

Pelvic pain in women: common and challenging

Cynthia M Farquhar

What is a reasonable approach to management of women with pelvic pain?

Pelvic pain in women is as common as the common cold, it seems. Certainly that is the impression one is left with after reading the article by Pitts et al (*page 138*) on the prevalence and correlates of pelvic pain in Australian women. Pitts and colleagues found that 72% of women experienced dysmenorrhoea and only one in four women did not report any kind of pelvic pain.¹ A systematic review of international studies reported a similar prevalence of dysmenorrhoea and pelvic pain.²

Is the experience of pelvic pain, particularly dysmenorrhoea, just a normal part of life? If this is the case, then we need to ask how clinicians should most appropriately respond to the many women presenting for assistance with chronic pelvic pain.

What proportion of women with pelvic pain will have underlying pathology? Most studies of women with dysmenorrhoea suggest that endometriosis is present in 30%–40% of cases.³ But the pain felt by women during menstruation may be no less severe than the pain experienced by women with pathology. Period pain can lead to lost days from school or the workplace and may have a considerable impact on daily living.

Which women with pelvic pain should be referred for further investigation with laparoscopy? Common sense suggests that women who warrant further investigation are those for whom empirical approaches (such as suppression of the menstrual cycle) have failed and those who have symptoms at the severe end of the spectrum. The guidelines of the Royal College of Obstetrics and Gynaecology in the United Kingdom and the consensus statement of the American College of Obstetrics and Gynecology support the use of an empirical approach before laparoscopy.^{4–6} Such an approach has been justified on the basis of the risks of the procedure and the possibility that pain will not be relieved even if surgery is undertaken, and that ongoing medical therapy will be necessary.⁷ Additionally, there would be the potential for harm if even 20% of adolescents with dysmenorrhoea were to undergo laparoscopy. A laparoscopy is an invasive procedure that may have unexpected consequences: performing extensive biopsies or peritoneal stripping could potentially lead to adhesion formation and impaired fertility.

Further considerations concern patients and doctors alike. Women have stated that they find diagnostic laparoscopy reassuring because it either confirms or rules out endometriosis.⁸ Surveys of women with established endometriosis have reported delays of up to 12 years between the onset of pain symptoms and the surgical diagnosis of endometriosis.⁹ Some women are frustrated about these delays, and there have been calls for such delays to be avoided through greater education of health professionals, changes in guidelines and increased access to diagnostic laparoscopic services.^{7,10} The assumption underlying these women's frustration is the possibility that when they first experienced pain they already had pathology that was not diagnosed. However, there is no evidence for this, as there are few longitudinal studies of pelvic pain and it is not possible to perform laparoscopy on all women with pelvic pain symptoms. Then there is the concern that the

delay in diagnosis of endometriosis may have an impact on future fertility. But it is possible that the experience of pain as an adolescent is unrelated to a later diagnosis of endometriosis.

So, on the one hand, clinicians are increasingly being asked to investigate women with pelvic pain, yet, on the other hand, the likelihood of pathology is less than 50%, especially in the adolescent age group. Furthermore, treatment of dysmenorrhoea can be initiated without a firm diagnosis. Decision making is thus a trade-off between missing a pathological condition and overinvestigation.

In the light of current evidence, what is a reasonable management approach to women who present with pelvic pain? In adolescents with dysmenorrhoea, the first-line strategy should be to prescribe non-steroidal anti-inflammatory drugs (NSAIDs) with the oral contraceptive pill. Both of these have been found to reduce the experience of pain and reduce days of absenteeism.^{11,12} Avoiding menstruation by skipping the non-hormonal pills and allowing bleeding only 3–4 times a year is another useful strategy, although some women will experience breakthrough bleeding. Reassurance should be given that the experience of dysmenorrhoea is normal and that serious pathology such as advanced endometriosis is unlikely to arise during the adolescent years. Women who fail to respond to first-line approaches may need to consult a gynaecologist for consideration of a laparoscopy. For women in their 30s and 40s with pelvic pain, doctors should be aware of the increasing likelihood of underlying pathology. New or worsening symptoms can initially be managed with simple strategies such as the use of NSAIDs and oral contraceptives, but women who fail to respond to these should be referred to a gynaecologist earlier rather than later, especially if they wish to conceive in the future. Finally, there is a small group of women with chronic pelvic pain who have had repeated surgery and may suffer from a form of neuropathic pain. Such patients generally require the help of a multidisciplinary team that should include gynaecologists, psychologists, pain specialists and physiotherapists.

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