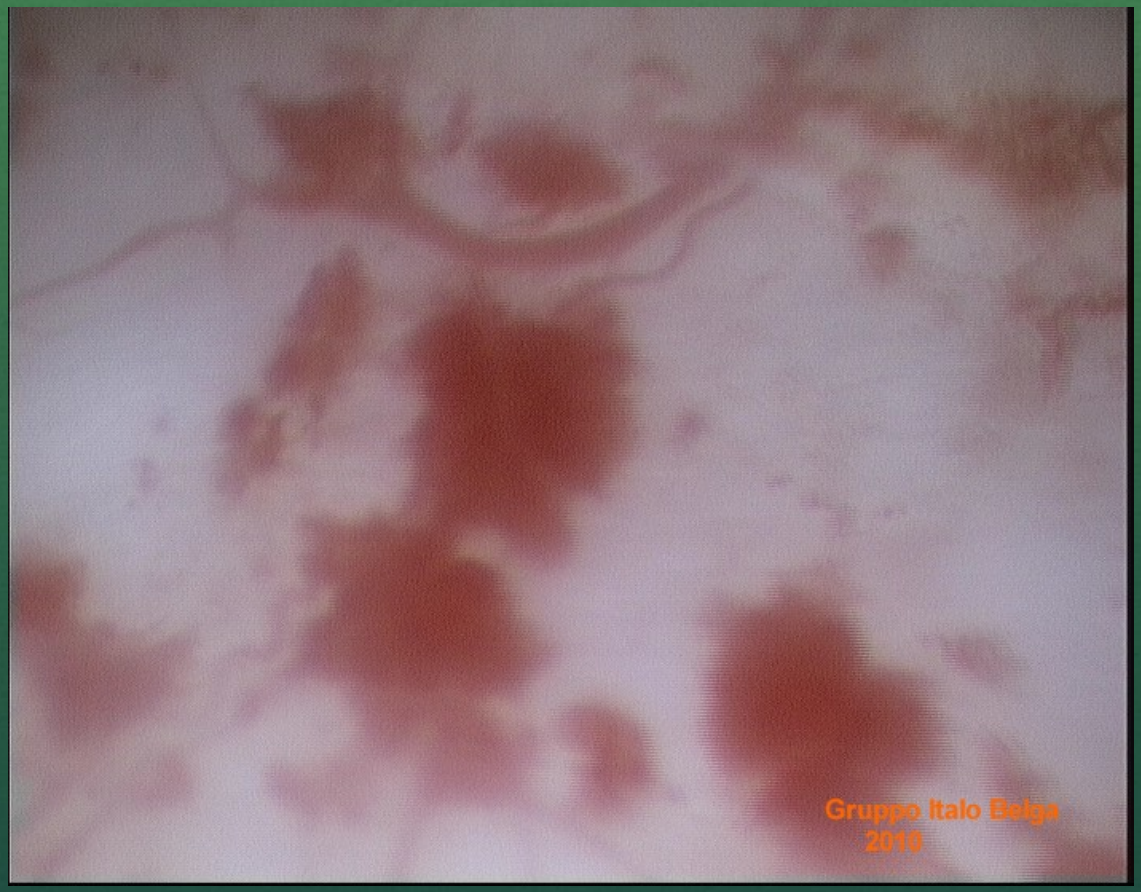
# IBS

- Rome criteria for IBS
  - Recurrent symptoms (2 of 3) present for at least 12 weeks in the preceding year
  - Abdominal pain relieved with defecation
  - Onset associated with change in frequency of stool
  - Onset associated with change in stool appearance
- Symptoms supportive of diagnosis
  - Abnormal stool frequency
  - Abnormal stool form
  - Abnormal stool passage
  - Passage of mucus
  - Bloating

# Interstitial Cystitis

- Considerable overlap exists in symptomatology in patients with IC and IBS.
- Required findings
  - Hunner ulcer or diffuse glomerulations (ie, small bleeding points on the bladder surface seen after hydrodistension of the bladder)
  - Pain associated with the bladder or urinary urgency
- A recent study found evidence of IC on cystoscopy findings in 38% of patients who underwent laparoscopy for chronic pelvic pain

# Interstitial Cystitis



# Myofascial Pain

- Myofascial etiologies occur in 15% of patients with chronic pelvic pain.
- Trigger points are hyperirritable spots usually within a taut band of skeletal muscle or in muscle fascia. These are painful upon compression and can give rise to characteristic referred pain, tenderness, and autonomic phenomena.
- Women may experience pain from trigger points (areas overlying muscles that induce spasm and pain) in the myofascial layers of the pelvic sidewall or pelvic floor.
- The obturator internus and levator ani are common sites and should be palpated.

# Myofascial Pain

- A recent study found levator pain in 87% of women with diagnosed interstitial cystitis.

- Coexisting symptoms, such as frequent headaches, non-restorative sleep, diffuse tender points, and fatigue, may be suggestive of systemic disorders such as fibromyalgia

# Hysterectomy for Chronic Pelvic Pain

- Long-term studies have shown that success with hysterectomy is disappointing when the only indication is pain.

- If the pain has persisted for more than 6 months, has not responded to analgesics, and is causing significant distress and impairment, then hysterectomy may be considered an option after counseling the patient that the pain may persist after surgery.

# Thanks

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