Surgical Evaluation and Treatment of the Patient with Chronic Pelvic Pain

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KEYWORDS

- Diagnostic laparoscopy and chronic pelvic pain
- Conscious laparoscopic pain mapping • Hysterectomy and chronic pain
- Presacral neurectomy • Laparoscopic uterine nerve ablation
- Adhesions and chronic pain

KEY POINTS

- Evaluation of the patient with chronic pelvic pain requires a detailed patient history, physical examination, ultrasonography, and pain diary.
- Nongynecologic sources of pelvic pain should be addressed concurrently. For example, constipation should be treated at the same time as cyclic dysmenorrhea.
- Diagnostic surgical evaluation should be offered to patients who have obvious abnormality on ultrasonography, in whom medical management has failed, or in whom the acuity of pain warrants an urgent diagnosis.
- Diagnostic laparoscopy and conscious laparoscopic pain mapping are useful in the surgical evaluation and treatment of chronic pelvic pain.
- Surgical treatments including excision of endometriosis, adhesiolysis, hysterectomy, and presacral neurectomy have been shown to provide relief to select patients. The possibility of persistent pain and new adhesion formation should be discussed with any patient considering surgery.

INTRODUCTION

Most gynecologists consider the definition of chronic pelvic pain to be pelvic pain of 6 months' duration. The subjective nature of pain makes studying pelvic pain with well-designed studies inherently difficult. Complicating matters, investigators of chronic pelvic pain often use variable definitions that include cyclic, intermittent, and noncyclic. In Practice Bulletin no. 51, the American College of Obstetricians and Gynecologists suggests one definition of chronic pelvic pain to be pain of 6 or more months' duration that localizes to the anatomic pelvis, anterior abdominal wall

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at or below the umbilicus, the lumbosacral back, or the buttocks, and is of sufficient severity to cause functional disability or lead to medical care.[1] Approximately 15% to 20% of women aged 18 to 50 years have pelvic pain for longer than 1 year.[1] Despite this prevalence, there are many patients for whom the etiology is unclear.[2]

At the patient's initial consultation, medical and surgical options should be outlined (Fig. 1). Reviewing possible gynecologic, gastrointestinal, genitourinary, and musculoskeletal causes of pain will help the patient understand the importance of documenting alleviating and aggravating influences. Having the patient keep a pain diary for 3 months is helpful to further characterize the pain. Medical options, including nonsteroidal anti-inflammatory drugs, combined oral contraceptives, gonadotropin-releasing hormone agonists, and progesterone therapy may be offered as nonsurgical options, especially if there is a cyclical pattern.[3–8] If the patient suffers from predominantly gastrointestinal or genitourinary symptoms, referral should be made to these specialties to rule out other nongynecologic causes before diagnostic laparoscopy. If these patients return with persistent pain, especially after improvement in these systems, diagnostic laparoscopy may be offered. For the patient suffering from severe, disabling pain or the patient who declines or does not respond to medical therapy, a diagnostic laparoscopy may be offered. This article focuses on surgical interventions that may be offered for chronic pelvic pain, excluding endometriosis (addressed separately in the article by Yeung elsewhere in this issue).

DIAGNOSTIC SURGICAL PROCEDURES

Diagnostic Laparoscopy

The etiology of chronic pelvic pain is not always obvious after thorough history, physical examination, and imaging. Diagnostic laparoscopy can be offered in the absence of abnormality on physical examination or imaging, and has been increasingly used as

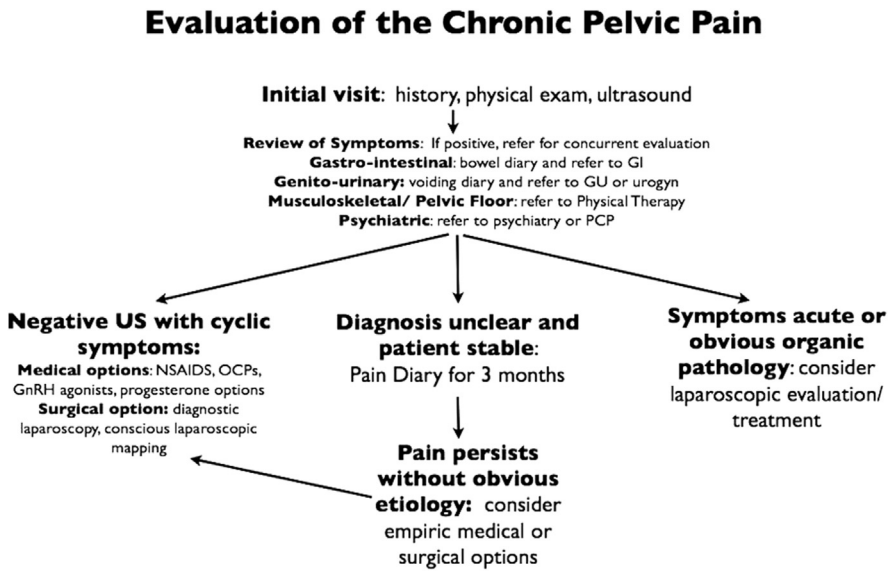

Fig. 1. Pathways of chronic pelvic pain management. GI, gastrointestinal; GnRH, gonadotropin-releasing hormone; GU, genitourinary; NSAIDs, nonsteroidal anti-inflammatory drugs; OCPs, oral contraceptive pills; PCP, primary care physician.