CHRONIC PELVIC PAIN:

Dr. F. Almasi
A non-cyclic pain perceived to be in the pelvic area that has persisted for three to six months or longer and is unrelated to pregnancy

Constant

Episodic

not include cyclic pain (ie, occurring only with menses, which is defined as dysmenorrhea)
Chronic pelvic pain sub-division:

1: well-defined classical pathology (such as infection or cancer): “specific disease-associated pelvic pain”

2: no obvious pathology: “chronic pelvic pain syndrome”
Incidence and prevalence:

- No adequate data on incidence were found.
- Large European study undertaken in 2004: chronic pain of moderate to severe intensity occurs in 19% of adult Europeans, seriously affecting the quality of their social and working lives.
- Study in the UK in 2019: prevalence of CPP of 14.8% in women over 25 years
Epidemiology and pathogenesis:

- 99 percent of all diagnostic laparoscopies for CPP in the United States affect 6 to 25 percent of reproductive-age women.
Epidemiology and pathogenesis:

- prospective observational study performed at a gynecology referral center:
  - the most common diagnoses identified:
    - 1; irritable bowel syndrome,
    - 2; adhesions,
    - 3; musculoskeletal causes
    - 4; endometriosis
Risk factors include many different factors from various areas, including genetic, psychological state, recurrent physical trauma and endocrine factors.
Clinical presentation:

- Non-cyclic pain localized to the pelvis of three to six months' duration or longer. Women with CPP may also have pain that radiates beyond the pelvis.
- Associated symptoms:
  - urinary or gastrointestinal symptoms,
  - impaired quality of life: no longer taking part in certain activities mental health changes: depression, anxiety
In women with CPP, severe pain can represent:
- worsening of the chronic pain syndrome result from an acute abdominopelvic process.
- emergent evaluation and management: unstable vital signs, peritoneal signs, or suspected life-threatening pathology (eg, ectopic pregnancy, bowel perforation).
The evaluation of women with CPP starts by taking a complete history that includes urinary, gastrointestinal, gynecologic, musculoskeletal, sexual, and psychosocial symptoms.
Gastrointestinal:

- CPP in irritable bowel syndrome, inflammatory bowel disease, diverticular colitis, celiac disease, chronic constipation, and cancer
- GI evaluation: diarrhea, constipation, rectal bleeding, urgency, and tenesmus
- Deep infiltrating endometriosis and intestinal disorders can present with similar symptoms.
IBS:

- **ROME 4 CRITERIA:**
- Recurrent abd pain at least one day per week in 3m/6m with 2 or more criteria:
  - related to defication
  - Associated with a change in stool frequency
  - Associated with a change in stool form
IBS SUBTYPE:

- IBS C
- IBS D
- IBS MIXED
- IBS UNCLASSIFIED
Initial evaluation:

- History and physical exam:
  - BSFS (Bristol Stool Form Scale)
  - MEDICATION
  - GASTEROENTRITIS
  - FH
<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>2</td>
<td>Sausage-shaped, but lumpy</td>
</tr>
<tr>
<td>3</td>
<td>Sausage-shaped, but with cracks on surface</td>
</tr>
<tr>
<td>4</td>
<td>Sausage or snake like, smooth and soft</td>
</tr>
<tr>
<td>5</td>
<td>Soft blobs with clear-cut edges (easy to pass)</td>
</tr>
<tr>
<td>6</td>
<td>Fluffy pieces with ragged edges, mushy</td>
</tr>
<tr>
<td>7</td>
<td>Watery, no solid pieces (entirely liquid)</td>
</tr>
</tbody>
</table>
LAB TEST:

- CBC
- IBS-D: Fecal calprotectin, stool test for giardia, serologic test for celiac, CRP
- IBS-C: Abd radiography, physiologic test in refractory or severe cases
- COLONOSCOPY?
ALARM FEATURES:

- Age > 50
- Rectal bleeding or melena
- Nocturnal diarrhea
- Progressive abd pain
- Unexplained weight loss
- IDA, CALPROTECTIN / CRP
- FH IBD / CRC
INITIAL TX:

1. Education and reassurance

2. Dietary modification: lactose avoidance, low FODMAP, gluten avoidance, food allergy test
Constipation:
- osmotic laxatives, lubiprostone, guanylate cyclase ago, 5HT4 Ago

Diarrhea:
- Antidiarrhea agent, bile acid sequestrants, 5HT3 Antagonist
ADJUNCTIVE TX:

- Abd pain and bloating:
  - Antispasmodic
  - Antidepressant
  - Antibiotic
  - Probiotic

- Refractory: behavior modification, anxiolytic
Functional Constipation:

- ROME 4:3M/6M IN 2 OF FOLLOWING:
  - Less than 3 /w
  - BSSF 1-2
  - Straining
  - Incompletet evacuation
  - Sensation of anorectal obstruction
  - Manual manouver
Evaluation:

- History and phy/exam
- Lab test
- Endoscopy
- CTT
- Balloon expulsion
- Manometry
- defecography
Initial management:

- Patient education
- Fiber and bulk forming agent
- Other laxatives: surfactant, osmotic, stimulant
- Biofeedback
- Surgical consult
Complications:

- Hemorrhoids
- Fissure
- Megacolon
Perianal disease:

- perianal abscess
- Perianal fistula
- Fissure
- Perianal cellulitis
IBD:

- ULCERATIVE COLITIS: inflammation of mucosal layer
- CROHN: transmural inflammation
Cardinal symptoms in CD: ABD PAIN, DIARRHEA, FATIGUE, WEIGHT LOSS
UC: COLITIS (diarrhea+_ blood, abd pain, urgency, tenesmus, incontinance)
Extraintestinal manifestation: musculoskeletal, eye, skin, hepato billiary, hematopoietic, pulmonary
Colorectal cancer:

- Common cancer: 149,500/year new cases in USA
- Third most common cause of cancer death in women and second in men
- Despite decline in mortality, incidence increase
Clinical presentation:

- Symptoms and signs: change on BH, rectal bleeding, rectal/abd mass, abd pain, IDA
- Asymptomatic in screening colonoscopy
- Emergency admission with GI obstruction, perforation, GIB
DIAGNOSIS:

- Colonoscopy
- Flexible sigmoidoscopy
- CT in incomplete colonoscopy / initial test
- OB/FIT
- Tumor marker?
Celiac disease:

- Gluten sensitive enteropathy
- Immune mediated inflammatory disease

Terminology:

1. Symptomatic disease (classic/atypical)
2. Asymptomatic disease
3. Potential celiac disease
GI symptoms:

- diarrhea, steatorrhea, malabsorption
PROCTALGIA FUGAX
Clinical manifestation:

- Recurrent severe anorectal pain
- Day or night
- Few seconds to minutes (<30min)
- Asymptomatic between episodes
- Attacks per year: 1-180 (50% less than 5)
- Sexual intercourse, stress, defecation, sitting, menstruation, constipation???
DX:

- Rome 4 criteria: 3m/6m
- 1. recurrent episode of anorectal pain not related to defecation
- 2. second to minutes (<30)
- 3. Absent of anorectal pain between episodes

- Exclude ibd, abscess, fissure, trombotic hemorrhoids, …
Evaluation:

- DRE
- Pelvic examination in women
- Lab data: cbc, crp
- Colonoscopy
- EUS/MRI: Refractory to management or with fever and leukocytosis
Pathophysiology:

- Muscle spasm/hypertrophy
- Nerve compression
- Visceral hypersensitivity, anxiety, association with other functional bowel disorder
Management:

- Mild and infrequent: reassurance
- Severe or frequent: sitz bath/topical antispasmodic (ng 0.2% diltizem 2%)
Subsequent therapy and evaluation:

- EUS/ MRI
- Biofeedback
- Inhaled b2 adrenergic agonist
- Botulinium toxin
- Pudendal nerve block
Levator ani syndrome:

- Levator spasm
- Puborectalis syndrome
- Piriformis syndrome
- Pelvic tension myalgia
• Rome 4 criteria: 3m/6m
• Chronic or recurrent rectal pain
• At least 30 min
• Exclude other rectal pain
• Pain elicited during pos. traction of puborectalis

• Unspecified functional anorectal pain
Pain in the tailbone on sitting in leaning back
- Pain on rising and prolonged standing
- Defication or sexual intercourse may be painful
- Pain radiate to pelvic floor
- F>M
- Often related to trauma

Coccydynia:
Dx:

Hx and ph/exam

DRE: tenderness or pain on movement of coccyx
Management:

- Less than 2 m: conservative tx (wedge pillow, analgesic, heat or cold application)
- More than 2 m: coccygeal injection (local anestheti/glcc)
- Coccygectomy in intractable cases
Thank you