Capsule Comment
January 11, 2012
Chronic Pelvic Pain in Women

Author:
Johanna Gulmatico, MD
PGY II, Florida Hospital Family Medicine Residency Program

Key Points:

- **A definitive diagnosis is made in less than 40% of women**
- **The key to diagnosis is a comprehensive history and physical exam**
- **Treatment should be multi-disciplinary and should avoid the use of narcotic pain medications**

Chronic pelvic pain (CPP) is a common problem among women. The clinical definition of CPP is noncyclic pain that lasts six or more months; that is localized to the pelvis, the anterior abdominal wall at or below the umbilicus, and may involve the lumbosacral back or buttocks; and severe enough to cause functional disability or require medical care.

The diagnosis and management of CPP is often difficult. As family physicians, we can provide the attention and comfort needed by women who suffer from this disabling condition and guide them towards the available treatment resources.

EVALUATION

A thorough history with psychological assessment and physical exam are the most important components of the diagnostic evaluation. They can narrow the differential diagnoses and guide further evaluation.

Knowing the most common conditions associated with CPP can be helpful and include endometriosis, pelvic inflammatory disease, interstitial cystitis/painful bladder syndrome, irritable bowel syndrome, pelvic floor dysfunction, myofascial pain and neuralgia. Non-gynecological sources should be considered and include gastrointestinal, urological, psychological, musculoskeletal, and neurological.

History

Ask the patient to complete a pelvic pain assessment form and a pain map to aid in obtaining a comprehensive history. A form created by the International Pelvic Pain Society is available online at www. pelvicpain.org. Asking the patient to make a pain calendar can also be of benefit.

Obtaining the characteristics of the pain, as well as risk factors for CPP such as physical and sexual abuse, obstetrical and surgical history is important. Red flag symptoms, such as unexplained weight loss, hematochezia, perimenopausal irregular bleeding, postmenopausal vaginal bleeding, or postcoital bleeding, should prompt an investigation to rule out malignancy or serious systemic disease.

Somatization, drug seeking behavior, opiate dependency, domestic violence, depression, and sleep disorders need to be considered in the evaluation.

Physical Exam

A comprehensive physical exam should include an evaluation of gait, lumbosacral spine, pelvic joints, abdomen, and an internal pelvic and rectal exam. The table below lists possible etiologies based on potential findings in the history and physical examination.

FINDING	POSSIBLE SIGNIFICANCE
HISTORY	
Dull and diffuse	Visceral
Localized	Somatic
Cyclic pelvic pain +/- severe dysmenorrhea	Endometriosis, adenomyosis, irritable bowel syndrome (IBS), interstitial cystitis
Onset during pregnancy or immediately postpartum	Musculoskeletal (pelvic girdle pain)
Hot/burning, electric shock-like or paresthesia	Nerve entrapment
Aggravated by urge or need to void	Interstitial cystitis
PHYSICAL EXAMINATION	
Uterosacral ligament abnormalities (i.e. nodularity, thickening, focal tenderness), cervical displacement	Endometriosis
Enlarged or irregular uterus	Uterine myomas
Uterine, adnexal, or cervical motion tenderness	Chronic endometritis related to PID, adhesions, pelvic congestion syndrome (PCS)
Burning, paresthesias, dysesthesias	Neuropathy
Adnexal mass	Ovarian neoplasm, residual ovary syndrome, ovarian remnant, endometrioma
Suburethral or suprapubic pain	Chronic UTI, interstitial cystitis/painful bladder syndrome, osteitis pubis
Tenderness and contraction of pelvic muscles	Piriformis/levator ani muscle syndrome
Lack of uterus mobility on bimanual examination	Endometriosis, pelvic adhesions
Pain on palpation of abdominal muscles and lumbosacral regions	Abdominal/pelvic wall source of pain, trigger points
Point tenderness of vagina, vulva, or bladder	Adhesions, endometriosis, nerve entrapment, trigger points, vulvar vestibulitis
Positive Carnett's sign (abdominal pain remains unchanged when muscles are tense)	Myofascial or abdominal wall cause of pain

Laboratory testing, Imaging, and Surgery

Limited laboratory and ultrasound evaluation can help clarify the diagnosis, as well as rule out serious disease. They include a complete blood count with differential, ESR, urinalysis, gonorrhea and Chlamydia cultures, and a pregnancy test. MRI and CT can be utilized to better define an abnormality detected on sonography.

Other diagnostic tools may include laparoscopy, intravesical potassium sensitivity testing, cystoscopy, and pelvic venography.

TREATMENT

The treatment approach is often dependent on the individual patient's preferences and requires a thorough discussion. There are three general approaches which are not exclusive of one another:

1. Empiric therapy based on diagnostic probabilities
2. Therapy targeted toward the specific problem
3. Non-specific pain relief (with avoidance of the use of narcotics)

The table below lists some of the available therapies.

Therapy	
Pharmacological	Hormonal treatments, analgesics (NSAIDs, neuroleptics), antidepressants (SSRIs), trigger point and botox injections
Surgical	Hysterectomy, endometrial ablation, myomectomy, lysis of adhesions, presacral neurectomy, sacral nerve stimulation , uterine artery ablation
Alternative	Nutritional supplementation with Vitamin B1 and Mg, magnetic field therapy, acupuncture, transcutaneous electrical nerve stimulation
Physical Therapy	Manual therapy , biofeedback, electrical stimulation, dilators, ultrasound, heat
Psychotherapy	Cognitive behavior therapy, relaxation, neuromodulation (*experimental*)

REFFERING

A multi-disciplinary treatment approach will benefit most patients with chronic pelvic pain. The referring family physician should coordinate the plan of care with any subspecialists involved which may include physical therapy, gastroenterology, urology, gynecology and colorectal specialists.

RESOURCES:

American Pain Society
www.ampainsoc.org

American Academy of Pain Management
www.aapainmanage.org

International Association for the Study of Pain
www.iasp-pain.org

International Pelvic Pain Society
http://www.pelvicpain.org

National Vulvodynia Association
www.nva.org

REFERENCES:

Ortiz DD. Chronic Pelvic Pain In Women. Am Fam Physician 2008; 77(11):1535-1542.
Rapkin. AJ, Hartshorn, TG, Partownavid, P. Pain Management. ACOG Clinical Updates in Women's Health Care 2011; 10(5).
ACOG Committee on Practice Bulletins–Gynecology. ACOG Practice Bulletin No. 51. Chronic pelvic pain. Obstet Gynecol. 2004;103(3):589–605.

Howard F. Evaluation of chronic pelvic pain in women. In: UpToDate: UpToDate, 2007.
Howard F. Causes of chronic pelvic pain in women. In: UpToDate: UpToDate, 2007.
Howard F. Treatment of chronic pelvic pain in women. In: UpToDate: UpToDate, 2007.

ACKNOWLEDGEMENT:

The author would like to thank Dr. Jennifer Keehbauch and Dr. Melissa Hartman for their mentoring and advice.