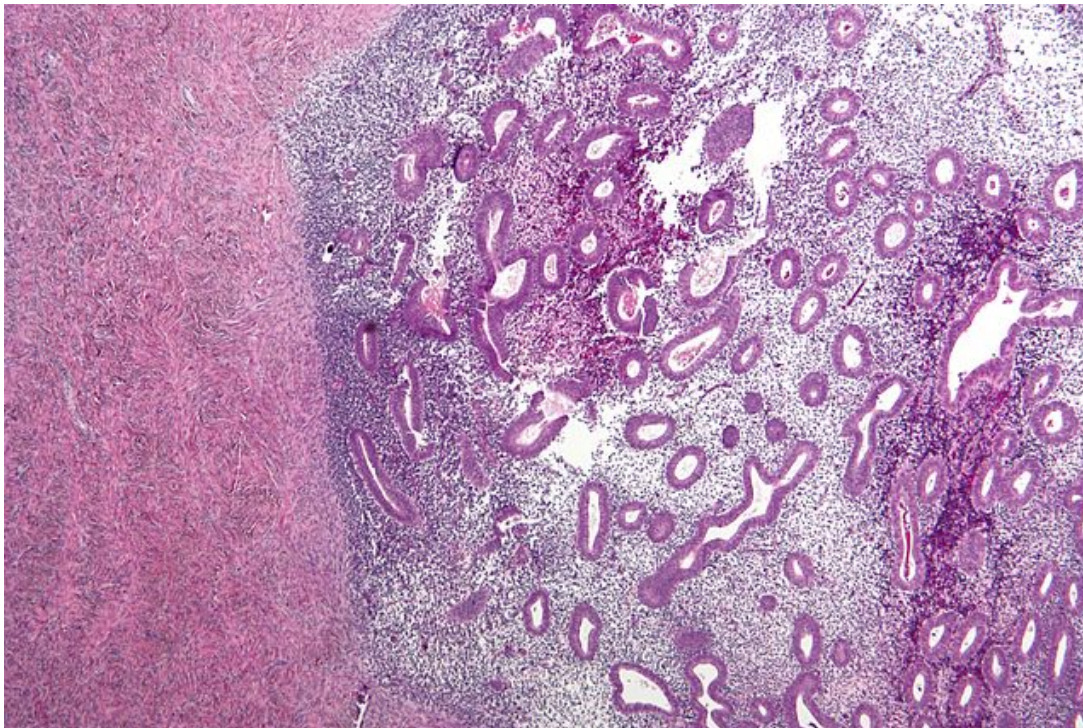


Female Pelvic Medicine: Chronic Pelvic Pain, Benign Gynecologic Conditions

[See online here](#)

Chronic pelvic pain (CPP) is a frequently occurring disorder in women and its etiology cannot always be determined. The pain could be in the urogenital tract, gastrointestinal tract, musculoskeletal or psychoneurological in origin. The common gynecologic causes of CPP are endometriosis, adhesions, and interstitial cystitis. Diagnosis is based on a detailed history, thorough physical examination, laboratory and imaging studies, and laparoscopy. Treatment could be symptomatic as well as a specific treatment of the gynecologic disorder.



Definition of Chronic Pelvic Pain

Chronic pelvic pain (CPP) is defined as **pelvic pain of non-menstrual origin lasting for six months or longer**. It is severe enough to cause functional disability and requires medical or surgical management.

Epidemiology of Chronic Pelvic Pain

Up to 20 % of women in the 15-50-year age group suffer from CPP. Many of them may have more than one source of pain.

Etiology of Chronic Pelvic Pain

Studies suggest that pain is often **multifactorial**. The following criteria have all been reported to be associated with CPP:

- psychological profile
- social situation
- history of physical or sexual abuse
- marital strife
- substance abuse

Presentation of Chronic Pelvic Pain

The common presentation is an **interval and chronic pelvic pain** unrelated to menses.

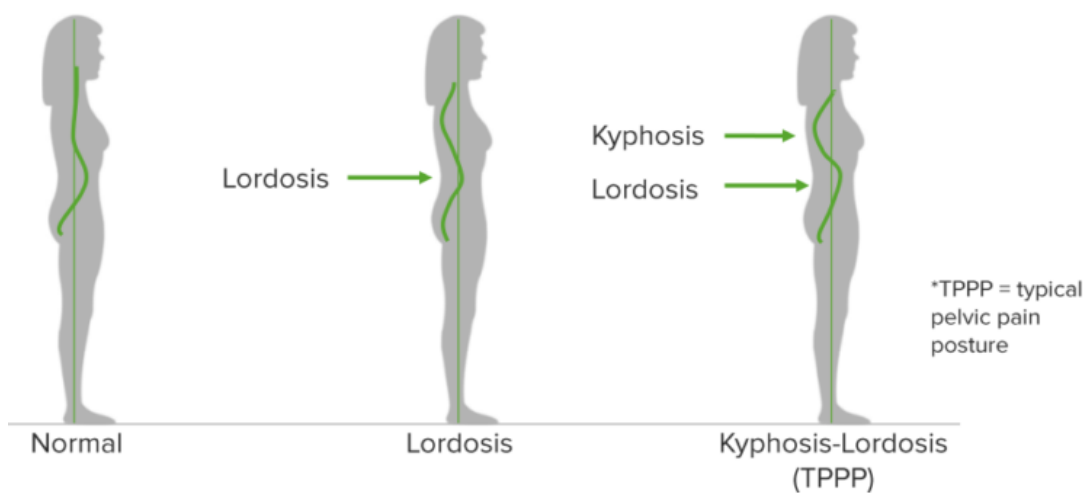
Physical examination of Chronic Pelvic Pain

It is important to **perform a physical exam gently** as these patients are often in severe pain and may not be able to co-operate during the examination. **Often, there may not be any positive findings after the examination.**

Using a moist cotton swab, one can determine **point tenderness** during the pelvic exam. This could detect any **neuroma** or **vulvar** inflammation.

Bimanual palpation is done by the examiner placing one hand on the abdomen and two fingers of the other hand in the vagina to determine the consistency of the cervix and uterus. It only performed if the patient is comfortable and it may help to diagnose pelvic masses. **Bladder tenderness** may indicate interstitial cystitis while **nodularity** may be suggestive of **endometriosis**.

Change of posture



Investigations of Chronic Pelvic Pain

- Complete blood count
- Urinalysis
- Urine culture
- Vaginal swab

- PAP smear
- Beta-human chorionic gonadotropin level test
- Ultrasound — pelvic as well as transvaginal
- Laparoscopy: Up to 40 % of patients may have a negative laparoscopy with no obvious pathology being detected.

Additional tests can be performed based on the findings of the examination and clinical diagnosis. **Interstitial cystitis can be difficult to diagnose** and may require a series of tests to be performed. Voiding diaries are useful to diagnose as well as to determine the patient's response to treatment.

Treatment of Chronic Pelvic Pain

Treatment of CPP can be frustrating for both the physician as well as the patient. A **multi-pronged strategy is often necessary** to manage the condition. Family physicians are usually able to coordinate this multi-pronged treatment better than any other physician or gynecologist.

Studies indicate that reassurance, combined with counseling, medroxyprogesterone, adhesiolysis and a multidisciplinary approach (lifestyle-dietary changes, physiotherapy, and psychotherapy) may prove beneficial in the treatment of CPP. Treatment is mainly focused on the following two problems:

Treatment of pain

Treatment with medication

First-line therapy is with **non-narcotic analgesics** like acetaminophen and non-steroidal anti-inflammatory drugs.

If pain is cyclical, then **hormonal treatment** like oral contraceptives, continuous progestins, or gonadotropin-releasing hormone (GnRH) agonists may relieve the pain, especially in:

- endometriosis,
- pelvic congestion syndrome
- ovarian retention
- ovarian remnant syndromes
- irritable bowel syndrome

Trigger point injection with long-acting local anesthetic can relieve localized abdominal tenderness.

Surgical treatment

Surgical treatment, e.g., hysterectomy with oophorectomy, nerve ablation play a limited role in relieving the pain.

Treatment of the underlying condition

If the underlying condition is diagnosed, then treatment can be directed towards the disorder.

For example, if **endometriosis** is diagnosed, then continuous administration of oral **contraceptives** in women not desirous of conceiving, can help to relieve pain in 70 % of

the women.

Progestins, GnRH agonists and danazol can relieve pain in up to 90 % of women with endometriosis.

Cauterization of the lesions of endometriosis via laparoscopy may be helpful in only about 60 % cases.

Hysterectomy with oophorectomy is considered **only if the pain is intractable**. Dense adhesions may benefit from **adhesiolysis**.

References

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