CHRONIC PELVIC PAIN

Week 29

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Reading Assignments:
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
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
### Differential Diagnosis of Chronic Pelvic Pain in Women

#### Gynecologic
- Endometriosis*
- Leiomyoma*

#### Musculoskeletal
- Abdominal wall muscle pain
- Pelvic floor tension
- Fibromyalgia*
- Coccygodynia*
- Piriformis syndrome

#### Neurologic
- Abdominal wall cough hypersensitivity
- Pudendal neuralgia
- Central sensitization

#### Vascular
- Vulvar varicosities
- Pelvic congestion

#### Conditions with level A evidence
- Inflammatory bowel disease
- Colorectal carcinoma
- Celiac disease
- Abdominal/pelvic infection

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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
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.
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
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.
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


