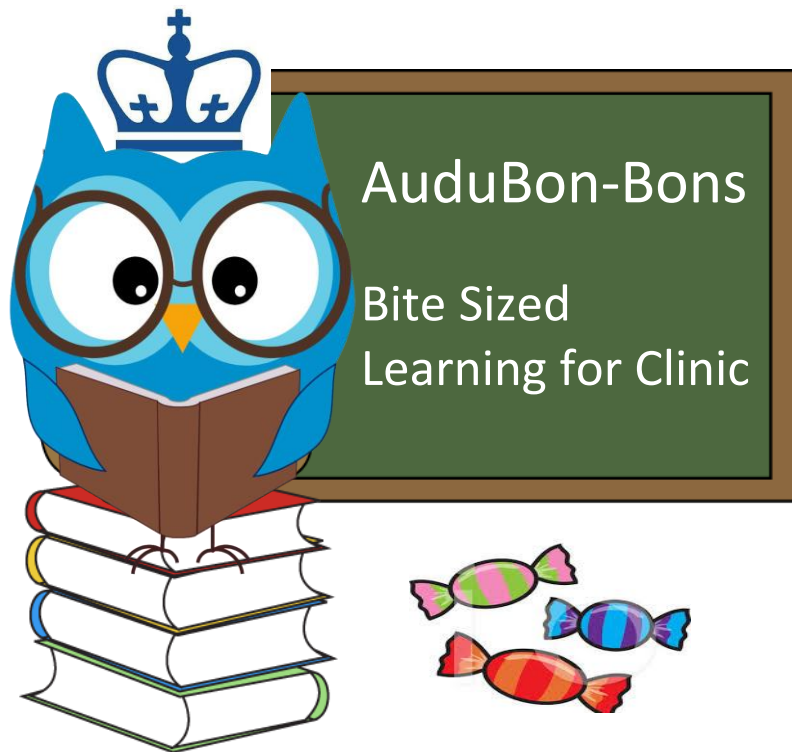


CHRONIC PELVIC PAIN

Week 29

Prepared by: Devon Rupley, MD

With SDH and .phrase slides by Chloé Altchek, MS4



Reading Assignments:

- *Pearls of Exxcellence: Management of pelvic pain after negative diagnostic laparoscopy* <https://www.exxcellence.org/pearls-of-exxcellence/list-of-pearls/management-of-pelvic-pain-after-negative-diagnostic-laparoscopy/?categoryName=&searchTerms=&featured=False>
- *Evaluation of chronic pelvic pain in women* uptodate.com/contents/evaluation-of-chronic-pelvic-pain-in-women

LEARNING OBJECTIVES



- To understand the definition of chronic pelvic pain
- To identify the common etiologies of chronic pelvic pain
- To determine best approach to evaluating and treating patients presenting with chronic pelvic pain



CASE VIGNETTE

Ms. Payne is a 44 year old G4 P3013 with DMII, depression and Class II obesity who presents to clinic for evaluation of 2 years of pelvic pain.

- Notes it is extremely bothersome with her life and is keeping her from having intercourse with her husband
- Describes it as constant “pulling”
- “Diffuse” across lower abdomen
- Worse with menses but always present
- Denies n/v/f/c, no abnl bleeding, no urinary problems, +chronic constipation for which she takes Miralax PRN



FOCUSED HISTORY

What elements of this patient's history are most relevant?

- **POB:** NSVD x 1, **LTCS x 2, ruptured ectopic pregnancy x1**
- **PGYN:** **Remote history of an “pelvic infection” 25 years ago**, no abnl paps, **a few known small fibroids**, no cysts, moderately heavy menses lasting 6-7 days longstanding every 3-4wks
- **PMH:** **T2DM, depression not on meds**
- **PSH:** **LTCS x 2, laparoscopic appendectomy, open salpingectomy i/s/o ruptured ectopic pregnancy 20 years ago**
- **MEDS:** Metformin
- **ALL:** NKDA
- **SOC:** Social etoh/ no tob or drugs, lives with husband and youngest child age 19, feels safe at home, works part-time as a HHA



PHYSICAL EXAM

- **VS:** BP 135/87, HR: 88, T: 98.2, BMI: 34.2
- **Gen:** No acute distress, sitting comfortably
- **Abd:** Obese, soft, non-distended. Well healed-Pfannenstiel incision and LSC port site incisions. **Mildly tender diffusely in bilateral lower quadrants.** No rebound or guarding
- **Speculum:** Normal external genitalia, physiologic discharge, no blood in vault, no cervical lesions
- **BME:** No CMT, uterus 6-8 wk size, sharply anteverted, **limited mobility, mildly tender to palpation diffusely especially anteriorly along Pfannenstiel scar,** no adnexal masses or tenderness
- **Ext:** WWP



DEFINITIONS- CHRONIC PELVIC PAIN

- **No consensus on definition**
- Definition from **RCOG**:
 - Intermittent or constant chronic pain in the pelvis lasting at least **6 months**
 - Occurring not exclusively with menstruation or intercourse
 - Not associated with pregnancy
- Definition from **uptodate**:
 - Non-cyclic pain perceived to be in the pelvic area persisting for 3 to 6 months or longer, and is unrelated to pregnancy
 - Cyclic pain with menses is categorized separately as DYSMENORRHEA
 - Limited to anatomic pelvis (between the umbilicus and inguinal ligament)
 - vulvar/ perineal disorders are categorized separately as VULVODYNIA
- No current practice bulletin from **ACOG**, however from an FAQ for patients on Chronic Pelvic Pain (FAQ099)
 - Defined as: pain in the pelvic area lasting 6 months or longer



Royal College of
Obstetricians &
Gynaecologists

UpToDate®



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

CPP-WHY IS IT IMPORTANT?

- Affects **6-25%** of reproductive-age women
- Accounts for **10%** of all office visits to gynecologists and up to **40%** of gyn laparoscopies
- Common source of frustration for patients and providers
- Symptom, not a diagnosis
- Can indicate **specific pathology** (ie endometriosis) or **functional pain syndrome**
- Often **multi-factorial**, and requires multi-faceted approach



Common non-mal

Gynecologic

- Endometriosis*
- Leiomyoma*

Musculoskeletal

- Abdominal wall m
- Pelvic floor tensio
- Fibromyalgia*
- Coccygodynia*
- Piriformis syndrom

Neurologic

- Abdominal wall ci
- Pudendal neuralg
- Central sensitizat

Vascular

- Vulvar varicositie
- Pelvic congestion

Conditions with level A e

- Inflammatory bow
- Colorectal carcino
- Celiac disease
- Abdominal/pelvic

envato

envato

envato

ic pain in women

Tu F, As-Sanie S.
Evaluation of chronic
pelvic pain in women.
Sharp, HT ed. *UpToDate*.
2019.
www.uptodate.com.
Accessed on October 30,
2019.



GYN CAUSES OF CPP

What are possible gynecological causes of chronic pelvic pain?

- Endometriosis
- Pelvic inflammatory disease
- Adhesive disease
- Adenomyosis
- Leiomyomatous uterus
- Pelvic floor prolapse/myalgia/trigger points

Less common causes:

- Pelvic congestion syndrome
- Ovarian remnant syndrome
- GYN malignancy



CPP-INITIAL EVALUATION

- Patients with CPP have often seen multiple providers for same problem or have waited many years before seeking care
- From beginning of visit must create **realistic expectations** with patient:
 - Clarify one cause of CPP might take time to find or may never be found definitively
 - Emphasize regardless of if cause is found or not, goal is to improve quality of life for patient
 - AND this might require prolonged, multi-modal therapy



CPP-INITIAL EVALUATION

Back to Ms. Payne: **what history are you going to obtain?**

- Pain characteristics:
 - onset
 - timing
 - quality
 - cyclic vs noncyclic
 - provocative/ palliating factors
 - location
- Medical, surgical, psychosocial/trauma, and sexual history information
- Look for symptoms to assess for 5 common etiologies of CPP:
 1. Musculoskeletal/ pelvic floor pain
 2. Irritable bowel syndrome
 3. Interstitial cystitis
 4. Chronic uterine pain disorders (endometriosis, adenomyosis, leiomyoma)
 5. Peripheral neuropathy



CPP-INITIAL EVALUATION

What will you look for on physical exam?

- General affect
- Abdominal exam
 - Operative scars
 - Carnett's test- to check for abdominal wall pain
 - Palpable masses
 - Hernias
- Pelvic exam
 - External visual exam: look for scarring or lesions
 - Consider "cotton swab test" to assess for vulvodynia
 - BME: assess pelvic floor for "trigger points," then traditional BME to assess for CMT, uterine tenderness/mobility/composition, adnexal masses/tenderness
 - Speculum exam with or without cultures
 - Consider RV exam if deep pain to assess for endometriosis
- External pelvic exam, pelvic floor examination, BME, speculum exam



Figure 1. Carnett's sign for patients with pelvic pain. The examiner places his or her finger on the tender area of the patient's abdomen and asks the patient to raise both legs off the table. An increase in the patient's pain during this maneuver is considered a positive test.

Fuente: Chronic Pain in women. David d. Ortiz
American Family Physician Volume 77, Number 11 June
1, 2008



NEXT STEPS IN EVALUATION OF CPP

- Further steps beyond H&P not needed in many cases
- Most CPP patients can be managed by PMDs/GYNs
- Consider referrals to GI/Urology/Psych as guided by H&P
- **Ancillary tests for further GYN workup:**
 - **Laboratory tests:** STI assessment, UA/Ucx
 - **Imaging:** Ultrasound, rarely MRI
 - **Surgical:** Diagnostic laparoscopy, cystoscopy, colonoscopy



CPP MANAGEMENT

- Management depends on suspected cause
- If work up is unrevealing, may consider **surgical diagnostic laparoscopy**
- Prior to surgical eval:
 - Consider trial of NSAIDS, implementing exercise regimens, pelvic floor therapy, bowel regimen optimization, +/- hormonal regulation with OCPs/ LNG-IUD for 3 months



MS. PAYNE PATIENT DIAGNOSIS

- Likely diagnosis?
- CPP likely multi-factorial including **adhesive disease, obesity, chronic constipation and dysmenorrhea**
- Care plan:
 - LNG-IUD to lessen bleeding/ cycle symptoms
 - Trial of NSAIDS around menses and PRN
 - Regular exercise regimen
 - Increased water/ fiber intake, miralax PRN for constipation
 - Agrees to referral to therapist for depression
 - RTC 3 months to assess for improvement
 - Symptoms still present but much improved
 - Will continue conservative management for now



SOCIAL DETERMINANTS OF HEALTH

- Depression, sleep disorders and psychological issues are often associated with CPP and may be the result of the pain
- Many women with chronic pelvic pain have histories of sexual or physical abuse and in particular child abuse that may provoke pain somatization
- African American women report significantly worse pain management and QOL scores than Caucasian women

Use of abuse screening questions may be helpful because patients do not generally associate history of abuse with current pain syndrome



EPIC .PHRASE

.BBonCPPCounseling

Description: Chronic Pelvic Pain Initial Evaluation Counseling

We discussed that chronic pelvic pain (CPP) is often multi-factorial including adhesive disease, obesity, constipation, and dysmenorrhea, and that causes of CPP might take time find or may never be definitively found. We discussed the patient's goals for quality of life, which include ***, and that achievement of these goals may require prolonged, multi-modal therapy. A workup including physical exam, STI assessment, urinalysis, and ultrasound was ordered, and a trial of NSAIDS, exercise, pelvic floor therapy, bowel regimen optimization, and hormonal therapy*** was initiated. The patient understands that if workup is ultimately unrevealing, that we may consider future surgical diagnostic laparoscopy.



CODING AND BILLING

R10.2: Pelvic and perineal pain

N73.4: Female chronic pelvic peritonitis

R10.30: Lower abdominal pain, unspecified

Related:

N30.10: Interstitial cystitis (chronic) without hematuria

N94.81: Vulvodynia

R30.9: Painful urination

N94.6: Dysmenorrhea, unspecified



REFERENCES

- Green-top guideline No. 41: The initial management of chronic pelvic pain. *RCOG*. 2012.
- Breen, M. Pearls of Excellence: Management of pelvic pain after negative diagnostic laparoscopy. <https://www.excellence.org/pearls-of-excellence/list-of-pearls/management-of-pelvic-pain-after-negative-diagnostic-laparoscopy/?categoryName=&searchTerms=&featured=False>. 2018. Accessed on November 1, 2019.
- Tu F, As-Sanie S. Evaluation of chronic pelvic pain in women. Sharp, HT ed. *UpToDate*. 2019. www.uptodate.com. Accessed on October 30, 2019.
- Carter JE. A systematic history for the patient with chronic pelvic pain. *JSLS*. 1999. Oct-Dec; 3(4): 245-252.
- FAQ099: Chronic pelvic pain. *ACOG*. 2011. acog.org. Accessed on October 2019.

