MASTER CLASS

Treatment of Chronic Pelvic Pain

BY CHARLES E. MILLER, M.D.

This is the second installment of the Master Class in Gynecologic Surgery on pelvic pain. In part 1, I drafted Dr. Fred Howard, who serves as associate chair for academic affairs, director of the division of gynecologic specialists, and professor of obstetrics and gynecology at the University of Rochester (N.Y.), to discuss the differential diagnosis and work-up of chronic pelvic pain. In part 2, he will turn from the diagnosis to the treatment of chronic pelvic pain.

I am certain that the reader will be immediately drawn to Dr. Howard's double-armed treatment regimen of both disease-specific therapy and pain-specific therapy. Although he recognizes the importance of surgical treatment—especially in cases of endometriosis, uterine fibroids, ovarian cysts, and other reproductive tract disorders—he is quick to point out that medical, psychological, or physical therapy will suffice in most women's cases. Moreover, as Dr. Howard recognizes, physicians as well as their patients must realize and accept that although a cure is the ultimate goal of treatment, pain management may be the reality. ■

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A Two-Pronged Approach

Treatment for most patients with chronic pelvic pain requires a two-pronged approach in which we must treat each of the disorders or diseases that may be a cause of or contributor to the pain, as well as the pain itself.

This combination of disease-specific and pain-specific therapies reflects the complexity of chronic pelvic pain and the fact that there most often will be more than one diagnosis, as well as the fact that pain itself will more often than not be one of the diagnoses and not only a symptom.

BY FRED M. HOWARD JR., M.D.

Just as we should be guided in our differential diagnosis by seeking diagnoses for which we have the best evidence of casual or associative roles in chronic pelvic pain, we should begin with treatments for which there is good level I evidence of efficacy.

Surgery will help a subgroup of women with chronic pelvic pain, especially those with endometriosis and other reproductive tract disorders, but the majority of women with chronic pelvic pain will benefit most from medical, psychological, and physical therapy.

There are strong data from studies of the treatment of irritable bowel syndrome (IBS) and pelvic congestion syndrome that show that adding psychological treatment to medical treatment is more effective than providing either by itself. Physical therapy, moreover, can be helpful for the secondary pelvic floor muscle pain that many women develop regardless of what problems were pain generators in the first place.

Disease-Specific Therapy

In trying to help women with chronic pelvic pain, we will most often find ourselves treating the common diagnoses that have level A evidence of association with the pain: IBS, endometriosis, interstitial cystitis, myofascial trigger points, depression, and chronic pain syndrome.

Endometriosis and interstitial cystitis are particularly common in women with chronic pelvic pain, and there is good evidence that the disorders not only cause the pain but also tend to occur together. The literature suggests that 30%-80% of women with endometriosis also have interstitial cystitis, and we know that treating one but not the other will significantly lessen our chances of success in treating pelvic pain.

For endometriosis, there is good level I evidence of efficacy for the use of hormonal treatments like GnRH agonists, progestins, and continuous oral contraceptives. Additionally, two randomized trials have confirmed that conservative—or organ-sparing—surgical removal of endometriosis lesions is effective in decreasing pain.

Combining surgery and medical treatment for endometriosis may be more efficacious than providing either by itself. We don't yet have level I evidence to support this approach—just as we don't yet have any published studies directly comparing medical and surgical treatments—but some of the completed clinical studies suggest that we should consider a combined approach in patients who are not trying to conceive.

For interstitial cystitis, randomized trials have demonstrated the efficacy of intravesical dimethyl sulfoxide and of oral pentosan polysulfate sodium.

Symptoms of IBS are present in a majority of women with chronic pelvic pain, and treatment tends to be based on which symptoms are predominant. For example, a number of good randomized trials have shown efficacy for the use of antispasmodics in patients whose symptomatology is predominantly abdominal pain, and for loperamide (Imodium) in patients with diarrhea-predominant symptomatology. Interestingly, tricyclic antidepressants, which often are prescribed to control chronic pelvic pain, can be useful for diarrhea-predominant IBS because constipation tends to be a side effect of the drugs. For constipation-predominant IBS, the newer drug tegaserod (Zelnorm) is frequently used.

In general, for our patients clearly troubled by IBS, evaluation and treatment with a gastroenterologist who is well versed in IBS are definitely worthwhile.

When it comes to myofascial and musculoskeletal pain, we don't have as much good data from randomized clinical trials to help direct our treatment decisions, but it certainly appears, based on clinical experience, that physical therapy—and, when indicated, trigger-point injections—is effective.

It is important to realize that physical therapy is often an important adjunct to the treatment of chronic pelvic pain, as well as a specific treatment. Regardless of what the pain generators or specific diagnoses are, many of these women develop secondary pelvic floor muscle pain, or pelvic floor tension myalgia.

Secondary pelvic floor muscle pain often does not respond to treatments for the specific diagnoses we make in women with chronic pelvic pain, and evaluation and treatment by a women's health physical therapist can thus be most useful. For this, contact the women's health section of the American Physical Therapy Association.

When it comes to the issue of surgery for chronic pelvic pain, endometriosis is one of the few diagnoses for which surgery has a clear role.

The treatment of adhesions, which are diagnosed in about one-quarter of women with chronic pelvic pain, is still controversial. It is not clear whether lysis of adhesions is effective in reducing pelvic pain, and it appears that the majority of adhesions that are surgically lysed do reform. The role of adhesions as a cause of pelvic pain, of course, is also controversial.

Pain-Specific Therapy

Here we have many different treatments—pharmacologic, psychological, and neuroablative—that rest, to some extent, on acceptance of the notions that pain may not necessarily be cured but can be managed, and that patients can progress toward more normal lives that are not dominated by pain.

It is important that we not use psychological treatment as a last resort. If we do everything else, and then tell a patient that everything else has failed and we are recommending psychological treatment, we are in essence sending her the message that we think her pain is not real. There are two errors here that warrant correction: First, psychological pain is indeed real. Second, most of the time, the etiology of chronic pelvic pain is not psychological.

What we should do right away, with all of our patients, is explain that cognitive-behavioral therapy, relaxation therapy, and other psychological techniques are extremely useful in helping patients decrease and cope with pain.

I sometimes use the analogy of how our emotions and mind can cause us to turn beet red and make us sweat and become tachycardic when we are embarrassed about something we have said or done. If our emotions can cause that kind of physical reaction, might not relaxation therapy, for instance, cause physiologic changes that help decrease our pain? More often than not, it is financial issues and the relatively poor coverage of mental health care in this country—and not patient acceptance—that is the major impediment to including psychotherapy in the treatment of chronic pelvic pain.

In the neuroablative arena, there is some evidence that adding presacral neurectomy (excision of the superior hypogastric plexus, or presacral nerve) to other treatments for endometriosis is sometimes indicated, although it's not perfectly clear what those indications are. I tend to use the therapy in patients who have previously failed medical or surgical therapy. It is one of the neurolytic therapies that may be useful in decreasing pain centrally even when there is no specific nerve dysfunction.

Tricyclic antidepressants, particularly amitriptyline, have been shown to be effective in treating chronic pelvic pain and other chronic pain syndromes, and therefore are a part of the pharmacologic arm of pain-specific therapy. In addition to reducing depressive symptoms—which is often an aim anyway in patients with chronic pelvic pain, as depression occurs with increased frequency in these women—it is generally thought that the tricyclic antidepressants improve pain tolerance.

Analgesics, of course, are a mainstay of pharmacologic pain-specific treatment of chronic pelvic pain, and there is little controversy about the use of analgesics like acetaminophen, NSAIDs, tricyclic antidepressants, and other neuropathic medications, such as gabapentin and other anticonvulsants used for chronic pain.

The use of opioids in the treatment of chronic pain remains controversial, however. Several studies, as well as clinical experience in pain centers, suggest that opioids are effective for chronic—and not only acute—pain: that the analgesics improve function and quality of life in patients who have failed other treatments. There is, however, the well-known risk of addiction, which is estimated to occur in anywhere from 3% to 15% of chronic pain patients.

As gynecologists, we can consider providing opioid treatment ourselves, but only if we are attuned to looking for addictive behaviors and only if we are familiar with state regulations that address chronic opioid use. Federal codes are quite clear in stating that the federal government has no intention of preventing physicians from treating chronic pain with opioids if such treatment is indicated, but state regulations vary. ■