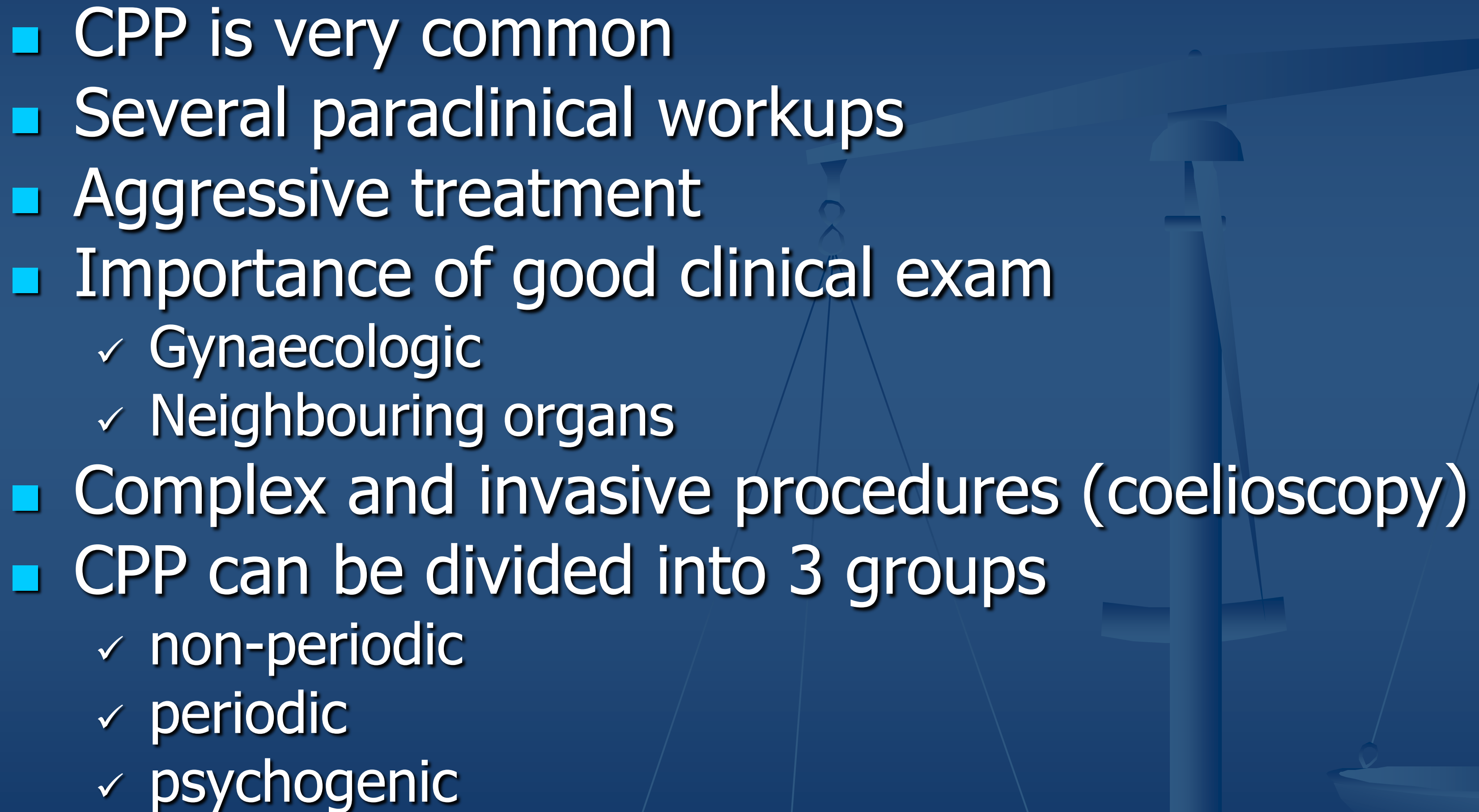
CHRONIC PELVIC PAIN (CPP)

By
Dr TIOMELA DOUANLA
Gynaeco-obstetrician
HGOPY

Postgraduate Training in Reproductive Health Research
Faculty of Medicine, University of Yaoundé 2007

INTRODUCTION



- CPP is very common
- Several paraclinical workups
- Aggressive treatment
- Importance of good clinical exam
  - ✓ Gynaecologic
  - ✓ Neighbouring organs
- Complex and invasive procedures (coelioscopy)
- CPP can be divided into 3 groups
  - ✓ non-periodic
  - ✓ periodic
  - ✓ psychogenic

1. NON PERIODIC CPP

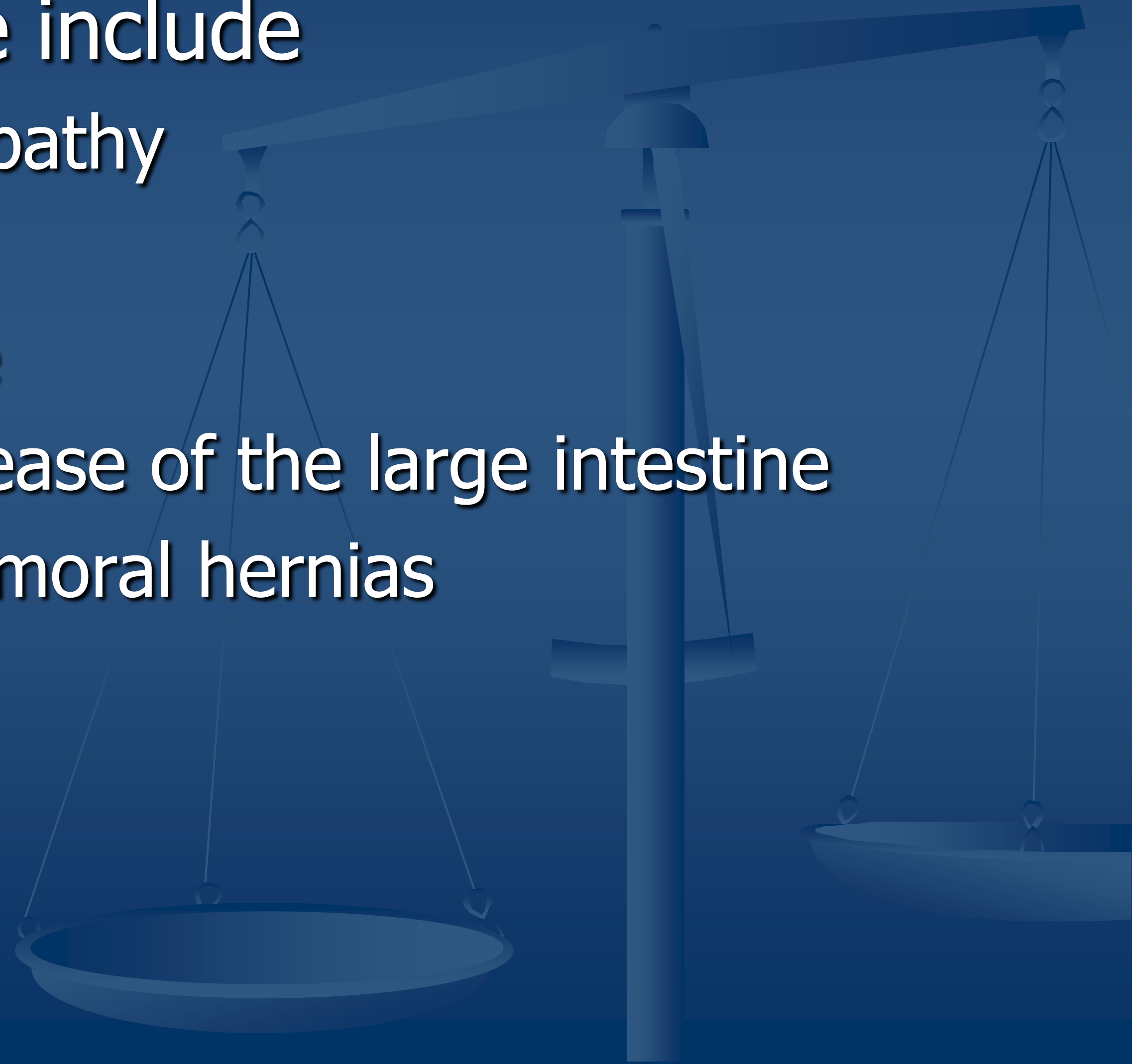
- Can involve the genitals or not

1.1 Extra genital CPP

- Bones and muscles pains: most often pathology of intervertebral disk, sacro-iliac and coxo-femoral joints, rarely from abdominal, ilio-psoas, piriform, pubo-coccygeus and obturator muscles

1.1a Pain from digestive origin

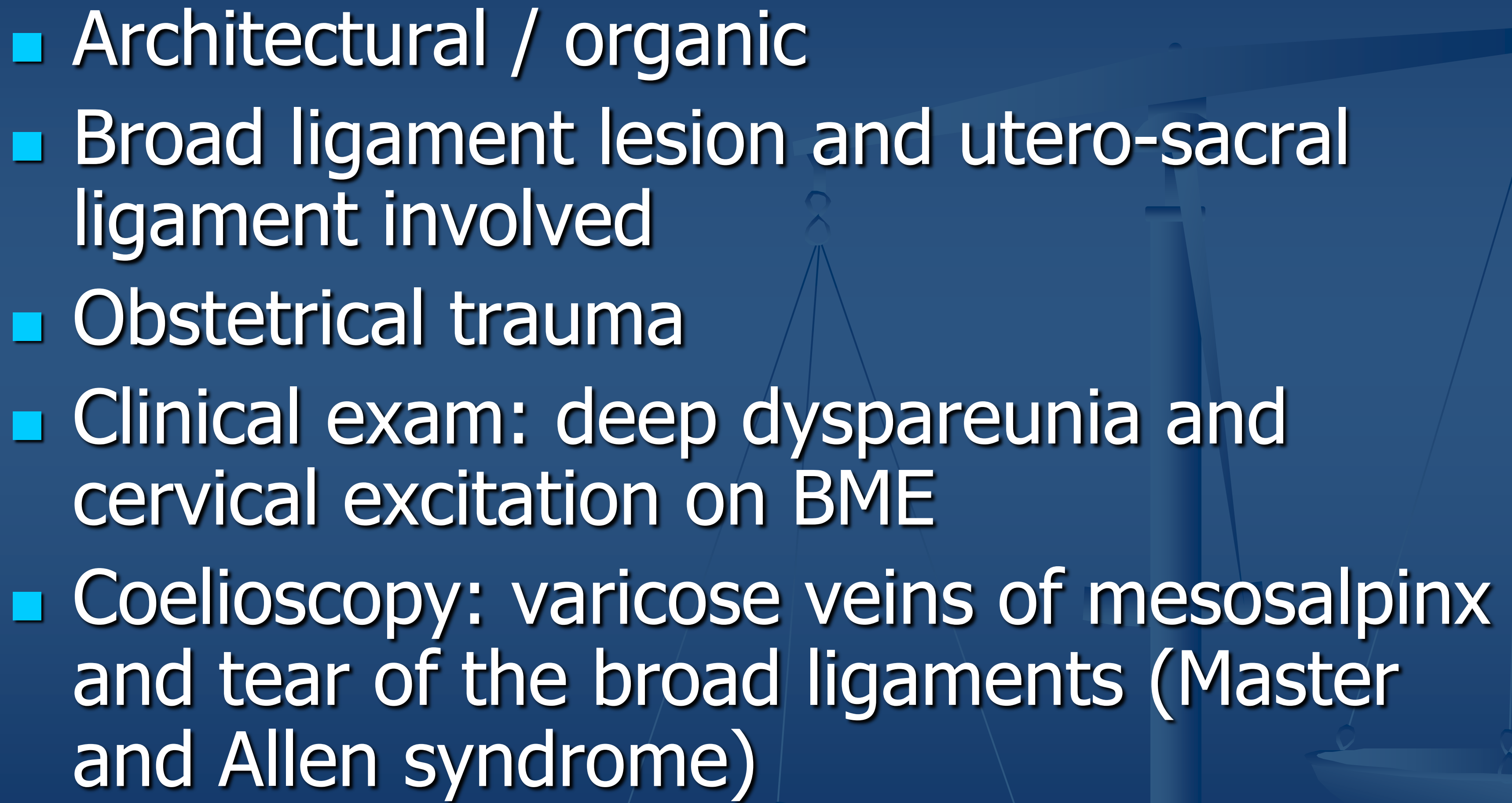
- Possible disease include
  - Functional colopathy
  - Recto-colitis
  - Crohn's disease
  - Diverticular disease of the large intestine
  - Inguinal and femoral hernias



1.1b Pain from urinary origin

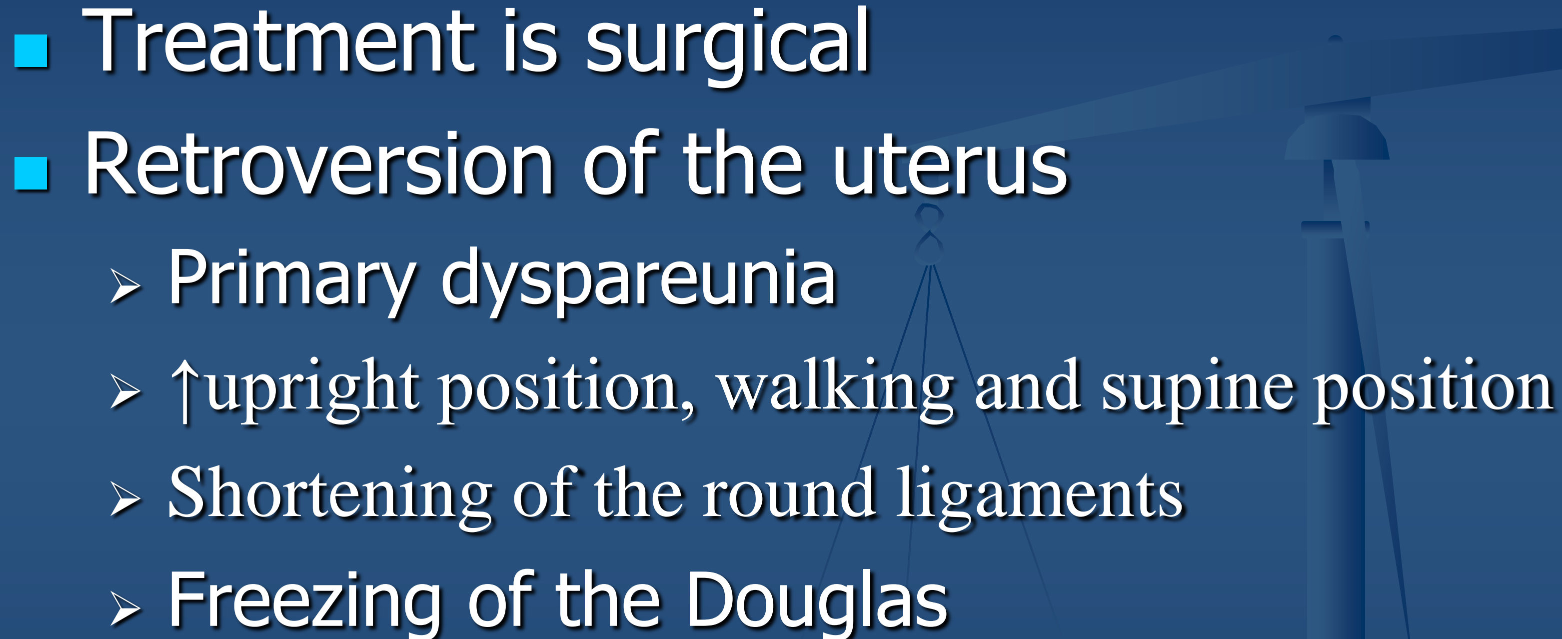
- Cystitis, stones especially ureteral

1-2 Genital pain



- Architectural / organic
- Broad ligament lesion and utero-sacral ligament involved
- Obstetrical trauma
- Clinical exam: deep dyspareunia and cervical excitation on BME
- Coelioscopy: varicose veins of mesosalpinx and tear of the broad ligaments (Master and Allen syndrome)

Suite



- Treatment is surgical
- Retroversion of the uterus
  - Primary dyspareunia
  - ↑upright position, walking and supine position
  - Shortening of the round ligaments
  - Freezing of the Douglas

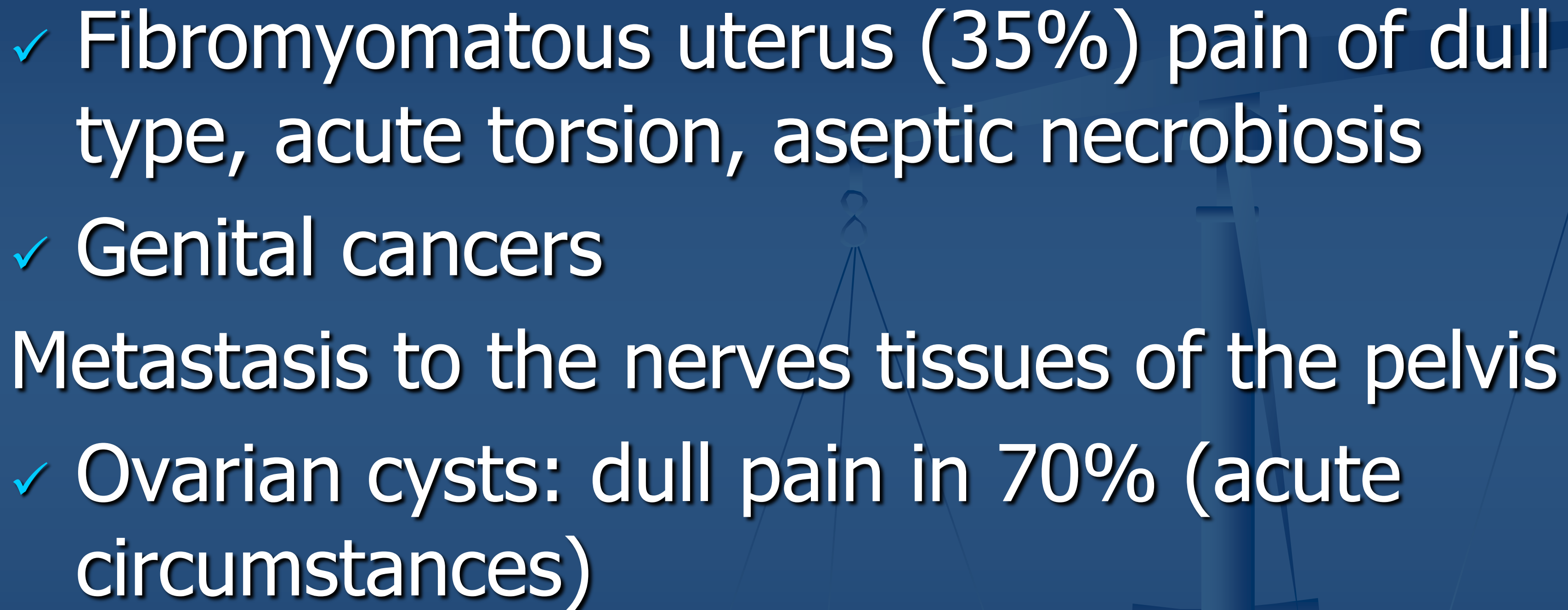
Suite

- Organic lesions of the genitalia

The disease history varies depending on the pathology and the organ affected

- ✓ Superficial dyspareunia ← atrophy of the vulva, genital prolapse, infectious vaginitis or past history of vaginal tear

Suite



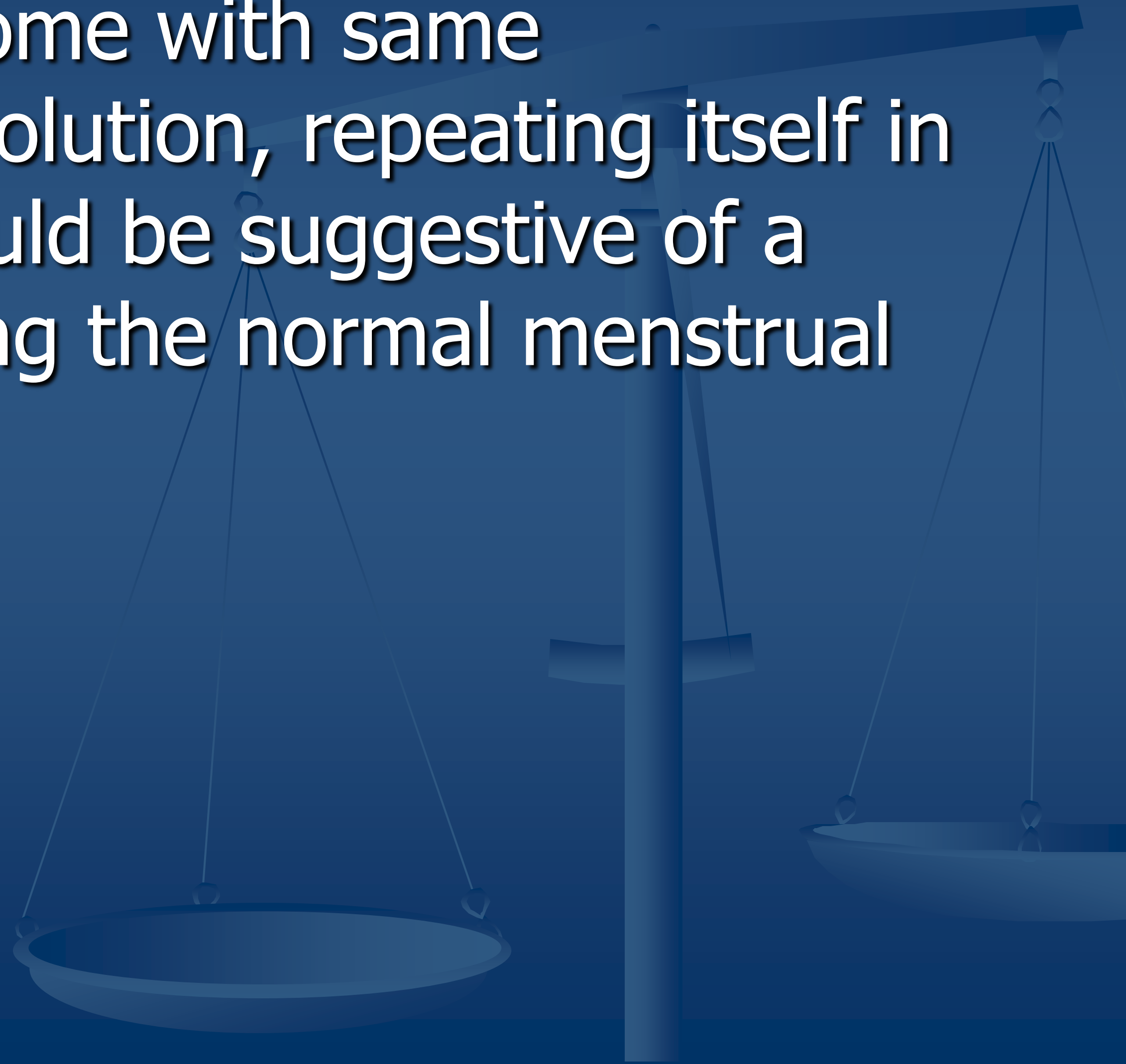
- ✓ Fibromyomatous uterus (35%) pain of dull type, acute torsion, aseptic necrobiosis
- ✓ Genital cancers

Metastasis to the nerves tissues of the pelvis

- ✓ Ovarian cysts: dull pain in 70% (acute circumstances)

2. CPP INFLUENCED BY THE MENSTRUAL CYCLE

- A painful syndrome with same spontaneous evolution, repeating itself in every cycle should be suggestive of a disorder affecting the normal menstrual cycle



2.1 Dysmenorrhoea

- Pain preceding or accompanying menses
- Associated symptoms: digestive, headache, oedema, lipothymy
- Primary D
- Secondary D (latent period)
- ✓ There is no essential dysmenorrhoea without an ovulatory cycle, that is a secretory endometrium and an impregnated myometrium by luteal secretions

Suite

- ✓ After 1st pregnancy, primary D is not common
- ✓ Several theories:
  - Spasmodic theory
  - Ischaemic theory
  - Congestive theory

Collection of factors: cervical, hormonal, neurologic, psychological

- Secondary D ← endometriosis, cervical stenosis genital infections, malformations

2.2 **Premenstrual syndrome**

- Collection of physical and psychological manifestations involving the entire organism

✓ Breast manifestations

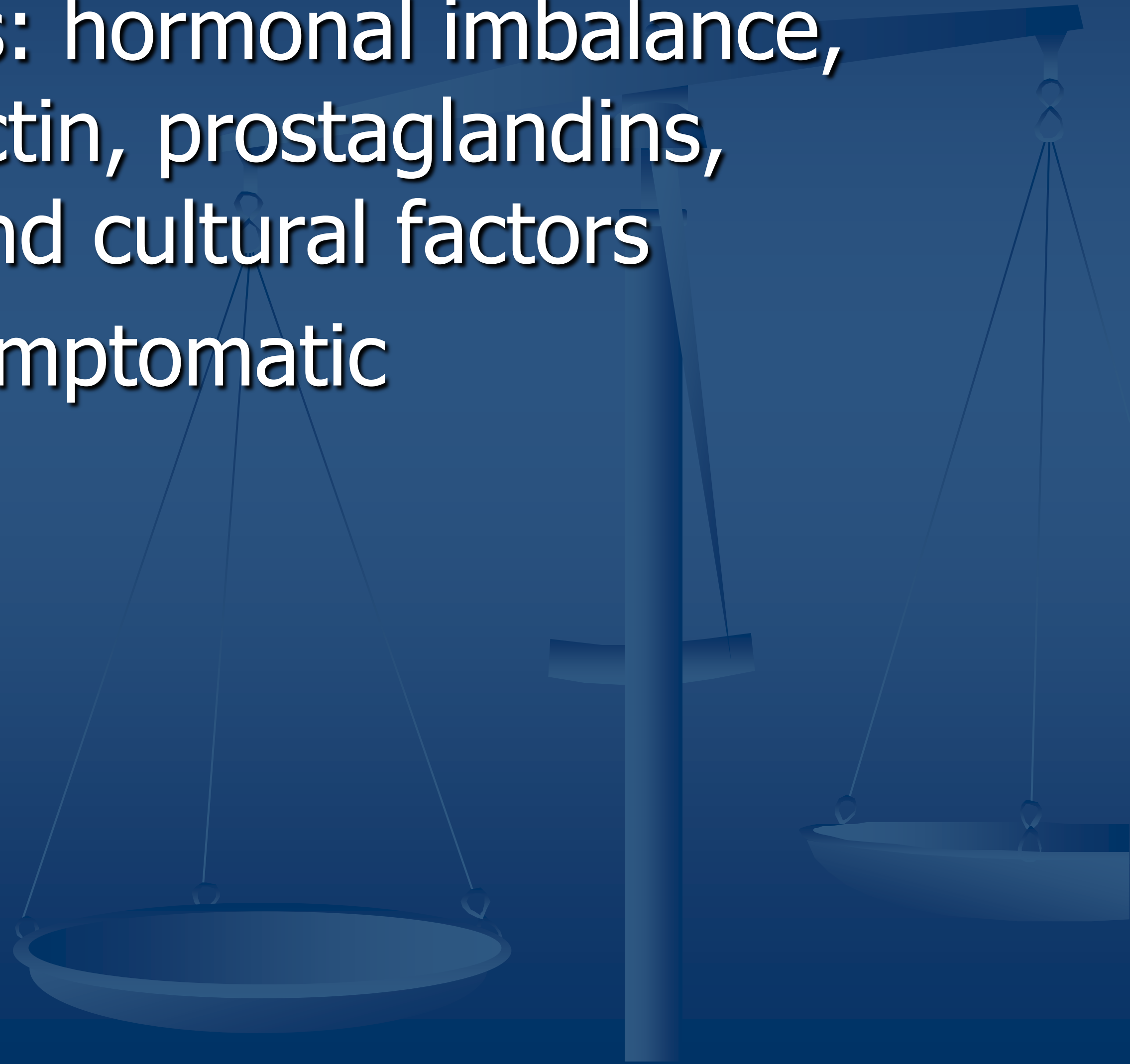
✓ Abdomino-pelvic signs

✓ Neuropsychic syndrome

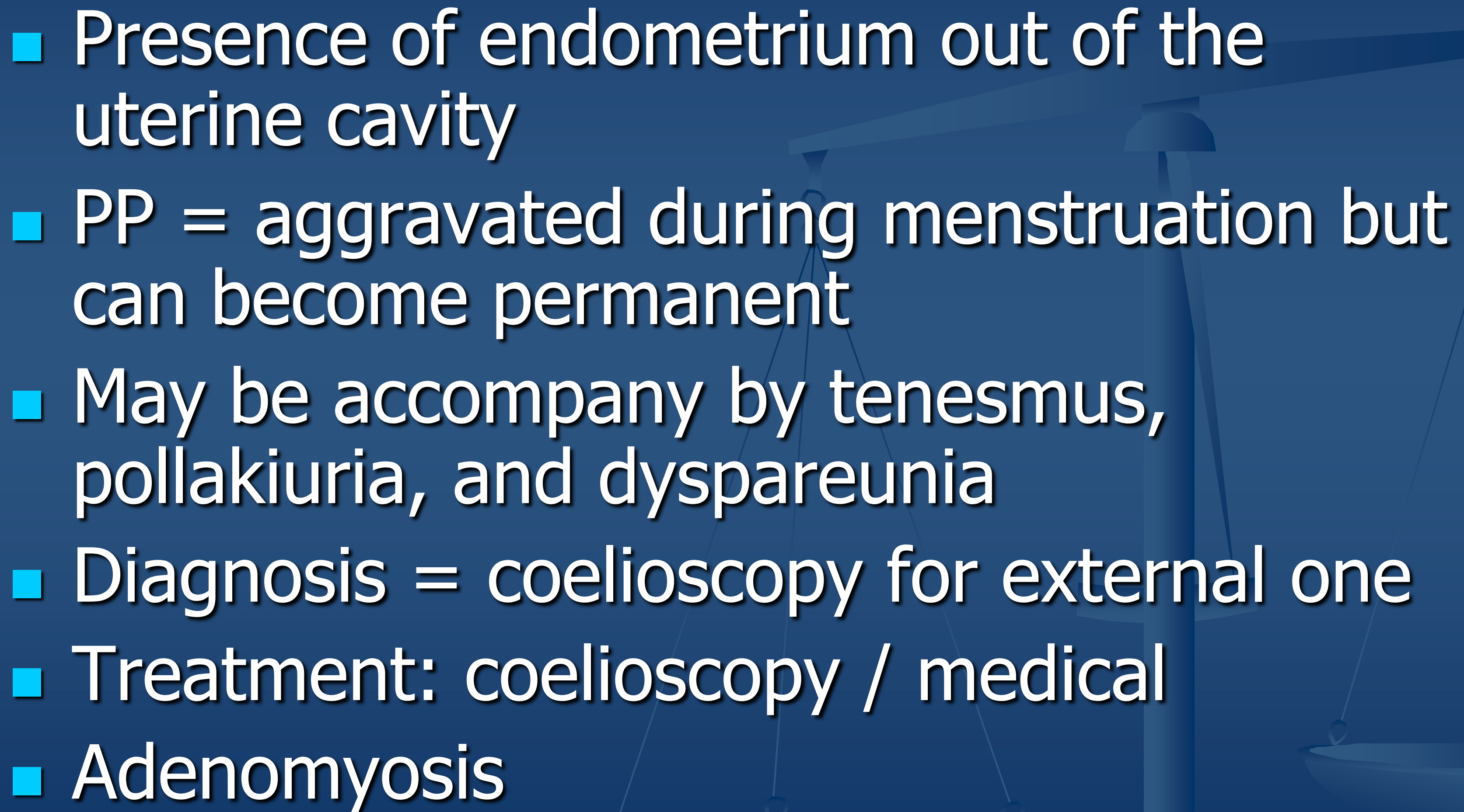
Disappearance at the onset of menses

Suite

- Several theories: hormonal imbalance, effects of prolactin, prostaglandins, psychological and cultural factors
- Treatment = symptomatic

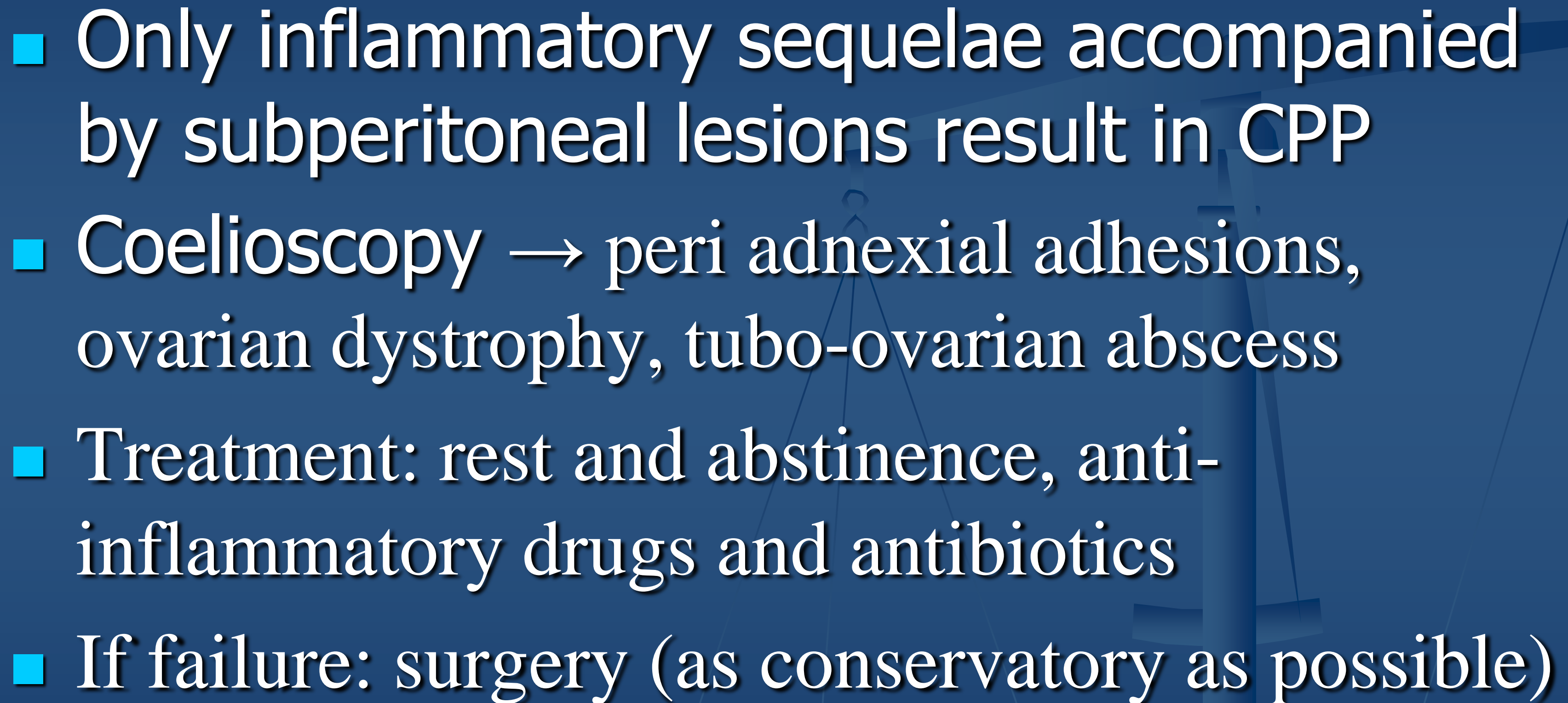


2.3 Endometriosis



- Presence of endometrium out of the uterine cavity
- PP = aggravated during menstruation but can become permanent
- May be accompany by tenesmus, pollakiuria, and dyspareunia
- Diagnosis = coelioscopy for external one
- Treatment: coelioscopy / medical
- Adenomyosis

2.4 Inflammatory sequelae



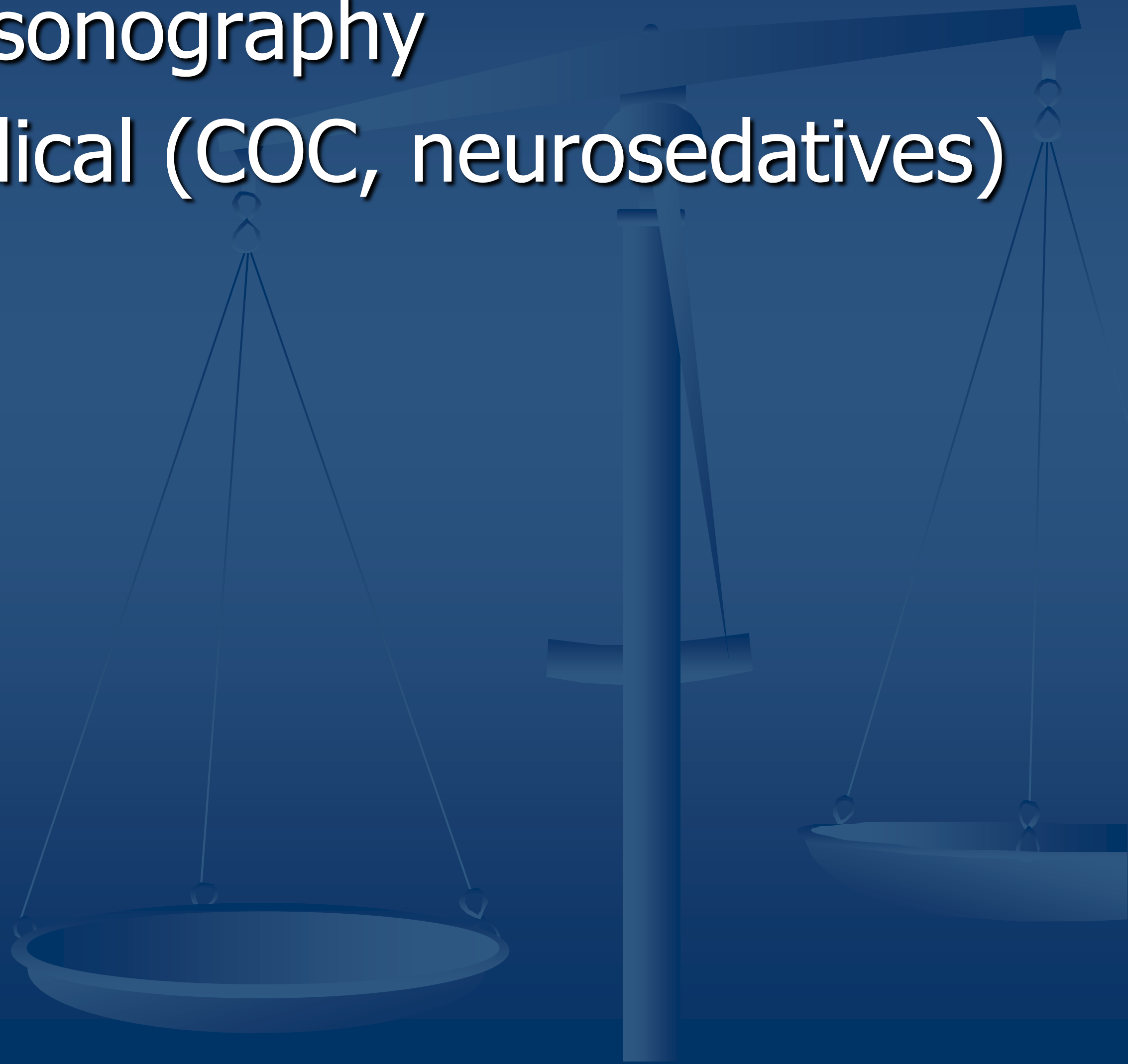
- Only inflammatory sequelae accompanied by subperitoneal lesions result in CPP
- Coelioscopy $\rightarrow$ peri adnexial adhesions, ovarian dystrophy, tubo-ovarian abscess
- Treatment: rest and abstinence, anti-inflammatory drugs and antibiotics
- If failure: surgery (as conservatory as possible)

2.5 Ovarian dystrophy

- Fertility disorders, menstrual disorders, hirsutism, and obesity
- Ovulatory pain
- BME: sensitive ovaries
- Volume ↑ (premenstrual period) ↓ after
- Speculum: abundantly persistent mucous indicating absence of ovulation and oestrogen predominance

Suite

- Diagnosis: ultrasonography
- Treatment: medical (COC, neurosedatives)



2.6 Functional cyst

- Several clinical presentations
  - Pelvic pain with onset at mid cycle
  - Menstrual disorders
  - Adnexal mass (BME)

Diagnosis = ultrasonography

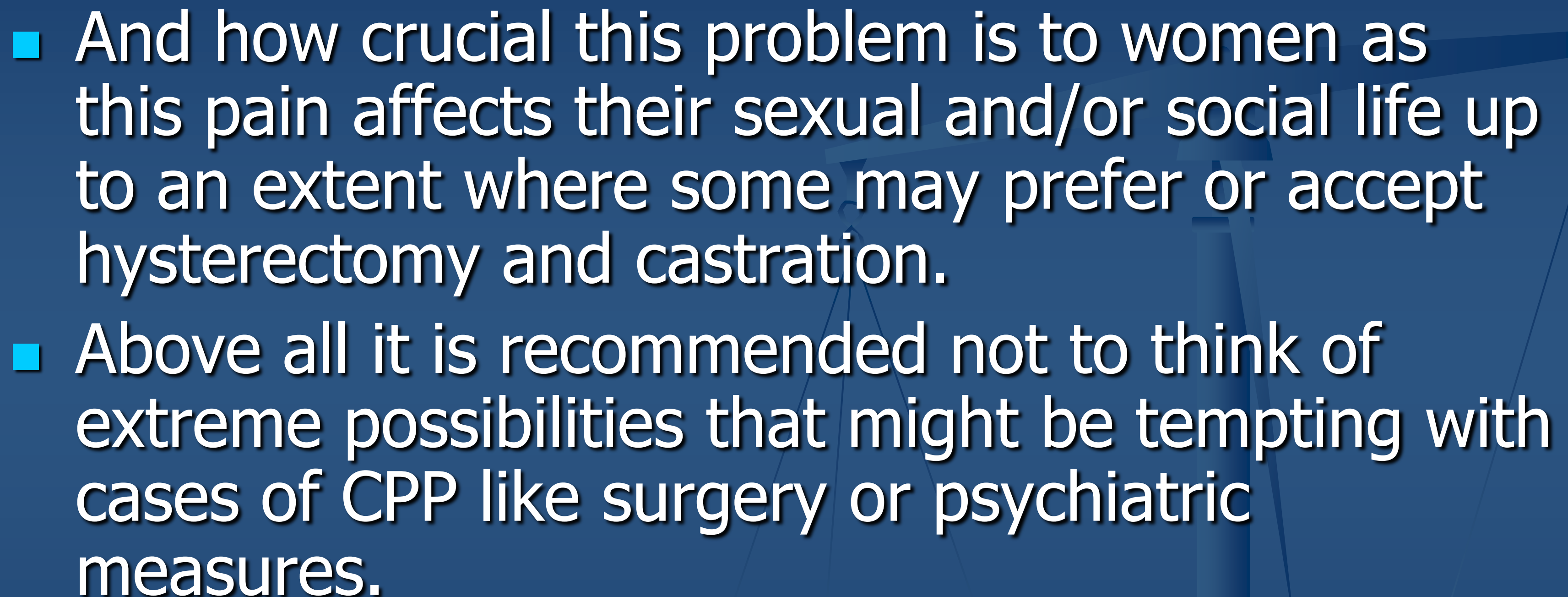
Treatment option: stoppage of ovarian activity x 3 months or surgery

3. Pelvic pain from psychological origin

CONCLUSION

- The importance of acute pelvic pain lies on its emergency that it presents. Diagnosis and treatment are usually rapid and efficient proved by biology, echography and cœlioscopy; unlike CPP in which we know:
  - How difficult the problem is
  - How our success and failure remain often unexplained

Suite



- And how crucial this problem is to women as this pain affects their sexual and/or social life up to an extent where some may prefer or accept hysterectomy and castration.
- Above all it is recommended not to think of extreme possibilities that might be tempting with cases of CPP like surgery or psychiatric measures.

THANK YOU