

# Chapter 22

## Chronic Pelvic Pain

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### INTRODUCTION

Chronic pelvic pain (CPP) and adhesions are the *bête noir* of the gynecologist. There are others, but these two will suffice as forerunners. One out of every ten patients are referred to a gynecologist for this symptom. Almost half of laparoscopies are performed because of CPP. One out of approximately ten patients has a hysterectomy because of this syndrome.

It is indeed a problem for the patient, as clearly delineated by Lucian and Duleba in recent publications. What indeed could be more complicated? The patient has a long-term problem, most of which is a complaint of "subjective" pain. So many factors are involved. In some instances, the factor causes the pain—in others, the pain causes the factor. The list is long: depression, marital problems, modification of physical activity, employment and attendance problems, impaired relationship with children, and the cost involved. Add to these factors those of the patient's personality and culture, the effect of stressful situations and even the patient's emotional reaction to the pain. Considering all of these factors in conjunction with one another and the inevitable interactions, the tapestry becomes confusingly incoherent. Further, let us not forget the following: many disabilities may arise resulting in a variety of further emotional reactions; often no single item can be identified; if an item is identified, the level of significance may not be discernible; most therapies have complications of their own and, sooner or later, the physician is confronted by a patient who is anxious, depressed, and hostile. Woe unto the physician whose reaction inevitably starts with sympathy and then moves rapidly through involvement, concern, discouragement, anger and (very often) to referral of the patient to another physician.

It is not the purpose of this chapter to review those factors involved in the evaluation and therapy of CPP, but

rather to point out the "complications" or "risks" encountered in the management of the patient with CPP.

### EVALUATION

Evaluation of the patient with CPP will invariably include an interview, psychological evaluation and questionnaires, physical examination, laboratory test (including imaging) and surgery, usually laparoscopy. Within this group lie several pitfalls:

- ◆ The visit to the gynecologist is not likely to be the patient's first visit to a specialist. The physician must be acutely aware that a small percentage of these individuals will be seeking additional drugs for symptoms real or imagined.
- ◆ Pain mapping has, on and off, been popular with physicians who would dearly love to relate specific organic findings to specific sites (or specific types) or pain. Their goal is admirable, but the method seems (to us) to suffer from inexactness. The most recent approach suggests that the diagnostic survey be performed by laparoscopy in the office under local anesthesia. A small catastrophe may await the inexperienced or relatively inadequate physician who attempts this procedure.
- ◆ The reliance on hospital full-fledged laparoscopy has drawbacks which must be faced. For example, endometriosis is found in a large number of such patients, but the direct relationship between cause and effect is not apparent, whereas involvement of the cul-de-sac and rectum may indeed be responsible for rectal tenesmus, endometriosis on the small and large bowel may be symptomless. The same inexactness pertains to adhesions. Very often, operative surgery involves hazardous areas such as the cul-de-sac, bowel, the sidewall and the ureter—areas at which operative complications occur with regularity.

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◆Laparoscopy has become the diagnostic tool of choice for patients with CPP, particularly if none of the other diagnostic modalities have revealed any specific abnormality. If no such laparoscopy is performed, the physician may be accused of an inadequate evaluation. If the laparoscopy is performed, the findings may be negative, occasionally with the patient suggesting that the operation was not really necessary. A negative laparoscopic procedure often leaves the surgeon in a more tenuous situation than before as his major diagnostic approach has not yielded results.

#### THERAPY

The list of therapeutic approaches for CPP is lengthening: analgesics, local anesthesia, ultrasound, CT scan, behavior modification, hypnosis, electrical stimulation, antidepressants, acupuncture, bio-feedback, and hormone therapy. The effectiveness of each of these varies considerably, but the complications are relatively well known:

- ◆NSAID (nonsteroidal anti-inflammatory drug) may result in gastrointestinal irritation and changes in platelet function.
- ◆Oral contraceptives may not only be ineffective but can cause many side effects or significantly disturb the entire reproductive system.
- ◆GnRH analogue therapy may relieve pelvic pain caused by endometriosis but results in hypo-estrogenism and all its attendant symptoms (which are occasionally relieved by add-back estrogen therapy) and does not provide permanent relief.
- ◆Danazol for endometriosis likewise creates hypo-estrogenism and hyperandrogenicity.
- ◆Progesterone for endometriosis often results in break-through bleeding, weight gain, and edema.
- ◆Analgesic medication may be non-opioid or opioid, the latter resulting in CNS (central nervous system) and respiratory depression.

Two surgical procedures have been specifically appointed for therapy of CPP, primarily due to endometriosis. Both of these procedures have been performed in the past with variable results.

◆The LUNA procedure is similar to the previously described Doyle procedure. In performance of this procedure by cutting the uterosacral ligaments (and surrounding nerves), there is the risk of vascular, ureteral and rectal injury if it is performed carelessly. Although up to 90% short-term pain relief has been reported, most of the patients had a recurrence of pain after one year.

◆Presacral neurectomy has been with the gynecologist for many decades and the results are more promising than LUNA. However, the risk of major retroperitoneal vascular injury exists, which can be serious. Other possible complications are ureteral and bowel injury.

#### CONCLUSION

Dr. Luciano, in his article, Chronic Pelvic Pain: Evaluation and Management of Chronic Pelvic Pain, refers to the "multi-faceted problem" of CPP and to the "gate control model" which "suggests that the incoming peripheral pain stimuli may be modulated (censored, heightened, even exaggerated) by messages from other sources, such as afferent input from cutaneous and deep somatic structures, endogenous opioid and non-opioid analgesic systems and several central excitatory and inhibitory influences from the brain stem, hypo-thalamus, and cortex." While all of this is being sorted out, first do no harm!

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