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Pelvic pain: a pathway for care developed for both men and women by the British Pain Society

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Editor's key points

- The British Pain Society has described pathways for different pain conditions.
- This special article complements the pathway developed for pelvic pain.
- Importantly, the article highlights some controversial and ill-understood areas of management of pelvic pain.
- The role of interventions, such as opioids and neuromodulation, is also discussed.

Summary. This paper aims to explain the key points and highlight some of the controversies in the development of the British Pain Society's pelvic pain patient pathway map. Many clinicians lack experience and confidence with this group of patients, and this issue is highlighted. Additionally, the difficulties of classification and definitions in this area are discussed in detail. These are historical causes of disagreement among specialists which can lead to confused clinical care. This group of patients have multiple issues that cross many professional boundaries; they are best managed by the co-ordinated involvement of multiple teams. Patients suffer from significant distress and disability that often needs specialist assessment and intervention (interdisciplinary). This suggests that an integrated approach is required across the historic boundaries of primary and secondary care. A variety of interventions, including opioids and neuromodulation are recommended in the pathway and the controversies surrounding these inclusions are aired in detail.

Keywords: chronic pain; chronic pelvic pain syndrome; pelvic floor disorders; pelvic pain; urogenital pain

This paper aims to review the key points and controversies around the British Pain Society's (BPS's) chronic pelvic pain patient pathway map (for men and women).[1] This pathway is one of an initial series of five, with the intention of improving and streamlining the delivery of timely, evidence-based and individualized care.[2–5] The pathways can be accessed through the BPS's website.

The principal focus of the pelvic pain pathway is on the initial non-specialist management of patients with pain perceived within the pelvis, and thereafter understanding pathways and timelines for onward referral to secondary and specialized tertiary care. To our knowledge, there are no comprehensive interdisciplinary and multispecialty guidelines of this sort for the generalist and as a consequence, we consider them as a major step forward in the management of this complex and potentially expensive to support group of patients.[6–9]

Whereas this work is intended to be complimentary to other guidance such as the National Institute of Health and Clinical Excellence (NICE) and the Chronic Pelvic Pain guidelines of the European Association of Urology (EAU),[10–12] we feel that this pathway has the benefit of being truly between teams and multispecialty and having a clear evidence base. All the BPS pathways have been commissioned by an Executive Working Group of the BPS consisting of BPS council members and co-opted experts. The five initial pathways were chosen for the following reasons:

- High burden of disease volume of patients attending non-specialist and specialist clinics.
- Unwarranted variation in care, that is a lack of uniform approaches to assessment and initial management as evidenced by the variability of referrals to specialists.
- Uncertainty as to application of the evidence base; thus, best value for patients was unclear.

The pathway has been developed in collaboration between the Map of Medicine editorial team, representatives of the BPS, and independent reviewers. The pathway is based on well-reputed secondary evidence, as selected in accordance with the Map of Medicine's editorial methodology for developing care pathways. Practice-based knowledge has been added by clinicians nominated by the BPS and by independent reviewers identified by the Map of Medicine editorial team. For the detailed editorial methodology see the pain pathway's provenance certificate (www.mapofmedicine.com). Map of Medicine care pathways can be customized to reflect local commissioning needs and practices to provide comprehensive, evidence-based local guidance and clinical decision support at the point of care. As with all the papers in this series, this article is complementary to the published pathway.

Practice point: care map information

In many ways, the supporting information behind the pathway tree (which is published as an integral part of the care map) is the most important part of the pelvic pain pathway as for most clinicians, the basic principles are unfamiliar. It is because of a lack of understanding of basic facts that treatment is often inappropriate.[10 11 13–15] There is a potential point of confusion for this pathway because it has to provide the basic principles early on, but an in-depth discussion is also given later in the pathway.

Discussion point: incidence and prevalence of chronic pelvic pain

In the literature figures around the incidence and prevalence of chronic pelvic pain are reported in an inconsistent manner which makes comparison and discussion difficult. The pathway highlights this:

1. (1) First, classifying pelvic pain has not been subject to a standard process for many years and this has only recently been fully addressed.[10 16]
2. (2) Secondly, much of what falls under the general heading of 'chronic pelvic pain' does not reach specialist care and is dealt with through self-management or with the support of primary care.[17]
3. (3) Thirdly, if specialist care is involved in the management, it is often spread between multiple specialities (urology, gynaecology, urogynaecology, colorectal services, pain medicine and even spinal services, rheumatology, and neurology). Patients may pass back and forth between different teams of the same speciality and between different specialities.
4. (4) Finally, there is no simple way of predicting or defining problematic pain.[18]

As a consequence of these issues, we do not have a true knowledge of the incidence or prevalence of chronic pelvic pain.

The pathway also emphasizes that whereas there will be some unique differences between male and female chronic pelvic pain, there are also many overlaps between in mechanisms and presentations;[10] it is common to separate the conditions based both on gender and the site of perceived pain, but this may be artificial.

The best available figures suggest the number of women in the UK with chronic pelvic pain as 1 million (compared with 1.6 million adults with low back pain).[17] Pelvic pain is thus an understated and major problem. A break down of prevalence for more specific terms is found in Table 1.[17]

Practice point: classification

To understand the pelvic pain pathway, it is important to understand the classification of pelvic pain and the significance of inappropriate classification. In particular, the pathway is about early recognition of 'well-defined conditions' that need to be separated from those categorized as 'chronic pelvic pain syndrome'. Pain associated with well-defined conditions requires the underlying process to be investigated and treated: red flags must be identified early and referred to the appropriate speciality either as an emergency (immediate referral) or for an urgent appointment (seen within several weeks).

Failure to accept that a patient's symptoms are primarily of a chronic pelvic pain syndrome may result in inappropriate investigations and treatment leading to a deterioration in the prognosis.[10 13] This classification system, and hence the pelvic pain pathway, emphasizes the importance of assessing and managing not only the pain but also its impact on the patient (psychosocial, behavioural, and sexual) and assessing and managing the multisystem disorders often found in patients of both sexes with chronic pelvic pain.

Practice point: psychosocial, behavioural, and sexual interactions and consequences

In addition to pain, this pathway emphasizes the evidence that these patients also suffer from psychological distress and concurrent negative behavioural and sexual consequences. This is introduced in the Care Map information box, but more details are presented in several of the subsequent key point boxes explaining that patients with pelvic pain often suffer with depression, anxiety, poor sleep, difficulty with work, and

Table 1 Prevalence of some chronic pelvic pain conditions

IASP syndrome	Prevalence	Notes	References
Chronic pelvic pain in women	1 million women in the UK		17
Vulvar pain syndromes	3–18%		19–22
Female dyspareunia	15–20%	Main age 18–29 yr, decreasing by 44 yr. 50% primary dyspareunia. Provoked most commonly in premenstrual women	21, 23–25
Male chronic pelvic pain syndrome	8.2% (range 2.2–9.7%)	Increases with age (men aged 50–59 have a 3.1-fold greater risk than those aged 20–39)	10, 26
Scrotal pain syndrome	Not known	After vasectomy surgery 2–20%. 2–6% have a visual analogue score >5 (/10)	10, 27, 28