Acknowledgements:
This document was created with support from the Orlando VA Healthcare System, Veterans Health Administration Office of Women's Health-Reproductive Health, and the International Pelvic Pain Society. The following collaborators were involved in developing this guide: Dr. Georgine Lamvu, Dr. Jorge Carrillo, Dr. Jessica Feranec, Dr. Chensi Ouyang, Dr. Alicia Christy, Dr. Elizabeth Patton, and Dr. Amanda Johnson

How to cite this document:
Lamvu G, Carrillo J, Feranec J, Ouyang C, Christy A, Patton E, Johnson A. Chronic Pelvic Pain Evaluation and Management Guide. Available open access online at www.pelvicpaineducation.com, 2022.

CHRONIC PELVIC PAIN EVALUATION GUIDE

For Patients with Persistent Pelvic Pain Associated with Disability and Distress

1 Biopsychosocial History and Physical

History: Pain history, pain burden, pain co-morbidities, contributing factors, consequences of pain, general history (medical, surgical, gynecologic) sexual history, medications, prior pain treatments.

Examination: General mood, affect, and mobility; external musculoskeletal and neurosensory evaluation;, external visual and neurosensory genital evaluation; internal single digit examination, speculum

2 Red flag symptoms screen

Fevers, vomiting, rectal bleeding, hematuria, unexplained weight loss, foul vaginal discharge, abnormal vaginal bleeding not related to menstruation, acute onset pain, pelvic mass, new onset pain after age 50.

YES: Begin evaluation for systemic or visceral disease.

NO: Begin evaluation for chronic / persistent pelvic pain (step 3).

3 Basic diagnostic testing for pelvic pain

Pregnancy test, urinalysis, vaginal swabs and pap if needed, pelvic ultrasound. Cystoscopy, colonoscopy, endometrial biopsy are only indicated if red flag symptoms are present.

4 Assess for conditions associated with persistent pelvic pain based on symptoms

Gastrointestinal

e.g., Irritable Bowel Syndrome (IBS), constipation, diarrhea
Symptoms: pelvic pain before or after defecation ± changes in bowel movements frequency or appearance of stool

Urinary

e.g., Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS), incontinence
Symptoms: pelvic pain before or after urination, urgency, frequency, dyspareunia, negative urinalysis

Musculoskeletal

e.g., Pelvic myalgia or dysfunction
Symptoms: pelvic pain with activity, dyspareunia, ± urgency or frequency, ± constipation, myofascial tenderness.

Gynecologic

e.g., Dysmenorrhea, endometriosis
Symptoms: pelvic pain ± worsens with menstruation, ±dyspareunia,± irregular menstrual bleeding, uterine tenderness

Neurologic

e.g., Neuralgias, neuropathy
Symptoms: pelvic pain ± burning sensation, radiates along dermatomes, ± hyperalgesia, ± allodynia

5 Assess for signs of central sensitization

Multiple pain sites / syndromes, hyperalgesia, allodynia, sleep and mood disturbance, debilitating cognitive distortions, e.g., catastrophic thinking, rumination.

CHRONIC PELVIC PAIN THERAPY GUIDE

For Patients with Persistent Pelvic Pain Associated with Disability and Distress

6 Education

Pain neuroanatomy, reconceptualize fear of pain, assess learning style then recommend self education through www.pelvicpaineducation.com. Establish treatment expectations for multi-modal therapy and multiple visits over time. Discuss short and long-term goals (functional goal setting) and self-care.

7 Multi-modal therapy selection

Select best ***combination of therapies based on patient needs***. Journals and diaries can be used to emphasize adherence and determine progress.

Pharmacotherapy	Interventional	Physical Rehabilitation	Psychological	Self-care
Analgesics	Neuromodulation	Physical therapy (PT)	Mood, mental health therapy	Diet
Disorder specific therapies	Trigger point injections	Occupational therapy	Sleep therapy	Exercise
Muscle relaxants	Anesthetic blocks	Massage	Coping mechanisms	Sleep
Hormone therapy	Bladder instillations	Chiropractic therapy	Interpersonal relationships	Stress management, meditation, mindfulness
Targeted GI therapies	Photobiomodulation		Environmental stressors	
Mood stabilizers	Acupuncture		Sexual therapy	Support systems
	Surgery			

Disorder Specific Therapies

IBS-constipation: fiber, water, stool softeners, laxatives, pro-biotics, Linaclotide, Lubiprostone, Tegaserod.
IBS-diarrhea: fiber, loperamide, probiotics, antispasmodics (dicyclomine, peppermint oil), TCA antidepressants, Rifaximin, Eluxadoline, Alosetron.
IC/BPS: avoid dietary irritants, pelvic PT, amitriptyline, cimetidine, hydroxyzine, pentosan Polysulfate sodium (be aware of side effects), bladder instillations, hydrodistension, botulinum toxin A, neuromodulation.
Chronic Low Back Pain: NSAIDS, physical therapy, tramadol, duloxetine, muscle relaxants, radiofrequency ablation, neurostimulation.
Myalgias: NSAIDS, muscle relaxants, physical therapy, trigger point injections (saline, lidocaine or botulinum toxin), acupuncture.
Neuralgias: anticonvulsants, anesthetic blocks, pelvic PT, neuromodulation, radio-frequency ablation, surgical decompression.
Fibromyalgia: PT, exercise, milnacipran, duloxetine, pregabalin.
Endometriosis: continuous suppression with OCPs, progestins (pills, IUD), GnRH analogues (antagonists or agonists), aromatase inhibitors, ± laparoscopic excision, hysterectomy.
Pelvic Vascular Insufficiency/Congestion: continuous hormonal suppression, venous occlusion, hysterectomy.
Vulvodynia: Pelvic PT, cognitive behavioral/ sexual therapy, vulvar care, topical estrogen in post-menopause, vestibulectomy.

8 Follow up

Therapies should be implemented for a minimum of 4 weeks. Effectiveness, quality of life, adherence, and goal progress should be assessed every 4-8 weeks after initial treatment. If improved, continue therapy. If not improved, seek consultation from pain specialist and interdisciplinary team and re- assess every 4-8 weeks until improved.