**Chronic Pelvic Pain**

**Behavioral Med Toolkit**

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*Definition:*

         Six months of pain below the umbilicus that is severe enough to cause functional disability or require treatment.

         15-20% of women in the US have pain >1year. Worldwide 5.7-26.6% of women depending on area/study type

         10% of gynecological referrals and the cause of 20% of benign hysterectomies and 40% of all gynecological laparoscopies in the US

         46.8% of women with CPP report h/o sexual or physical trauma

*Causes:*

Most common:

         Endometriosis

         Pelvic adhesions

         Interstitial cystitis

         Irritable bowel syndrome

Others:

         Gynecologic (CA, PID, leiomyomata, post-op peritoneal cysts, adenomyocytis, non-endometriotic adnexal cysts, IUD, prolapse, cervical stenosis, TB salpingitis, ovarian remnant syndrome, pelvic congestion syndrome)

         Urologic (CA, constipation, IBD, colitis, chronic intermittent bowel obstruction, diverticulitis, celiac dx)

         MSK (trigger points, chronic back/coccygeal pain, poor posture, fibromyalgia, neuralgia, pelvic floor myalgia, herniated/compressed disc, DJD, hernia, strains/sprains, spondylosis)

         Pregnancy related (MSK due to vacuum/forceps delivery, LGA infant, C-section; pelvic girdle syndrome (can last up to 2 years after delivery)

         Surgical (nerve entrapment, adhesions, sx such as abdominal, pelvic, urinary, cervical)

         Psychological (somatization d/o, bipolar d/o, physical or sexual abuse)

*Diagnosis:*

History and Physical:

<http://www.pelvicpain.org/docs/resources/forms/History-and-Physical-Form-English.aspx>

         Don't forget to ask about previous trauma: sexual, physical or psychological abuse, domestic violence, substance abuse. The best way is to just ask! Or use screening tools – PHQ9, PSTD screen, 2 question screener for substance abuse/alcohol

         Pain diary with relation to menses, mood, medication, bowel/bladder function, coitus, physical activity

         Physical exam can be very painful or traumatizing if they have a history of abuse

         Looking for tenderness on abdominal exam and pelvic exam that correlates to their pain map/symptom description

Labs:

         CBC, ESR, UA, STDs (esp Chlamydia/gonorrhea), Pregnancy test, CA-125

Imaging:

         Pelvic ultrasound – r/o mass, cysts or determine origin

         MRI (if sono positive) to further identify lesion

         Cystoscopy, CT, colonoscopy, barium enema

Laparoscopic surgery:

         To r/o endometriosis, adnexal mass, adhesions, uterine abnormalities, PID

         Can consider pain mapping (with local anesthesia)

         Findings: NO visible pathology -35%, endometriosis 33%, adhesions 24%, chronic PID 5%, ovarian cysts 3%

         Do not need laparoscopic evidence to start tx for endometriosis

         Lysis of adhesions does not necessarily help pain

*Treatment:*

         Hormonal therapy – combined OCPs, GnRH agonists, high-dose progestin,

         Pain control – NSAIDs, COX2 inhibitors, opioids

         Vit B1 or magnesium

         Antidepressants

         Laparoscopy – destruction of endometriosis, adhesion lysis

         Presacral neurectomy

         Hysterectomy

         Sacral nerve stimulation

         Trigger point injections

         Diet changes for IBS

         Counseling – may help even if it doesn’t improve pain and may improve response to medical treatment

         Counseling supported by u/s

         PT – pelvic floor muscles