

## Consensus Guidelines for the Management of Chronic Pelvic Pain

This guideline was developed by the Chronic Pelvic Pain Working Group and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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understood, these treatments have met with variable success rates.

**Outcomes:** Effectiveness of diagnostic and therapeutic options, including assessment of myofascial dysfunction, multidisciplinary care, a rehabilitation model that emphasizes achieving higher function with some pain rather than a cure, and appropriate use of opiates for the chronic pain state.

**Evidence:** Medline and the Cochrane Database from 1982 to 2004 were searched for articles in English on subjects related to CPP, including acute care management, myofascial dysfunction, and medical and surgical therapeutic options. The committee reviewed the literature and available data from a needs assessment of subjects with CPP, using a consensus approach to develop recommendations.

**Values:** The quality of the evidence was rated using the criteria described in the Report of the Canadian Task Force on the Periodic Health Examination. Recommendations for practice were ranked according to the method described in that report (Table 1).

**Recommendations:** The recommendations are directed to the following areas: (a) an understanding of the needs of women with CPP; (b) general clinical assessment; (c) practical assessment of pain levels; (d) myofascial pain; (e) medications and surgical procedures; (f) principles of opiate management; (g) increased use of magnetic resonance imaging (MRI); (h) documentation of the surgically observed extent of disease; (i) alternative therapies; (j) access to multidisciplinary care models that have components of physical therapy (such as exercise and posture) and psychology (such as cognitive-behavioural therapy), along with other medical disciplines, such as gynaecology and anesthesia; (k) increased attention to CPP in the training of health care professionals; and (l) increased attention to CPP in formal, high-calibre research. The committee recommends that provincial ministries of health pursue the creation of multidisciplinary teams to manage the condition.

### Chapter 2: Scope, Definition, and Causes of Chronic Pelvic Pain

1. Because of the complex nature and multifactorial development of its common state, CPP should be increasingly incorporated into the educational curricula of health professionals (medical students, residents, nurses, physiotherapists, specialists) (III-B).

### Chapter 3: History-taking, Physical Examination, and Psychological Assessment

1. Thorough history-taking that generates trust between caregiver and patient and a pain-focused physical examination should be part of the complete evaluation of the patient with CPP (III-B).
2. Clinical measurement of pain level could be done at each visit for CPP (II-B).

### Abstract

**Objective:** To improve the understanding of chronic pelvic pain (CPP) and to provide evidence-based guidelines of value to primary care health professionals, general obstetricians and gynaecologists, and those who specialize in chronic pain.

**Burden of Suffering:** CPP is a common, debilitating condition affecting women. It accounts for substantial personal suffering and health care expenditure for interventions, including multiple consultations and medical and surgical therapies. Because the underlying pathophysiology of this complex condition is poorly

**Key Words:** Pelvic pain, myofascial pain syndromes, endometriosis, endosalpingiosis, adenomyosis, pelvic peritoneal defects, pelvic inflammatory disease, adhesions, ovarian cysts, residual ovary syndrome, ovarian remnant syndrome, pelvic congestion syndrome, hysterectomy, uterine fibroids, adnexal torsion, diagnostic imaging, laparoscopy, hormonal treatment, complementary therapies

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3. The patient can be asked two questions that are simple and effective: "On a scale of 0 to 10, 0 being no pain and 10 being the worst pain imaginable, How is your pain today and how was your pain 2 weeks ago?" It is important to provide a reference for 10 such as "pain that is so bad that you cannot care for your children, who are in imminent danger" (II-B).
4. The physical examination can be conducted differently in these patients, with special attention placed on individual pelvic structures, to help differentiate sources of pain. Identifying a focal area of tenderness can help target specific therapy (II-B).
5. Owing to the high prevalence of mental health and other significant psychological coexisting problems and sequelae of CPP, gynaecologists and family physicians should routinely screen patients for chronic pain syndrome and refer as appropriate (II-2A).
6. Access to multidisciplinary chronic pain management should be available for women with CPP within the publicly funded health care system in each province and territory of Canada (III-B).

**Chapter 4: Investigations**

1. Patient-assisted laparoscopy should be subjected to clinical trial (III-C).

**Chapter 5: Sources of Chronic Pelvic Pain**

1. Hysterectomy for endometriosis or adenomyosis with ovarian conservation can be an acceptable alternative. The patient should be informed of the possible consequences (residual ovary syndrome, persistent pain, and reactivation of endometriosis) (II-2A).
2. Ovarian cystectomy, rather than oophorectomy, should be an individual decision, based on the patient's age and wishes, fertility issues, and surgical feasibility (II-3B).
3. The management of symptomatic uterine fibroids should follow the clinical practice guidelines of the Society of Obstetricians and Gynaecologists of Canada (II-3B).

4. The management of adnexal torsion should be determined according to the patient's age and wishes, fertility issues, and surgical judgment (II-3B).
5. Since the rate of recurrence of endometriosis with hormone replacement therapy (HRT) in women undergoing hysterectomy plus bilateral salpingo-oophorectomy (BSO) is very low, HRT should not be contraindicated (I-B).
6. In women with an intact uterus, when total hysterectomy has not been performed because of technical difficulties, the recurrence of endometriosis contraindicates the use of HRT (I-B).
7. Hysterectomy can be indicated in the presence of severe symptoms with failure of other treatment when fertility is no longer desired (I-B).
8. Pelvic peritoneal defects (pockets) are frequently associated with endometriosis and should be treated surgically (II-B).
9. Endosalpingiosis is an incidental histologic finding and does not appear to require specific treatment (II-2B).
10. Current evidence does not support routine adhesiolysis for chronic pelvic pain. However, diagnostic laparoscopy remains of value (I-B).

**Chapter 6: Urologic and Gastrointestinal Causes of Chronic Pelvic Pain**

1. Cystoscopy by trained specialists, with or without diagnostic laparoscopy, should be considered when interstitial cystitis (IC) is suspected (III-B).
2. Women with chronic pelvic pain will require detailed gynaecologic, urologic, gastroenterologic, and psychological assessment. Appropriate evaluation can lead to optimal treatment and decrease the rate of inappropriate interventions (III-B).

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