Chronic Pelvic Pain

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CASE PRESENTATION

- ***A 27 years old G1 P1 L1 woman with a pain at periumblical area since 15 hours ago. Today is 18th day of her menstrual cycle.***

What is your idea about the origin of this pain?

A: ***Deoudenum***

B: ***Ovary***

C: ***Uterus***

D: ***STOMACH***

CASE PRESENTATION 2

An 18 years old single, a medical student girl has referred to your clinic with CC of persistent lower abdominal pain since 2 years ago.

The pain was cyclic at beginning, and became permanent gradually. What is your PRIMARY IMP.. ?

A: Pelvic Inflammatory Disease

B: Uterine Myoma

C: Endometriosis

D: Irritable Bowel Syndrome

Definition

- **There is no accepted definition of chronic pelvic pain, but one proposed definition is :**
- **Noncyclic pain of three or six or more months that is localized to the pelvic, anterior abdominal wall at or below the umbilicus, the lumbosacral back, or the buttocks and is severe enough to cause functional disability .**

Chronic Pelvic Pain

Diagnostic Strategies

Diagnosis

- Vague pain is associated with a visceral or intra abdominal process.
- Localized pain is associated with a musculo-sceletal origin.
- Constipation/flatulence/bloating are associated with GI causes.
- Urinary frequency or burning is associated with urinary origin.

Patient Evaluation: Physical Exam

- ***Abdominal exam***
  - ***Listen for bowel sounds***
  - ***Ask patient to point to exact location of pain, radiation, and grade its severity (scale of 0 to 10)***
  - ***Palpate entire abdomen with a single digit, with and w/o abdominal wall flexion (Carnett sign)***
  - ***Palpate from least painful area to most painful area***
  - ***Referred pain?***

Etiology: Gynecologic

- Gynecologic
  - Endometriosis
  - Adhesions
  - Chronic PID
  - Ovarian remnant syndrome
  - Pelvic congestion syndrome
  - Recurrent hemorrhagic ovarian cysts
  - Uterine Myoma (degenerating)
  - Adenomyosis

Patient Evaluation: History

- Characteristics of the pain:
  - Onset
  - Location
  - Duration
  - Radiation
  - Severity
  - Alleviating/aggravating factors
  - Relation to menstrual cycle
  - Cyclic vs. non-cyclic
  - Evolution over time
  - Responses to treatments

Patient Evaluation: Physical Exam

- **Pelvic Exam**
  - Fixed retroverted uterus & uterosacral tenderness/nodularity
    - Endometriosis
  - Bilateral, tender, irregularly enlarged adnexal structures
    - Chronic salpingitis (PID)
  - Enlarged, tender, boggy uterus
  - Adenomyosis
  - Don’t forget the recto-vaginal examination!
    - Especially when history includes central pain, or dyspareunia.
    - To eliminate the recto-vaginal exam in such cases is malpractice.

Patient Evaluation: Further Studies

- ***Laboratory***
  - *Complete blood count (CBC)*
  - *Elevated sedimentation rate (ESR) - nonspecific*
  - *Urinalysis (UA)*
  - *Urine pregnancy test (UPT)*
  - *Gonorrhea/Chlamydia*

- ***Testing***
  - *Transvaginal ultrasound (adnexal mass, uterine irregularity)*
  - *Abdominal and pelvic CT (bowel or urinary signs)*
  - *Diagnostic laparoscopy*
    - *Ultimate method of diagnosis for CPP of undetermined etiology*

INDICATION OF LAPARASCOPY IN ADOLESCETS

- **DYSMENORRHEA UNRESPONSIVE TO USUAL THERAPY**
- **CLINICALLY SUSPECTED TO ENDOMETRIOSIS ,PID,ADHESIONS OR PELVIC SEROSITIS**
- **UNDIAGNOSED PAIN**

Post op diagnosis in 282 adolescets

• Endometriosis	126	45%
• Adhesions	37	13%
• Serositis	15	5%
• Ovarian cyst	14	5%
• Uterine anomaly	15	5%
• Others	4	2%
• No finding	71	25%

PID

- The majority of PID cases (85 percent) are caused by sexually transmitted pathogens or bacterial vaginosis-associated pathogens.
- most cases are associated with **gonorrhea** and genital **chlamydial** infections, two very common STDs
- Fewer than 15 percent of acute PID cases are associated with enteric *Escherichia coli, Bacteroides fragilis*, Group B streptococci*Haemophilus influenzae*, *Streptococcus pneumoniae*, Group A streptococci, and *Staphylococcus aureus*

Symptoms

- Lower abdominal pain is the cardinal presenting symptom in women with PID.
- The abdominal pain is usually bilateral .
- The character of the pain is variable, and in some cases, may be quite subtle.
- The recent onset of pain that worsens during coitus or with jarring movement may be the only presenting symptom of PID.
- The onset of pain during or shortly after menses is particularly suggestive .

Treatment (PID)

- Because culture of specimens from the upper genital tract are difficult to obtain and because multiple organisms may be responsible for an episode of PID,we will prescribe at least two antibiotics that are effective against a wide range of infectious agents.

  Doxycycline

  Metronidazol

Pelvic congestion syndrome

- The syndrome is typically a condition of the reproductive years.
- Is equally prevalent among parous and nulliparous women.
- Prominent symptoms are a shifting location of pain, deep dyspareunia and postcoital pain, and exacerbation of pain after prolonged standing.
- One theory is that damage to the valves in the ovarian veins results in valvular incompetence leading to reflux and chronic dilation; however, incompetent and dilated pelvic veins are a common finding in asymptomatic women

Pelvic congestion syndrome

- Radiologic features of pelvic congestion are dilated uterine and ovarian veins with reduced venous clearance of contrast medium.
- Transuterine venography can be helpful.

Therapy

- Hormonal treatment in combination with stress and pain management,.
- Medroxyprogesterone acetate 50 mg daily has been shown to be effective
- GnRH agonists with or without estrogen “add-back” are increasingly used in this indication
- Hysterectomy and bilateral salpingo-oophorectomy followed by long-term estrogen replacement therapy

Adhesions

- The relationship between CPP and presence of adhesions is poorly defined.
- There is some evidence that dense adhesions that limit organ mobility cause visceral pain , and evidence from conscious laparoscopic pain mapping that adhesions may account for pelvic pain in some patients.

Adenomyosis

Triad symptoms:

1. Hypermenorrhea
2. Dysmenorrhea
3. dyspareunia

- Pain may be due to bleeding and swelling of endometrial islands confined by myometrium.
- Symptoms typically develop between the ages of 40 and 50 years.
- Adenomyosis can be present diffusely throughout the myometrium, or confined to a discrete area termed an adenomyoma

Ovarian remnant and residual ovary syndrome

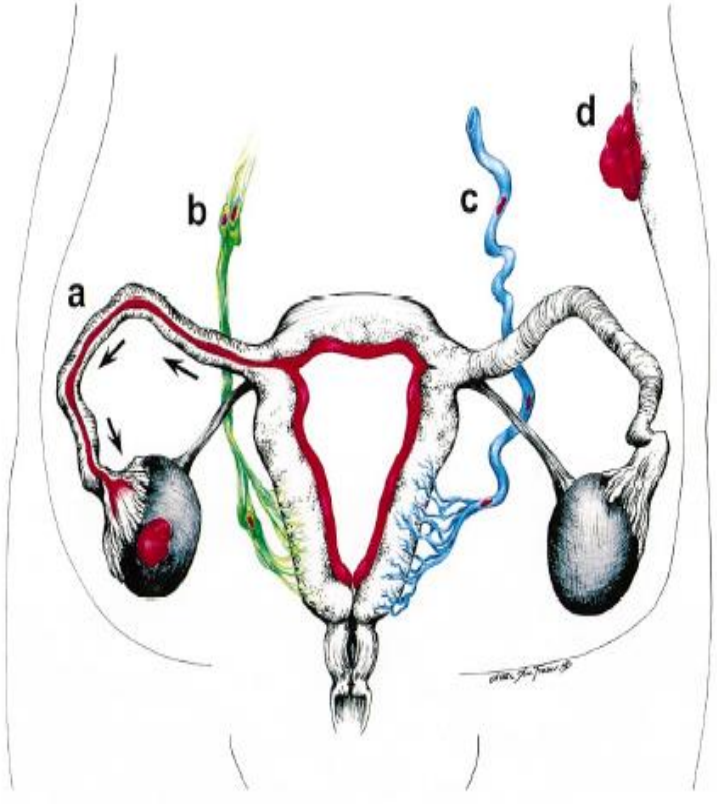
- It should be distinguished from the residual ovary syndrome (ROS), in which the ovary was intentionally preserved and subsequently developed pathology.
- The typical patient presents with cyclic pelvic pain and a mass, although the pain may be persistent with acute flare-ups.

Dysmenorrhea

Chronic Pelvic Pain

ENDOMETRIOSIS

Chronic Pelvic Pain



IMPLANTS:

76% ovaries

69% posterios and anterior cul de sac

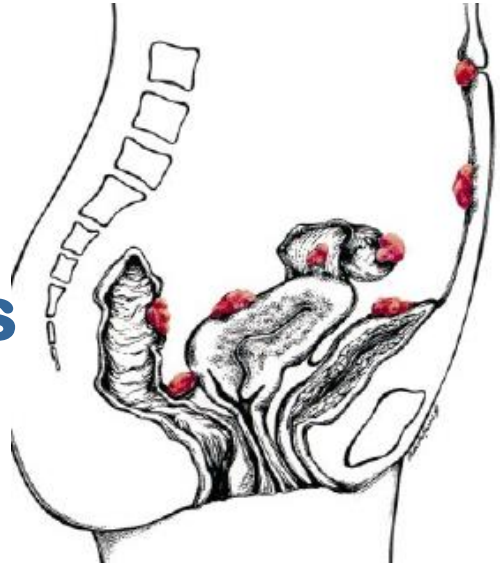
47% posterior broad ligament

36% uterosacral ligaments

11% uterus

6% fallopian tubes

4% sigmoid colon



Points of pain perception

Ovary: **T10 umbilical area.**

Uterus: **T12 lower abdominal wall.**

Vagina: **L1 skin over groin.**

Pelvic Denervation Surgery for Chronic Pelvic Pain treatment

Pelvic Denervation Surgery

- Former concepts of pelvic neuroanatomy bolstered by ***anecdotal*** clinical reports and observational studies have encouraged the performance of **uterosacral nerve ablation and presacral neurectomy** as effective procedures in alleviating pelvic pain.
- Recent critical reviews in the gynecologic literature have concluded that quality evidence is lacking to support further use of surgical denervation procedures in the female pelvis.

Surgical Studies and Critiques From the Literature

- The first is the “Consensus statement for the management of chronic pelvic pain and endometriosis, an expert panel of over 50 gynecologists who evaluated the available literature.
- The second is the Cochran Review of “Surgical interruption of pelvic nerve pathways for primary and secondary dysmenorrhea,” which was updated in January 2003.
- Both reviews conclude that the addition of Uterosacral nerve ablation does not benefit chronic pain patients with either endometriosis or secondary dysmenorrhea, especially over time.

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Take Home….

- ***Chronic pelvic pain is pelvic pain of more than 6 months duration that has a significant effect on daily function and quality of life.***
- ***It affects 15-24% of American women in varying degrees of severity and accounts for a large portion of office visit and time.***
- ***Chronic pelvic pain is caused by a variety of factors including gynecologic, genitourinary, gastrointestinal, neuromuscular, and psychological.***
- ***Diagnostic laparoscopy is the ultimate method of diagnosis for patients with chronic pelvic pain of undetermined etiology.***
- ***Multidisciplinary approach has been shown to be more effective than pharmacologic or surgical therapy alone.***
- ***Even when etiology is determined, chronic pelvic pain can be difficult to treat and patients need to be seen regularly and provided much support***.