GYNAECOLOGY & OBSTETRICS UPDATE

Issue 40 | **May , 2005**

Author

T.M.Malak

MB, BCh., M.Sc., Ph.D., DFFP, MRCOG, FRCOG

Consultant Obstetrician Gynaecologist & Urogynaecologist

Eastbourne District General Hospital

Address

Esperance House
Esperance Hospital
Hartington Place
BN21 3BG

Tel: 01323 414816/ 410717/ 410929
Fax: 01323 730313

Web address

For Professionals
MarkMalak.com

For Patients
MrMalak.com

Reference

For the full RCOG Guideline and a **FLOW CHART** of management visit MarkMalak.com **or**

http://www.rcog.org.uk/resources/Public/pdf/initial_%20manage-ment_chronic_pelvic_pain41.pdf

Initial Management of CHRONIC PELVIC PAIN (CPP)

Chronic Pelvic Pain (CPP) affects one in six of the adult female population and presents in the primary care as frequently as migraine or low back pain. CPP can be defined as intermittent or constant pain in the lower abdomen or pelvis of at least 6 months' duration, not occurring exclusively with menstruation or intercourse and not associated with pregnancy. The advice is based on a RCOG guideline (No 41– April, 2005)

Adequate time should be allowed for the initial assessment of women with CPP Patients need to feel that they have been able to tell their story and have been listened to and believed. Many women present because they want an explanation for their pain. Often, they already have a theory or a concern about the origin of the pain which should be discussed, ideally, during the first visit.

Ask questions about the pattern of the pain , its association with other problems (psychological, bladder and bowel symptoms) and the effect of movement and posture

- Bleeding per rectum
- New bowel symptoms over 50
- New pain after the menopause
- Pelvic mass
- Suicidal ideation
- Excessive weight loss
- Irregular vaginal bleeding over 40
- Post coital bleeding

- **Symptoms suggestive of serious diseases should be identified and managed**
- There is frequently more than one component to CPP (e.g. physical, psychological and social). **This multifactorial nature of CPP should be discussed and explored from the start**. Child sexual abuse may initiate, in some cases, a cascade of reactions which make women more vulnerable to develop CPP as an adult .Women continue to be abused are particularly at risk.
- CPP which is strikingly cyclical is usually gynaecological in nature due to a variety of hormonally driven conditions e.g. Endometriosis. **A therapeutic trial using the combined contraceptive pill or gonadotrophin-releasing hormone (GnRH) agonist can be offered for 3–6 months. Mirena could also be considered.**
- Symptoms suggestive of irritable bowel syndrome (IBS) or interstitial cystitis are often present in women with CPP (50% and 38– 84% respectively) as a primary cause or a component of CPP. Symptom-based diagnostic criteria can be used with confidence to make the diagnosis of IBS. IBS symptoms may vary a little with the menstrual cycle with 50% experiencing a worsening of their symptoms with the period. **Patients with IBS symptoms should be advised to amend their diet and offered a trial of antispasmodics**.
- Musculoskeletal pain may be a primary or an additional source of CPP (in 75% of cases).
- Nerve entrapment in scar tissue, fascia or a narrow foramen may result in pain in the distribution of that nerve. Nerve entrapment in a scar is defined as highly localised, sharp, stabbing or aching pain, exacerbated by particular movements and persisting beyond 5 weeks or occurring after a pain-free interval.
- Depression and sleep disorders are common with CPP. This may be a consequence rather than a cause of the pain but **specific treatment may improve the woman's ability to function.**
- **A daily pain diary for 3 months may help to identify provoking factors or temporal associations.**

Suitable samples to screen for infection, particularly chlamydia and gonorrhoea, should be taken if there is any suspicion of pelvic inflammatory disease (PID) A positive result from the cervix supports but does not prove the diagnosis of PID. The absence of infection does not rule out the diagnosis of PID.

Trans-vaginal scanning is appropriate to screen for and assess adnexal masses and for adenomyosis.

Appropriate analgesia to control their pain should be offered even if no other therapeutic manoeuvres are yet initiated e.g. regular non-steroidal anti-inflammatory drugs, with or without Paracetamol

Referral to the relevant healthcare professional if exam (abdominal, pelvic, etc.) and/or investigation (e.g. pelvic scan) revealed abnormality or the initial management is associated with unsatisfactory improvement. Referral depends upon the findings and could be to the following departments: gynaecology, gastroenterology, urology, genitourinary medicine, physiotherapy, osteopathy, psychology and/or psychosexual counselling

Evidence to demonstrate that adhesions cause pain or that laparoscopic division of adhesions relieves pain is *lacking* except in cases of dense vascular adhesions.

Flowchart for the suggested management of chronic pelvic pain