# Pelvic Pain: An Overview

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**KEYWORDS**

• Chronic pelvic pain • Pelvic pain of myofascial origin • Downtraining pelvic floor

**KEY POINTS**

- Although the cause of chronic pelvic pain (CPP) is multifactorial, a substantial number of cases have musculoskeletal and neuromuscular causes.
- Multiple stakeholders, including physicians with varying degrees of pain training ranging from primary care physicians, obstetricians, gynecologists, urologists, neurologists, gastroenterologists, psychologists, physical therapists, and physiatrists, are involved in the care of these patients.
- Unfortunately, little cross-collaboration occurs among specialty providers, and the patient often consults with these varying specialists in sequential order because few interdisciplinary centers exist.
- Physiatrists play a pivotal role in the treatment of patients with CPP because their training focuses on improving quality of life through a holistic approach to patient management and on the musculoskeletal and neuromuscular systems.

Pelvic pain is defined as pain localizing to the pelvis, the anterior abdominal wall at or below the umbilicus, the lumbosacral back, or the buttocks.[1] Acute pelvic pain has a sudden onset that requires prompt diagnosis and expeditious treatment. Chronic pelvic pain (CPP) is constant or recurring and arbitrarily defined as lasting for more than 6 months and frequently carries significant physical, functional, and psychological burdens that negatively affect quality of life (QoL). Consequently, the management of patients with CPP is drastically different from that of acute pelvic pain and can be very challenging. CPP is a multifactorial condition with overlapping causes driven by visceral, somatic, as well as complex pelvic neural circuitry.[2] More than 70 different diagnoses[3] are associated with CPP, with most patients often suffering from coexisting bowel, bladder, and sexual dysfunction. Multiple stakeholders, including physicians with varying degrees of pain training ranging from primary care physicians, obstetricians, gynecologists, urologists, neurologists, gastroenterologists, psychologists, physical therapists, and physiatrists, are involved in the care of these patients.

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The authors have nothing to disclose.

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## EPIDEMIOLOGY

Although CPP affects women of all ages, epidemiologic studies of CPP have been hampered by a lack of a unifying definition, unclear cause and pathophysiology, and the absence of a definitive diagnostic marker. Overall, the prevalence of CPP in women ranged between 5.7% and 26.6% worldwide.[4] More than 15% of women experience CPP for over a period of 1 year,[5] with the average duration of symptoms of 2.5 years.[6] Lifetime prevalence may reach 33% in women. There is no significant correlation with mean gravidity and parity, rates of elective abortion, race, or mean educational level.[7] Annually, approximately 400,000 laparoscopies are performed to evaluate CPP with 40% of patients having negative results.[1] The prevalence by CPP subtype varies with endometriosis in 11% of reproductive age women, interstitial cystitis or painful bladder syndrome ranging from 1.2 to 4.5 per 100,000[8] to as high as 1 in 4.5 women,[9] vulvodynia from 8.3%[10] to 16%,[11] and pelvic floor myofascial pain from 9% to 24%.[12] Pelvic floor myofascial pain often coexists in patients with these subtypes of CPP. For example, more than 50% of patients with endometriosis also have pelvic floor myofascial pain.[13] CPP also afflicts men, with a worldwide prevalence of 2% to 16% in those less than 50 years old.[5]

## DISABILITY

Patients with CPP have a significantly poorer QoL. The Short Form 36 Health Survey Questionnaire (SF-36) is the most frequently used subjective measurement of QoL in CPP studies.[14] SF-36 scores are inversely proportional to the degree of pelvic pain. In other words, higher pain scores correlate with lower QoL. Physical function, bodily pain, general health, vitality, social function, and mental health scores are lower among women with CPP.[15] Urinary symptoms, including frequency, nocturia, and dysuria, also negatively impact both men and women with CPP. In addition, sexual dysfunction secondary to pain and discomfort related to intercourse is common to both genders. However, overall, women with CPP are less sexually active than men.[16] Bowel dysfunction such as irritable bowel syndrome is also prevalent[17–20] and can significantly decrease QoL. Women with a history of physical and sexual trauma have a significantly higher rate of CPP and experience more posttraumatic stress,[21] which can further impair their mental health QoL.[22] These women experience a higher incidence of sleep disturbances as well as limitations of mobility.[23,24]

### *Risk Factors for Chronic Pelvic Pain*

Multiple factors can predispose a patient to the development of CPP. A list of risk factors that have been identified follows[25]:

- Trauma/microtrauma
  - Timing may be remote or recent
  - In many cases, the specific trauma or inciting event may not be identified
- Vaginal or urinary tract infections
- Pregnancy and childbirth (vaginal or operative delivery)
- Musculoskeletal problems affecting the back, hips, and legs or pelvic girdle