**Chronic pelvic pain and backache**

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Definition:

recurrent pain of at least 6 months duration, unrelated to pregnancy, periods or intercourse; localizes to the pelvis, infraumbilical anterior abdominal wall, or lumbosacral back or buttocks; and leads to degree of functional disability.

**Causes of chronic pelvic pain in women:**

1. gynecological

2. urological

3. gastrointestinal

4. musculoskeletal

5. others.

**Causes:**

1-Gynecological causes:

A.extrauterine as adhesions, endometriosis, adnexal cysts, chronic pelvic inflammatory disease, chronic ectopic and residual ovary syndrome.

 B.uterine as adenomyosis, chronic endometritis, cervical stenosis.

2. urological:

As chronic urinary tract infection, renal stones and interstitial cystitis

3. gastrointestinal:

Inflammatory bowel disease and irritable bowel syndrome.

4-musculoskeletal:

Coccydynia, disc herniation, fibromyositis, degenerative joint disease and faulty or poor posture.

5. others:

Psychiatric disorders, shingles, neurologic dysfunction and abdominal cutaneoous nerve entrapment.

**Clinical assessment**:

**1. pain history:**

-The onset and duration of the pain

-location and radiation

- exacerbating and relieving factors

-relation to period and intercourse

-severity and impact on quality of life

- associated features.

**2. physical examination:**

-general examination:

 look for the gait of the patient

-examination of the back:

limitation of body movements may indicate orthopedic problem .

-Neurological examination to exclude Neuropathies.

-abdominal examination:

- inspection looking for scars and hernia

- distinguish visceral from abdominal wall tenderness." Trigger point" tenderness elicited by palpation with one finger will suggest a nerve entrapment often involving the ilioinguinal or iliohypogastric nerve e.g. after surgery.

 - auscultation for bowel sounds,

increased activity in irritable bowel syndrome.

-pelvic examination:

inspection of the vulva for any lesion, erythema as in

vulvalvestibulitis, and thinning of vulvar skin as in lichen

sclerosus

- systematic pressure point palpation with a small

cotton swab looking for site of tenderness as in

vestibulodynia

- digital examination for pelvic floor tenderness as

in pelvic infection

- retroverted uterus with nodularity in the pouch of

Douglas suggest endometriosis

- adnexal tenderness suggests pelvic congestion 

Syndrome.

**3. Investigations:**

A. Laboratory tests:

\*urinalysis and urine culture may reveal infection

\* TSH assay:thyroid disease can affect bowel and bladder function

\*random blood sugar as diabetes can lead to neuropathy

\*endocervical swabs to detect Chlamydia Infection.

B. Radiological imaging and endoscopy:

\*transvaginal ultrasound with Doppler study to detect uterine or adnexal pathology such as ovarian cyst

\*pelvic venography to diagnose pelvic congestion syndrome

\*CT or MRI, but add little information to sonography

\*laparoscopy to diagnose and treat endometriosis and adhesions, newer laparoscopic approach is performed under

local anesthesia and the patient is conscious and asked about the site of pain, this termed" conscious pain mapping“.

 \*in bowel symptoms, barium enema and colonoscopy may be used.

**Treatment:**

- If an identifying source is found then treatment will depend on the diagnosis

- if no pathology is identified then treat the dominant symptoms.

1.medical treatment:

A. Analgesics: such as acetaminophen or NSAIDs , these

are particularly helpful if inflammatory states underline the

pain. If pain not relieved, then mild opiod can be used such as codeine or hydrocodone. If pain persists,

stronger opiods such as morphine and methadone can be used with regular follow up.

B. Hormonal suppression: may be considered especially in those with co-existent dysmenorrhea or dyspareunia. Combined oral contraceptive pills, progestin such as medroxy progesterone acetate, gonadotrophin-releasing hormone (GnRH) agonist, and certain androgens have proven effective.

C. Antidepressants and anticonvulsants:

tricyclic antidepressants such as amitriptyline have documented efficacy in the treatment of neuropathic and nonneuropathic pain syndromes.

Anticonvulsants such as carbamazepine are used to reduce neuropathic pain.

D. Polypharmacy: combining drugs may increase pain relief, for example a NSAID and an opiod may be used in inflammatory conditions.

2. surgery:

A. Neurolysis: involves nerve destruction or injection of a

neurotoxic chemical.

Presacral neurectomy and laparoscopic uterosacral nerve

ablation (LUNA) involve destruction of nerve fibers to the uterus, these are useful for centrally located pelvic pain.

B. Hysterectomy for patients with organic pathology, is effective in resolving pain and improving the

quality of life. Oophorectomy may be indicated in patient whose pain respond to GnRH agonist therapy.however if the pain is neuropathic, surgery may make it

worse.

C. Lysis of pelvic adhesions (which may result from surgery, infection and endometriosis) may improve the pain, on the other hand may result in more adhesions, so decision to lyse adhesions should be individualized.

d. Acupuncture D may benefit patients with dysmenorrhea.

E. Pelvic congestion syndrome attributed to the presence of pelvic varicosities(usually in multiparous women who present with pelvic pain, dysmenorrhea, and dyspareunia) may improve after radiological embolization.