

## Chronic Pelvic Pain – Referral Pathway

### Document purpose

- To improve the quality of care for women with chronic pelvic pain by providing an integrated care pathway for management of pelvic pain in women
- To reduce referrals from primary to secondary care
- To reduce the number of consultant to consultant referrals

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### Change Control

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<b>Approved by</b>	<i>To go to Oxfordshire Clinical Commissioning Group</i>		
<b>Notes</b>			
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## 1. Chronic pelvic pain – pre menopausal women

### DIAGNOSIS

**Chronic pelvic pain (CPP)** can be defined as pain experienced in the lower abdomen or pelvis that has lasted six months or longer.

At presentation in primary care, diagnosis of the cause of CPP in a pre-menopausal woman should be approached as follows: *(NB additional appointment time may be necessary)*

#### 1. Take detailed history

- Nature and duration of pain
- Pattern of provoking or relieving factors, including movement
- Menstrual / bowel / urinary history
- Sexual history *(to establish any current risk or history of sexually transmitted diseases, tactful inquiry about previous sexual trauma may be appropriate).*
- Psychological enquiry

#### 2. Examination

- abdominal
- vaginal

### MANAGEMENT

#### Initial management

##### 1. Pain

Offer analgesia

- Paracetamol
- NSAIDs
- Mild opioids

If pain strikingly cyclical try:

- COCP *OR*
- levonorgestrel-releasing intrauterine systems if COCP contraindicated *OR*
- depo/LARC sub dermal implant *OR*
- cyclical analgesia alone, especially if wanting to conceive

##### 2. Pain suggestive of IBS

see Rome Criteria at:

[http://www.romecriteria.org/assets/pdf/19\\_RomeIII\\_apA\\_885-898.pdf](http://www.romecriteria.org/assets/pdf/19_RomeIII_apA_885-898.pdf)

- Trial of exclusion diet +/-
- Antispasmodics or antidiarrheals

(see NICE Clinical Guideline: <http://www.nice.org.uk/CG61>)

##### 3. Mood/sleep disturbance or other psychological symptoms

- Screen for depression
- Consider referral to counseling services or other appropriate pathway

##### 4. Consider STI screen (Practice or at GUM clinic) to rule out STD/Pelvic Inflammatory Disease if :

- sexually active *AND*
- in new relationship *AND/OR* <25 years old
- Irregular/post coital bleeding/vaginal discharge

*If STI is likely, even if screen negative, suggest empirical standard 2 week treatment for PID (see National Guidelines*

<http://www.google.co.uk/url?q=http://www.bashh.org/documents/3205&sa=U&ei=CFIjT4-gHlel8gPf4KWLCA&ved=0CByQFjAB&usq=AFQjCNErf4djVV5hv9VLP2d77SqQo1NaSA>

<p><b>MANAGEMENT</b></p>	<p><b>5. Concern re. ovarian cysts - refer for trans vaginal USS</b> if examination suggests abnormality, or if patient is concerned about cysts.  <i>See guidelines for the management of ovarian cysts:</i>  <a href="#">Post-menopausal guidelines</a>  <a href="#">Pre-menopausal guidelines</a></p> <p><b>6. If history suggests CPP is movement or posture-related</b> refer to specialist physiotherapy in The Women's Centre (John Radcliffe Hospital)  Tel: 01865 221530 8.30am - 2.30pm (answerphone outside these hours)  Email: <a href="mailto:physiotherapy.womenshealth@orh.nhs.uk">physiotherapy.womenshealth@orh.nhs.uk</a></p>
<p><b>REFER ONLY</b></p> <p><b>Routine</b></p>	<p><b>Referral to the CPP clinic is appropriate if there is:</b></p> <ul style="list-style-type: none"> <li>▪ Failure of one or more appropriate treatments suggested above, ineffective after 3-6 months</li> <li>▪ Complex mixture of symptoms, including psychological</li> <li>▪ Pelvic pain associated with an ovarian cyst (<i>Referral guidelines for the management of ovarian cysts published separately – see link in Appendix 2 below. <b>Check these to inform whether 2WW referral to gynae oncology is appropriate</b></i>)</li> </ul> <p><b>Referral to fertility clinic</b> may be more appropriate if pelvic pain is associated with delay in conceiving</p> <p><b>Referral to a urologist or bowel specialist</b> may be more appropriate in the presence of prominent bladder or bowel symptoms, including rectal bleeding or haematuria</p>
<p><b>Referral letter</b></p>	<p><b>Must include</b></p> <ul style="list-style-type: none"> <li>▪ Reason for referral</li> <li>▪ Detailed history, as described above</li> <li>▪ Previous therapy and length of treatment</li> <li>▪ Results of USS, other interventions or tests</li> </ul>
<p><b>ONGOING MANAGEMENT</b></p>	<p>Once symptoms are well controlled</p> <ul style="list-style-type: none"> <li>▪ Women referred back to primary care for ongoing management.</li> <li>▪ Hormonal treatment, if effective, should usually be ongoing.</li> </ul> <p>If the source of the CPP is found then treatment will focus on the cause. If no cause can be found, treatment for CPP will focus on managing the woman's pain.</p> <p>It may be helpful to advise women presenting with CPP that the cause may be hard to find: in some cases a specific diagnosis to explain the pain may never be found.</p>
<p><b>ADDITIONAL INFORMATION</b></p>	<p>RCOG guideline: Chronic Pelvic Pain, Initial Management (Green-top 41)  <a href="http://www.rcog.org.uk/womens-health/clinical-guidance/initial-management-chronic-pelvic-pain-green-top-41">http://www.rcog.org.uk/womens-health/clinical-guidance/initial-management-chronic-pelvic-pain-green-top-41</a></p> <p>RCOG patient information:  <a href="http://www.rcog.org.uk/womens-health/clinical-guidance/long-term-pelvic-pain-information-you">http://www.rcog.org.uk/womens-health/clinical-guidance/long-term-pelvic-pain-information-you</a></p> <p>Baranowski AP. Chronic pelvic pain. <i>Principles of Clinical Gastroenterology</i> 2009;23(4):593-610  <a href="http://blog.cardiacforum.org/2009/08/download-principles-of-clinical-gastroenterology-free-rom-rapidshare/">http://blog.cardiacforum.org/2009/08/download-principles-of-clinical-gastroenterology-free-rom-rapidshare/</a></p> <p>Vercellini P et al. Chronic pelvic pain in women: etiology, pathogenesis and diagnostic approach. <i>Gynecological Endocrinology</i> 2009;25(3):149-158  <a href="http://informahealthcare.com/doi/abs/10.1080/09513590802549858?journalCode=gye">http://informahealthcare.com/doi/abs/10.1080/09513590802549858?journalCode=gye</a></p>

## Appendix 1: Rome III Criteria

[http://www.romecriteria.org/assets/pdf/19\\_RomellI\\_apA\\_885-898.pdf](http://www.romecriteria.org/assets/pdf/19_RomellI_apA_885-898.pdf)

### Rome II criteria C. Functional Bowel Disorders

*\*Diagnostic criterion*

#### **C1. Irritable Bowel Syndrome**

Recurrent abdominal pain or discomfort\*\* at least 3 days/month in the last 3 months associated with **two or more** of the following:

- Improvement with defecation
- Onset associated with a change in frequency of stool
- Onset associated with a change in form (appearance) of stool

\* Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

\*\* "Discomfort" means an uncomfortable sensation not described as pain.

In pathophysiology research and clinical trials, a pain/discomfort frequency of at least 2 days a week during screening evaluation is recommended for subject eligibility.

#### **C2. Functional Bloating**

Must include **both** of the following:

- Recurrent feeling of bloating or visible distension at least 3 days/month in the last 3 months
- Insufficient criteria for a diagnosis of functional dyspepsia, irritable bowel syndrome, or other functional GI disorder

\*Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

#### **C3. Functional Constipation**

1. Must include **two or more** of the following:

- a. Straining during at least 25% of defecations
- b. Lumpy or hard stools in at least 25% of defecations
- c. Sensation of incomplete evacuation for at least 25% of defecations
- d. Sensation of anorectal obstruction/blockage for at least 25% of defecations
- e. Manual manoeuvres to facilitate at least 25% of defecations (e.g., digital evacuation, support of the pelvic floor)
- f. Fewer than three defecations per week

2. Loose stools are rarely present without the use of laxatives

3. Insufficient criteria for irritable bowel syndrome

\*Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

#### **C4. Functional Diarrhoea**

Loose (mushy) or watery stools without pain occurring in at least 75% of stools

\* Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

### **C5. Unspecified Functional Bowel Disorder**

Bowel symptoms not attributable to an organic aetiology that do not meet criteria for the previously defined categories

\*Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

### **D. Functional Abdominal Pain Syndrome**

Must include **all** of the following:

- Continuous or nearly continuous abdominal pain
- No or only occasional relationship of pain with physiological events (e.g., eating, defecation, or menses)
- Some loss of daily functioning
- The pain is not feigned (e.g. malingering)
- Insufficient symptoms to meet criteria for another functional gastrointestinal disorder that would explain the pain

\*Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

## **Appendix 2: Management of ovarian cysts**

See:

1. *Referral guidelines for the management of ovarian cysts in premenopausal women:*

[Pre-menopausal guidelines](#)

2. *Referral guidelines for the management of ovarian cysts in postmenopausal women:*

[Post-menopausal guidelines](#)