Spire Bushey Hospital

Chronic Pelvic Pain

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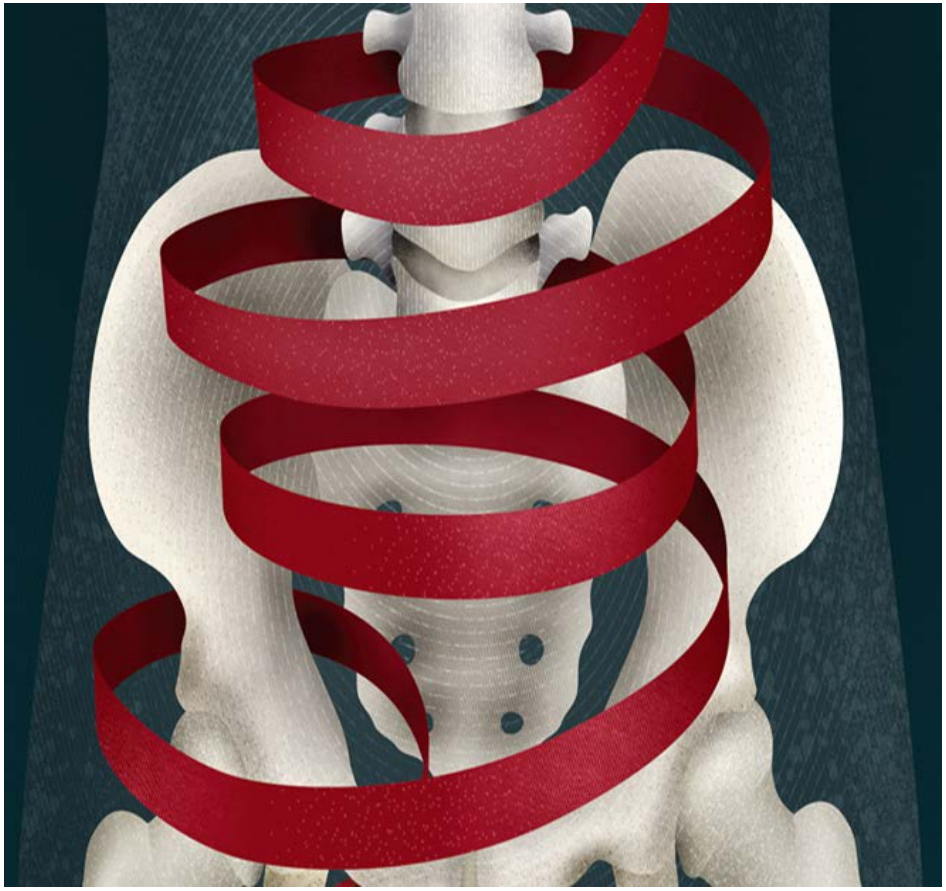
Consultant Gynaecologist

Headache in Pelvis



Confusion and lack of clarity

What we think?

‘But to me it’s a pain that you’ve tried in every way to solve, by surgery, by pain killers, by treating what you feel is the underlying condition, but that pain has not gone away.’

What we think?

‘And sometimes pelvic pain can be misdiagnosed as, you know, probably possibly irritable bowel syndrome, but you have to be careful that you don’t put it down to irritable bowel syndrome as it may be something more serious gynaecologically’

What we think?

Gynaecologists were seen as being the least useful in the management of this patient group.

‘I would always try and keep them out of gynaecology because I find that once I’ve referred them to gynaecology it’s a gravy train, and then they, they go to gynaecology and they get pushed from this investigation to that investigation to the other investigation and basically they never get better (laughing) gynaecology never let go of them either…’

What we think?

‘I mean I don’t know whether it (pressure) is necessarily coming from the patient, it might be a pressure from my own sort of inability to make people better but I, I do feel there is pressure from, from the patients. Because I do see, see that it is, I find it very difficult to try and bring patients round to looking at ways of coping with the pain, or maybe looking at psychological inputs, or a psychological reason for the pain, I find that extremely difficult.’

What we think?

‘Yeah, I think, I mean, the problem is, as always, that time’s an issue and, uhm, and *these patients are often people who have got named seats in the waiting room,* so you see them very frequently. And when you look back over the years almost everything’s been tried for them, uhm, and I mean there does come a time with some patients where you say, *well I’m sorry, this is something you’ll just have to live with.’*

What we think?

‘I don’t know. It’s just *massively frustrating*, and I mean we know ourselves, because if somebody comes to see me and they’ve got chronic pelvic pain and they’ve come to see me lots of times before and they’re not getting any better I feel frustrated and I feel down hearted before we start as well. *And the fact that people with chronic pelvic pain do make me feel frustrated, means that people probably aren’t particularly satisfied,* doesn’t it, I meant these are the sorts of things that, these are the sorts when you feel people aren’t satisfied.’

What we think?

'*Oh, nightmare! Because I'd just feel that there was nothing I'd be able to offer her because I'm not aware of anything that's there for her.* It would cross my mind, which is awful, whether it is a psychological thing, which is that's awful because there's nothing worse than having this thing and nobody's taking you seriously but again, if a Consultant has failed and the GP, what role, do you understand the position I'm in? *What could I offer where they have failed and as yet, I don't really know?*'

Chronic Pelvic Pain

Intermittent or constant pain in the lower abdomen or pelvis of a woman of at least 6months in duration, not occurring exclusively with menstruation or intercourse.

It is surprisingly common with approximately 38 per 1000 women attending primary care services each year with CPP, a rate comparable to that of asthma and back pain.

Community surveys report between 15 and 24 % of women aged 18 to 50 years old report experiencing CPP within the last three months.

Causes

Gynaecological

- Endometriosis
- Adenomyosis
- Fibroids
- Adhesions
- Pelvic infection
- prolapse of the womb
- recurrent ovarian cysts
- Pelvic venous congestion?

Gastrointestinal

- Irritable bowel disease
- Inflammatory bowel disease

No obvious cause (CPPS)

Urological

- Recurrent urinary tract infection
- Chronic interstitial cystitis /BPS

Musculoskeletal/Neurological/Others

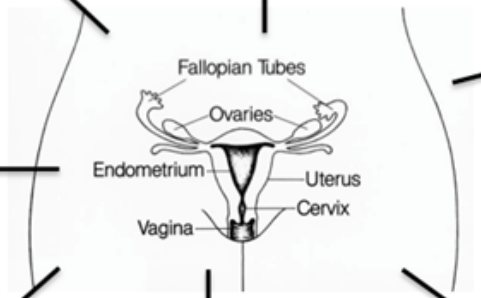
- Hernia
- Trapped or damaged nerves in the pelvic area
- Lower back pain

Causes

Endometriosis / Adenomyosis

Pelvic inflammatory disease

Painful bladder syndrome (aka interstitial cystitis)



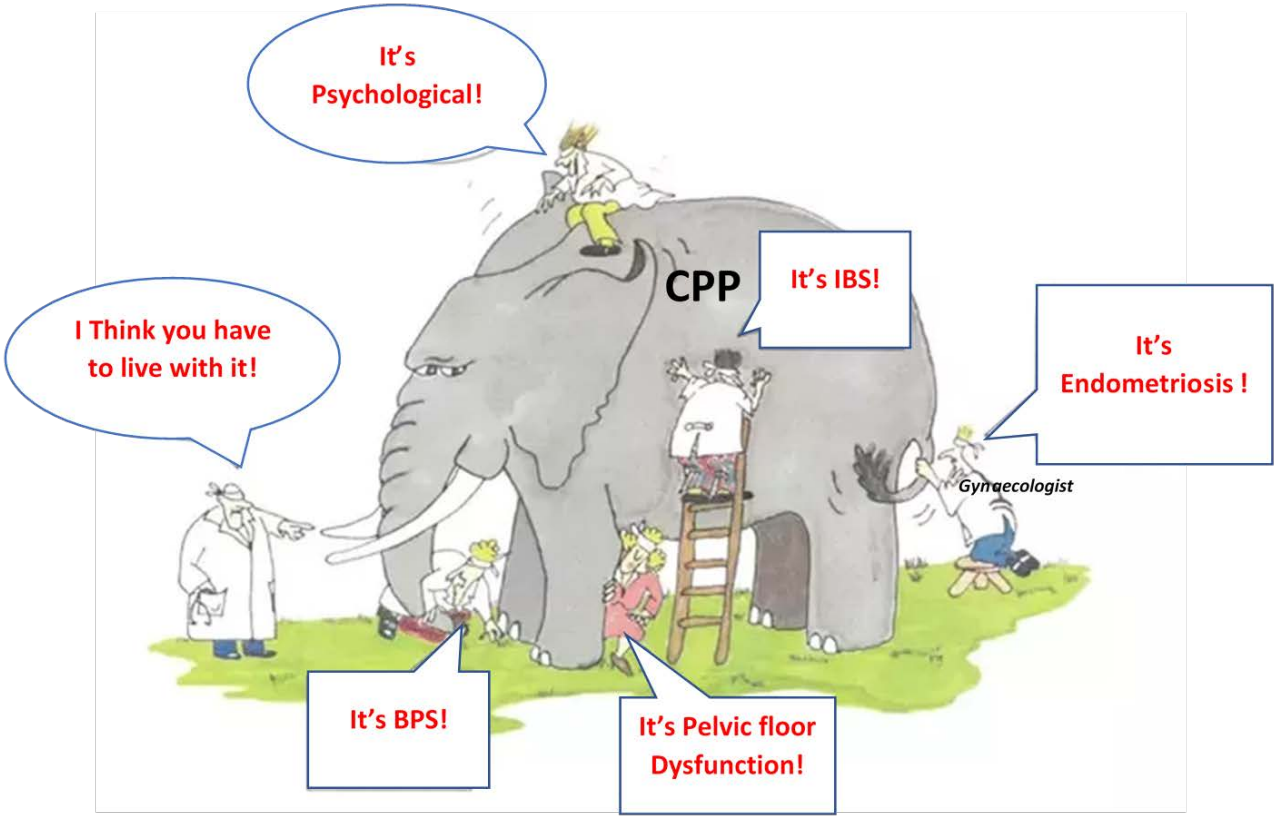
Nerve Entrapment / Musculoskeletal

Irritable bowel syndrome

Adhesions

Pain where no cause is found

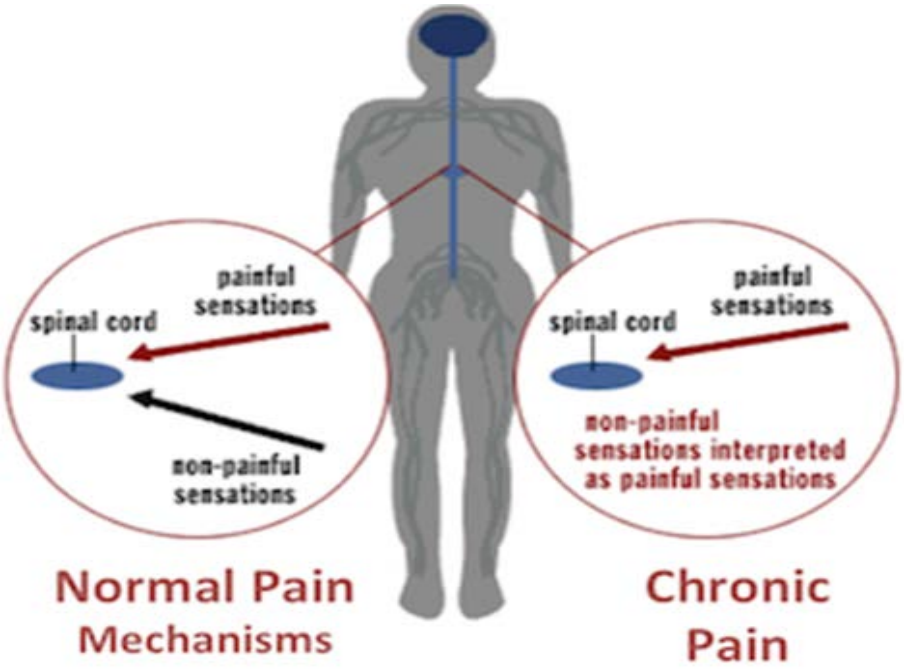
CPP


It's Psychological!
CPP
It's IBS!
I Think you have to live with it!
It's Endometriosis !
Gynaecologist
It's BPS!
It's Pelvic floor Dysfunction!

Management of CPP

Management requires knowledge of all pelvic organ systems and their association with other systems and conditions, including musculoskeletal, neurologic, urologic, gynaecologic and psychological aspects, promoting a multidisciplinary approach.

Mechanism of pain



Mechanism of pain

Acute pain reflects fresh tissue damage and resolves as the tissues heal.

Chronic pain, additional factors come into play and pain may persist long after the original tissue injury or exist in the absence of any such injury. Major changes are seen in both afferent and efferent nerve pathways in the central and peripheral nervous systems.

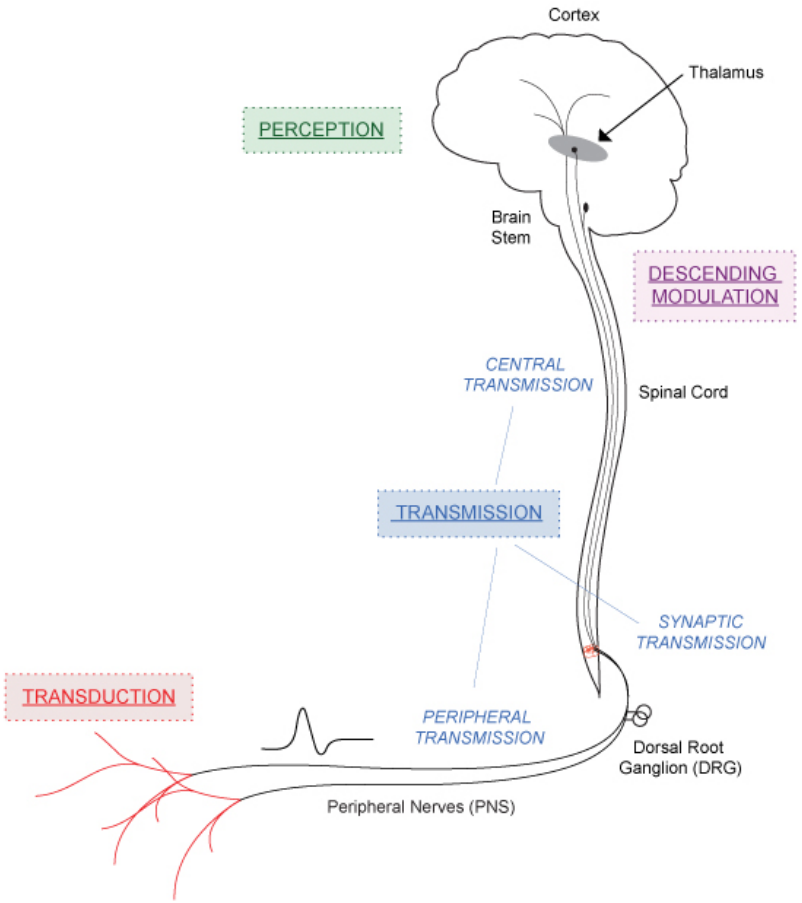
Local factors, such as tumour necrosis factor alpha (TNF-) and chemokines,may change peripheral nerve function and/or stimulate normally quiescent fibres,resulting in altered sensation over a wider area than that originally affected. A persistent barrage of pain may lead to changes within the central nervous system, which magnify the original signal.

Mechanism of pain

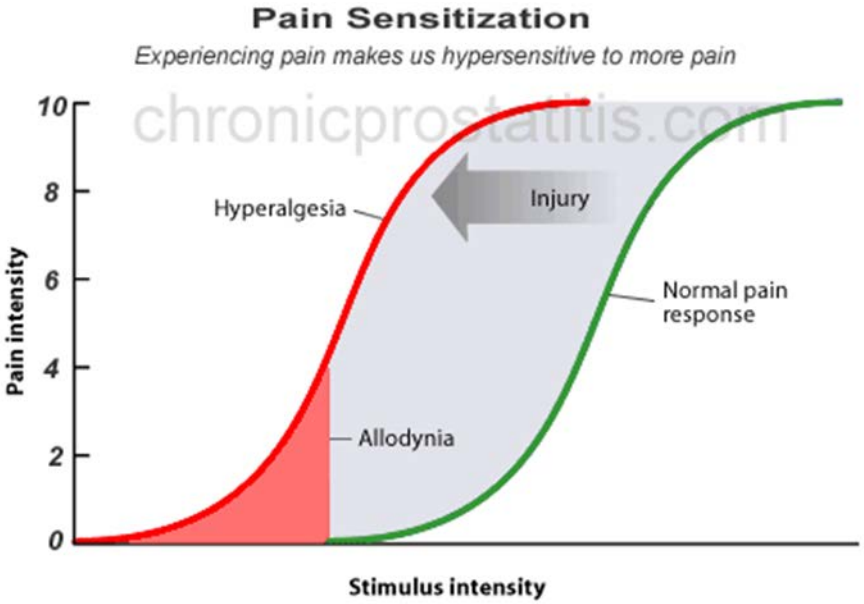
Descending information from the central nervous system,possibly influenced by previous experiences and current circumstances, may modify pain perception and visceral function. Alteration in visceral sensation and function, provoked by a variety of neurological factors,has been termed‘visceral hyperalgesia’.

Nerve damage following surgery, trauma, inflammation, fibrosis or infection may play a part in this process. Pain as a result of changes in the nerve itself is termed‘neuropathic pain’ and is characteristically, but not exclusively, burning, aching or shooting in nature.

Mechanism of pain



Mechanism of pain



Noxious stimuli can sensitize the nervous system response to subsequent stimuli. The normal pain response as a function of stimulus intensity is depicted by the curve at the right, where even strong stimuli are not experienced as pain. However, a traumatic injury can shift the curve to the left. Then, noxious stimuli become more painful (hyperalgesia) and typically painless stimuli are experienced as pain (allodynia)

Management of CPP

Chronic pelvic pain in urological and gynaecological practice is often complex and difficult to treat.

The aim is to try and determine a remediable cause and treat it using the most effective available therapy.

However, in 30% of cases, no cause is ever determined and this presents a therapeutic challenge (CPPS).

Management
(History)

Taking a detailed medical history is essential to making a diagnosis. The nature, frequency and site of the pain, and its relationship to precipitating factors and the menstrual cycle, may provide vital clues to the aetiology. A detailed menstrual and sexual history, including any history of sexually transmitted diseases and vaginal discharge is mandatory. Discrete inquiry about previous sexual trauma may be appropriate.

Association with bladder, bowel, movement or posture.

Case Scenario

23 years old with pelvic pain on right side for one year

Swabs negative

Scan normal

Tried pain killers, Pills- no relief

Came to discuss laparoscopy

Case Scenario

25 years old

Persistent pelvic pain

2 years follow up

Had a named seat in the waiting area!

No positive history

Always attended with partner

History review in his absence-

SA

counselling

Case Scenario

30 years old

Had CS 12 months ago

Pain since then

No other symptoms(bowel, urinary)

Swabs normal

Scan normal

Detailed history in absence of husband- none

Tried pain killers

Pills

Laparoscopy no adhesions/ endometriosis

Loaded rectum

Referred to colorectal team

Examination

Abdominal and pelvic examination will exclude any gross pelvic pathology (tumours, scarring, and reduced uterine mobility), as well as demonstrating the site of tenderness if present. The examination of a woman should be directed to the determination of cutaneous allodynia along the dermatomes of the abdomen (T11-L1) and the perineum (S3). The degree of tenderness of the muscles and on the perineum.

Case Scenario

42 years old

Abdo pain

Had CS in the past

Abdominal wall tenderness at specific point below umbilicus

Case Scenario

42 years old

Pelvic pain

Pressure

Frequency of urine

Urine analysis normal

No other symptoms

Scan normal(TVS)

Investigations

Vaginal and endocervical swabs (All sexually active women with chronic pelvic pain should be offered screening for sexually transmitted infections (STIs) :RCOG)

Pelvic imaging, using ultrasound scanning or magnetic resonance

Laparoscopy is perhaps the most useful invasive investigation to exclude gynaecological pathology and to assist in the differential diagnosis of CPP in women.

(There have been three diverse studies of laparoscopy.)

Case Scenario

45 years old

Had coil removed GP surgery (10 years)

Acute pelvic infection

Pain

Antibiotics

Persistent pain

Laparoscopy- frozen pelvis

Biopsy- actinomycosis

Case Scenario

30 years old

Saw her in theatre

Booked for laparoscopy for pain

Reviewing the old records and scan from other trust

10 cm fibroid!

Case Scenario

18 years old

Pain in lower abdomen

Swabs negative

Scan normal

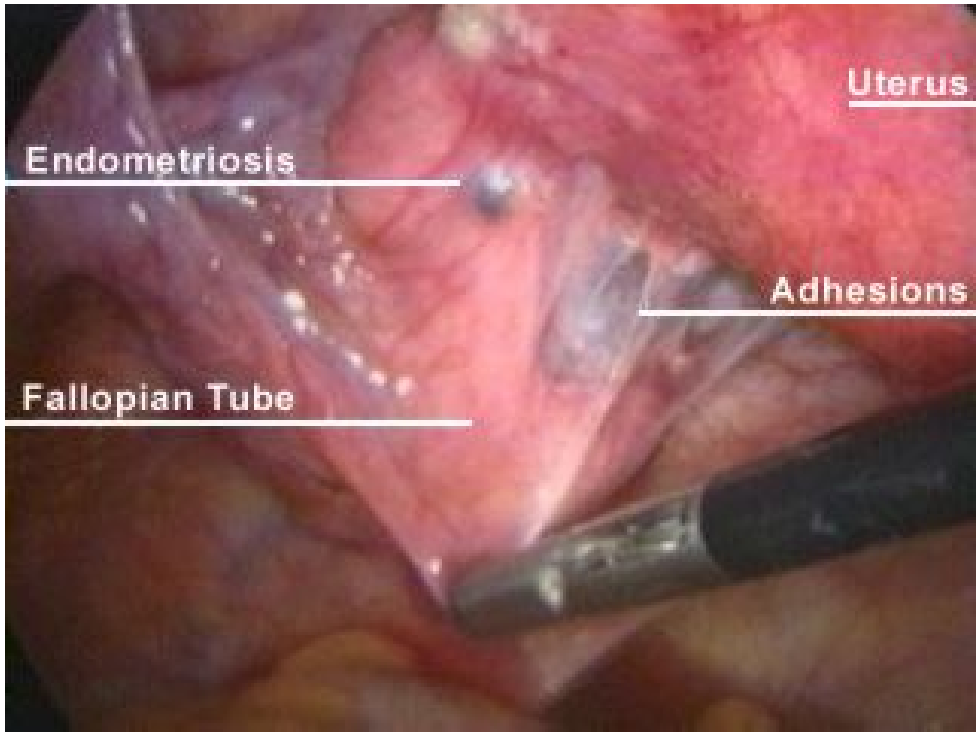
Tried pain killers for 12 months

Missing school

Pain worse during exams

Laparoscopy endometriosis

Case Scenario



Treatment

Endometriosis/ Adenomyosis (Women with cyclical pain should be offered a therapeutic trial using hormonal treatment for a period of 3–6 months before having a diagnostic laparoscopy).

Fibroids/ ovarian cysts

Adhesions?

Pelvic organ prolapse

Pelvic infection

Treatment of CPP

Multidisciplinary management

Primary and secondary care

Treatment of CPP

Conservative Management

Pharmacological

Surgical

Treatment

Assessment process should allow enough time for the woman to be able to tell her story. This may be therapeutic in itself.

A pain diary may be helpful in tracking symptoms or activities associated with the pain.

Case Scenario

45 years old lady with lower abdominal/ pelvic pain with previous 2 CS

Affecting her life and work

All investigations normal

Scan normal

Wanted hysterectomy

Management of CPP and sexual dysfunction

Sexual behavioural strategies

Vaginal dilators

Hypoallergenic lubricants

Local estrogen

Physio

Massage

Laser?

Management of CPP and sexual dysfunction

50 years old

Breast cancer

Had therapy

Pelvic pain mainly vaginal

Dyspaerunia

Tried all

Not keen on Estrogen vaginal

Laser!

Psychological and social issues

Depression and sleep disorders are common in women with chronic pain. This may be a consequence rather than a cause of their pain, but specific treatment may improve the woman's ability to function.

The relationship between chronic pelvic pain and sexual or physical abuse is complex

Child sexual abuse may initiate a cascade of events or reactions which make an individual more vulnerable to the development of chronic pelvic pain as an adult. Women who continue to be abused are particularly at risk

Case Scenario

46 years old

Pelvic pain

Seen many gynaecologists (Had laparoscopy twice in different hospitals)

Tried pain killers, pills

Seen by bowel surgeons- colonoscopy

Endometrial ablation

Swabs normal

Mini pill

Scan ?adenomyosis

Case Scenario

42 years old

Pelvic pain

Urinary symptoms

GP- urine screen negative/ swabs negative

Urologists – cystoscopy normal

Repeated urinary screen negative

Gynaecologist ?endometriosis

Gastro team- IBS

Psychologist – CBT

Physio

Treatment evidence

Despite the frequency of CPP, relatively few studies have specifically looked at the medications used in CPP patients. Further specific research is required in this group of patients.

Treatment evidence

Paracetamol- Somatic pain A - Evidence based on arthritic pain with good benefit

NSAIDs- Pelvic pain with inflammatory process –A- effective

Central mechanisms? (e.g. endometriosis) A- No good evidence

Antidepressants including tricyclic antidepressants- A Effective. No specific evidence for CPP

Anticonvulsants –Neuropathic pain-Gabapentin, Pregabalin - A Effective

Gabapentin Women with CPP B Effective

Opioids Chronic non-malignant pain- A Beneficial in a small number of patients- (opioid-induced hyperalgesia)

Acupuncture-B-Effective and safe but not long lasting?

Nerve blocks C Have a role as part of a broad management plan

TENS A No good evidence of benefit

Neuromodulation Pelvic pain C Role developing with increasing research

Evidence of its use in OAB and Faecal incontinence is robust but limited in CPP.

Nice guidance in use of SCS.

Treatment evidence

Paracetamol- Less side effects

NSAIDS-There is no good evidence to suggest one NSAID over another for pelvic pain.

At a practical level, NSAIDs could be considered as analgesics for patients with pelvic pain. The should be tried (having regard for the cautions and contraindications for use) and the patient reviewed for improvement in function as well as analgesia. If this is not achieved, or there are side effects, then the NSAID should be stopped.

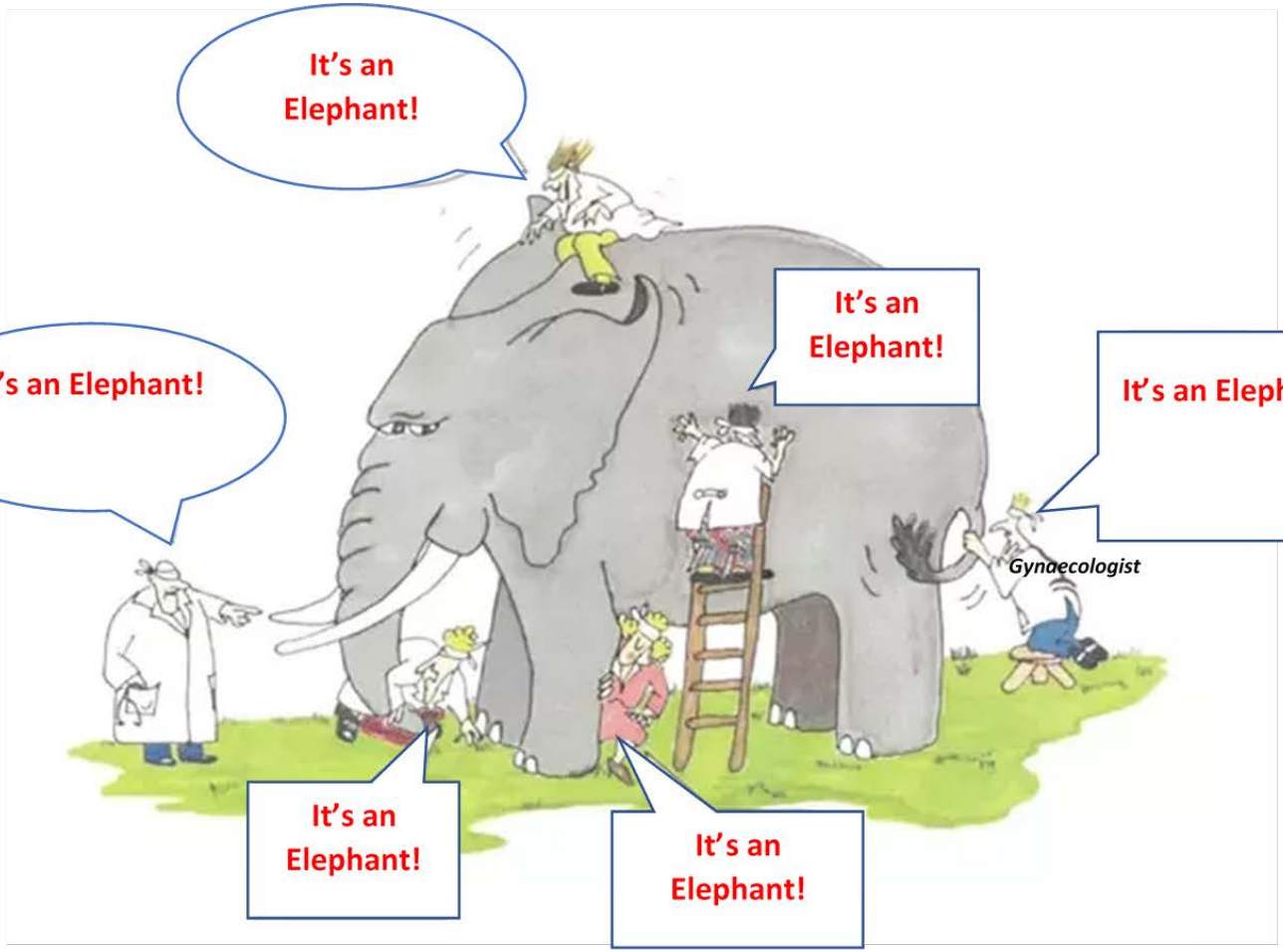
Tricyclic antidepressants Amitriptyline is the most commonly used member of this group.

Other antidepressants- Venlafaxine, Duloxetine (SNRI)- more side effects

SSRI- insufficient evidence but side ffects are less

Anticonvulsants- Gabapentin is commonly used for neuropathic pain and has been systematically reviewed. It provides good quality relief. Studies of its use in CPP. Pregabalin is another commonly used neuromodulator.

Thank You!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