Chronic pelvic pain in women

Key practice points:

- Chronic pelvic pain can arise from pathology affecting any of the structures located within the pelvis and lower abdomen, including related structures, or there may be no identifiable cause
- The first goal of treatment is to acknowledge the pain and understand how this affects the woman's life
- Unless a specific cause is found that can be treated, management focuses on strategies for pain modulation, including exercise, diet and sleep
- Analgesia and adjuvant medicines may be considered, such as paracetamol, non-steroidal anti-inflammatory drugs, tricyclic antidepressants and gabapentin
- The overall aim is to provide the woman with support to self-manage and be able to cope with her pain

Chronic pelvic pain is defined as intermittent or constant pain in the lower abdomen or pelvis of at least six months' duration, which does not occur exclusively with menstruation or intercourse. "Chronic pelvic pain syndrome" is the appropriate diagnosis where pain is the dominant feature in the absence of pathology.[1, 2]

For most women with chronic pain, it is of upmost importance for their pain to be validated. In the absence of an identifiable cause, it is essential to educate women that there is no one "magic bullet" that will resolve their pain. It is a journey that both doctor and patient will go on, with the hope of finding strategies to help cope with and minimise the pain over time. Women with chronic pelvic pain report a lower quality of life, with high rates of functional impairment, psychosocial distress and sexual dysfunction, risk being "labelled" as difficult or needy and may struggle to be believed when accessing healthcare services.

Diagnosis and investigation of chronic pelvic pain

Assessment begins with acknowledging the pain and understanding how this affects the woman's life. **A comprehensive history is essential**, covering the characteristics of pain, contributing factors and co-morbidities, which may help identify the underlying cause(s). The history should include questions about the woman's:[3]

- Pain (characteristics, duration, frequency)
- Menstrual cycle
- Bowel and bladder function
- Sexual function (including any history of abuse)
- Level of functioning
- Co-morbidities
- Medicine use including any medicines used to manage the pain

Examine for postural abnormalities, as well as performing abdominal and pelvic examination, including assessment of pelvic floor muscles. Neuropathic testing can be used to identify any altered areas of sensation over the lower abdomen

and the perineum, such as allodynia, hyperalgesia or sensory loss. Assessment should exclude any red flags and consider the specific aetiologies of reported symptoms.

Red flags which require referral include:[3]

- Rectal bleeding
- Irregular vaginal bleeding in a woman aged over 40 years
- Post-coital bleeding
- Onset of new bowel symptoms in a woman aged over 50 years
- Excessive or unexplained weight loss
- Onset of pelvic pain in a post-menopausal woman
- Pelvic mass

Laboratory tests may include swabs to rule out sexually transmitted infections, a cervical smear if due or if there is an abnormality on examination, a urine sample to exclude pregnancy or urinary tract infection, and blood tests such as full blood count, creatinine and electrolytes and C-reactive protein. Ultrasound and laparoscopy can help detect pelvic pathology such as uterine leiomyomas, ovarian tumours and some cases of endometriosis, and may be appropriate in some women.

Management of chronic pelvic pain

Unless a specific cause is found that can be treated, management focuses on strategies for pain modulation, including exercise, diet and sleep:

- Exercise produces symptomatic improvements in most patients with chronic pain[4]
- Physiotherapy can be valuable, particularly for women who have hypercontractility of the pelvic floor. Exercises which increase pelvic floor tone should be avoided as these can exacerbate pelvic floor hypercontractility.
- Improving sleep quality with sleep hygiene techniques can decrease chronic pain
- Smoking cessation; smoking is associated with higher levels of physical impairment and increased pain in patients with fibromyalgia and a similar association is likely in patients with any type of chronic pain[5]
- Dietary changes may improve chronic pain symptoms:
  - Increasing intake of fruit and vegetables
  - Bladder irritation can be minimised by reducing the intake of caffeine, citrus fruits, spicy foods, carbonated drinks and alcohol and ensuring adequate hydration[6]

Information on exercises to relax the pelvic floor is available online, e.g. www.pelvicpain.org.au/information/women/yoga-poses-relax-pelvis/

Analgesia and adjuvant medicines may be considered, such as paracetamol, non-steroidal anti-inflammatory drugs (NSAIDs), tricyclic antidepressants (TCAs) and gabapentin. The overall aim is to provide the woman with support to self-manage and be able to cope with her pain.

Prescribing points for the use of analgesics in women with chronic pelvic pain include:[1, 7]

- Paracetamol should be used on a regular daily basis rather than "as required", particularly if there is somatic pain
- NSAIDs are widely used for chronic pelvic pain and can be beneficial for some women, particularly if there is an inflammatory component to the pain
- All opioids should be avoided as they can cause a paradoxical increase in sensitivity to pain, as well as the risks of addiction, tolerance and constipation. Benzodiazepines should also be avoided.
- TCAs and gabapentin affect neuropathic or centrally mediated pain, and there is some evidence that these medicines may benefit patients with chronic pelvic pain. TCAs should be trialled for at least six to eight weeks before assessing response as they can take some time to produce benefit.
- Other pharmacological options include clonidine (usually a transdermal patch) as an adjuvant analgesic and botulinum toxin A injections which may reduce spasm of the pelvic floor muscles, particularly if used in combination with pelvic floor physiotherapy

Patient resources

The International Pelvic Pain society produces an educational document for women with chronic pelvic pain, available from: **http://pelvicpain.org/docs/patients/basic-chronic-pelvic-pain.aspx**

The Pelvic Pain Foundation of Australia also has an informative website designed for patients and their families, available from: **www.pelvicpain.org.au**

For further information, see: "Chronic pelvic pain in women", BPJ 70 (Sep, 2015).

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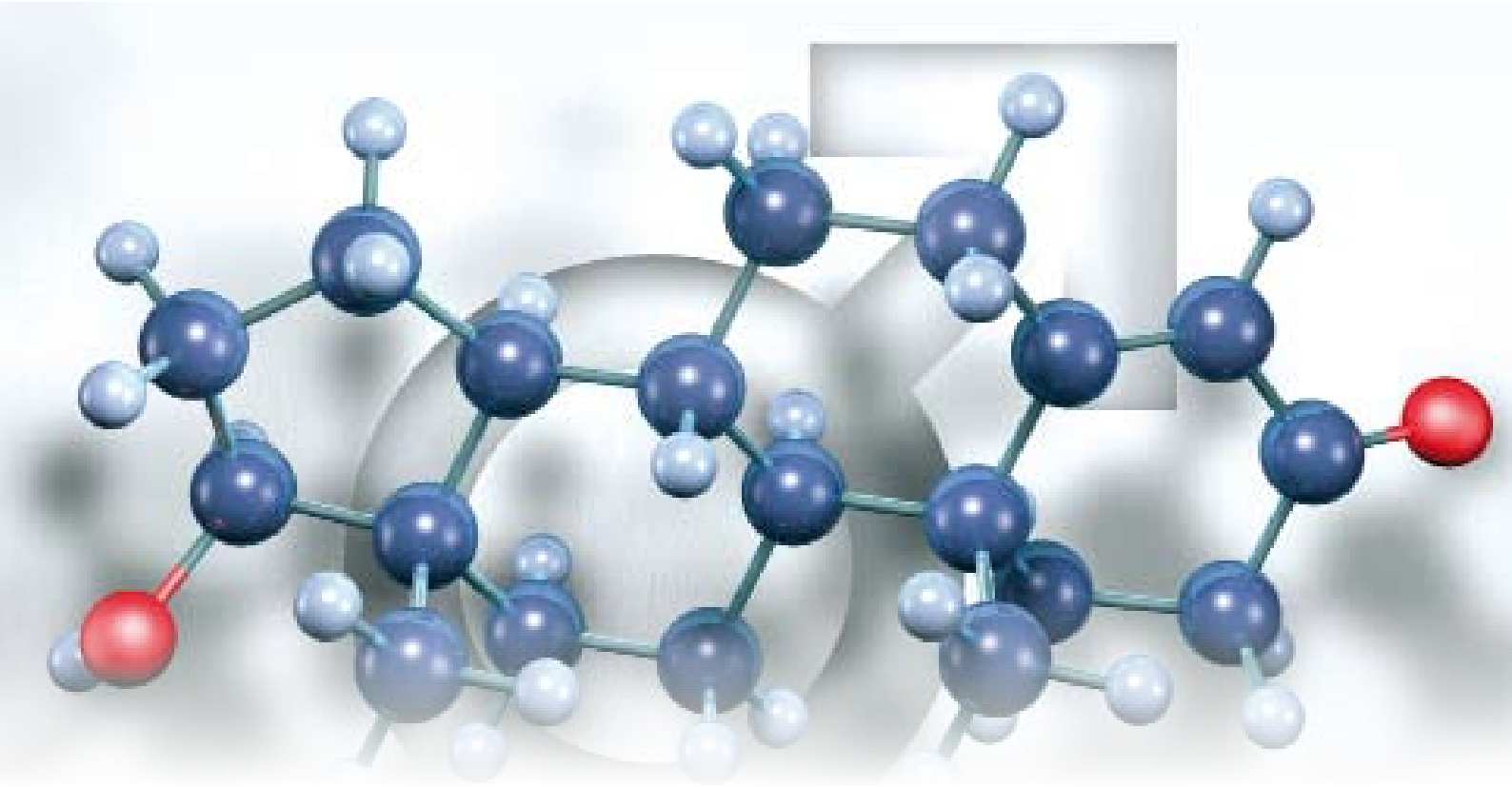

Testosterone use in older males

Although testosterone levels in males decline with age, the risks and benefits of testosterone supplementation in this age group are unclear.

Older males may present with signs and symptoms suggestive of hypogonadism; some of these are less specific, such as decreased energy or depressed mood, and others more specific, such as decreased or absent morning or spontaneous erections, reduced libido and erectile dysfunction.[1]

The first step is to consider medical conditions or other factors which could be managed to improve signs and symptoms.

A number of medical conditions can influence the function of the HPG axis and are associated with hypogonadism, including:[2–4]

- Type 2 diabetes
- End-stage renal disease
- Osteoporosis
- Moderate to severe COPD
- Severe obstructive sleep apnoea
- Pituitary tumour
- HIV