

4.1 Persistent Pelvic Pain

Like other chronic pain conditions, in persistent pelvic pain (PPP) there is: pain from end organs (pelvic organs); the musculoskeletal response to pain; central sensitisation; and the psychological sequelae of the pain condition. In addition, PPP presents personal challenges above and beyond those suffered by others with chronic pain. Patients may be reluctant to present to health care providers as their pain has embarrassing gender, fertility and sexual overtones.

The specialist pain medicine physician (SPMP) needs a sound understanding of the social context and the psychological impact of PPP in order to develop a comprehensive management plan. Learning outcomes are an extension of those in the essential topic areas (ETA), especially, ETA 5 on Visceral Pain.

By the end of training, a trainee will be able to:

Background

4.1.1	Describe epidemiology and natural history of pelvic pain in women and men.
4.1.2	Discuss the psychological sequelae of persistent pelvic pain and the implications it may have on medical management.
4.1.3	Be cognisant that persistent pelvic pain usually presents with multiple issues and is likely to have four components: <ul style="list-style-type: none"> • Pelvic organ contributions or causes of nociception • Somatic nociception • Peripheral and central sensitisation, cross sensitisation between organs • Patient's adaptation to chronic pain
4.1.4	Recognise the lifestyle, posture, exercise and obstetric issues that predispose to the development of pelvic pain.
4.1.5	Identify nociception involving the pelvic floor muscles and ligaments, their presenting symptoms, examination findings and management options.
4.1.6	Discuss in detail the concept of neural plasticity, i.e. sensitisation or neuropathic mechanisms in persistent pelvic pain.
4.1.7	Outline the mechanisms of pain in: <ul style="list-style-type: none"> • Surgical nerve injury, e.g. ilioinguinal/hypogastric, obturator, pudendal • Irritable bowel syndrome • Painful Bladder Syndrome • Pudendal Neuralgia
4.1.8	Describe gender specific mechanisms in pain, including the role of sex hormones
4.1.9	Describe the mechanisms by which menstrual suppression may have an effect on pain control.

4.1.10	<p>Outline the mechanisms of pain in:</p> <ul style="list-style-type: none"> • Dysmenorrhoea • Endometriosis • Vulvodynia • Menstrual Migraine • Chronic Candidiasis
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Assessment

4.1.11	<p>Elicit a history from the patient with pelvic pain to evaluate the pain and its impact on physical and social function, including:</p> <ul style="list-style-type: none"> • Bladder function • Bowel function including 'bloating' • Food intolerances • Surgical history • Cognitive factors such as fear-avoidance beliefs and coping styles • Precipitating neural injury • Pain or relief of pain through exercise and activity • Sexual history • Abuse history
4.1.12	<p>Distinguish clinically conditions that are suggestive of:</p> <ul style="list-style-type: none"> • Inflammatory and neuropathic sources of pelvic pain • Nociception from pelvic muscles including pubococcygeus and obturator internus. • Central sensitisation • Symptoms and signs that reflect convergence
4.1.13	<p>Elicit the presence of pelvic muscle allodynia by both history and appropriate examination.</p>
4.1.14	<p>Describe the possible causes of acute 'flares' of pain in the context of persistent pelvic pain.</p>
4.1.15	<p>Evaluate the relationship between pain and the menstrual cycle, including the effect of hormonal changes.</p>
4.1.16	<p>Perform a thorough physical examination to exclude infection and diagnose the cause of pelvic pain.</p>

Management of Pelvic Pain

4.1.17	<p>Discuss treatment options for</p> <ul style="list-style-type: none"> • bladder symptoms of frequency, nocturia or urgency • irritable bowel and food intolerance • pudendal neuralgia
4.1.18	<p>Discuss the management of pelvic muscle pain, including the contribution of obturator internus, pubococcygeus, puborectalis, piriformis, mechanical allodynia and the role of pelvic physiotherapy.</p>
4.1.19	<p>Describe the role of psychological measures in the management of pelvic pain.</p>

4.1.20	Describe the role of neuropathic medications and pharmacological combinations of therapy, including but not limited to: <ul style="list-style-type: none"> • Amitriptyline • Anticonvulsants including pregabalin and gabapentin • SNRI medications including duloxetine
4.1.21	Describe gender specific risks and consequences of long term pharmacotherapy including hormonal therapies used in the treatment of pelvic pain.
4.1.22	List the allied health professionals that may be involved in the care of persistent pelvic pain and outline their respective contributions to management.
4.1.23	Discuss the importance of psychological support strategies in conjunction with other treatment.
4.1.24	Explain the role of multidisciplinary management, i.e. combinations of pharmacotherapy and non-pharmacological treatments in the management of persistent pelvic pain.
4.1.25	Discuss specific treatment options for <ul style="list-style-type: none"> • dysmenorrhea • endometriosis • vulvovaginal irritation • chronic candidiasis • menstrual migraine
4.1.26	Describe the indications, effectiveness and adverse effects of pharmacotherapies used to suppress ovarian and uterine function.
4.1.27	Discuss the evidence base for the indications, effectiveness and adverse effects of surgical interventions as a treatment for pelvic pain, including but not limited to laparoscopy and hysterectomy.
4.1.28	Outline the treatment options available for women with persistent pelvic pain who are trying to conceive.
4.1.29	Critically discuss the treatment options for management of persistent pelvic pain during pregnancy, the postpartum period and breastfeeding.