EDITORIAL

Chronic Pelvic Pain: Addressing a Common Debilitating Condition of Women

Chronic pelvic pain (CPP) is a common debilitating condition of women affecting perhaps one in six of the adult female, mostly in their reproductive life[1]. CPP accounts for substantial personal sufferings and health care expenditure for interventions, including multiple consultations, medical & surgical therapies. Chronic pelvic pain (CPP) 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[1]. It is a symptom, not a diagnosis, though not a life threatening condition, has significant impact on quality of life and functional capability. As the underlying patho physiology of this complex condition is poorly understood, CPP is difficult to diagnose & treat and more often difficult to get complete cure and patient's satisfaction creating frustration for the patients as well as their attending physicians. Magnitude of problem growing day by day. Statistics reveal that CPP accounts for about 1 in 10 outpatient gynaecology visits, is the indication for an estimated 15% to 40% laparoscopies, 12% of hysterectomies and costs $3 billion US Dollar annually in United States[2], reflecting heavy economic and social burdens. Limitation of activities is also alarming as evidenced by a study on 5325 US women, of which 16% reported with CPP, 11% of which limited their home activities, 15.8% took medications, 11.9% limited their sexual activities & 3.9% missed at least 1 day of work per month[3]. Disruption of women's life in the form of doing endless investigations, referral & interventions, leave the women ultimately with a feeling that "nothing can be done more than that". Aiming for accurate diagnosis and effective management from the very beginning could minimize this tragedy.

Although women with CPP are no longer different in terms of age, race, ethnicity, education, socioeconomic or employment status, demographic profile of large surveys reveals higher incidence in reproductive life among single, separated or divorced women. 40-50% women are victim of sexual abuse. Chronic Pelvic Pain symptom usually encompasses the following clinical characteristics – duration of six months and longer, incomplete relief with most treatments, significantly impaired functional capabilities at home or work, associated with signs of depression like insomnia, anorexia, weight loss and altered family roles.

Pelvic pain is associated with a wide range of conditions involving reproductive, gastrointestinal, genitourinary, musculoskeletal or psychological systems. There is frequently more than one component of CPP and the severity and consistency of pain often increases with multisystem involvement. Clinical evaluation must therefore be thorough from a medical, surgical and psychological stand points to assess the contributory factors. Thorough history taking that generates trust between care givers and patient and a pain focused physical examination should be the key to formulating a diagnosis. A useful model for understanding CPP is Steege's integrated Model[4] which includes the following elements – biological events initiating pain, alteration of life style & relationship over time, anxiety and affective disorders and the circular interaction among these elements. Initial interview should convey interest listen with attention, validate patient's experience and avoid telling her that problem must be psychological as no visible pathology is found. To obtain focused history use of the "Review of systems" could be followed to explore the organ system involvement.

Physical examination is very different from the routine gynaecological examination, may need to defer for a second time to exam her when she is in pain. Using a pelvic pain numerical scale to obtain a feedback from patient is useful. Physical examination should always be conducted to focus on review of systems. Enquiries should be made regarding psychological and social issues as CPP is often associated with psychological instability. The multi factorial nature of CPP should be

explored & discussed from the start. As the differential diagnosis of CPP is intensive it is the challenge for the gynaecologist as well as the attending physician to think "Out of the uterus".

Women with CPP are often subjected to endless investigations although focused history taking and examinations can guide specific diagnostic tests appropriate for particular patient. Screening for infections by blood count, culture of endo cervical swabs and urine analysis may be the first line investigations. Diagnostic imaging should only be performed rationally. Trans Vaginal Sonography (TVS) is useful for evaluation of adnexal masses but of little value to evaluate the other causes of CPP. TVS may play role to identify women who needs laparoscopy[5]. MRI may be an adjunct but its role to diagnose small peritoneal endometriotic deposits are doubtful[6]

Diagnostic laparoscopy is regarded in the past as "gold standard" for the diagnosis of CPP, now better seen as "second line investigation" if therapeutic intervention fails[1]. It may have role in developing women's belief about pain. Only diagnostic laparoscopy will not improve the pain pulsation with positive & negative findings and negative results do not exclude diseases or organic causes. So recommendation is that laparoscopy should be offered with an aim to have both diagnostic and therapeutic contribution.

Adequate time should be allowed for clinical assessment of women with CPP & diagnosis and treatment should align with positive and negative findings. Many women demand an explanation for their pain and multi factorial nature of the pain should be discussed. Integrated approach should be taken to address organic, psychological and environmental factors. Daily pain diary could explore the provocating factors and temporal association. Appropriate referral for non gynaecological component of pain should be done.

Great concern is not to dismiss organic cause as psychological and to remember that organic causes are often masked by overwhelming psychological factors. Women should not leave with a feeling that she has to live with pain.

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References:

1. Royal College of Obstetricians and Gynaecologists. The initial management of chronic Pelvic pain, Green Top Guideline. No. 41, London. RCOG; May 2012
2. Society of Obstetricians and Gynaecologists of Canada. Consensus guidelines for the management of chronic pelvic pain. SOGC Clinical Practice Guidelines. No. 164, Part one of two, August 2005.
3. Mathias SD, Kupperman M, Liberman RF, LipSchuLtz RC, Steege JF. Chronic Pelvic Pain: Prevelance, health related Quality of lifes and economic correlations. Obstel Gynaecol 1996, 87: 321-7.
4. Steege JF, Metzger DA, Levy BS. Chronic Pelvic Pain: and integrated approach Philadelphia W.B. Saunders 1998. P12.
5. Okaro E, Condous G, Khalid A, Timmerman D, Ameye L. Huffel SV et al. the use of ultrasound based "soft markers" for the prediction of pelvic pathology in women with chronic pelvic pain – can we reduce the need for laparoscopy? BJOG 2006, 113: 251-6.
6. Duehold M, Lundrof E, Hansen ES, Sorensen JS, Ledertough S, Olesten F. Magnetic resonance Images and transvaginal untrasonography for the diagnosis of adenomyosis. Fertil Steril 2001; 76: 588-94.