

## Chronic Pelvic Pain can be a Symptom of a Disease

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### Abstract

Sometimes the main cause of pelvic pain can only be achieved by the elimination process because it can be caused by many disorders. Discovering the cause of chronic pelvic pain is a long lasting process, and in many cases the exact explanation is never even found. The cause of pelvic pain is often difficult to determine. Many women never get an accurate diagnosis that would explain their pain, but that doesn't mean it's an imaginary or incurable type of pain. Chronic pelvic pain has a number of symptoms. Some of these are sharp and constant pain, pain that occurs and disappears, cramps, pressure or a feeling of heaviness in the pelvic area, pain during sexual intercourse, or pain while sitting. Pain is considered chronic if it lasts longer than six months, otherwise it is an acute condition. The aim of this paper is to point out the described health problem as well as to try to help people who have it. Study method is desk analysis.

**Keywords:** Pain; Pelvic Pain; Chronic Pelvic Pain; Diagnosis; Management

### Introduction

Chronic pelvic pain is defined as pain below the umbilicus, which lasts for at 6 months, is debilitating enough to affect the patient's ability to function, and causes her to seek medical care [1]. Women seeking care for chronic pelvic pain (CPP) can account for as much as 25% of gynecologic office visits, and it has been estimated that this debilitating condition can affect as many as one out of seven women in the United States. As with many chronic pain conditions, such as migraine or back pain, the complex psychosocial components involved make evaluation and treatment for these women and their physicians a challenge.

For women presenting with CPP, there are many characteristics which are similar to other chronic pain conditions; however, there can be unique characteristics that the clinician should be aware of in order to provide optimal therapy. It is well known that patients presenting with CPP have a higher incidence of childhood sexual abuse than the general population. It has been postulated that these women suffer from a type of post-traumatic stress disorder and remodeling of their neurological response to pain, especially if the subsequent painful stimulus involves the anatomical region of the pelvis. It is understandable that women suffering with CPP also have a higher incidence of anxiety and depression than the general population which affects not only their ability to respond to treatments but must be considered in the holistic approach to care for these women [1].

Concern about pelvic pain is the reason for 1% to 2% of all healthcare visits made by women [2]. Historically, when a woman presented with pelvic or lower abdominal pain, the clinician automatically focused solely on the gynecologic organs, assuming they were the cause of the problem. This narrow clinical view risks categorizing normal female physiologic processes as abnormal and encourages the use of

surgical interventions because it assumes pathology. A number of the causes of pelvic pain in women are unrelated to the gynecologic organs. Often pelvic pain is caused by multiple factors, requiring clinicians to take a multidisciplinary, holistic approach to its assessment and management. An appreciation for the intertwining influence of the mind and the body during assessment and in planning interventions is important. This approach places the woman at the center of her management plan, and respects her credibility as the authoritative “knower”.

### Gynecological Aspects of CPP

Abdominal and pelvic examination to exclude gross pelvic pathology, as well as to demonstrate the site of tenderness is essential. Abnormalities in muscle function should also be sought. Clinical pelvic examination should be a single digit examination if possible. The usual bimanual examination can generate severe pain so the examiner must proceed with caution. Examining a woman with CPP is difficult, and many authors recommend that one should assess cutaneous allodynia along the dermatomes of the abdomen (T11-L1) and the perineum (S3, and the degree of tenderness should be recorded).

Vaginal and endocervical swabs to exclude infection are recommended, and cervical cytology screening is advisable. Pelvic imaging can provide useful information about pelvic anatomy and pathology. Areas of tenderness detected during a transvaginal scan can help determine the possible presence of current or preexisting visceral disease. Laparoscopy is perhaps the most useful invasive investigation to exclude gynaecological pathology and to assist in the differential diagnosis of CPP in women. Often, it is combined with cystoscopy and/or proctoscopy to help identify the site of multi-compartment pain.

Pain in the vagina or the female external genital organs is most commonly due to infection or trauma, as a consequence of childbirth or surgery. Pain is usually a precedent to dyspareunia. When the pain persists for > 6 months, it can be diagnosed as “vulvodynia” or “chronic vaginal/vulvar pain syndrome” with no known cause. It is still a poorly understood condition, and thus difficult to treat.

There are two main subtypes of vulvodynia: generalised vulvodynia (GV), where the pain occurs in different areas of the vulva at different times; and vulvar vestibulitis (VV), where the pain is at the entrance of the vagina. In GV, the pain may be constant or occur occasionally, but touch or pressure does not initiate it, although it may make the pain worse. In VV, the pain is described as a burning sensation that comes on only after touch or pressure, such as during intercourse.

The causes of vulvodynia are many and include:

- History of sexual abuse
- History of chronic antibiotic use
- Hypersensitivity to yeast infections, allergies to chemicals or other substances
- Abnormal inflammatory response (genetic and non-genetic) to infection and trauma
- Nerve or muscle injury or irritation
- Hormonal changes

Although therapeutic options remain limited and require a multidisciplinary pain management approach, with psychological and physiotherapy input, they can be treated effectively with physiotherapy, stretching exercises and even botulinum toxin, though in the case of the latter the evidence is variable.

### Pain

Pelvic pain is usually defined as chronic when it has lasted for 6 months or more on a continuous or a cyclic basis [3].

### Interstitial cystitis

Interstitial cystitis is one of the most common bladder problems associated with chronic pelvic pain [4].

### PID

Pelvic inflammatory disease (PID) refers to a clinical syndrome resulting from infection or inflammation involving the usually sterile upper genital tract in women [5]. The term PID is generally reserved for infection initiated by sexually transmitted organisms rather than for pelvic infections secondary to a medical procedure, pregnancy or other primary abdominal infections which have a similar clinical presentation.

Most cases of PID are caused by ascent of microorganisms from the vagina and endocervix into the upper genital tract. The passage of organisms through the cervix is facilitated by disruption of the cervical barrier; e.g. by a sexually transmitted infection (STI), such as *Chlamydia trachomatis* and *Neisseria gonorrhoeae* or by a surgical procedure.

Early identification and treatment are important to reduce the serious sequelae of PID, which include ectopic pregnancy, chronic pelvic pain and infertility.

### Etiology

Addressing both the somatic and psychological aspects of chronic pelvic pain is a fundamental approach to its diagnosis and treatment [4].

### Health problem

Chronic pelvic pain is a significant problem facing primary care providers [4].

### Pelvic exam

The pelvic examination can be a very challenging examination to execute because of associated patient discomfort, anxiety, and embarrassment [6].

### Ultrasound

Pelvic ultrasounds (US) are commonly ordered in the outpatient setting [7].

When ordering pelvic US for such women, and in general, the more clinical information provided to the radiologist, the more helpful. This should include at minimum the patient's age, last menstrual period (LMP), pregnancy status, menopausal status, and of course the indication(s) for the exam. Additional helpful information would include the patient's hormonal status (if they are on any oral contraceptive pills, hormone replacement therapy, fertility drugs, etc.), personal or family history of cancer, history of prior pelvic surgery, and/or results of prior imaging studies.

### Diagnosis

For many patients with chronic pelvic pain, they will complain of symptoms involving multiple organ systems including the pelvic organs as well as the gastrointestinal and urinary tract [1]. It has been postulated that CPP, for some women, can be a type of regional pain syndrome with an association with painful or frequent urination, urinary urgency or incontinence, irritable bowel syndrome, or chronic constipation. It is imperative that the history for these patients includes a review of systems approach which incorporates gastrointestinal and urinary functioning and associated pain in order to fully evaluate women presenting with CPP [1].

Other medical conditions associated with CPP in women include psychosocial factors such as depression and anxiety. The occurrence of CPP in adult women has been associated with childhood sexual trauma and abuse which many experts believe leads to a type of post-traumatic syndrome changing the neurological response to painful stimuli.

### Management

CPP can be a debilitating condition that is difficult to diagnose and treat [2]. It is very important the clinicians understand that even a distinct diagnosis does not ensure that treatment will be curative; indeed, recurrence of CPP is common. Awareness of the many causative possibilities, formulation of a differential diagnosis, and initiating appropriate treatment strategies will ensure the best possible outcomes for women with CPP [2].

Enlisting the woman's input in developing her treatment plan and encouraging her to take an active role in and feel ownership of the plan are encouraged and often critical to the success of the management plan. Treatment needs to be comprehensive and may include both pharmacologic and complementary approaches. The treatment plan is most often dictated by the diagnosis. If no pathology is identified, however, treatment is aimed at relieving the dominant symptoms [2].

There are several treatment options. Those are Potentially beneficial medications, Pelvic floor physical therapy, Behavioral therapy, Hysterectomy eg.

### Conclusion

Chronic pelvic pain can be a symptom of a disease, and can itself be labeled as a condition. It is often difficult to determine the cause of chronic pelvic pain. This does not mean that the pain is not real and cannot be treated. Pelvic pain is a symptom that can occur in women as well as men. Pelvic pain may indicate the existence of unidentified conditions, which represent an abnormal function. The distinction between acute and chronic pain is important in understanding chronic pelvic pain syndrome. Acute pain is the most common, and occurs in patients after surgery or other soft tissue trauma. This pain is usually immediate, severe and short-lived. Pain that extends beyond the normal recovery period and lasts longer than six months is chronic pain.

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