MANAGEMENT OF CHRONIC PELVIC PAIN

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CPP

• No consensus on definition
• Non-menstruel pain of >6 months duration that localizes to the anatomic pelvis and is severe enough to cause functional disability and require medical or surgical treatment

RCOG / Kennedy S, Moore S. The initial management of chronic pelvic pain. 2005
• Chronic pelvic pain (CPP) is one of the most frustrating problems encountered in gynecology (frustrating not only to the patient and her family, but also to her gynecologist.)
• The prevalence of CPP among women of reproductive age in the general population is estimated to be as high as 25%.

In the UK, the annual prevalence of chronic pelvic pain in primary care is estimated to be 3.8% in women aged 15–73 years, which is higher than the prevalence of migraine (2.1%), and is similar to that of asthma (3.7%) and back pain (4.1%).

CPP

- 10% of all visits to a gynecologist
- 12-40% all laparoscopies
- 12% of hysterectomies

4. Rapkin and Kames. The Female Patients 13:100, 1988
• Direct annual costs of health care for chronic pelvic pain in the United States is around $880 million, which escalates to over $2 billion when combined with indirect costs (e.g. time off work).

CAUSES OF CHRONIC PELVIC PAIN

CYCLIC
- Mittelschmerz
- Dysmenorrhea
  Primary
  Secondary
- Lesion of the lower genital tract or uterus

ACYCLIC
- Causes outside the reproductive tract
- Causes within the reproductive tract
  Pelvic adhesive disease
  Endometriosis
  Ovarian tumors, pelvic varicosities
- No organic cause
Differential Diagnosis-1

• **Gynaecological**: endometriosis, adhesions (chronic pelvic inflammatory disease), leiomyoma, pelvic congestion syndrome and adenomyosis

• **Gastrointestinal disease**: including constipation, irritable bowel syndrome, diverticulitis, diverticulosis, chronic appendicitis and Meckel’s diverticulum
Differential Diagnosis-2

• **Myofascial disease**: including fasciitis, nerve entrapment syndrome and hernia (inguinal, femoral, umbilical and incisional)

• **Genitourinary disease**: including interstitial cystitis, bladder dyssynergia and chronic urethritis
Differential Diagnosis-3

• **Skeletal disease**: including scoliosis, L1-2 disc disorders, spondylolisthesis and osteitis pubis

• **Psychological disorders**: including somatisation, psychosexual dysfunction and depression

• **Neuropathic disorders**: pudendal nerve entrapment and spinal cord neuropathies

• (C. Farquhar and P. Latthe. Chronic pelvic pain: Aetiology and therapy. / Reviews in Gynecological and Perinatal Practice 6 (2006) 177-184)
Multidisciplinary approach to CPP

Team composition

- Gynecologist
- Psychologist
- Other specialists
- Nurse
PREOPERATIVE EVALUATION: TO OPERATE OR NOT TO OPERATE

• Before contemplating or scheduling any surgical procedure, nongynecologic causes of pain should be sought and the surgical procedure should be based on this diagnosis.
• Diagnostic laparoscopy has been used as the gold standard in the investigation of CPP, but in approximately 40% of cases, no cause for the pain is found.


• Porpora MG & Gomel V. The role of laparoscopy in the management of pelvic pain in women of reproductive age. Fertility and Sterility 1997; 68: 765-779
THE LAPAROSCOPE AS A DIAGNOSTIC TOOL

• Laparoscopy serves three important diagnostic functions:

  1) Diagnostic confirmation.

  2) Histologic documentation.

  3) Patient reassurance
L/S: What can it reveal in CPP patients?

- Endometriosis
- Adhesions
- C.PID
- Pelvic varicosities
- Other (e.g., ovarian remnant syndrome)
- NO VISIBLE PATHOLOGY
Advantages of laparoscopy in CPP

• Differentiation between gynecologic and non-gynecologic etiology

• **Diagnosis of endometriosis, adhesions** etc

• Allows histologic documentation of diagnoses

• Immediate surgical treatment possible

• Advantages of operative laparoscopy
• Endometriosis is an estrogen-dependent disease characterized by the presence of functional endometrial tissue outside the uterus.

• It is an important cause of long-term morbidity, commonly from chronic pelvic pain and infertility.

PELVIC PAIN

ENDOMETRIOSIS

With symptoms

No symptoms

A. Fauconnier et al. / Gynécologie Obstétrique & Fertilité 37 (2009) 57–69
• Cardinal symptoms associated with endometriosis:
  - CPP
  - Dysmenorrhea
  - Dyspareunia
• A woman having all three, has 3.1 (95% confidence interval 1.5±6.5) times as likely to have endometriosis found at laparoscopy as a woman with no symptoms.
## L/S FINDINGS IN WOMEN WITH CPP

<table>
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Correlation of r-AFS staging & depth of infiltration

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Correlation of depth of infiltration with pelvic pain

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<td>&gt;6 mm</td>
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• Some studies have been able to correlate the degree of pain with features such as


- the number of implants (Perper MM, Nezhat F, Goldstein H et al. Dysmenorrhoea is related to the number of implants in endometriosis patients. Fertility and Sterility 1995; 63: 500-503).

- the depth of infiltration beneath the peritoneal surface (Koninckx PR, Meuleman C, Demeyere S et al. Suggestive evidence that pelvic endometriosis is a progressive disease, whereas deeply infiltrating endometriosis is associated with pelvic pain. Fertility and Sterility 1991; 55: 759-765).
Endometriosis & CPP

Pathophysiology

- PGs
- Mechanical
• Endometriosis appears in a number of forms, some of which may be difficult to identify at laparoscopy. (Jansen RPS & Russell P. Nonpigmented endometriosis: clinical laparoscopic and pathologic definition. American Journal of Obstetrics and Gynecology 1986; 155: 1154-1159)

• The earlier, more inflammatory forms probably cause more pain than the "burnt out" forms, even though they may be harder to identify. This superficial form of the disease may cause pain by releasing inflammatory mediators of pain, such as bradykinins and prostaglandins. (Vernon MW, Beard JS, Graves K & Wilson EA. Classification of endometriotic implants by morphologic appearance and capacity to synthesize prostaglandin F. Fertility and Sterility 1986; 46: 801-806).
• Extensive nodular disease in the rectovaginal space may appear at laparoscopy as a few blue or black pin pricks on the uterosacral ligaments. Pain associated with these forms of endometriosis may be caused by traction on tissues, or by infiltration or constriction of nerves themselves.
Endometriosis & CCP - Medical

• The medical management of endometriosis is a management strategy only in that it is not curative.
• Medical treatments are directed towards inducing atrophy within these deposits in an attempt to alleviate the problem.
Farquar and Sutton examined the evidence for the management of endometriosis and in particular evaluated medical interventions including:
- medroxyprogesterone acetate (MPA),
- gestrinone,
- combined oral contraceptive pills,
- gonadotrophin-releasing hormone (GnRH) analogues
- ‘add-back therapy’
- danazol

Medical therapies were compared with either a placebo or against each other.
• As a conclusion,
  - All currently available medical therapies are equally effective in treating pelvic pain due to endometriosis
  - Medical treatment was more effective than placebo alone
• Recently, aromatase inhibitors have been proposed as novel potential candidates for treatment of endometriosis.
• Aromatase is a key enzyme in the synthesis of estrogens.
• It mediates the conversion of androstenedione and testosterone to estrogens.
• High aromatase expression in endometriotic cysts/extra-ovarian endometriotic implants resulting in local production of estrogens accounts for failure of conventional medical treatment.
• It is on this basis that aromatase inhibitors have been proposed for the treatment of endometriosis-related pelvic pain refractory to conventional treatment.

• There is also a prospective open-label phase 2 trial reporting significant pain relief with the use of anastrazole and oral contraceptive [Amsterdam LL, Gentry W, Jobanputra S, Wolf M, Rubin SD, Bulun SE. Anastrazol and oral contraceptives: a novel treatment for endometriosis. Fertil Steril 2005;84:300–4.].

• Progesterone and oral contraceptive pill are used in the treatment of endometriosis and hence may have synergistic effect when used with anastrazole.

• Letrozole and Norethisterone acetate are used in one study to reduce CPP.

Endometriosis & CCP - Surgery

Objectives

- Debulking of ectopic implants
- Restoration of normal pelvic anatomy
- Pelvic denervation?
Endometriosis & CPP

Endoscopic procedure

• Conservative

• Radical
Endometriosis & CPP

Conservative endoscopic procedures

- Uterina anterior ligamentopexy
- LUNA
- Presacral neurectomy
- Resection of bowel, rectum or bladder
Endometriosis & CPP - Surgery

Energy modalities

• Mechanical
• Electrical
  -monopolar
  -bipolar
• Laser
  -CO₂ laser excision / vaporization
  -others
## Pelvic pain status 1 year after endoscopic treatment of endometriosis

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Endometriosis-CPP and laparoscopic surgery

Outcome measures

- % of “significant” pain relief
- Length of time to be pain free
- Recurrence rate
Anterior uterine ligamentopexy

• To minimize the recurrence of adhesions following liberation of cul-de-sac obliteration or adnexal adhesiolysis

• To relieve deep dyspareunia & CPP

• Shortening round ligaments with yoon rings or Gilliam-type uterine suspension
# ANTERIOR UTERINE LIGAMENTOPEXY

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<td>89</td>
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UTEROSACRAL LIGAMENT RESECTION (LUNA)

• The use of laparoscopic uterine nerve ablation has been advocated by Lichten and Bombard in order to transect the afferent pain fibers within the uterosacral ligaments.

• The expected pattern of sympathetic fibers from T10 to L1 passing through the uterosacral ligaments occurred in only 70% of patients. In the remaining 30%, alternate pathways were present.
LUNA

• Laparoscopic uterine nerve ablation

• INTERRUPTION OF UTEROSACRAL LIGAMENTS AT THEIR ATTACHMENT TO THE POSTERIOR PORTION OF THE SERVIX (2 CM LONG; 1 CM DEEP)
LUNA

Complications

• Bleeding

• Ureteral injury

• Complications of L/S
“Surgical treatment of primary dysmenorrhea with laparoscopic uterine nerve ablation”

<table>
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<td>81*</td>
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*p<0.05

J Reprod Med 1987;32:37-41
## RESULTS OF LUNA

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<td>74</td>
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LUNA

- Safe and easy to perform
- A viable option for midline pelvic pain
- Routine performance complemented to surgery for endometriosis associated pain?
- May not provide complete cure
- Further double blind randomized trials are warranted to establish its efficacy

LAPAROSCOPIC PRESACRAL NEURECTOMY

• Presacral neurectomy is the excision of the superior hypogastric plexus, which is also known as the presacral nerve.
• This procedure is typically used for women with severe dysmenorrhea or endometriosis.
• It has also been used for women with chronic pelvic pain [Zullo F, Pellicano M, DeStefano R. Efficacy of laparoscopic pelvic denervation in central-type chronic pelvic pain: a multicentre study. J Gynecol Surg 1996;12:35–40].
• Whereas presacral neurectomy may be effective for both primary dysmenorrhea and endometriosis-related pelvic pain,

• the role of uterine nerve ablation should be reserved for patients with primary dysmenorrhea only, as evidenced by several randomized trials.

Relationship of inferior mesenteric artery and surrounding structures with retraction of peritoneal edge. Abbreviations: IMA, inferior mesenteric artery; URE, ureter; LEFT CIA, left common iliac artery; LEFT CIV, left common iliac vein; PSN, presacral nerve.
Entry into avascular space (arrow) between inferior mesenteric artery and left common iliac vein. Abbreviations: IMA, inferior mesenteric artery; LEFT CIV, left common iliac vein.
Presacral nerve reflected cephalad to expose the left common iliac vein. Abbreviations: LEFT CIV, left common iliac vein; PSN, presacral nerve.
# LAPAROSCOPIC PRESACRAL NEURECTOMY

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<td>52</td>
<td>94</td>
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• One retrospective report of 655 women undergoing laparoscopic presacral neurectomies suggests that the benefit may be greater in women with dysmenorrhea (n = 392) than chronic pelvic pain (n = 135).

• Overall, pain was significantly decreased following PSN—72% with dysmenorrhea, and 62% with chronic pelvic pain

• [Chen FP, Soong YK. The efficacy and complications of laparoscopic presacral neurectomy in pelvic pain. Obstet Gynecol 1997;90:974–7].
• Short term results for PSN and LUNA for dysmenorrhoea seem to be similar,

• PSN has better results in the long term


• Further work is required in this area.

• Vercellini et al. studied 180 patients undergoing operative laparoscopy as first-line therapy for stages I–IV symptomatic endometriosis.

• The authors concluded that the addition of uterosacral ligament resection to conservative laparoscopic surgery for endometriosis did not reduce the medium- or long-term frequency and severity of recurrence of dysmenorrhoea.

DO PELVIC ADHESIONS CAUSE CPP?
Resolution of CPP after laparoscopic lysis of adhesions

• Improvement in 63% of cases
• Recurrence of CPP in 37%
• No correlation between patients’s rating of CPP/dyspareunia and severity of adhesions
• Pain located in the areas of adhesions in 90% of the cases

### Pain relief after laparoscopic adhesiolysis

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<td><strong>TOTAL</strong></td>
<td>103</td>
<td>85</td>
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Treatment Possibilities for CPP

• PRIMARY CARE
  – MEDICAL TREATMENT
    • Non-steroidal anti-inflammatory analgesia (1)
    • Combined oral contraception
    • Progestins
    • Diet: high in fibre, more fluid
    • Anti-bowel spasmodics
  – SURGICAL
    • None
  – PSYCHOLOGICAL
    • Psychosexual counselling;
    • Cognitive psychotherapy;
    • antidepressants
• SECONDARY CARE

  – MEDICAL TREATMENT
    • Gonadotrophin-releasing hormone agonists (endometriosis)
    • Sodium pentosan polysulphate (interstitial cystitis)
    • Injecting abdominal myofascial pain trigger points (local anaesthetic, botulinum toxin A)
    • Pelvic floor neuromodulation and biofeedback

  – SURGICAL TREATMENT
    • Excision or ablation of endometriosis;
    • Presacral neurectomy
    • Laparoscopic uterine nerve ablation (LUNA)
    • Adhesiolysis (controversy exists over its therapeutic value) (2)
    • Hysterectomy +/- bilateral salpingo-oophorectomy

  – PSYCHOLOGICAL
    • Similar to primary care
    • Psychiatry
Practice Points

• CPP has a significant neurological mechanism.
• In CPP, the symptoms may be well localised or diffuse (regional or systemic); as well as pain, functional visceral and musculoskeletal symptoms may exist.
• Assessment should aim to identify contributory factors rather than assign causality to a single pathology.
• Adequate time should be allowed for the initial assessment of women with CPP. They need to feel that they have been able to tell their story and that they have been listened to and believed.
• Management should be holistic and include treatments aimed at pain, functional symptoms, and psychological conditions (e.g., depression, anxiety and catastrophising and social and sexual disorders).

• Management of the patients should be both multidisciplinary and interdisciplinary and concentrate on symptomatology.

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• Ideal practice is to diagnose and treat endometriosis surgically

• Severe cases of endometriosis should be referred to units with the necessary expertise to offer all available treatments in a multidisciplinary context, including advanced laparoscopic surgery