Chronic Pelvic Pain: Taking a Different Perspective

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Objectives

At the end of this presentation, the attendee will be able to:

1. List common non-gynecologic etiologies of pelvic pain.
2. Describe methods of evaluation for pelvic pain.
3. Explain the role of surgical and non-surgical treatments for pelvic pain.

Gynecologic Causes of Pelvic Pain

- Endometriosis
- Adhesions (PID/post-operative)
- Leiomyomata
- Adenomyosis
- Pelvic congestion syndrome
- Mittelschmerz
- Adnexal masses

Gynevision

Chronic Pelvic Pain

vs.

Chronic Lower Abdominal Pain

Non-gynecologic Causes of Pelvic Pain

- Gastrointestinal
- Urologic
- Musculoskeletal
- Psychologic

Gastrointestinal Causes of Pelvic Pain

- **IRRITABLE BOWEL SYNDROME**
  - **Rome Criteria**
- Chronic appendicitis
- Inflammatory bowel disease (Crohn's)
- Diverticulitis
- Diverticulosis
- Meckel's diverticulum

Urologic Causes of Pelvic Pain

- **INTERSTITIAL CYSTITIS**
- Urethral syndrome (chronic urethritis)
- Unstable bladder (detrusor instability)

Musculoskeletal/Myofascial Causes of Pelvic Pain

- **TRIGGER POINTS**
- Hernias (inguinal, femoral, umbilical, incisional, spigelian)
- Nerve entrapment (neuritis)
- Fasciitis
- Scoliosis
- Disc disease
- Fibromyalgia (Criteria?)
- Osteitis pubis

Psychologic Causes of Pelvic Pain

- **DEPRESSION**
- Anxiety
- Psychosexual dysfunction/abuse
- Hypochondriasis
- Somatization
- Personality disorder

Chronic Pelvic Pain Management Team: A Virtual Pelvic Pain Clinic

- Gynecologist
- Gastroenterologist
- Urogynecologist
- Muscle-ologist/physical therapist
- Psychologist/Psychiatrist

Traditional vs. Nontraditional Pelvic Pelvic Pain Therapy

- N=106
- Standard vs. integrated approach
- Laparoscopy standard vs. not standard
- Organic cause priority vs. somatic / dietary / psychologic / physiotherapeutic / environmental
- 20% negative sexual experiences

Results of Treatment of Chronic Pelvic Pain in the Standard- and Integrated-Approach Groups

	Standard (N=49)	Integrated (N=57)	Signif. (P)
General pain experience			
Improvement	20 (41%	43 (75%)	<.01
No improvement	29 (59%)	14 (25%)	
Disturbance of daily activities			
Improvement	18 (37%)	39 (68%)	<.01
No improvement	31 (63%)	18 (32%)	
Associated symptoms			
More	26 (53%)	4 (7%)	<.01
Some	10 (20%)	10 (18%)	
Fewer	13 (27%)	43 (75%)	
McGill Score			
Improvement	24 (47%)	22 (39%)	.38
No improvement	25 (51%)	35 (61%)	

Premorbid State – Baseline Adjustment

- Family
- Work
- Marriage
- Finances
- Sex
- Sleep

Acute Pain (2 months)

- Realistically expects to get better

Subacute Pain (2-6 months)

- Denies chronic disability
- Subtle behavior changes
  - Social
  - Work
  - Sleep
- No depression – hope persists

Chronic Pain (>6 months)

- Doctor shopping
- Dependency
- Depression
- Hostility
- Lowered self-esteem

Subchronic Pain (Prolonged pain)

- Learned to live with it
- Doesn't accept it
- Resolution of some findings
  - Drugs
  - Job
  - Sex

Irritable Bowel Syndrome

- Most common functional GI complaint – 30% of all patients
- Female:male = 2:1
- Altered motor reactivity to meals, stress, etc.
- Variations: chronic pain and constipation
  - Painless, intermittent diarrhea
  - Alternating constipation/diarrhea
- Complicated by hysterics, depressive, bipolar personality disorders
- RX: bulk agents, dietary fiber, sedation with tranquilizers/phenobarbitol

Irritable Bowel Syndrome and Chronic Pelvic Pain

- 48% of dx scope patients; 40% of hysterectomy patients
- 1 yr after scope, IBS patients less improved
- 1 yr after hyst, IBS less improved

Longstreth, Oct. 1990

Medical Treatment of IBS

Symptom	Therapy	Typical daily dosage	Side effects
Diarrhea	Loperamide	4 mg	Constipation
	Diphenoxylate	20 mg	Euphoria, sedation
	Hyoscyamine	< 1.5 mg	Dry mouth
	Dicyclomine	80-160 mg	Blurred vision
	Desipramine	150 Mg	Dry mouth, confusion, hypertension
	Amitriptyline	25-50 mg	Dry mouth, confusion
Constipation	Fiber (any source)	>30 g	Bloating, abdominal pain
	Lactulose	10-30 g	Bloating
	Sorbitol	10-30 mg	Bloating
	Cisapride	40-80 mg	Dizziness, headache
Abdominal pain	Desipramine	150 mg	Dry mouth, sedation, confusion, hypertension
	Hyoscyamine sulfate	<1.5 mg	Hypotension, constipation

G: What to ask

- "How often do you have a bowel movement?"
- "Are you troubled by constipation or diarrhea?"
- "Is your pain related to when you do or don't have a bowel movement?"

Urethral Syndrome - Diagnosis

- Diagnosis of exclusion
  - No UTI, bladder pathology, detrusor instability
- Symptoms complex
  - Urgency, frequency, dysuria
- Urethroscopic findings
  - Erythema, exudate, inflammatory fronds and cysts

Urethral Syndrome: Etiologies

- Chronic urethritis
- Hypoestrogenism
- Urethral spasm
- Urethral stenosis
- Psychiatric disturbances

Urethral Syndrome
Clinical Clues: History

- Pelvic pain
- Dyspareunia
- Post-coital voiding problems

Urethral Syndrome
Clinical Clues: Physical Examinatio

- Urethral tenderness
- Bladder base tenderness
- Absence of uterine tenderness
- Absence of adnexal tenderness

Urethral Syndrome
Work-Up

- Urinalysis
- Cysto-urethroscopy
- Voiding studies

Urethral Syndrome Treatment

- Chronic antibiotic suppression
  - Macrodantin 50 mg qhs x 3 months
- Urethral dilatations
  - x3 q 2 weeks

Interstitial Cystitis

- Chronic, irritative voiding symptoms
  - Frequency, urgency, nocturia, pelvic/suprapelvic pain
- *Relief with voiding, worse with bladder filling, worse with certain food/drink
- Dyspareunia common
- Incontinence unusual
- Dysuria, 1/3

Interstitial Cystitis

- ? Collagen vascular
- ? Autoimmune
- ? Allergic
- ? Infectious

Interstitial Cystitis

- Anterior vaginal tenderness
- Sterile urine
- Cytology negative
- Cystoscopy under anesthesia
  - Reduced bladder capacity
  - Mucosal ulceration
  - Petechiae on redistention
- Potassium sensitivity test

Interstitial Cystitis - Treatment

- Hydrodistention
- Dimethyl sulfoxide (DMSO) 50%
  - 50cc periodically
- Bladder retraining
- Biofeedback
- Antidepressant (e.g., Elavil, Tofranil)
- Antihistamines
- SSRIs
- Pentosan polysulfate (Elmiron)

U: What to ask

- "How often do you go to bathroom?"
- "Do you have a sense of urgency?"
- "Do you sometimes feel like you have to go, but there's nothing that comes out?"
- "Do you get up in the middle of the night to go?"

Myofascial Syndromes

- Physical examination
- "Trigger points"
- Pressure reproduces pain

Abdominal Pelvic Pain

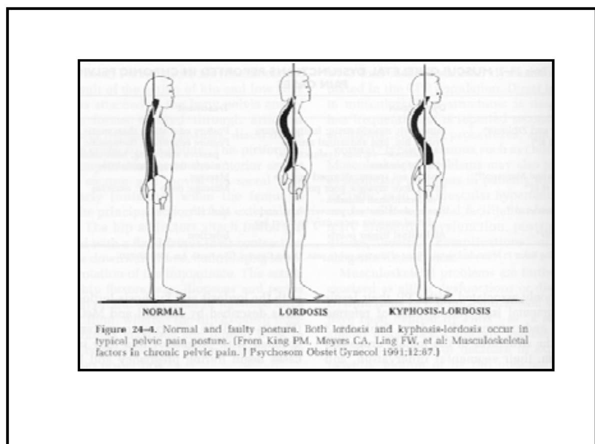
Pain response	Patients (N)	%
No pain	64	52.5
Occasional pain	36	29.6
Present, but better	9	7.4
No change	13	10.7
Worse	00	0
TOTAL	122	100

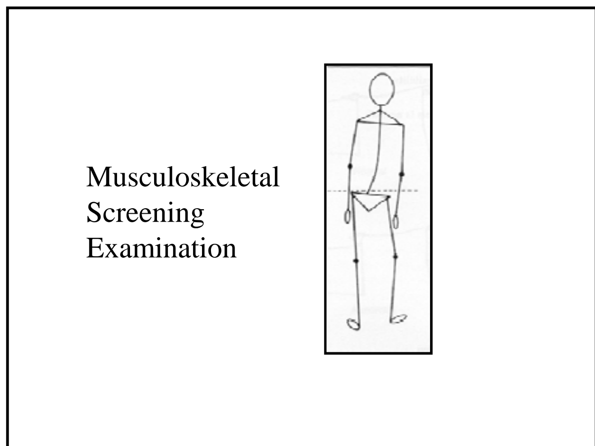
Slocumb, 1984

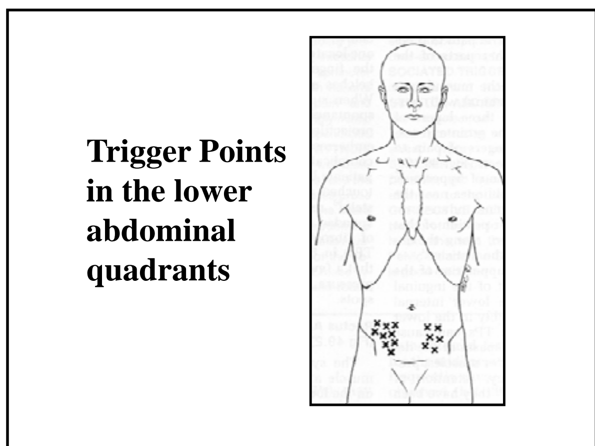
Typical Pelvic Pain Posture

At least 3 of the following 5 characteristics must be present:

- Increased lumbar lordotic curvature
- High apex lumbar lordotic curve
- Anterior pelvic tilt
- Unilateral ilial torsion
- Unilateral standing posture


NORMAL
LORDOSIS
KYPHOSIS-LORDOSIS
Figure 24–4. Normal and faulty posture. Both lordosis and kyphosis-lordosis occur in typical pelvic pain posture. [From King PM, Meyers CA, Ling FW, et al: Musculoskeletal factors in chronic pelvic pain. J Psychosom Obstet Gynecol 1991;12:87.]


Musculoskeletal
Screening
Examination


Trigger Points
in the lower
abdominal
quadrants

Response to Physical Therapy Intervention

	Group I	Group II
Complete relief	15 (20%)	11 (19%)
Significant relief	39 (52%)	28 (49%)
Worse	0 (0%)	0 (0%)
No change	5 (7%)	9 (16%)
Lost to follow up	16 (21%)	9 (16%)
Total	75 (100%)	57%)

Musculoskeletal Screening Examination for Patients Presenting with Chronic Pelvic Pain - History

- Normal laparoscopy
- History of trauma to low back or lower extremities, including motor vehicle accident or fall
- Pain is altered by positional changes, particularly prolonged standing or sitting
- Lack or response to previous gynecologic intervention
- Exacerbation with stress

Muscle Relaxants for Patients Presenting with Chronic Pelvic Pain

Trade name	Generic name	Dosage
Parafon Forte	Chlorzoxazone	500 mg q tid or qid
Robaxin	Methocarbamol	500 mg 3 tabs qid
Soma compound	Carisoprodol	200 mg 1-2 tabs qid
	Aspirin	325 mg qid
Valium	Diazepam	2-10 mg qid

M: What to ask

- "When does it hurt?"
- "Does it hurt to have sex?"
- "Can you point to where the pain is?"

Response to Antidepressant Treatment for Patients with Chronic Pain and Depression by Onset Pattern

Patient Onset Pattern	No Relief	Relief	Total
Developed pain then depression	11 (25%)	33 (75%)	44
Developed pain and depression simultaneously	6 (10%)	52 (90%)	58
Developed pain after depression	3 (21%)	11 (79%)	14
Total	20	96	116

Response Following Administration of Three Major Antidepressants

	# of trials	(in 116 pts)	Total
Antidepressant	No Relief	Relief	Trial
Imipramine (Tofranil)	11 (25%)	33 (75%)	44
Amitriptyline (Elavil)	4 (16%)	21 (84%)	25
Desipramine (Norpamin)	10 (23%)	34 (77%)	44
Total	30 (22%)	105 (78%)	135

Somatization Disorder

- Chronic psychiatric condition
- Onset before 30
- Multiple somatic problems – no adequate explanation
- 14 of 37 symptoms

Management of Somatization Disorders

- See patient regularly
- Accept her need to be "ill"
- Do not make MD contact contingent on somatic complaints
- Do not vary contact time in proportion to symptom severity

Management of Somatization Disorders

- Allow patient to structure content of visit
- Minimize secondary gain
- Teach the patient to express emotions in words
- Control strong reaction to patient
- Watch for new pathology

Chronic Pelvic Pain and Sexual Abuse

- N=43
  - 22 with history of daily pelvic pain
  - 21 with no pain
- Sexual assault interviews
- Psychological self reports

Walker et al. Am J Psych 1992

Chronic Pelvic Pain and Sexual Abuse

- More dissociation
  - Alterations in memory, consciousness, identity
- More psychological distress
- Medically disabled
- Vocational and social dysfunction
- Physical symptoms amplified
- Childhood sexual abuse
  - 18/22; 9/21 control
  - Severe 12/22 CPP; 1/22 controls

Walker et al. Am J Psych, 1992

P: What to ask

- "What about your appetite? Sleep? Energy? Libido? Interest in hobbies?"
- "Have you ever been touched against your will either as a child or as an adult?"

"Compartmentalized" Pelvic Exam

- Perineum
- Pelvic floor
- Urethra / bladder
- Cervix
- Uterus / adnexa

"Doctor, I've had this pain in my ovary…right here."

Physical Examination

"Is this the pain?"

Consider the Optometry model for pelvic pain.

Physical Examination:

Organ-specific tenderness
↓
Surgical procedure:
Specific pre-operative diagnosis

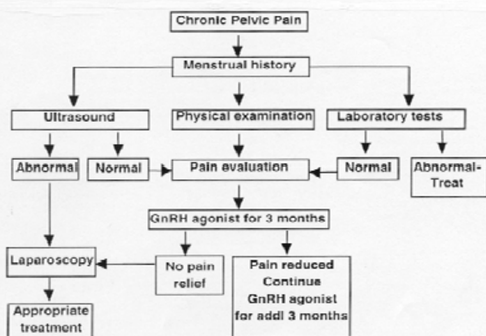
The Pelvic Witch Hunt

Be wary of claims for:

- Presacral neurectomy
- Uterine suspension
- LUNA
- Surgery for pelvic congestion
- Lysis of adhesions
- Hysterectomy
- Pain Mapping

Empiric GnRH Agonist for Pelvic Pain

- N=100
- Multi-centered trial
- Randomized, double-blind, placebo-controlled
- Diagnostic laparoscopy within 2 weeks of therapy
- Potential role for empiric GnRH prior to laparoscopy



Empiric GnRH

- Not for everyone
- Role of estrogen add-back
- Role of oral contraceptives/progestins
- Thorough work-up mandatory

Ovarian Vein Embolization for Pelvic Congestion Syndrome

- 9 of 11 "total or nearly total" relief (Johns Hopkins & Tripler)
- 18 or 23 "significant improvement of pain (Univ of British Columbia)
- Pooling of blood in ovarian vessels
- Stainless steel coils or liquid glue

Frequency of Hysterectomy for CPP Before and After Initiation of Clinic

	Before clinic	After clinic
Duration of interval (months)	30	52
Quarterly gyn admissions	487 $\pm$49	451 $\pm$81
Total hysterectomies	657	810
Annual rate	262.8	187
No of CPP (%)	107 (16.3)	47 (5.8)
Annual rate	42.3	10.9
P<0.0001		

In Patients with Negative Gyn Work-up, Consider:

- Gastroenterologic (IBS)
- Urogynecologic (IC, urethral syndrome)
- Musculoskeletal (trauma, trigger points)
- Psychiatric (sexual abuse, somatization, depression)