

Chronic Pelvic Pain: Treatment Options

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Chronic pelvic pain-noncyclic pain that persists for more than six months and alters lifestyle and behavior-is a significant cause of discomfort, distress, medical office visits, and surgery. In the United States chronic pelvic pain accounts for more than 80,000 hysterectomies and one-third of all laparoscopies(1), often without a cure.

Causes

Although commonly thought to be primarily of gynecologic origin, chronic pelvic pain can also be caused by musculoskeletal, urinary, gastrointestinal, and psychiatric pathology. Table 1 lists the wide differential diagnoses of chronic pelvic pain.

Laparoscopy, used for many years as the primary diagnostic tool, has yielded mixed reviews. One study found that in 9 to 66 percent of women with chronic pelvic pain, no anatomic abnormalities were discovered with laparoscopy. By comparison, women undergoing elective sterilization had rates of endometriosis and adhesions of 15 percent and 14 percent, respectively(2,3). Chronic pelvic pain is unusual in that the degree of physical abnormality is poorly correlated with the level of pain.

Table 1: Causes of Chronic Pelvic Pain

Gynecologic

Extrauterine

- ?? Adhesions
- ?? Chronic ectopic pregnancy
- ?? Endometriosis
- ?? Chronic pelvic infection
- ?? Residual ovary syndrome

Uterine

- ?? Adenomyosis
- ?? Leiomyomas
- ?? Pelvic congestion
- ?? Chronic endometriosis
- ?? Pelvic support defects
- ?? Intrauterine contraceptive device

Musculoskeletal

- ?? Disc problems
- ?? Coccydynia
- ?? Degenerative joint disease
- ?? Hernias
- ?? Fibromyalgia
- ?? Herpes zoster
- ?? Levator ani syndrome

- ?? Myofascial pain
- ?? Nerve entrapment
- ?? Strains/sprains

Urologic

- ?? Chronic urinary tract infection
- ?? Interstitial cystitis
- ?? Kidney stone
- ?? Detrusor overactivity

Gastrointestinal

- ?? Chronic appendicitis
- ?? Cholelithiasis
- ?? Constipation
- ?? Diverticular disease
- ?? Neoplasia
- ?? Irritable bowel syndrome
- ?? Inflammatory bowel disease

History

A patient's history can provide valuable information about the origin of pelvic pain. Cyclic pain occurring near or during menstruation may indicate gynecologic pathology such as endometriosis, fibroids, or ovarian neoplasia.

A history of abnormal vaginal bleeding can accompany the pain and indicates endometriosis or uterine pathology.

Patients presenting with dyspareunia (intercourse pain) should differentiate between introital (external) or deep pain. Deep dyspareunia can be a symptom of endometriosis.

Changes in bowel habits that accompany pelvic pain may indicate intestinal problems like inflammatory bowel disease. Pain with defecation may be caused by endometriosis or pelvic floor tension myalgia.

Pelvic floor tension myalgia is a musculoskeletal condition involving the levator ani muscle—a collection of muscles that attach from around the anus and perineum to the bony prominences of the lower pelvis. This muscle is an important support structure of the pelvic organs, and like other skeletal muscles is susceptible to chronic strain. Trigger points, areas of localized, painful muscle that can refer pain in unusual distribution, often develop in the pelvic floor and are responsible for chronic pain with no apparent physical cause.

Physical Examination

A careful, thorough examination must be performed if a cause is to be identified. The abdomen, low back, pelvic and abdominal muscles must all be examined to be complete.

Diagnosis

If examination and historical findings are lacking, diagnostic studies such as intravenous pyelograms, barium enemas, small intestine investigations and computed tomography are rarely helpful. As mentioned, laparoscopy has mixed reviews and should not be used as a screening tool for chronic pelvic pain patients. Laparoscopic examination is best utilized in women with abnormal palpatory findings with pelvic examination or symptoms that suggest endometriosis.

Treatment

Conventional treatment of chronic pelvic pain consists of NSAIDS, oral contraceptives, Depo-Provera, Elavil, anesthetic injections, or antibiotics-the specific use of which is dependent on the suspected cause.

The alternative therapy I provide is also dependent on the cause of the pain. Many women I work with have seen other physicians that have failed to complete a thorough examination. A significant number of these patients have pelvic floor tension myalgia or other lower abdominal trigger points responsible for their pain. In these women, a medical cause" is many times lacking because the doctor who examined them was not aware of the musculoskeletal component in pelvic pain, did not spend sufficient time with the patient, or simply lacked the skill. In these patients, treatment focuses on the involved muscles with myofascial release techniques.

For women with symptomatic uterine fibroids, acupuncture, herbs, and nutritional alterations can achieve fibroid diminution with subsequent pain relief. From a Traditional Chinese Medicine perspective, fibroids indicate blood stagnation and both acupuncture and botanical therapy disperses the tumor.

Treatment of endometriosis relies on changes in diet(more vegetarian), and the use of acupuncture, herbs, and chiropractic manipulation. While cimicifuga racemosa and dioscorea villosa are effective in relieving acute pain, vitex and taraxacum can diminish chronic symptoms.

Lastly, there are women with chronic pelvic pain in which no cause can be identified. Many of these cases are labeled psychosomatic and told to see a therapist. Although emotional and psychological issues play a strong role in chronic pain, I find that physical treatment is nonetheless necessary to effect a cure. Acupuncture and manipulative therapy are the treatments of choice in these women.

Resources:

1. Walling MK, Reiter RC, O'Hara MW, Milburn AK, Lilly G, Vincent SD, et al. Abuse history and chronic pain in women: I. Prevalences of sexual abuse and physical abuse. *Obstet Gynecol* 1994;84:193-9.
2. Howard FM. The role of laparoscopy in chronic pelvic pain: promise and pitfalls. *Obstet Gynecol Surv* 1993;48:357-87.
3. Steege JF, Stout AL, Somkuti SG. Chronic pelvic pain in women: toward an integrative model. *Obstet Gynecol Surv* 1993;48:95-110.