Persistent Pelvic Pain

Disclaimer

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Background

About Persistent Pelvic Pain

Persistent pelvic pain is pain in the area of the pelvis (below the umbilicus) that has been present on most days for more than 6 months. The pain:

➢ has often been present since adolescence and may have started as dysmenorrhoea.
➢ frequently presents as a complex diagnostic problem, with symptoms of irritable bowel syndrome, painful bladder syndrome (interstitial cystitis), painful pelvic muscles, vulval pain, dyspareunia, chronic headache, anxiety, low mood and fatigue.
➢ may be disproportionate to the extent of disease identified and persist even after optimal treatment, due to central sensitisation.

Persistent pelvic pain affects 15 to 25% of women aged between 15 to 73 years.

Persisting pain leads to central sensitisation, which can cause pain to continue even when the original pathology has resolved.

Endometriosis is the most common cause, but in most patients a specific cause cannot be identified.

Assessment

1. Take a history:
   - Assess **history of pain and associated symptoms**. Consider:

   **History of pain and associated symptoms**

   Ask about:

   ➢ age of onset and progression of symptoms. If late-onset pain in an older woman, suspect underlying pathology.
   ➢ patterns of pain e.g., association with menses, intercourse, bowel motions, micturition.
   ➢ any co-existent gastrointestinal pain
   ➢ triggers and the effect of movement and posture on pain.
   ➢ vulval pain or vaginal discharge including recurrent candidiasis.
   ➢ abnormal vaginal bleeding.
   ➢ weight loss.
   ➢ reduced appetite.
   ➢ **rectal bleeding**.
   ➢ haematuria.
   ➢ possibility of pregnancy.
   ➢ last menstrual cycle.
   ➢ family history of gynaecological or gastrointestinal cancers, or endometriosis.

   • using the Pelvic Pain Assessment Form.
   • asking the patient to record symptoms in a menstrual or pain diary, and a bladder diary if any urinary symptoms.

   • Assess all medications and treatments tried (including non-prescription, herbal and supplements).
   • Ask about the impact of symptoms on daily life, e.g. work, sleep, relationships, sexual functioning, daily living activities.
   • Take a full gynaecology, obstetric, and sexual history.
• Ask about history of sexual abuse and intimate partner violence. Assess current safety if indicated.

2. Check for contributing or coexistent mood disorders, e.g. depression or anxiety.

3. Perform examination.

Examination

Consider arranging a chaperone for patients undergoing pelvic, rectal and abdominal examinations.

- Check height, weight, and BMI.
- Lower back:
  - Check mobility of spine and hips to rule out referred pain.
  - Palpate lower back and sacroiliac joints for tenderness, trigger points, or asymmetry.
- Abdomen – check for any tenderness, obvious masses, organomegaly, ascites.

If patient discloses sexual abuse, ask patient specifically if they require psychological support before undertaking pelvic or rectal examination.

- Pelvis (unless patient has never had vaginal intercourse):
  - Speculum exam:
    - Inspect vagina and cervix.
    - Take a high vaginal swab (HVS) if required for MCS investigation.
    - Perform sexually transmitted infection (STI) screening if increased STI risk.
    - Perform cervical screening test if due.
  - Inspect the vulva and introitus. Using a cotton-tip swab, check for pain indicating vulvodynia.
  - Bimanual pelvic examination – check:
    - uterine size, position, and mobility.
    - for pelvic masses and/or tenderness
    - lateral pelvic walls for levator ani spasm and tenderness.
    - utero-sacral ligaments (posterior to cervix) for tenderness and nodular endometriosis.
    - urethra and bladder (examine anterior vaginal wall) for tenderness.
  - Rectal examination – exclude a mass or chronic constipation.

4. Consider differential diagnosis, which may be multifactorial. A specific cause may not be found.

Differential diagnosis

Common causes of persistent pelvic pain:

- Gynaecological:
  - Endometriosis
  - Adenomyosis
  - Chronic pelvic inflammatory disease (PID)
  - Vulvodynia
  - Pelvic congestion syndrome
- Urological:
  - Interstitial cystitis
Interstitial cystitis is a chronic bladder condition with pelvic pain, dysuria, urinary frequency, urgency and pressure in the bladder and pelvis, in the absence of proven urinary infection or other obvious pathology. There is no known cause or consensus on treatment.

- See Patient – Interstitial Cystitis.
  - Recurrent UTI
  - Urethral syndrome

➢ Gastrointestinal:
  - Irritable bowel syndrome
  - Diverticular disease
  - Coeliac disease
  - Constipation
  - Inflammatory bowel disease (IBD)
  - Adhesions due to endometriosis, previous surgery or previous pelvic infection

➢ Musculoskeletal:
  - Pelvic floor spasm or myalgia
  - Levator ani syndrome
  - Coccydynia
  - Fibromyalgia
  - Chronic abdomen wall pain
  - Vaginismus

➢ Neurological:
  - Neuralgia which may be associated with previous surgery
  - Central sensitisation

➢ Psychological:
  - Depression, anxiety
  - Sexual abuse
  - Somatisation

➢ Opiate dependency

5. Arrange investigations but avoid extensive investigation:
   - FBE, CRP
   - Urine microscopy, culture, and sensitivities (MCS)
   - Urine cytology – consider if symptoms of interstitial cystitis.
   - Urine pregnancy test
   - High vaginal swab for MCS.
   - STI screening if indicated.
   - Cervical screening test if indicated.
   - Ultrasound:
     - Transvaginal ultrasound if sexually active, or
     - Transabdominal pelvic ultrasound if not sexually active, or if patient does not consent to transvaginal ultrasound pelvis.
Management

1. If acute, severe pelvic or abdominal pain, arrange immediate gynaecology referral or admission.

2. Discuss and explore the **multifactorial nature of persistent pain**

   **Multifactorial nature of persistent pain**
   - Pain from end organs (pelvic organs)
   - The musculoskeletal response to pain
   - Central sensitisation of nerve pathways
   - The psychosocial sequelae of the pain condition

3. Manage any **specific identified cause**.

   **Management for specific identified cause**
   - **Chronic pelvic inflammatory disease (PID):**
     - See Pelvic Inflammatory Disease (PID) pathway.
     - If PID suspected from history and examination, give appropriate antibiotic treatment – negative swabs do not rule out PID.
   - **Gastrointestinal:**
     - Irritable Bowel Syndrome (IBS).
     - Correct constipation.
     - Consider antispasmodics:
       - mebeverine (e.g. Colofac, Colese) 135 mg, 3 times a day as required, or
       - hyoscine butylbromide (e.g. Buscopan) 10 to 20 mg, 4 times a day as required.
     - Consider requesting dietitian services and low FODMAP diet.
   - **Musculoskeletal:**
     - Consider referral to a women’s health physiotherapist.
     - Consider requesting exercise physiology for a graduated exercise programme.
   - **Psychological – consider:**
     - requesting **counselling or psychological intervention** as appropriate.
     - treatment for any depression or anxiety disorder.
   - **Urological:**
     - Treat recurrent UTIs.
     - Systematically **manage interstitial cystitis**, or request **urology assessment**, if appropriate.

   **Manage interstitial cystitis**
   - There is no consensus on treatment – management is generally symptomatic and supportive. There is some evidence to suggest certain exclusion diets may help, but this is not conclusive. There is limited evidence for any oral medications.
     - Advise the patient to avoid any irritants that may exacerbate symptoms, e.g. caffeine, alcohol, artificial sweeteners, and hot pepper.
Consider:
- medications for chronic pain e.g. tricyclic antidepressants.
- a trial of NSAIDs or oxybutynin if not contraindicated.
  - Follow [Urinary Incontinence in Women](#) pathway for bladder retraining, bladder relaxant medications.

Vulvodynia

4. If cyclical aggravation of pain, trial menstrual suppression as per [Endometriosis](#) pathway.

5. Provide:
   - **support and education.**

**Support and education**

Provide regular contact with the patient to:

- listen to and reassure them – once serious pathology is no longer suspected, the benefit of the general practitioner performing this role should not be underestimated.
- educate them about central sensitisation and the role of pain management strategies.
- inform them that persistent pain syndromes often improve with time.
- monitor their physical and emotional symptoms, and any impact on functioning.

- **options for pain relief** – avoid opioid medications.

**Options for pain relief**

- Trial non-opioid analgesics – start with NSAIDs if no contraindications and/or paracetamol.
- Consider other medication options:
  - Tricyclic antidepressants, e.g. amitriptyline, nortriptyline
  - SNRIs, e.g. Duloxetine
  - Anticonvulsants, e.g. gabapentin, sodium valproate, pregabalin
  - Botulinum toxin injections for severe cases
- Consider non-pharmacological options:
  - Heat treatments (hot packs, heating pads, baths)
  - TENS
  - Acupuncture
  - Magnesium

- **lifestyle advice.**

**Lifestyle advice**

- Optimise:
  - BMI and increase exercise and fitness levels.
  - sleep patterns.
- Recommend:
  - avoiding aggravating activities, e.g. core strength exercise, prolonged positions.
  - smoking cessation.
➢ Encourage:
   o a healthy diet.
   o relaxation techniques such as yoga, stretching, meditation, mindfulness and breathing exercises.
   o behavioural therapy, including behavioural activation, e.g. scheduling activities the patient enjoys.

6. Aim for a multidisciplinary approach and create a GP Management Plan and Team Care Arrangement and/or a GP Mental Health Treatment Plan.

7. Request gynaecology assessment if:
   • suspicion of malignancy.
   • significant ultrasound findings.
   • pain not responding to adequate medical management.

8. If the patient has difficulty managing persistent pain, despite maximal medical and gynaecological interventions, consider requesting pain specialised assessment if available in region. See National Pain Services Directory.

Referral

- If acute, severe pelvic or abdominal pain, arrange immediate gynaecology referral or admission.
- Request gynaecology assessment if:
  • suspicion of malignancy
  • significant ultrasound findings.
  • persistent pelvic pain that has not responded to adequate medical management.
- If interstitial cystitis, consider urology assessment.
- If musculoskeletal cause:
  • consider referral to women’s health physiotherapist.
  • consider requesting exercise physiology for a graduated exercise programme.
- If gastrointestinal cause, consider requesting dietitian services.
- Consider requesting counselling or psychological therapy as appropriate.
- If the patient has difficulty managing persistent pain, despite maximal medical and gynaecological interventions, consider requesting pain specialised assessment if available in region. See National Pain Services Directory.

Information

For health professionals

Education

Pain Australia – Education & Training

Further information

- Australian Family Physician – Management of Persistent Pelvic Pain in Girls and Women
- O&G Magazine – Pelvic Pain [Vol.21, No.2, Winter 2019]
- Patient – Interstitial Cystitis/Painful Bladder Syndrome
For patients

- Pain Australia – Fact Sheets
- Patient – Painful Bladder Syndrome: Interstitial Cystitis
- Pelvic Pain Foundation of Australia – Information for Women
- RANZCOG – Chronic Pelvic Pain
- Urological Society of Australia and New Zealand – Interstitial cystitis or Painful Bladder Syndrome

References


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- Royal College or Obstetricians and Gynaecologists (RCOG). London: RCOG; Chronic Pelvic Pain, Initial Management (Green-top Guideline No. 41). 2012. [updated 2017 Sep 07; cited 2019 Apr 23].

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