Persistent pelvic pain service

Practitioner toolkit

The following signs and symptoms may suggest persistent pelvic pain (PPP)

- pain experienced by patient on most days for more than 6 months
- pelvic pain that persists after initial cause gone
- complicated pain symptoms – multiple pain issues, eg, fibromyalgia, IBS, painful bladder syndrome (PBS), migraines, non-specific symptoms, hyperalgesia/allodynia
- pain accompanied by fatigue/feeling unwell/headaches
- multiple tests all returning normal results
- multiple treatments with limited success.

Patients who present with these signs/symptoms can be referred to the Jean Hailes PPP Service

(Patients can also self-refer, as initial consultation will be with a PPPS women's health specialist GP.)

PPPS referral steps

1. Write referral.
2. Direct patient to contact the Jean Hailes Clinic on (03) 9562 7555 for the PPP Service.
3. The patient will be asked to complete and return a pelvic pain questionnaire before an appointment will be made.
4. Direct patient to the Jean Hailes website (jeanhailes.org.au), or the Pelvic Pain Foundation of Australia website (pelvicpain.org.au) to begin persistent pain education.

Jean Hailes Persistent Pelvic Pain Service

Initial appointment with Jean Hailes Women's Health Specialist GP (1 hour) includes:

- review of questionnaire and any procedure results
- patient's pain journey
- detailed history and examination, with particular attention to reproductive, genitourinary and gastrointestinal systems
- organise high-quality gynaecological ultrasound (COGU specialist) if not already done, and other tests as needed
- introduce concept of PPP and multidisciplinary team (MDT) approach
- discuss and initiate management options, such as menstrual suppression (aim for amenorrhoea) analgesia and initial pain education
- organise timely review
- consider referral to other PPPS practitioners as needed.

Other members of the PPPS team

GYNAECOLOGIST	NATUROPATH/ MEDICAL ACUPUNCTURIST	PAIN PHYSICIAN	PHYSIOTHERAPIST	PSYCHOLOGIST
• possible endometriosis • laparoscopy • complicated menstrual issues.	• exploring alternative and complementary approaches.	• more complex management needs • consideration of intervention, including nerve blocks.	• musculoskeletal or pelvic muscle component • vulvodynia • vaginismus and dyspareunia • bladder/bowel dysfunction.	• address negative pain behaviours, such as distress and avoidance • develop coping strategies • address any mood disorders.

Medication options for managing PPP

Amitriptyline

- Tricyclic antidepressant – a nerve stabiliser in low doses
- About 50% of women find it useful
- Can help with pelvic muscle overactivity, stabbing pain, irritable bladder and bowel symptoms, bloating, poor sleep and vulvodynia.

Dose

- Start at low dose (5-10mg) 3 hours before bed.
- Increase gradually (5-10mg increments) over 6 weeks, until symptom relief or intolerable side effects.

Side effects

- Dry mouth, constipation, drowsiness.

Caution

- Category C in pregnancy.

Duloxetine/other SNRI/SSRIs

- SNRI effects – increase norepinephrine effect in brain, which treats pain
- SSRI effects – increase serotonin effect in brain, which treats anxiety
- Duloxetine, venlafaxine and desvenlafaxine have both SNRI and SSRI effects.

Dose

- Start dose at 30mg and increase gradually to 60mg.
- Half dose/15mg dose achieved by opening capsule, discarding half the granules and closing capsule to swallow.

Side effects

- Nausea, diarrhoea, weight changes, insomnia, sexual dysfunction.

Caution

- Category B3 in pregnancy.

Pregabalin and gabapentin

- Neuroleptics useful for sharp, stabbing and burning pain.
- Less sedating than Amitriptyline.

Dose

- Start with low dose and gradually increase when side effects settle.

Pregabalin

- Start 75mg or dissolve 75mg in 1 cup of water so that 1/3 cup = 25mg.
- Gradually titrate up to 150-600mg in divided doses.

Gabapentin

- Start at 100mg nocte, increase by 100mg nocte dose until 300mg before adding daytime doses.

Side effects

- Dizziness, sleepiness, weight gain, bowel disturbance, memory impairment.

Caution

- Category B3 in pregnancy.

Opioids

- Useful for short-term pain relief/flares (days rather than weeks)

Caution

- Longer-term use is associated with tolerance, addiction, sensitisation, overdose.

Addressing potential components of PPP

Functional gastrointestinal disease (FGID)

Low abdominal/pelvic pain often towards left side, associated with bloating and variable bowel habit.

Rule out pathology – 'red flags' include rectal bleeding, weight loss, iron deficiency, history of bowel cancer risk.

Investigations

- FBE, CRP (exclude infections/ inflammatory disease), iron studies, LFT, U&E, Ca
- Coeliac serology, H. pylori serology (upper GI symptoms), faecal calprotectin (lower GI symptoms – exclude inflammatory bowel disease)
- Refer for colonoscopy for red flags or persistent symptoms.

Treatment

- Lifestyle – regular exercise, stress management, avoid overeating or eating rapidly
- Dietary – minimise irritants (caffeine, alcohol, spicy /fatty foods, artificial sweeteners)
- Soluble fibre – oats, peas, beans, apples, citrus fruits, carrots, barley, psyllium
- Supervised FODMAP diet
- complementary
  - peppermint oil capsules taken 3-4 times daily, or peppermint tea
  - Iberogast liquid, 20 drops 2-3 times daily
- pharmacological
  - antispasmodics – hyoscine (buscopan), Mebeverine (colofac – to be effective, needs to be used on a longterm basis tds)
  - affecting transit rates: loperamide transit time, prucalopride
  - pain-modifying meds: TCA, low dose (sleep benefit), SSRIs, especially if comorbid depression.

Painful pelvic muscles

Pain is often described as being sharp or stabbing, aggravated by high-intensity exercise/ core strengthening, internal examinations, sex, stress; relieved with lying down, foetal position, heat packs.

- Physical examination, if indicated, can show increased resting tension throughout pelvic floor muscles, with tenderness and inability to relax
- Perineal/anal indrawing – may be vaginismus with speculum/ examination
- Allodynia on vulval sensory testing.

Treatment

- Walking/dancing/ swimming/yoga, starting small and building up
- NOT pelvic floor tightening, core training, high impact, boot camp, Cross-fit or HIIT
- Pelvic floor muscle stretches – see www.jh.today/ PPF_stretch
- Education in pelvic muscle relaxation with a specialised women's health physio
- Avoid intercourse if painful.

Painful bladder symptoms

Often urinary frequency, urgency and possible incontinence associated with painful bladder filling, irritative symptoms diagnosed as frequent UTI without MCS testing.

Investigations – diagnosis of exclusion

- MSU M&C
- urethral/vaginal swabs
- consider cystoscopy, urodynamics, renal/pelvic ultrasonography.

Treatment

- A program of dietary and fluid management, time and stress management, and behavioural modification
- amitriptyline – starting at 5 mg three hours before bedtime, increasing slowly up to 25 mg if required
- mirabegron (betmiga®) 25 or 50mg, taken once a day
- oxybutynin (Ditropan) 5mg 2-3 times daily
- complementary therapies (eg, acupuncture, hypnosis, pelvic floor massage).

Vulvodynia

- Chronic vulval pain can be localised or generalised, provoked or unprovoked
- Often little to see on examination
- Check for infection, dermatoses, atrophic vulvovaginal changes, trauma, potential neoplasia
- Trial of suppression for chronic candidiasis (can check with low vaginal swab, speculum not needed)
- Sensory testing with cotton tip (Q-tip test) – can have marked tenderness around inner vaginal vestibule
- The diagnosis of vulvodynia is clinical.

Treatment

- good genital skincare
- avoid triggers
- team approach may be necessary with patient referral for medical, psychological and physiotherapy treatment and dietary advice to address different facets of pain
- topical treatments can include oestrogen; compounded neuromodulators; short-term use of local anaesthetic pre-sex
- systemic treatment includes low dose (5-25mg) amitriptyline early each evening, or duloxetine (15-60mg); neuromodulators.

Management of acute flare of persistent pelvic pain

The principles of management are to:

- exclude acute intra-abdominal pathology such as appendicitis, ectopic pregnancy, ovarian cyst accident with directed history, examination and investigations. Ultrasound (transvaginal if appropriate) is the best imaging modality to define acute pelvic pathology
- confirm symptoms are consistent with an exacerbation of long-term pain
- recognise and manage the likely trigger for the recent flare of pain. Triggers can include:
  - urinary – UTI; acute retention
  - GIT – constipation
  - gynaecological – menstruation; ovulation; ovarian cyst; PID
  - musculoskeletal – pelvic muscle spasm
  - vulval – acute vulvovaginitis
  - systemic illness, psychological distress.
- reassure patient and reduce fear with an explanation about acute exacerbation and likely trigger
- suggest non-pharmacological approaches such as heat packs, mindfulness, deep breathing 6/minute, pelvic muscle stretches (www.pelvicpain.org.au/for-women/easy-stretches-to-relax-the-pelvis-women).
- stepwise analgesia
  - oral ibuprofen/paracetamol; IV parecoxib/paracetamol or PR diclofenac if vomiting
  - Pregabalin 25-75mg orally may be helpful if central sensitisation likely
  - for acute pelvic floor muscle spasm, can use 5mg diazepam PV/PR
- opioids increase central sensitisation when used regularly and should be avoided where possible, when acute pathology is excluded
- if required – tramadol 50-100mg PO or slow IV (beware of serotonin syndrome with concominant use of SSRI/SNRIs)
  - Tapentadol IR 50mg PO
  - If opioids prescribed, only give enough tablets for 3 days use; use in conjunction with aperients such as Movicol
  - If patient already using prescribed opioids, main practitioner should remain the sole prescriber
- provide education and emphasis on self-management
- encourage gentle mobilisation rather than bedrest to reduce muscle spasm
- have appropriate and timely follow-up.

Jean Hailes FOR WOMEN'S HEALTH

1800 JEAN HAILES (532 642)
jeanhailes.org.au

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