Finding the root of pelvic pain

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Pelvic pain is very common but is not recognised as a national health priority.

PELVIC pain affects about one in 10 women, costs $6 billion annually, is under-recognised and has multidimensional impacts on the individual (physical, psychological and social).

It is also related to long-term complications such as infertility.

Despite prevalence figures similar to conditions such as asthma, pelvic pain is not a national health priority and barely rates a mention in the national women's health policy.

DEFINITION

Pelvic pain is abnormal pain below the umbilicus and can present as acute (of recent onset and probable limited duration with usually an identifiable temporal and causal relationship to injury or disease) or chronic (lasting for more than three months).

It is associated with a significant diagnostic delay, in some cases up to eight years, and lost productivity of, on average, 11 hours per week.

The burden of this diagnostic delay appears to be disproportionally carried by young women.

DIAGNOSTIC CHALLENGES

GPs cite factors such as the complex nature of the condition, under-reporting by patients, reticence to be examined, and the lack of streamlined services to treat pelvic pain as some of the barriers to timely diagnosis.

AETIOLOGY

The list of potential causes is growing and includes endometriosis, adenomyosis, pudendal neuralgia, painful bladder syndrome, irritable bowel syndrome, pelvic floor pain and dysfunction, pelvic inflammatory disease, vulvodynia, inflammation, proctalgia fugax, pelvic adhesions, urethral syndrome, ovarian cyst pathology, recurrent dysmenorrhoea, post-surgical neuralgia, neuropathic pain, post-trauma pain and cancer survivor pain.

However, a common barrier to achieving timely diagnosis, appropriate referral and treatment for pelvic pain is a focus on finding one cause and consequently one management approach.

New research indicates that aetiology is multifactorial and includes neuropathic peripheral drivers of pain that may be initiating factors, also central sensitisation of nerve pathways and the brain adaptation to chronic pain.

This research indicates pelvic pain may be considered a diagnosis in itself rather than a symptom of a related condition.

Potential new approaches to management may include techniques to minimise de-novo central sensitisation following surgery, inclusion of comorbidities in treatment evaluation, and looking at the role of diet in inflammation and symptom management.

Others are optimal pelvic physiotherapy techniques in women with pelvic muscle spasm, refinement of the clinical situations in which surgical intervention is appropriate and optimal dosage regimes for neuropathic medications.

Other approaches include improved management of postoperative pain where narcotics are ineffective, and investigation of the factors that influence the transition from severe dysmenorrhoea to chronic pelvic pain.

It may be appropriate, as determined on a case by case basis, to refer beyond the traditional boundaries of a gynaecologist. Other disciplines to consider include pelvic physiotherapists using muscle down-training, dietitians specialising in food intolerance, psychologists working in chronic pain, pain medicine specialists, vulval dermatologists, psychiatrists and gastroenterologists experienced in the management of functional bowel symptoms.

CHRONIC PELVIC PAIN

Patients with chronic pelvic pain will, in most cases, present to a healthcare provider when they have exhausted their self-treatment capabilities.

Some patients will wait years, even decades, before presenting themselves for help.

In other cases, patients are channelled in the wrong direction and do not get appropriate support.

PREVENTION

Chronic pelvic pain may be one of the few areas of chronic pain where prevention is possible. For example, adolescents with severe dysmenorrhoea unresponsive to the OCP or anti-inflammatory medications appear to be a group at higher risk of chronic pelvic pain.

Effective management has the potential to alter outcomes.

Effective care provides an opportunity to avoid longer-term problems such as prescription opioid dependence, infertility and psychological deterioration.

Jean Hailes for Women's Health is a national, not-for-profit organisation focusing on clinical care, innovative research and practical educational opportunities for health professionals and women. **www.jeanhailes.org.au**

Practice Points

- Causation of pelvic pain in some cases may not fit into the existing range of related conditions and may become a diagnosis in itself
- Patients missing significant time at school or work due to pain, despite medical management, need further investigation
- Adolescents with severe dysmenorrhoea unresponsive to OCP and NSAIDs require referral to appropriate specialists
- Refer to interdisciplinary pain clinics where available.

Source: Jean Hailes for Women's Health.

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