Chronic Pelvic Pain

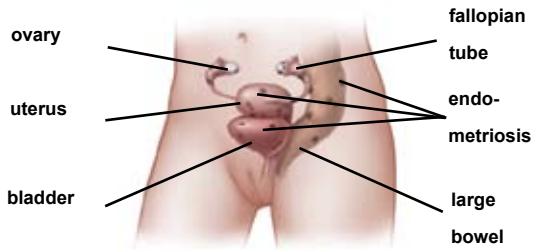
What is pelvic pain, and when is it chronic?

Pelvic pain is pain in your pelvic region that is severe enough to interfere with your life and may lead you to seek medical care. Pelvic pain is very common, affecting up to one in five women. Pelvic pain is defined as chronic when it lasts longer than six months. It can be due to more than one cause and may be difficult to diagnose. The discomfort from chronic pelvic pain may be relatively mild or severe enough to interfere with your daily activities, work, sexual life, relationships and emotional state.

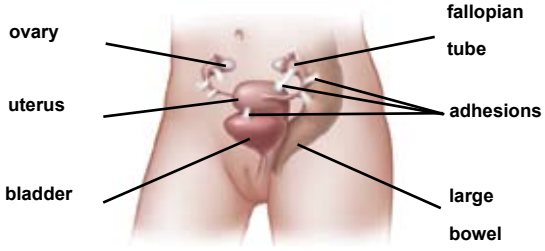
What causes chronic pelvic pain?

Chronic pelvic pain often stems from more than one source. The location, severity and quality of the pain (e.g., constant or intermittent) can help your healthcare provider uncover the cause(s). Common causes are:

- Irritable Bowel Syndrome (IBS): The most common source of chronic pelvic pain, IBS usually causes abdominal discomfort as well as bowel movement problems such as constipation, diarrhea, changes in stool form, mucus in the stool, abdominal bloating, or straining with bowel movements. Having a bowel movement often relieves the pain. Abdominal investigations are unlikely to reveal any abnormalities. While the cause of IBS is unknown, researchers speculate that people with IBS have a more sensitive stomach and intestines, leading to impaired motility (ability to move the food along) and pain.
- Endometriosis and Adenomyosis: Unduly painful periods that persist over the years may be due to endometriosis (when uterine lining grows outside the uterus) or adenomyosis (when the uterine lining grows into the muscle layer of the uterus). The pain from endometriosis or adenomyosis usually worsens when you have your period, but it can occur at any time of the month. You may experience pain during sexual intercourse, bowel movements and/or with urination. The periods themselves can have heavy bleeding as well as bleeding between periods.



- Interstitial Cystitis (IC): IC causes pain in the bladder and pelvic region. Women with IC often believe they have bladder infections as they need to urinate frequently, have difficulty getting to the bathroom on time and/or need to get up at night to urinate. Urine cultures are usually negative. The cause of IC is unknown.
- Adhesions: Adhesions are bridges of scar tissue that form between two or more internal organs. Your risk of adhesions increases if you've had surgery or infections in the pelvic area. Adhesions can also form if you have had pelvic inflammatory disease, Crohn's disease, ulcerative colitis or endometriosis.



Chronic pelvic pain has many other causes including pelvic congestion (dilated veins in the pelvis causing pain), muscle or bone problems and certain neurological conditions. Women, who have been physically or sexually abused, as well as women with depression, are at higher risk for chronic pelvic pain.

How is chronic pelvic pain diagnosed?

To help uncover the cause of the pain, your healthcare professional may ask you to write a pain diary, recording when the pain occurs, what makes it better or worse, whether it is constant or intermittent, and whether it seems linked to menstrual, bladder or bowel symptoms. For a blank diary sheet go to http://www.obgyn.net/english/pubs/features/carter/monthly_pain.pdf.

Your healthcare professional will perform an internal examination and may order tests such as urine cultures, blood work or a pelvic ultrasound. Ultrasound uses sound waves to create a picture of the uterus and surrounding organs and can detect cysts or other masses that may account for the pain. It can be preformed two different ways. For a transabdominal exam a hand-held device is pressed on the lower abdomen. You will need to drink four to five glasses of liquid before the exam without urinating. For the transvaginal exam a probe is inserted into your vagina and the bladder must be empty.

If none of these tests reveal the source of the pain, your healthcare professional may suggest certain drugs to help control the pain. If drug treatment doesn't resolve the problem, you may benefit from a laparoscopy, a procedure that involves inserting a laparoscope (long, thin viewing device) into your pelvic area through a small cut in your navel. Laparoscopy uncovers endometriosis in one-third of women and adhesions in one-quarter of women undergoing the procedure for chronic pelvic pain, but fails to yield a diagnosis in 35 percent
of cases.

If bowel problems are the suspected source of your pain, your healthcare professional may order tests such as a barium enema (X-Ray with dye in rectum) or a colonoscopy (flexible viewing tube in rectum). Suspected bladder problems may call for a cystoscopy (small telescope inserted into the bladder).

How is chronic pelvic pain treated?

The treatment of chronic pelvic pain may involve several strategies, either individually or in combination.

Nonmedical treatment

Chronic pelvic pain can impair your quality of life on many levels. Pursuing nonmedical treatments can help you cope with the pain. Relaxation, exercise and stress management are all known to relieve various forms of pain. Counseling may also help you manage the pain.

Avoiding certain foods may lessen the pain caused by irritable bowel syndrome or interstitial cystitis. Common irritant foods include lactose (dairy products), caffeine (coffee, tea, chocolate, cola drinks), sorbitol (a sugar substitute) and fructose (found in fruit juice and dried fruit).

Medical treatment

- Initial pain-relief medications: Over-the-counter pain medications like ibuprofen (Advil®, Motrin®) or

acetaminophen (Tylenol®) are usually tried first. If these don't work, your healthcare professional may prescribe stronger anti-inflammatory medications such as naproxen (Naprosyn®, Anaprox ®) or sodium diclofenac (Voltaren®). These drugs may have gastrointestinal side effects and should not be taken if you have a history of stomach ulcers.

- Oral contraceptives (birth control pills): Oral contraceptives relieve pain in 60–70 percent of women with endometriosis. While generally well tolerated, these drugs may cause such side effects as nausea, breast tenderness, irregular bleeding, weight gain, headaches, high blood pressure and (more rarely) blood clots. You should not take oral contraceptives if you are a smoker over the age of 35.
- Progestins: Progestins (another word for the female hormone progesterone) can shrink endometriosis and can reduce the pain from endometriosis by 80–90 percent. Progestin may be taken in pill form (e.g., medoxyprogesterone [Provera®], northindrone [Micronor®]), by injection (medoxyprogesterone [Depo-Provera®]) , or via a special intrauterine system (Mirena® IUS), as described below. Side effects may include breakthrough bleeding (bleeding between periods), nausea, weight gain, breast tenderness and depression. Taking medoxyprogesterone (Provera®) by mouth in high doses may help the pain from pelvic congestion.
- Mirena® Intrauterine system (IUS): A T-shaped device inserted into the cavity of the uterus, Mirena® IUS releases progesterone into the endometrial tissue. It commonly causes irregular bleeding in the first six months after insertion, then periods typically decrease and may even stop completely. The Mirena® IUS can be left in place for up to five years.
- Gonadatrophin-releasing hormone (GnRH) agonists (e.g., Leupride acetate [Lupron®], Naferelin [Synarel®], Goserelin [Zoladex®]): These costly drugs may be tried if oral contraceptives or progestins fail to resolve the pelvic pain. GnRH agonists are hormones that lower estrogen levels by "turning off" the ovaries, thus inducing a short-term condition that resembles menopause. Periods typically subside or stop completely. Common side effects include hot flashes, sleep disturbances, headaches, mood swings, vaginal dryness, irregular or absent bleeding, and osteoporosis (thin bones). Given as an injection or nasal spray, GnRH agonists cannot be used for more than six months if taken alone. If you respond to these drugs, estrogen/progestins can be "added back" to your drug regimen, allowing you to take the GnRH agonists for a longer time.
- Medications for bowel problems: Medications for constipation include psyllium (Metamucil®), methylcellulose (Prodium ®), lactulose and tegaserod (Zelnorm®). Loperamide (Imodium®) counteracts diarrhea, and pinaverium bromide (Dicetel®) can relieve bowel cramps and spasms.
- Medications for interstitial cystitis: Most commonly, these include sodium pentosan polysulfate (Elmiron®), antihistamines and amitriptyline (Elavil®).
- Antidepressants: While these drugs do not appear to relieve chronic pelvic pain, they can improve your overall mood if you are depressed.
- Opioids: These stronger medications decrease pain but do not seem to improve function or well-being. Medications in this class can be combined with acetaminophen (i.e., codeine for Tylenol® 1, 2 and 3 or oxycodone for Percocet®). Since these drugs can have many side effects, such as dependency, constipation and confusion, they are generally used only after many other treatments have been tried.

Surgical treatment

Surgical treatment may be warranted if the pain persists despite medical treatment. Endometriosis may be treated through laparoscopic surgery to destroy the endometrial tissue outside the uterus. However,

symptoms return in about half the women who have this surgery. Only women with very severe adhesions seem to benefit from having their adhesions cut during surgery. Hysterectomy (surgical removal of the uterus) has a fairly high success rate, particularly if the ovaries are also removed. Overall, 74 to 90 percent of patients remain pain free a year after having a hysterectomy. The success rate is lower in women less than 30 years old and in those with an unidentified source of pain. Hysterectomy is a major operation and thus considered a treatment of last resort. For more information see Understanding Hysterectomy.

Final word

Chronic pelvic pain is a complex syndrome. It can be frustrating not to be given a specific diagnosis, despite having significant pain. Having patience and taking an active role in your treatment will help you manage your symptoms.

Mini-Glossary

- Adenomyosis: growth of the lining of the uterus into the muscle wall of the uterus
- Adhesions: scar tissue that forms between organs
- Endometriosis: presence of the lining of the uterus in other parts of the body
- Estrogen: a female hormone produced in the ovaries
- Laparoscopy: a procedure in which a long, thin camera is used to view the pelvic organs or perform surgery
- Progesterone: a female hormone that matures the lining of the uterus

Additional information

Mayo Clinic
http://www.mayoclinic.com/health/chronic-pelvic-pain/DS00571

Women's Health Matters Sunnybrook and Women's
http://www.womenshealthmatters.ca/centres/pelvic_health/chronic_pain/

The International Pelvic Pain Society
http://pelvicpain.org/pdf/CPP_Pt_Ed_Booklet.pdf