Recent advances in understanding and managing chronic pelvic pain in women with special consideration to endometriosis. Ball E, Khan K s. 04 Feb 2020, 9(F1000 Faculty Rev):83 (https://doi.org/10.12688/f1000research.20750.1)

May 2020  Pelvic Physiotherapy Distance Journal Club

I. INTRODUCTION
A. Defining Chronic Pelvic Pain (CPP) – cyclic or non- cyclic pain in the pelvis lasting greater than 6 months. Aspects of pain may include dysmenorrhea, dyspareunia, dysuria, dyschezia.
B. CPP affects up to 24% women worldwide
C. Constitutes up to 20% of all Gyn consults
D. Large societal cost in $ and sick leave; in US – direct costs up to $12,118/year, indirect costs-$15,737
E. Often occurs after a bout of acute pain, no longer structural rather idiopathic cause
F. Brain changes are noted in patients with endometriosis but not patients with CPP.
G. Surgical stats in patients with endometriosis: 20-25% - no reduction in pain, 25.5% repeat surgery within 2 years, 40-50% repeat surgery at 5 years
H. NEEDED: Evidenced based treatment program to include a multimodal, holistic approach in conjunction with surgical interventions.
I. “CPP is a chronic, idiopathic, and incurable but successfully treatable condition.”

II. RECENT ADVANCES IN MANAGEMENT OF ENDOMETRIOSIS
A. One of most common causes of CPP is endometriosis; affect 6-10%of reproductive age women.
B. Typical pain management- pain meds, hormonal interventions, surgical excision of lesions
C. 7-9 year delay in diagnosis.
D. No specific biomarkers to assess for condition.
E. Research priorities- improved treatment, non-invasive prediction model.
F. PCM record review: Correlation between pain, menstrual symptoms and lower GI symptoms within 90 days of gyn pain- predictor of endometriosis years prior to formal diagnosis.
G. “Normal” (standard) US not a diagnostic tool. Specialized US proving promising. (4-D US?)
H. Newer evidence (NICE guidelines: More severe disease with increased pain as disease invades pelvic organs)
I. Team approach in UK: Gyn, Uro, Colorectal surgeons, fertility specialists, specialist nurses
J. RCT 39 women with endometriosis- 80% improvement with surgery
K. NIHR – sponsored trial – purpose to create predictive algorithm underway
L. * Surgery must be complete to excise all deep infiltrating lesions
M. Residual pain potential causes: reoccurrence of lesions, adenomyosis, IBS, bladder pain syndrome, pain memory
N. Current RCT – role of progesterone-containing contraceptives in reducing recurrence post surgically.

III. ARE THERE EFFECTIVE HOLISTIC AND PSYCHOLOGICAL APPROACHES TO ENDOMETRIOSIS AND CPP?
A. Diet – largest RCT n=3800 nurses, results: women consuming red meat had 56% increased
risk of endometriosis; need trials looking at milk products
B. Exercise- endometriosis is both inflammatory and estrogen-dependent- both affected by exercise-authors state research does not show levels of significance
C. Acupuncture – 1 study supporting lower dysmenorrhea score; 2 other studies were unable to be meta-analyzed secondary to methods of reported data. A well-designed study using acupuncture for endometriosis pain is underway.
D. Psychological interventions- 3RCT:
   1. Relief with Chinese medicine, hypnotherapy, cognitive behavior therapy, and mindfulness.
   2. Daily pain reduced with Yoga
   3. Progressive Muscle Relaxation group (PMR) – significant relief of anxiety, trait anxiety, and Depression
   4. Awaiting results of study on mindfulness and CPP reduction

IV. RECENT ADVANCES IN MANAGEMENT OF CHRONIC PAIN
   A. Diagnostic tools – Laparoscopy ‘gold standard’ test for endometriosis, MRI shown NOT to be accurate diagnostic tool
   B. Cochrane relief of non surgical treatments- Meds: progesterone cause bloating and weight Gain; other med combinations have not proved helpful or not well researched
   C. Pain management -GAPP study underway- titrated dose of Gabapentin; physiotherapy-myofascial trigger points, pelvic floor relaxation, biofeedback

V. CONCLUSION
   While advancements in improved disease awareness, early diagnosis, and treatment are being made, evidence of non-surgical intervention for pain management utilizing a multidisciplinary group appear to be the most efficacious for patient relief. As always, more RCT are needed.

Strengths: Multiple studies cited
Weakness: Poor coverage of physiotherapy

1. Are there specific tests/measures that we can use to objectify pelvic pain, to be better able to record changes post treatment (allowing for better quality research)?
2. Are we as PTs getting involved in early intervention of CPP, i.e. the teen with LBP/LE pain cyclically?
3. We can we do to educate researchers and providers as to our intervention skills?
4. Do we have the training to get involved with mindfulness training or cognitive behavioral therapy?
5. What pain education resources are you using for your patients?

Additional Resources: