Clinical update

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Factors such as the complex nature of the condition, under reporting by patients, reluctance by some women to be examined and the lack of streamlined services to treat PP, are some of the barriers identified by doctors to achieving a timely diagnosis.

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Prevention of chronic pelvic pain

According to Professor Vancaillie from the Women's Health and Research Institute of Australia, chronic pelvic pain may be one of the few areas of chronic pain where prevention is possible. For example, adolescents with severe dysmenorrhoea which is unresponsive to the oral contraceptive pill or anti-inflammatory medications, appear to be a group at higher risk of chronic PP. Effective management has the potential to alter outcomes and provides an opportunity to avoid longer term problems such as prescription opioid dependence, infertility and psychological deterioration.

New approaches to management

Potential new approaches to management may include: techniques to minimise nerve sensitisation following surgery; inclusion of comorbidities in treatment evaluation; looking at the role of diet in inflammation and symptom management; optimal pelvic physiotherapy techniques in women with pelvic muscle spasm; refinement of the clinical situations in which surgical intervention is appropriate; optimal dosage regimes for neuropathic medications; improved management of postoperative pain where narcotics are ineffective; and importantly, investigation of the factors that influence the transition from severe dysmenorrhoea to chronic PP.

Therefore, it may be appropriate, as determined on a case by case basis, to refer beyond the traditional boundaries of a gynaecologist only. Other disciplines to also consider are: pelvic physiotherapists using muscle down training; dieticians specialising in food intolerance; psychologists working in chronic pain; pain medicine specialists; vulval dermatologists; psychiatrists; and gastroenterologists experienced in the management of functional bowel symptoms. In essence, a broader multidisciplinary team approach to diagnosis and management may be more appropriate.

Women experiencing severe and chronic pelvic pain face an intolerable burden which significantly contributes to a reduced quality of life, infertility, psychological deterioration and opioid dependence. Societal taboo surrounding pelvic pain, perpetuated in unacceptable diagnostic delays and ineffective treatments has limited advances in this area.

The emergence of new approaches which include: an extension of the diagnostic criteria to include PP as a diagnostic category; a broadening of the understanding of causation to be inclusive of neuropathology, brain adaption and high risk patient profiles; and greater specialisation in multidisciplinary management, may significantly reduce the burden of this condition.

References

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Pelvic pain case studies

Case study 1

20 year old Marissa presents to a gynaecologist with severe period pain. Marissa has experienced pain since menarche but with increasing severity. She has seen her GP on seven occasions since the age of 14 and was put on several different contraceptive pills and higher doses of analgesia. She is now missing a day or two of university per month and her marks are dropping. She is showing signs of depression and becomes very anxious in the lead up to her period in fear of the pain. Marissa has an aunt who has had period pain all her life and was unable to have children. The specialist sent her for a laparoscopy which provided a definitive diagnosis of endometriosis.

Treatment

Marissa underwent an operation to remove the endometrial tissue and was placed on suppressive hormonal therapy.

Case study 2

Mona aged 53 years presents with dyspareunia increasing in severity. She has been happily married for 20 years with a good sex life. She had her last period over a year ago. She complained of continuous low grade pelvic pain. Her relationship with her husband has been impacted as she is fearful of having sex and feels they are growing apart. Her GP conducted tests to exclude recurrent UTIs and thrush. She was diagnosed with menopausal vaginismus related to a drying of the vulvar and vaginal tissues as a result of reduced oestrogen.

Treatment

Treatment included topical oestrogen and referral to a physiotherapist specialising in 'pelvic down training'. The physiotherapist provided a range of manual treatments such as myofascial release and trigger point therapy. Treatment also encompassed the use of dilators or trainers. Finally, it was recommended she use lubricants such as sweet almond oil or vegetable oils.

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