Chronic Pelvic Pain

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Question 1:

If the gate-control theory is applicable to chronic pelvic pain, should the approach to treatment of these patients more often include antidepressants and neuroleptics than traditional gynecologic treatments, particularly in the absence of palpable pathology?

Response from Dr. Steege:

There is always a balance between treating recognized pelvic pathology and treating pain as an illness in itself. When first-line treatments fail, such as in endometriosis, the evaluation should always consider the agents you list, instead of simply escalating the aggressive application of other medical and surgical therapies.

Question 2:

In your management overview you discuss the importance of simultaneous treatment of many factors, most of which are outside the scope of the average gynecologist’s skill set. What roles should be played by colleagues in psychology and psychiatry, case management, pain management, and marriage counseling in typical cases of chronic pelvic pain?

Response from Dr. Steege:

In terms of making any mental health referral, it is up to the gynecologist to do two things:

i. Make a reasoned judgment that such help might be useful. To do this, the gynecologist will need to have taken enough history in a sensitive manner to have this suggestion arise from data.

ii. Demonstrate, by good interview technique, that talking about sensitive issues is possible and tolerably comfortable. This is a “free sample” of what it might be like for the patient to talk with a mental health professional, and thus have them see the referral as a helpful suggestion, as opposed to a rejection by the gynecologist.
In terms of “case managers,” I have no personal experience with them; hence, no feel for how they might help. For pain management, the type of help available varies greatly by geographic location. While consultation from a gynecologist trained in pelvic pain is available in some areas, in many the practicing gynecologist is obliged to do the best they can on their own. Help from an anesthesia pain clinic can be useful if it is part of a collaborative effort with the gynecologist. To simply turn the patient over to the anesthesia group and cease involvement with the patient is less useful, as the anesthesia providers generally do not perform pelvic exams, and many such clinics refuse to accept a referral for pelvic pain.

**Question 3:**

It does not seem that the history-taking and physical exam you suggest can be adequately done in a typical 40-minute consult appointment or follow-up in a 20-minute return visit. How much time do you allot for an initial appointment for a chronic pelvic pain patient? How much time for a follow-up appointment?

**Response from Dr. Steege:**

Our time for a new patient evaluation varies from 45 to 90 minutes, and a return appointment from 10 to 30 minutes. It is very difficult to adhere to a strict schedule, as needs vary so much from one patient to the next.

The gynecologist needs to simply give up the idea that they can confine a pain evaluation to the time slot given to the vanilla new gynecology patient.

One way that works for some practices is to set up a clinic half day about every 2 weeks or so for longer appointments. These can be used for 30–45 minute sessions with patients who need a lot of education and listening, whether their problem is related to pain or not. When a more challenging pain problem emerges in the course of an initial gynecology visit, the patient can be reappointed to one or more of these longer slots to pursue the issues further. This is a loss leader. It will not make money.

**Question 4:**

Under what circumstances do you refer your patients for consultation with gastroenterology and urology prior to being medically or surgically treated for chronic pelvic pain? What proportion of your patients is sent for consultation and how often does the consultation lead to a change in management plans?

**Response from Dr. Steege:**

Gastroenterology referrals: If I am truly concerned that there may be a problem such as gluten enteropathy or inflammatory bowel disease, then I will refer to a gastroenterologist. If the problem is much more likely to be irritable bowel syndrome, then I will try to work with their primary care physician, as colonoscopy (in the absence of true signs of bowel disease, i.e., passage of blood and or mucous) is uniformly negative, and gastroenterology specialists, as a rule, refer irritable bowel syndrome patients back to their primary care physicians.

Urology: If I think the patient may have interstitial cystitis, and also merits laparoscopy, then I will do both the laparoscopy and the cystoscopy with bladder distention under anesthesia. If only a cystoscopy seems warranted, then I will refer to a urologist who is comfortable dealing with bladder function disorders.

These consultations often contribute to our already established management plan, but rarely replace our plans completely.
Question 5:
Apart from history taking and physical examination, are there any diagnostic studies or psychometric tests that most of your patients undergo?

Response from Dr. Steege:

Psychometric tests: At an earlier stage of my career, I used to use psychometric tests such as depression inventories, etc. However, with increased experience, I found that they contributed less and less to the diagnostic process. For the clinician with less experience, they may be helpful, but, of course, do not replace a good interview.

Diagnostic studies: Imaging of the pelvis has a limited role in assessing pelvic pain, assuming that a reasonably thorough pelvic exam was possible. If a good appreciation of the adnexa is not possible, then pelvic ultrasound is useful. It certainly should never replace the pelvic exam, as elements such as pelvic floor and hip muscle contributions are best assessed by exam. Magnetic resonance imaging and computerized tomography rarely add useful information if the exam is sufficiently thorough.

Question 6:
What is the most common form of treatment your chronic pelvic pain patients receive?

Response from Dr. Steege:

Far and away, the most often overlooked component of chronic pelvic pain is the contribution of pelvic floor and hip muscles. Hence, our most common treatment is referral for pelvic physical therapy. However, this is almost always combined with other treatments selected on an individual basis, such as management of endometriosis, treatment of irritable bowel syndrome, treatment of bladder components, etc.

Question 7:
Patients often will present their complaints of chronic pelvic pain without warning, usually during the busiest session of the week. Do you have any tips for the over-booked gynecologist who must see a chronic pelvic pain patient among other obstetric and gynecologic patients? Are there any features of a brief history or physical examination that would indicate that the patient should be triaged to a chronic pelvic pain specialist?

Response from Dr. Steege:

Probably the best indicators that a pain problem may be out of the reach of the primary care gynecologist are the degrees of impairment of function at work, as a parent, as a spouse, etc.

The next best indicator is the answer to the “what if” question: What will happen in your life if this cannot be improved?” If the answer describes catastrophe, the patient should probably be referred.

Physical exam: If true allodynia is evident, this is likely to require more in depth evaluation and treatment. Don’t forget the recto-vaginal exam in anyone with deep dyspareunia, focal cul-de-sac pain on exam, or pain with bowel movements. If found, the patient needs to have their laparoscopy performed by someone prepared to perform or arrange for bowel surgery.