

Why is chronic pelvic pain not on the agenda?

Is it because there hasn't been a patient advocacy organisation to raise and pursue issues on behalf of patients? Is it because there is little understanding of the mechanisms of pain and the impact of chronic pelvic pain on a patient's quality of life? Is it because of attitudes towards pain in women?



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THERE IS NO international agreement on a definition of chronic pelvic pain (CPP). The Royal College of Obstetricians and Gynaecologists (RCOG) has proposed a simple, practical, symptom-based definition of "pain in the lower abdomen or pelvis that is experienced either intermittently or constantly for at least six months". CPP patients may experience pain causing dysfunction and disability, preventing them from performing the most fundamental of body movements such as sitting and standing.

CPP in women is common in the UK with a prevalence in primary care comparable with that of migraine, back pain and asthma.¹ These estimates do not include men with pelvic pain consulting in primary care. The prevalence in the general population is likely to be considerably higher. Around 40% of laparoscopies are carried out for pelvic pain and between one-third and a half of these are negative. However, a negative laparoscopy does not mean absence of disease. Endometriosis is one of the main diagnoses but it has a large variety of appearances and many authorities consider that it is significantly underdiagnosed at laparoscopy.²

Patient experience and access to services

CPP may be gynaecological, urological, gastrointestinal, musculoskeletal or neurological in origin. Musculoskeletal and neurological causes have received little attention. When patients are referred, it is generally to a gynaecologist who may have a limited view of the possible causes of pain. Those who are referred represent just the tip of the iceberg.³ The number of gynaecologists with specialist knowledge of pelvic pain is limited. In a 2006 international chronic pelvic pain survey on access to services and quality of life, patients in the USA were much more likely to be

referred to a neurologist than those in the UK. In France, patients were much more likely to have access to a multidisciplinary team including a pain specialist and physiotherapist. The latter approach was found to be helpful by patients.⁴ Patients in the UK report great difficulty in accessing physiotherapy expertise.

The pain may be due to one or more causes with several factors requiring assessment and treatment. Patients frequently have several coexisting conditions. For example, nodular endometriotic disease in the rectovaginal area may infiltrate or constrict nerves or develop new pain nerves.⁵ Peritoneal adhesions can lead to intestinal obstruction, CPP and infertility. There is a need for greater collaboration between disciplines: gynaecologists, pain specialists and others including allied health professionals.

Another problem is that patients are generally not asked to rate their pain by health professionals in the UK and yet pain is key to the patient experience. Generally, the first question to be asked by close friends and relatives relates to pain, which is a clear indication of the importance of pain relief in people's lives whatever the cause, benign or not. In the USA, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) routinely enquires about pain assessment and management practices, monitoring patient outcomes in both inpatient and outpatient care areas.⁶

Recent developments

During the last 10–15 years significant advances have been made in the understanding of pain mechanisms and the reasons for the development of chronic pain. A great deal more is known about the risk factors for developing chronic and neuropathic pain. Multiple studies suggest that certain groups

TABLE 1

A new pain manifesto from The Chronic Pain Policy Coalition – June 2007

	<i>Patients should</i>	<i>Professionals should</i>	<i>Parliamentarians should</i>
1. Education So that pain education is an integral part of all professional training	Be listened to, treated with respect, and assessed by appropriately trained professionals	Expect pain management to be an integral part of all early education and ongoing professional development	Ensure that the government gives more priority to pain education as an important part of effective chronic pain management
2. Empowerment To support people to make decisions about their condition	Be treated as a partner with healthcare professionals and kept fully informed of diagnosis and treatment options	Be able to provide accurate and accessible information and advice about managing chronic pain	Liaise with the local health sector to improve services for people living with chronic pain
3. Collaboration So that all stakeholders share in a joined-up strategy	Expect to work with their employer, GP and other services to ensure the best health outcomes	Recognise when a person living with chronic pain could gain extra support from their employers and pain management services, and facilitate this as appropriate	Support and encourage the development of local multidisciplinary pain management services and commit to reforming the 'MED 3' sick note
4. Early access To prevent acute pain becoming chronic pain	Be aware of preventive techniques and be given rapid access to appropriate pain services where necessary	Work to adopt care pathways for people at risk of developing chronic pain across the primary, community and secondary sectors	Ensure that the government supports primary care trusts and employers in taking a long-term view on tackling chronic pain
5. Measurement Of pain as the fifth vital sign	Have their pain assessed at the earliest opportunity, on a regular basis and with the same priority as the four vital signs	Use appropriate measurement tools to listen to patients' personal experiences of pain	Campaign for local primary care trusts to adopt pain as the fifth vital sign

of patients who experience moderate-to-severe pain have been undermedicated and not adequately assessed. Populations requiring special consideration include: women; those with a history of chronic and preoperative pain; those who “look healthier”; and those with neuropathic pain. Genetic factors have been linked to the risk of developing chronic postsurgical pain. Chronic pain following surgery can be a risk especially for certain types of surgery and pain management interventions before, during and post-operatively can be helpful in reducing this risk. According to chronic pelvic pain and quality-of-life patient survey data,⁴ patients gain little benefit from existing medications, many of which do little more than take the edge off the pain. Presentations at the recent World Congress on Neuropathic Pain in Berlin stated that less than half of patients gain effective relief with existing monotherapy.⁷

The duty of health professionals

Good Medical Practice (GMC, November 2006) states that doctors must “take steps to alleviate pain and distress whether or not a

cure may be possible”. The Chronic Pain Policy Coalition recently launched “a new pain manifesto” with five pledges for patients, professionals and parliamentarians, which include: education; empowerment; collaboration; early access; and effective measurement of pain (see Table 1).

The International Association for the Study of Pain’s (IASP) theme for 2007–08 is “Pain in women”. There will be many events linked to this theme in the UK and worldwide. Perhaps this will provide an impetus for greater collaboration between disciplines. It is the duty of healthcare providers to recognise those women suffering with pelvic pain and to empower them to take control by providing accessible information and advice. Patients often need time to talk and not always to doctors.⁸ Patients report that talking to others with similar issues is extremely motivating and empowering. For patients to be told to “put up” with constant pain is unhelpful and does not inspire hope or motivation. Patients need a sense of hope. How much pain do we expect people to tolerate in a civilised society? Is it ethical not to act? ✚

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7. Jackson KC. *Pain Pract* 2006;6(1):27-33.
8. Selve S, et al. *Pain* 1998;77:215-25.

RESOURCES

- Pelvic Pain Support Network**
www.pelvicpain.org.uk
- The International Pelvic Pain Society**
www.pelvicpain.org
- The International Association for the Study of Pain (IASP)**
www.iasp-pain.org
- The Chronic Pain Policy Coalition**
www.paincoalition.org.uk
- The European Federation of IASP Chapters (EFIC)**
www.efic.org