Bringing to life the best in women's healt

The Initial Management of Chronic Pelvic Pain

This is the second edition of this guideline. The first edition was published in 2005 under the same title.

1. Purpose and scope

The purpose of this guideline is to provide an evidence-based summary for the generalist to facilitate appropriate investigation and management of women presenting for the first time with chronic pelvic pain.

2. Background and introduction

Chronic pelvic pain 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. It is a symptom not a diagnosis. Chronic pelvic pain presents in primary care as frequently as migraine or low-back pain[1] and may significantly impact on a woman's ability to function.[2]

Living with any chronic pain carries a heavy economic and social burden. Aiming for accurate diagnosis and effective management from the first presentation may help to reduce the disruption of the woman's life and may avoid an endless succession of referrals, investigations and operations. This guideline provides an evidence-based framework for the initial assessment of women with chronic pelvic pain. It is intended for the general

Although many symptom complexes such as irritable bowel syndrome (IBS) and pain perception itself[17] may vary a little with the menstrual cycle (with 50% of women experiencing a worsening of their symptoms in association with their period

In a consecutive series of 26 women with laparoscopy-negative chronic pelvic pain undergoing magnetic resonance imaging (MRI), 20 were found to have injuries to the levator ani. In a pain-free control group undergoing MRI, none of the 20 nulliparous and two of the 32 multiparous women had such injuries.[28] Spasm of the muscles of the pelvic floor is proposed as a cause of pelvic pain which can be reduced by botulinum toxin injections.[29,30] A number of controlled and

5. What should underline the initial assessment of chronic p

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The initial history should include questions about the pattern of the pain and its association with other problems, such as psychological, bladder and bowel symptoms, and the effect of movement and posture on the pain.

Symptoms alone may be used to diagnose IBS positively in this group (see Appendix 1).

On taking the woman's history, special note should be taken of any 'red flag' symptoms (see Appendix 2)

All sexually active women with chronic pelvic pain should be offered screening for sexually transmitted infections (STIs).

7. What therapeutic options are available?

Women with cyclical pain should be offered a therapeutic trial using hormonal treatment for a period of 3–6 months before having a diagnostic laparoscopy.

Women with IBS should be offered a trial with antispasmodics.

Women with IBS should be encouraged to amend their diet to attempt to control symptoms.

Women should be offered appropriate analgesia to control their pain even if no other therapeutic manoeuvres are yet to be initiated. If pain is not adequately controlled, consideration should be given to referral to a pain management team or a specialist pelvic pain clinic.

Ovarian suppression can be an effective treatment for cyclical pain associated with endometriosis. The effect can be achieved with the combined oral contraceptive, progestogens, danazol or GnRH analogues, all of which are equally effective but have differing adverse effect profiles.[67,79] The levonorgestrel-releasing intrauterine system (Mirena®; Bayer) could also be considered, even in adolescents.[80] Non-endometriosis-related cyclical pain also appears to be well controlled by these treatments.[81–83]

In a randomised controlled trial, 100 women with clinically suspected endometriosis received

Voluntary organisations such as Endometriosis UK can be an important source of information and support for some patients. A list of such organisations is given in section 10. Self-management techniques as suggested by the Department of Health's Expert Patient Initiative may also be of value to some women.

8. Summary

in consultations for chronic pelvic pain. *o ns H t* 1998;7:1041–8.

52. Peters AA, van Dorst E, Jellis B, van Zuuren E, Hermans J, Trimbos JB. A randomized clinical trial to compare two different approaches in women with chronic pelvic pain. *st t G n o* 1991;77:740–4.

53. Flor H, Fydrich T, Turk DC. Efficacy of multidisciplinary pain treatment centers: a meta-analytic review.

88. National Institute for Health and Clinical Excellence. *rr t o s n ro n u ts D nos s n n nt o rr t o s n ro n pr r r* NICE clinical guideline 61. London: NICE; 2008 [http://www.nice.org.uk/guidance/CG61/NICEGuidance].
89. Jaiwala J, Imperiale TF, Kroenke K. Pharmacologic treatment of

APPENDIX 3

Grades of recommendations

At least one meta-analysis, systematic review or

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