CHRONIC PELVIC PAIN

A Guide for Women

Chronic pelvic pain (CPP) is ongoing pain in the lower abdomen or pelvis. It is not caused solely by menstruation or sexual intercourse, although either can aggravate the condition. CPP is not related to pregnancy. CPP is common, affecting about one woman in six. It tends to occur most often in women of childbearing age. CPP is not a disease or a diagnosis, but rather a symptom. The cause can be difficult to diagnose. Sometimes, no cause can be found. It often consists of several disorders that occur at the same time. One difficulty is that no two women with CPP have the same experience of pain.

POSSIBLE CAUSES OF CHRONIC PELVIC PAIN

The following list is a summary of common causes. CPP may be caused by other conditions.

Disorders of the female pelvic organs

- Endometriosis: the growth of endometrium (tissue that normally lines the uterus) in the pelvis, outside the uterus. This is the most common gynaecological cause of CPP.
- Pelvic inflammatory disease (PID): an infection of the fallopian tubes, ovaries or uterus.
- Adhesions: bands of scar tissue that may form after injury, infection or surgery. For example, abdominal adhesions may restrict the movement of the intestines or pull on a pelvic organ. Pelvic adhesions may twist a fallopian tube, causing pain. Minor adhesions do not cause CPP.
- Retained ovary syndrome: an ovary that remains after surgery to remove the uterus.
- Ovarian cysts have often been blamed for causing CPP but do so rarely.
- Cysts due to endometriosis may cause pain because they are often linked to scar-tissue adhesions and endometriosis.

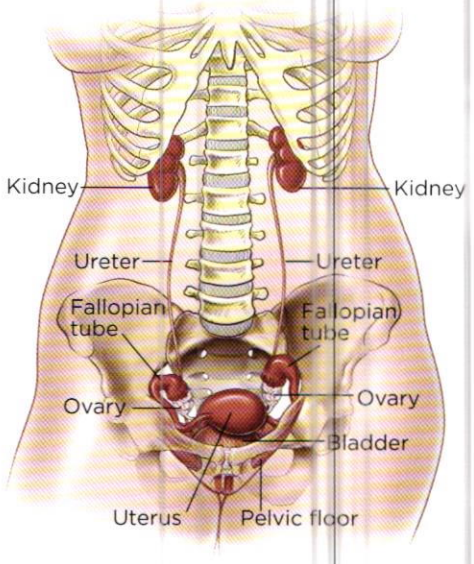
Disorders of the urinary tract

- Interstitial cystitis – inflammation of the bladder lining that can cause scarring and ulceration of the bladder. This is the most common urologic cause of CPP.
- Bladder neoplasm – abnormal growth in the bladder that may be benign (non-cancerous) or malignant (cancerous).
- Urethral syndrome – inflammation of the urinary tract that causes symptoms similar to urinary tract infection.

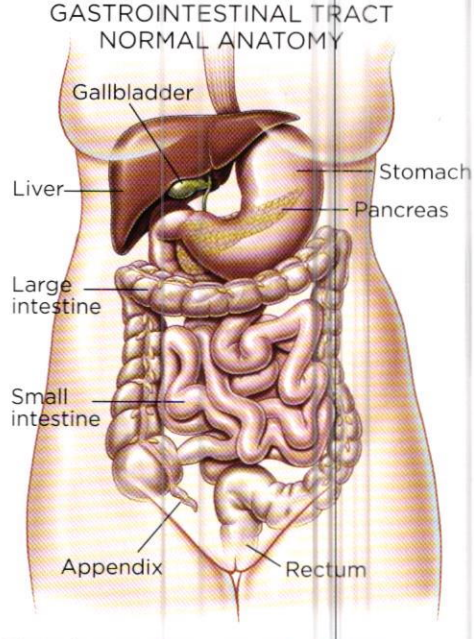
Disorders of the gastrointestinal tract

- Irritable bowel syndrome – the most common gastrointestinal cause of CPP. Symptoms include abdominal pain, alternating diarrhoea and constipation, and mucus in the stool. Painful sexual intercourse can also occur with irritable bowel syndrome.
- Chronic constipation.
- Inflammatory bowel disease – inflammation of the small and large intestines.
- Diverticular disease – a condition where weakened sections of the intestinal wall allow pouches to form. Food trapped inside the pouches may cause inflammation and infection.
- Coeliac disease (intolerance to gluten).

FEMALE PELVIC ORGANS AND URINARY TRACT NORMAL ANATOMY



GASTROINTESTINAL TRACT NORMAL ANATOMY



Disorders of the musculo-skeletal system

- Poor posture, particularly for women who have a sedentary lifestyle.
- Weakened muscles, particularly those of the pelvic floor and lower abdomen; muscles may be weakened due to chronic constipation, childbirth, overstretching with obesity, or lack of exercise.
- Trigger points (irritable and painful spots in a tightened area of skeletal muscle); they can be in the abdominal wall or pelvic floor muscles.
- Fibromyalgia – chronic muscle pain that has no obvious cause.

IMPORTANT: FILL IN ALL DETAILS ON THE STICKER BELOW

DEAR DOCTOR: When you discuss this pamphlet with your patient, remove this sticker, and put it on the patient's medical history or card. This will remind you and the patient that this pamphlet has been provided. Some doctors ask their patients to sign the sticker to confirm receipt of the pamphlet.

PEEL HERE

TREATMENT INFORMATION PAMPHLET

PROCEDURE: _____

PATIENT'S NAME: _____

DOCTOR'S NAME: _____

EDITION NUMBER: _____ DATE: D D / M M / Y Y Y Y

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Other known causes of CPP

- Nerve entrapment – "pinched" nerve. A surgical incision across the lower abdomen (a caesarean section, for example) may result in nerve entrapment during and after healing.

Back problems can result in nerves being pinched, causing pain in the lower abdomen and groin.

Trauma to the ilioinguinal nerve can cause pain.

- Pudendal neuralgia – damage to the pudendal nerve in the pelvis may cause pain in the genitals, rectum and anus.
- Herniated spinal disc – the discs are circular pads of shock-absorbent tissue located between the bones (vertebrae) of the spine.

A herniated disc means the outer shell of the disc has ruptured, with its contents putting pressure on spinal nerves.

- Certain cancers - such as ovarian, bone or bladder cancer. Additional symptoms and signs (such as bleeding from the rectum) may suggest a serious underlying disease such as cancer.
- For reasons that are unclear, women who are depressed, have a sleep disorder or who have a history of sexual or physical abuse are more likely to have CPP.

Your medical history

Tell the doctor your full medical history. Prior or current medical conditions, complications during childbirth and factors such as previous surgery can give your doctor clues about the possible causes of CPP.

Give your doctor a list of all medicines you are taking or have taken, including prescription and over-the-counter medications, herbal remedies and vitamins.

The doctor may ask you to keep a "pain diary" that includes menstruation dates. A pain diary kept for two or three menstrual cycles may reveal a pattern. Detailed questions about your general health including diet, bowel habits, lifestyle, state of mind, and the quality of your relationships may also help to steer medical investigations. If you have any ideas about what may be causing the CPP, share them with your doctor.

A thorough and detailed patient history will often be as important in the diagnosis as any other signs, symptoms or tests.

Diagnostic tests

Medical tests to diagnose CPP may take a long time. Despite every effort, a precise cause cannot always be found. It is common for a woman to feel disappointed or upset if she does not have a diagnosis after undergoing many tests. However, treatment of symptoms can manage CPP in most cases. Some diagnostic tests are invasive, which can involve possible complications. Tests to help diagnose CPP include:

- Physical examination
- Pelvic examination – the doctor may perform genital, vaginal and rectal examinations
- Abdominal or vaginal ultrasound
- Urine test to check for infection or blood
- Blood test to check hormone levels and screen for signs of infection or inflammation
- Tests to check for a sexually transmitted disease or pelvic inflammatory disease
- Stool test to check for the presence of hidden (occult) blood in the stool, which can suggest a range of gastrointestinal disorders
- X-ray examinations, including a barium enema
- CT or MRI scans
- Laparoscopy – a thin telescope (laparoscope) is inserted through a small incision to allow the doctor to see the patient's abdominal and pelvic organs. A laparoscopy can help to diagnose conditions such as endometriosis, chronic pelvic infection and adhesions. Surgery to treat the problem may be performed during the same procedure.
- Hysteroscopy – a thin telescope (hysteroscope) is inserted through the cervix to allow the doctor to see the inside of the uterus.
- Other tests – depending on your symptoms and medical history, the doctor may suggest other tests such as nerve function tests, a bone scan or a cystoscopy (the insertion of a slender tube into the urethra to allow the doctor to see the inside of the bladder). Your doctor may refer you to other specialists, such as a urologist (to check the bladder), a gastroenterologist (to check the bowel) or a physiotherapist (to check the muscles of the lower back, abdomen and pelvic floor).

Anaesthesia

Surgery and some diagnostic tests may be performed under local or general anaesthesia. Modern anaesthesia is safe and effective but does pose some risks. Rarely, side effects from an anaesthetic can be life threatening. Ask your doctor and anaesthetist for more information.

Talk to your doctor

The aim of this pamphlet is to provide you with general information. It is not a substitute for advice from your doctor and does not contain all the known facts about CPP or every possible risk, benefit and limitation of treatments. Use this pamphlet only in consultation with your doctor.

Some medical terms in this pamphlet may need further explanation by your doctor. Your doctor will be pleased to answer questions. It may be helpful to make a list of questions you wish to ask. If you have any concerns about treatment, discuss them with your doctor.

Your doctor cannot guarantee that treatment will meet all of your expectations and has no risks. You may wish to seek a second opinion from another specialist.

Consent form

If you decide to undergo surgery, the doctor will ask you to sign a consent form. Read it carefully. If you have any questions about the consent form, the procedure, risks or anything else, ask your doctor.

Costs of treatment

It is best to discuss costs with the doctor before treatment rather than afterwards. The doctor can give you an estimate of hospital, surgical and anaesthetic fees.

Ask the doctor about costs that may be covered by public or private health funds.

As the course of treatment may differ from the proposed treatment, the final account may vary from the estimate. Extra costs may apply if further surgery is needed to treat complications.

TREATMENT OPTIONS FOR CPP

Treatment depends on the underlying cause or causes. If the tests reveal physical problems, the doctor can provide specific treatments. Even if no physical problems can be found, the doctor may suggest a range of treatments to help control pain and treat other symptoms. The doctor may need to trial various treatments to achieve good results.

Treatment also depends on your general health and personal preferences. Some treatments reduce fertility, so it is important to tell your doctor whether or not you intend to become pregnant. You may be referred to a pain specialist or pain clinic where specially trained doctors can supervise treatment options, such as medications, physiotherapy, psychological counselling and so on.

In some cases of CPP, surgery is the preferred treatment. In other cases, surgery may only be considered if other treatments have failed to improve symptoms. In remaining patients, surgery has no role. The doctor may suggest that you first try non-surgical treatments.

Medications

Medications may be used to manage CPP symptoms. However, the symptoms are likely to return if you stop taking the medications. The doctor may suggest one or more of the following medications:

- **Pain relievers** – typically paracetamol, paracetamol with codeine, aspirin or NSAIDs (non-steroidal anti-inflammatory drugs such as ibuprofen). The doctor can prescribe stronger medications if over-the-counter preparations fail to give relief.
- **Oral contraceptives** – used to treat CPP in women who have pain associated with the menstrual cycle, including women with endometriosis.
- **GnRH agonists** – hormone therapy to prevent the ovaries from making hormones. This can help to thin the uterine lining in women with endometriosis, which may offer relief of symptoms.
- **Antibiotics** – to treat infection and pelvic inflammatory disease.
- **Smooth-muscle relaxants** – to ease the bowel spasms associated with irritable bowel syndrome.
- **Antidepressants** – in low doses, antidepressants can be very useful pain killers. Stronger doses may help certain patients to improve their capacity to cope with depression and other emotional stress that might aggravate the pain.
- Other medications may be prescribed to improve quality of life; for example, a short course of sleeping tablets may assist in breaking a cycle of insomnia.

Side effects of medications: All drugs can have unwanted side effects. Carefully read the Consumer Medicine Information leaflet that comes with the medication. See your doctor promptly if you think the drugs you are taking are causing side effects.

Lifestyle

Lifestyle changes that may improve symptoms include reduced smoking and coffee intake, and increased exercise. Dietary changes may improve symptoms, for example, in women with irritable bowel syndrome. The doctor may suggest an "exclusion diet" that involves eliminating most foods from the daily diet and introducing suspect foods one at a time. Generally speaking, grains and dairy products most commonly cause abdominal pain and bloating in people with irritable bowel syndrome. Also, some women with interstitial cystitis find that avoiding alcohol and acidic foods (such as tomatoes) can help to ease symptoms.

Counselling

Counselling may be helpful to:

- manage depression
- improve coping skills
- uncover and manage other stresses that may be making the pain worse.

Physiotherapy

Physiotherapy is often useful in treating muscular trigger points. Physiotherapists trained in women's health can teach how to tighten and relax the muscles more effectively. Injections of local anaesthetic may also help to relieve trigger points in some cases.

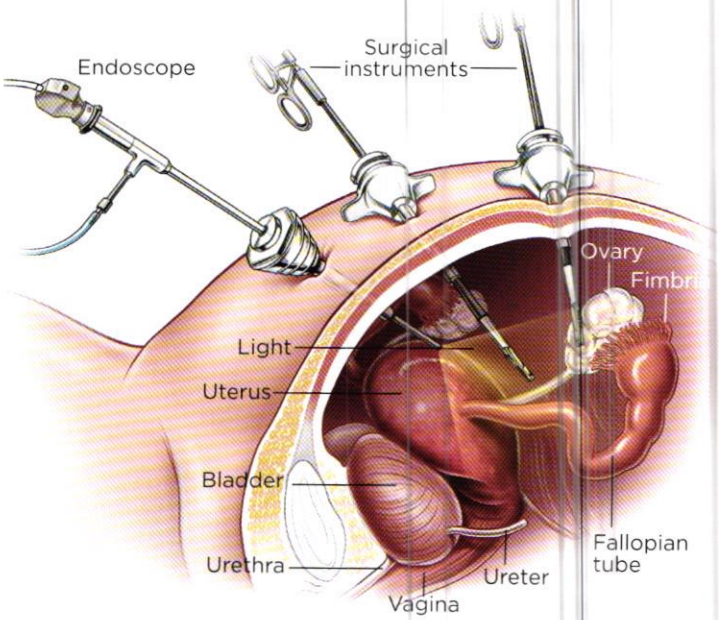
Complementary therapies

Some women with CPP choose to treat symptoms with therapies such as massage or acupuncture. Talk to your doctor first. Some people have an increased risk of complications if they use certain complementary therapies. Tell your complementary therapist about any prescription medications you are taking. Vitamins, minerals and some herbal remedies can change the effect of prescription medications.

Surgery to treat chronic pelvic pain

The type of surgery recommended by your doctor depends on the underlying cause. As CPP has many different causes, this pamphlet outlines only some of the more common surgeries. Ask your doctor for further information about the type of surgery (if any) recommended for you.

- Laparoscopy may be used to treat gynaecological problems such as endometriosis, ovarian cysts, ovarian remnant syndrome or pelvic adhesions.



Different types of CPP surgery may be performed using laparoscopy.

- Hysterectomy is rarely needed but can be useful in certain cases.
- Neuroablative therapy is surgery to cut or destroy nerves that send pain signals. Presacral neurectomy has been used in the past and occasionally may still be done today for the treatment of CPP. A collection of nerve tissue called the "presacral plexus" is located in the lower back. The doctor uses laser energy or electrocautery to destroy the presacral plexus and stop the pain messages. In most cases, this operation is done using laparoscopy. Sometimes, a special "neurotoxic" chemical is injected near the nerves to inactivate them.

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- Cancer surgery usually involves removing part, or all, of the diseased organ. The surgery depends on the location, type, size and stage of the cancer. For example, hysterectomy is the surgical removal of the uterus. A cystectomy is an operation to remove part, or all, of the bladder.

For further information, the following patient education pamphlets may assist you. They are available from your doctor.

- Understanding Endometriosis
- The Laparoscopic Treatment of Endometriosis
- Pelvic Inflammatory Disease
- Laparoscopy
- Hysteroscopy
- Hysterectomy.

Before surgery: If surgery becomes necessary, the doctor will give you pre-operative instructions. Follow them carefully.

Do not consume alcohol in the few days before the surgery. Alcohol can interfere with the effect of some medications.

Stop smoking at least two weeks beforehand. Smoking impairs healing and increases the risk of complications such as blood clots and breathing problems.

Recovery after surgery

The length of hospital stay depends on the amount of surgery performed during the procedure. Most women can go home within a few hours of having a day procedure. Some may need to stay in hospital overnight or longer if they had a complicated or lengthy operation.

Arrange for a relative or friend to drive you home from hospital. After general anaesthesia, avoid driving for at least 24 hours, and do not make any important decisions for about two days.

If the surgery required skin incisions, non-dissolvable stitches can be removed in about one week. Hospital staff, the local GP or district nurse can remove them.

Recovery time depends on the procedure. In most cases, normal physical and sexual activity can be resumed once the woman is feeling well enough. The doctor will advise about a return to work.

Attend all follow-up appointments. You may need to discuss further treatment plans or have tests to find out whether or not the surgery was successful.

POSSIBLE COMPLICATIONS OF SURGERY FOR CHRONIC PELVIC PAIN

Despite the highest standards of surgical skills, all surgery carries some degree of risk. It is not usual for a doctor to dwell at length on every possible side effect, and the rare but serious complications of any surgical procedure. However, it is important that you have enough information to weigh up the benefits, risks and limitations of surgery. Most women who have surgery to treat CPP will not have complications, but if you have concerns about possible complications, discuss them with your doctor.

The following possible complications are listed to inform you, not to alarm you. There may be other complications that are not listed.

General surgical risks

- Heavy bleeding that may, uncommonly, require a transfusion
- Infection that may require treatment with antibiotics
- Short-term nausea following general anaesthesia and other risks related to anaesthesia
- Allergic reaction to sutures, dressings or antiseptic solutions
- The collection of blood (haematoma) around the operative site that may require further surgery
- Cardiovascular complications such as heart attack, deep venous thrombosis, stroke or pulmonary embolism
- Raised, itchy and reddened scars (keloid or hypertrophic scars). These can be annoying but are not a threat to health.

Specific risks of CPP surgery

- Even after a confident diagnosis and surgical treatment, CPP may persist in varying degrees. Some women report that CPP has decreased significantly, while others may report that it has not changed or may have worsened.
- Constipation is a common side effect after anaesthesia and abdominal surgery. Treatment includes medicines as recommended or prescribed by your doctor.

Laparoscopy

- About one diagnostic laparoscopy in every four does not result in a diagnosis to explain CPP. In this situation, other causes may have been overlooked, such as irritable bowel syndrome, inflammatory bowel disease, or muscular trigger points.
- Laparoscopic instruments may injure nearby organs or structures such as the uterus, bladder or abdominal wall. The doctor may have to immediately convert to open surgery (laparotomy) to repair the damage. Discuss with your doctor the possibility of laparotomy.
- Laparoscopy has a small risk of peritonitis, an infection of the membrane that lines the abdomen (peritoneum). This can be life threatening. Treatment includes antibiotics and possible surgery.
- After laparoscopy and laparotomy, scar-tissue adhesions may form during the healing process. Such adhesions may cause CPP. Treatment, including further surgery, may be needed.

Hysteroscopy

- The hysteroscope or other instruments may puncture the uterus. In most cases, the surgery is stopped and rescheduled. The uterus must heal before the surgery can be performed again.

Report to your doctor

Notify your doctor at once if you have any of the following:

- fever (greater than 38°C) or chills
- nausea and vomiting
- increasing or persisting abdominal or back pain
- persistent bleeding from the vagina
- pain or burning on passing urine or the need to pass urine frequently
- an enlarging bruise under the incision site
- swollen abdomen
- any other concerns about the surgery or your recovery.

If you cannot contact your doctor, go to your family doctor or Accident and Emergency at your nearest hospital.

Your Obstetrician

This patient education has been reviewed by obstetricians and gynaecologists in Australia and New Zealand

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