Brin

The Initial Management of Chronic Pelvic Pain

This is the second edition of this guideline. The first edition was published in 2005 under the same title.

1. Purpose and scope

The purpose of this guideline is to provide an evidence-based summary for the generalist to facilitate appropriate investigation and management of women presenting for the first time with chronic pelvic pain.

2. Background and introduction

Chronic pelvic pain can be defined as intermittent or constant pain in the lower abdomen or pelvis of a woman of at least 6 months in duration, not occurring exclusively with menstruation or intercourse and not associated with pregnancy. It is a symptom not a diagnosis. Chronic pelvic pain presents in primary care as frequently as migraine or low-back pain[1]

Careful scrutiny of the woman's history and physical findings will frequently reveal factors that may be contributing to the pain and can therefore be at least partially treated. Given the incomplete understanding

Although many symptom complexes such as irritable bowel syndrome (IBS) and pain perception itself[17] may vary a little with the menstrual cycle (with 50% of women experiencing a worsening of their symptoms in association with their period[18]), strikingly cyclical pain is likely to be gynaecological in nature.

A s ons

There is no evidence to support the division of fine adhesions in women with chronic pelvic pain.

Division of dense vascular adhesion should be considered as this is associated with pain relief.

Adhesions may be a cause of pain, particularly on organ distension or stretching. Dense vascular adhesions may cause chronic pelvic pain. However, adhesions may be asymptomatic. Evidence to demonstrate that adhesions cause pain or that laparoscopic division of adhesions relieves pain is lacking. However, in a randomised controlled trial, 48 women with chronic pelvic pain underwent laparotomy with or without division of adhesions. Although overall there was no

In a consecutive series of 26 women with laparoscopy-negative chronic pelvic pain undergoing magnetic resonance imaging (MRI), 20 were found to have injuries to the levator ani. In a pain-free control group undergoing MRI, none of the 20 nulliparous and two of the 32 multiparous women had such injuries.[28] Spasm of the muscles of the pelvic floor is proposed as a cause of pelvic pain which can be reduced by botulinum toxin injections.[29,30] A number of controlled and

5. What should underline the initial assessment of chronic pelvic pain?

5 *H stor*

The initial history should include questions about the pattern of the pain and its association with other problems, such as psychological, bladder and bowel symptoms, and the effect of movement and posture on the pain.

Symptoms alone may be used to diagnose IBS positively in this group (see Appendix 1).

On taking the woman's history, special note should be taken of any 'red flag' symptoms (see Appendix 2) which may need further investigation and referral to a specialist. If the situation allows, it may be helpful to ask directly about past or present sexual assault, particularly intimate partner violence. The doctor must be prepared to listen and accept these experiences as stated and know where to access specialist support.

Completing a daily pain diary for two to three menstrual cycles may help the woman and the doctor

All sexually active women with chronic pelvic pain should be offered screening for sexually transmitted infections (STIs).

A positive endocervical sample supports but does not prove the diagnosis of PID.The absence of a result positive for

Diagnostic laparoscopy is the only test capable of reliably diagnosing peritoneal endometriosis and adhesions. Gynaecologists have therefore seen it as an essential tool in the assessment of women with chronic pelvic pain. However, it carries significant risks: an estimated risk of death

7. What therapeutic options are available?

Women with cyclical pain should be offered a therapeutic trial using hormonal treatment for a period of

Voluntary organisations such as Endometriosis UK can be an important source of information and support for some patients. A list of such organisations is given in section 10. Self-management techniques as suggested by the Department of Health's Expert Patient Initiative may also be of value to some women.

8. Summary

Chronic pelvic pain is common, affecting perhaps one in six of the adult female population.[96] Much remains unclear about its aetiology, but chronic pelvic pain should be seen as a symptom with a number of contributory factors rather than as a diagnosis in itself. As with all chronic pain it is important to consider psychological and social factors as well as physical causes of pain. Many non-gynaecological conditions such as nerve entrapment or IBS may be relevant. Women often present because they seek an explanation for their pain.

The 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. Where pain is strikingly cyclical and no abnormality is palpable at vaginal examination, a therapeutic trial of ovarian suppression may be more helpful than a diagnostic laparoscopy. Other conditions such as IBS require specific treatment. Even if no explanation for the pain can be found initially, attempts should be

11. Scialli AR. Evaluating chronic pelvic pain. A consensus recommendation. Pelvic Pain Expert Working Group. *pro* 1999;44:945–52.
12. Eskenazi B, Warner M, Bonsignore L, Olive D, Samuels S,

in consultations for chronic pelvic pain. *o ns H t* 1998;7:1041–8.

52. Peters AA, van Dorst E, Jellis B, van Zuuren E, Hermans J, Trimbos JB. A randomized clinical trial to compare two different approaches in women with chronic pelvic pain. *st t G n o* 1991;77:740–4.
53. Flor H, Fydrich T, Turk DC. Efficacy of multidisciplinary pain treatment centers: a meta-analytic review. *n* 1992;49:221–30.
54. Kames LD, Rapkin AJ, Naliboff BD, Afifi S, Ferrer-Brechner T. Effectiveness of an interdisciplinary pain management program for the treatment of chronic pelvic pain. *n* 1990;41:41–6.
55. Albert H. Psychosomatic group treatment helps women with chronic pelvic pain. *s oso st t G n o* 1999;20:216–25.
56. Fass R, Longstreth GF, Pimentel M, Fullerton S, Russak SM, Chiou CF, et al. Evidence- and consensus-based practice

88. National Institute for Health and Clinical Excellence. *rr t o s n ro n u ts D nos s n n nt o rr t o s n ro n pr r r* NICE clinical guideline 61. London: NICE; 2008 [http://www.nice.org.uk/guidance/CG61/NICEGuidance].
89. Jaiwala J, Imperiale TF, Kroenke K. Pharmacologic treatment of the irritable bowel syndrome: a systematic review of randomized, controlled trials. *Ann nt rn* 2000;133:136–47.
90. Nanda R, James R, Smith H, Dudley CR, Jewell DP. Food intolerance and the irritable bowel syndrome. *Gut* 1989;30:1099–104.
91. The British Pain Society. *p o s or p rs st nt p n Goo pr t* . A consensus statement prepared on behalf of the British pain Society, the Faculty of Pain Medicine of the Royal College of Anaesthetists, the Royal College of General Practitioners and the Faculty of the Royal College of Psychiatrists. London: The British Pain Society; 2010 [http://www.britishpainsociety.org/book_opioid_main.pdf].
92. Wiffen P, Collins S, McQuay H, Carroll D, Jadad A, Moore A. Anticonvulsant drugs for acute and chronic pain. *Co r n D t s st* 2005;(3):CD001133.
93. National Institute for Health and Clinical Excellence. *urop t p n p r o o n nt o n urop t p n n u ts n non sp st s tt n s*. NICE clinical guideline 96. London: NICE; 2010 [http://guidance.nice.org.uk/CG96/NICEguidance/pdf/English].
94. Daniels J, Gray R, Hills RK, Latthe P, Buckley L, Gupta J, et al.; LUNA Trial Collaboration. Laparoscopic uterosacral nerve ablation for alleviating chronic pelvic pain: a randomized

APPENDIX 3

Grades of recommendations

At least one meta-analysis, systematic review or

