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Chronic Pelvic Pain: A Case Study and Management

Series Editors: Matthew F. Davies, MD, FACOG

Associate Professor of Obstetrics and Gynecology, Residency Program Director, Chief, Division of Women's Health and Division of Medical Education in Obstetrics and Gynecology, Pennsylvania State University College of Medicine, Department of Obstetrics and Gynecology, Hershey, PA

Jordan G. Pritzker, MD, MBA, FACOG

Assistant Professor, Albert Einstein College of Medicine, Montefiore Medical Center, Bronx, NY, Obstetrics and Gynecology Faculty Practice, Women's Comprehensive Health Center, Long Island Jewish Medical Center, New Hyde Park, NY

Contributor: Joseph E. Patruno, MD

Assistant Professor of Obstetrics and Gynecology, Medical Student Clerkship Director, Associate Residency Program Director, Pennsylvania State University College of Medicine, Hershey, PA

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Chronic Pelvic Pain: A Case Study and Management

Joseph E. Patruno, MD, and Matthew F. Davies, MD, FACOG

I. INTRODUCTION

Chronic pelvic pain (CPP) in women is a common problem that has substantial effects on both the patient and society. This debilitating and often enigmatic condition afflicts 15% of reproductive age women in the United States and accounts for more than 10% of gynecologic referrals.¹ The ramifications of pelvic pain (eg, loss of productivity, effects on family, and cost to society) are considerable.

CPP, defined as nonmenstrual pain of at least 3 months' duration or menstrual-related pain that persists for more than 6 months, may afflict women in any age group. The most common population affected by chronic pain, however, is women between 18 and 50 years of age.² In evaluating the symptom of chronic pelvic pain, various gynecologic and non-gynecologic causes should be considered. The most common non-gynecologic causes of CPP include conditions of the gastrointestinal (GI), urologic, and/or musculoskeletal system. Also, psychiatric illnesses may manifest as or contribute to symptoms of CPP. Common gynecologic explanations for CPP include endometriosis, pelvic adhesive disease, and structural lesions of the uterus and ovaries (eg, cysts and leiomyomas).

The medical community has become more familiar with the physiology and causes of CPP; however, ideal diagnostic algorithms and management protocols have not been established. Because gynecologists often see these patients, they should be familiar with all the conditions in the broad differential diagnosis and be able to provide both diagnostic and therapeutic recommendations.

II. CASE PATIENT I PRESENTATION

Patient 1 is a 28-year-old nulligravida married woman who presents with a 12-month history of worsening pelvic pain. The pain is constant and described as "achy" in nature with intermittent sharp "stabbing" episodes.

Her symptoms are worse immediately before, and during, her menses. She also notes worsening dyspareunia with deep penetration during the past several months. A review of systems is pertinent for intermittent constipation and diarrhea but is negative for bladder symptoms such as dysuria, increased frequency, or hematuria. Her cycles occur every 30 days, last approximately 1 week, and are described as "very heavy." She denies a history of abnormal Papanicolaou (Pap) smears, sexually transmitted diseases, or pelvic inflammatory disease. Additionally, there is no history of abdominal surgeries or medical co-morbidity (eg, GI, musculoskeletal, or psychiatric disorder). She denies any prior or current sexual, physical, or emotional abuse. Notably, patient 1 mentions that she and her spouse have been unable to conceive during the past 2 years.

- Which of the following presenting complaints is most consistent with a diagnosis other than endometriosis?
 - Deep dyspareunia
 - Intermittent bowel dysfunction
 - Primary infertility
 - Progressive dysmenorrhea

DISCUSSION

The correct answer is B. Patients with CPP often present a diagnostic dilemma because several conditions may explain their pain symptoms. It is essential to obtain a complete and accurate history and to ask certain questions as described in **Table 1**. In this case, patient 1 meets the criteria for CPP because she has had symptoms for more than 6 months. The fact that her pain is exacerbated by menses should alert the practitioner to a likely gynecologic origin, and endometriosis is the most likely cause. Approximately 71% to 87% of women with pelvic pain have endometriosis.^{3,4} Common associated symptoms of endometriosis include dysmenorrhea, menorrhagia, and deep dyspareunia. In patients with infertility (with or without associated CPP), 25% are found by laparoscopy to have evidence of endometriosis.⁵ Patients with endometriosis only rarely present with bowel or