Women Chronic Pelvic Pain:
Sharing interdisciplinary experience

Thomas BAPTISTE-WEISS – Co Founder FSF-IHCE – Osteopathic Therapist in Integrative and Alternative Medicine- Geneva, Switzerland, Doctor Beatrice CUZIN - Urologist, sexual and reproductive Medicine, Lyon, September 24th 2021.

Chronic pelvic pain is a common, burdensome, and costly condition that disproportionately affects women, affecting an estimated more than 20% of people worldwide, chronic pelvic pain is a common problem. It affects approximately 1 in 7 women[1]. In one study of reproductive-aged women in primary care practices, the reported prevalence rate of pelvic pain was 39%[2]. Of all referrals to gynecologists, 10% are for pelvic pain[3].

10% of the world's population - approximately 60 million people - endure chronic pain[4] and fairly reliable estimates in individual countries and regions indicate chronic pain prevalence closer to 20-25%[56]. Primary care settings in Asia, Africa, Europe, and in the Americas had patients reporting persistent pain prevalence of 10 to 25%. Consistent estimates of chronic pain prevalence in the U.S. range from 12 to 25%, and prevalence of 20% has been noted in Europe[7]. The WHO has estimated that as many as 1 in 10 adult individuals are newly diagnosed with chronic pain each year.[8]

Chronic pelvic pain differs from acute pelvic pain in several important ways. Acute pain typically arises from an inflammatory, infectious, or anoxic event or traumatic injury that resolves over time with treatment and repair. When pain persists, a chronic stress phenotype may emerge and is characterized by a vicious cycle of physical and psychologic consequences. Prolonged activity restriction can lead to physical deconditioning. Continued fear, anxiety, and distress can lead to long term deterioration in mood and social isolation. Although mood symptoms are ubiquitous in chronic pain syndromes, criteria for major depression are met in approximately 12–33% of women across samples of women living with or seeking care for chronic pelvic pain.

Diagnosis and initial management of chronic pelvic pain in women are within the scope of practice of specialists mainly in obstetrics and gynecology. Indeed, the complexity of the muscular and osteopathic structures and pelvis innervation with the anatomical proximity of pelvic viscera means this condition frequently overlaps traditional medical specialties, and could benefit from complementary medicine such as osteopathy, physiotherapy, traditional Chinese medicine.

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Because chronic pelvic pain is often multifactorial, most patients will have multiple pain generators and comorbid conditions. Although many conditions are associated with chronic pelvic pain, determining how pain changes with sexual activity, menstruation, urination, and defecation is a good starting point. Patients often focus on visceral etiologies, yet neuromuscular issues such as myofascial trigger points may be more common and are often overlooked.[9] Single-digit or swab palpation for tenderness of pelvic floor muscles, or palpation of the abdomen and the lower back, including the sacroiliac joints, that reproduces pain can identify possible neuromuscular conditions. In one small study, pelvic floor muscle tenderness or a positive flexion, abduction, and external rotation test identified 85% of patients with chronic neuromuscular pelvic pain. Other clinical signs were statistically significantly associated with long term pelvic chronic pain in Women: suicidal risk, alcoholism and smoking, psychotropic drug use, psychosomatic and sleep disorders, post-traumatic stress disorder, vaginal discharge, pelvic pain, sexual disorders, diarrhea, chest pain.

A detailed medical history and physical examination, with particular attention to the abdominal and pelvic neuromusculoskeletal examination, are recommended for the evaluation of chronic pelvic pain. Physical findings that increase the likelihood of neuromusculoskeletal contributors to chronic pelvic pain include pelvic floor muscle tenderness and abdominal wall tenderness that reproduce the patient's pain.

Psychosocial factors play a role in all types of pain and can affect symptom severity and prognosis. Pelvic pain and dyspareunia are more prevalent in women with a history of abuse, mental illness, lack of support, social stressors, and relationship discord. These comorbidities do not alter the visceral or neuromusculoskeletal pain generators but may worsen the associated symptom burden and psychological effects. Treating psychosocial factors as separate but equally important pain contributors can increase the woman's awareness of her conscious and unconscious perception of pain and facilitate her recovery. Female genital mutilations should not be forgotten

So Chronic pelvic pain should receive greater attention as a global health care priority for women, particularly in developing countries.
In order to be able to provide adequate and inexpensive care and treatment because pain management is a human right, as well as access to care for vulnerable populations. All health care systems must and have the duty to provide this access to women.

The non-exhaustive list of pelvic pain disorders could include: dyspareunia, cystalgia, bladder hyperexcitability, coccygodynia, dysmenorrhea and hypo fertility, interstitial cystitis, vulvodynia, endometriosis, pelvic floor tension, sacral pain, lumbar pain, inter-discal pain, abdominal pain, with associated symptoms , like insomnia, headaches, nausea, and gastro-intestinal dysfunctions, Trauma (e.g. secondary to vaginal delivery), surgery (e.g. any abdominal wall incision including caesarean section), pelvic floor muscle pain syndrome, vaginal muscle spasm, neuralgia from nerve entrapment or irritation, pain arising from the lower part of the spine (e.g. from sprains, strains, fractures, degenerative disease, disc lesions), sacroiliac joint dysfunction, symphysis pubis dysfunction, coccygeal pain, piriformis syndrome, myofascial pain syndrome, abdominal migraines.

The main recommendations for the management of pelvic pain vary from woman to woman depending on her personal life history. Recommendations are often based on listening to and understanding the needs of women with this complex condition. The time required to treat these women varies according to the time spent on clinical evaluation and the means available to physicians for their treatment. The cost of the consultation also res a choice to be made regarding the spectrum of the general clinical evaluation and the orientations granted according to the location of the pathology. The total cost of care will differ from one country to another depending on the level of training of the caregivers and the treatments available. (i) practical assessment of pain levels measured by type, myofascial pain, medications and surgical interventions, principles of opioid management, increased use of magnetic resonance imaging (MRI); documentation of the extent of disease seen through surgery; non-conventional therapies (acupuncture, osteopathy, pelvic reeducation through electrostimulation; access to multidisciplinary models of care with components of physiotherapy, posturology, psychological and psychiatric care for trauma, in conjunction with other medical disciplines, such as gynecology and anesthesia also play a significant role in the causal orientation of this type of pathology.

The organization Formations Sans Frontières - International Health Care Education[10] has been working since 2004 to sensitize health authorities, national and local associations to promote training in sexual and reproductive health.

[9] 1: Chronic Pelvic Pain: ACOG Practice Bulletin, Number 218. Obstet Gynecol. 2020 Mar;135(3):e98-e109.
[10] www.fsf-ihce.com, www.fsf-ihce.ch, www.fsf-ihce.mx, www.fsf-ihce.africa

By considering broad measures in favor of the creation of multidisciplinary teams through advanced training of health professionals in its sectors, thus strengthening local capacities to ensure the management of this pathology.

The evidence-based literature on the treatment of chronic pelvic pain remains limited.
The majority of treatments are too often focused on symptomatic pain relief, due to a lack of multidisciplinary working capacity of health care providers and financial resources for training and treatment. The approach to the treatment of chronic pelvic diseases should be focused on the pathology and the history of the person, considering the co-morbidity factors of the individual in his medical history and life condition. If, however, the origin of the pelvic pain remains unknown, it is recommended that the patient undergo further evaluation with alternative approaches such as osteopathy, traditional Chinese medicine, yoga, breathing exercises, hypnosis, EMDR if the case may be traumatic, such as following rape and or abusive touching that is often perpetuated - and or unspoken during medical consultations.

Multidisciplinary management of chronic pain should be offered to women with chronic pelvic pain within the public health care system of each country. The strengthening of training programs for health care providers should be systematically considered in health care centers and systematically include a program in medical and paramedical universities.

Raising women's awareness from an early age is also a way to get the message across during sexuality prevention campaigns in school programs.