Chronic Pelvic Pain in women

Chronic pelvic pain is defined as intermittent or constant pain in the lower abdomen or pelvis of at least six months duration, that does not occur exclusively with menstruation or intercourse. Recent European guidelines, however, recognise a more encompassing view of chronic pain than this traditional definition and chronic pelvic pain should be considered a symptom rather than a diagnosis.

Chronic pelvic pain can arise from pathology affecting any of the structures located within the pelvis and lower abdomen, as well as other structures related to these areas, such as the skeletal system, pelvic floor muscles and nerves, or there may be no cause identified. Endometriosis, chronic infection and irritable bowel syndrome frequently cause chronic pelvic pain, and specific treatment can be implemented to manage these conditions. However, in some women the pain will continue despite appropriate identification and management. In some cases the pathology may be an incidental finding. Although a peripheral stimulus may have produced pain initially, additional mechanisms produce chronic pain due to central nervous system modulation. These mechanisms may be associated with other sensory, behavioural and psychological phenomena, which is why women with chronic pelvic pain require multi-disciplinary care.

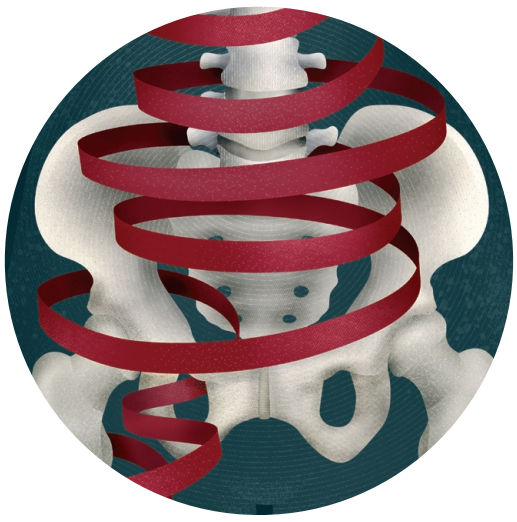
Women with chronic pelvic pain report a lower quality of life, with high rates of functional impairment, psychosocial distress and sexual dysfunction, risk being "labelled" as difficult or needy and may struggle to be believed when accessing healthcare services.

Assessment begins with acknowledging the pain and understanding how this affects the woman's life. Red flags should be excluded and specific aetiologies considered. A comprehensive history covers the characteristics of pain, contributing factors and co-morbidities. It also promotes development of a therapeutic relationship, enabling education, increased understanding and ideally acceptance of the pain. Physical examination should include assessment for musculoskeletal abnormalities, as well as abdominal and pelvic examination, including evaluation of pelvic floor muscles. Laboratory tests can rule out infection; ultrasound and referral for laparoscopy may be appropriate in some cases. Diagnostic laparoscopy is the gold standard for the diagnosis of endometriosis and adhesions, although a cause for the pain will not be found in approximately one-third to one-half of all diagnostic laparoscopies. A negative finding at laparoscopy can, however, be positive for the patient as it rules out certain pathophysiological causes for their pain.

Education, recognition and reassurance are important parts of the multi-faceted management strategy. 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, NSAIDs, TCAs and gabapentin. The overall aim is to provide the woman with support to self-manage and be able to cope with her pain.

Peer group discussion points:

1. What aspects do you find challenging in managing women with chronic pelvic pain?
2. What is your normal approach when assessing women with chronic pelvic pain?
3. Non-pharmacological strategies for pain modulation (such as exercise and sleep) are recommended – do you find that these strategies are well accepted and effective?
4. How much emphasis do you place on managing the patient's psychological aspects of chronic pelvic pain? What techniques do you use to help patients deal with these issues?
5. Do you currently prescribe opioids for women with chronic pelvic pain? Does this article give you encouragement and tools to reconsider this practice?



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