CHRONIC PELVIC PAIN (CPP)

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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 diseases 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
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 $\uparrow$ (premenstrual period) $\downarrow$ 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 coelioscopy; unlike CPP in which we know:

- How difficult the problem is
- How our success and failure remain often unexplained
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