



Complete Summary

GUIDELINE TITLE

The initial management of chronic pelvic pain.

BIBLIOGRAPHIC SOURCE(S)

Royal College of Obstetricians and Gynaecologists (RCOG). The initial management of chronic pelvic pain. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2005 Apr. 12 p. (Guideline; no. 41). [60 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Chronic pelvic pain

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide an evidence-based framework for the initial assessment of women with chronic pelvic pain

TARGET POPULATION

Women with chronic pelvic pain

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnostic Assessment

1. Patient history and symptom assessment
2. Physical examination
3. Screening for chlamydia, gonorrhoea, and other sexually transmitted diseases
4. Completion of pain diary
5. Diagnostic laparoscopy
6. Imaging
 - Transvaginal scanning
 - Magnetic resonance imaging
7. Addressing psychological and psychosocial issues

Treatment

1. Ovarian suppression
 - Oral contraceptive pill
 - Gonadotrophin-releasing hormone (GNRH) agonist
 - Levonorgestrel-releasing intrauterine system
2. Smooth-muscle relaxants such as mebeverine for irritable bowel syndrome
3. Referral to relevant healthcare professional for non-gynaecological pain
4. Dietary modification for irritable bowel syndrome

MAJOR OUTCOMES CONSIDERED

- Risk for chronic pelvic pain
- Pain control
- Side effects of treatment
- Accuracy of diagnostic tests

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The Cochrane Library and the Cochrane Register of Controlled Trials were searched for relevant randomised controlled trials, systematic reviews, and meta-analyses. A search of Medline from 1966 to March 2004 was also carried out. The database was searched using the Medical Subject Heading (MeSH) terms "pelvic pain," "dysmenorrhoea," and "chronic disease," including all subheadings. This was combined with a keyword search using the terms "chronic pelvic pain" and "dysmenorrhoea."

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

Ia: Evidence obtained from meta-analysis of randomised controlled trials

Ib: Evidence obtained from at least one randomised controlled trial

IIa: Evidence obtained from at least one well-designed controlled study without randomisation

IIb: Evidence obtained from at least one other type of well-designed quasi-experimental study

III: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, and case studies

IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The recommendations were graded according to the level of evidence upon which they were based. The grading scheme used was based on a scheme formulated by the Clinical Outcomes Group of the National Health Service (NHS) Executive.

Grade A - Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence levels Ia, Ib)

Grade B - Requires the availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendations (evidence levels IIa, IIb, III)

Grade C - Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates an absence of directly applicable clinical studies of good quality (evidence level IV)

COST ANALYSIS

A previously published economic evaluation of the use of gonadotrophin releasing hormone (GnRH) agonists as empirical treatment for cyclical pain prior to laparoscopy demonstrated improved patient and physician satisfaction at reduced cost.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Following discussion in the Guidelines and Audit Committee, each green-top guideline is formally peer reviewed. At the same time the draft guideline is published on the Royal College of Obstetricians and Gynaecologists (RCOG) Web site for further peer discussion before final publication.

The names of author(s) and nominated peer reviewers are included in the original guideline document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the original guideline document.

Levels of evidence (**Ia-IV**) and grading of recommendations (**A-C**) are defined at the end of the "Major Recommendations" field.

Possible Aetiological Factors in Chronic Pelvic Pain

The concept of the biophysical model describes this complex interplay of physical and psychosocial factors. Possible contributory factors are separated out for the purposes of discussion, but the problem must be seen as a whole by both patient and doctor.

C - Pelvic pain which varies considerably over the menstrual cycle may be due to a variety of hormonally driven conditions (Scialli, 1999).

C - It is thought that adhesions may be a cause of pain, particularly on organ distension or stretching. Dense vascular adhesions are likely to be a cause of chronic pelvic pain, as dividing them appears to relieve pain. However, adhesions may be asymptomatic.

Adhesions may be caused by endometriosis, previous surgery, or previous infection. Two distinct forms of adhesive disease are recognised: residual ovary syndrome (a small amount of ovarian tissue inadvertently left behind following oophorectomy which may become buried in adhesions) and trapped ovary syndrome (in which a retained ovary becomes buried in dense adhesions following hysterectomy). Removal of all ovarian tissue or suppression using a gonadotropin-releasing hormone (GnRH) agonist may relieve pain.

B - Symptoms suggestive of irritable bowel syndrome or interstitial cystitis are often present in women with chronic pelvic pain. These conditions may be a primary cause or a component of chronic pelvic pain.

B - Musculoskeletal pain may be a primary source of pelvic pain or an additional component resulting from postural changes.

C - Nerve entrapment in scar tissue, fascia, or a narrow foramen may result in pain and dysfunction in the distribution of that nerve.

B - Addressing psychological and social issues which commonly occur in association with chronic pelvic pain may be important in resolving symptoms.

Depression and sleep disorders are common in women with chronic pain. This may be a consequence rather than a cause of their pain but specific treatment may improve the woman's ability to function. [Evidence level III]

Assessment

History

B - Symptoms alone may be used to diagnose irritable bowel syndrome positively in this age group (Fass et al., 2001; Jones et al., 2000)

Several validated symptom-based tools are also available for the detection of psychological comorbidity. However, simply enquiring generally about things at home and symptoms such as sleep or appetite disturbance and tearfulness may be enough.

Examination

C - Suitable samples to screen for infection, particularly chlamydia and gonorrhoea, should be taken if there is any suspicion of pelvic inflammatory disease (PID). Ideally, all sexually active women below the age of 25 years who are being examined should be offered opportunistic screening for Chlamydia (Pimenta et al., 2003).

A positive result from the cervix supports but does not prove the diagnosis of PID. The absence of infection does not rule out the diagnosis of PID. If PID is suspected clinically, this condition is best managed by a genitourinary medicine physician in order that up-to-date microbiological advice and contact tracing can be arranged. [Evidence level IV]

Initial Management

A - The multifactorial nature of chronic pelvic pain should be discussed and explored from the start. The aim should be to develop a partnership between clinician and patient to plan a management programme.

Many women with chronic pelvic pain can be managed in primary care. General practitioners might consider referral when the pain has not been explained to the woman's satisfaction or when pain is inadequately controlled.

Investigations

Laparoscopy

C - Diagnostic laparoscopy has been regarded in the past as the "gold standard" in the diagnosis of chronic pelvic pain. It may be better seen as a second line of investigation if other therapeutic interventions fail.

The risks and benefits of diagnostic laparoscopy and the possibility of negative findings should be discussed before the decision is made to perform a laparoscopy. Perhaps it should only be performed when the index of suspicion of

adhesive disease or endometriosis requiring surgical intervention is high, or when the woman has specific concerns which could be addressed by diagnostic laparoscopy, such as the existence of endometriosis or adhesions potentially affecting her fertility.

B - Diagnostic laparoscopy may have a role in developing a woman's beliefs about her pain.

Imaging

B - Transvaginal scanning is an appropriate investigation to screen for and assess adnexal masses.

B - Transvaginal scanning and magnetic resonance imaging (MRI) are useful tests to diagnose adenomyosis. The role of MRI in diagnosing small deposits of endometriosis is uncertain.

While MRI lacks sensitivity in the detection of endometriotic deposits, it may be useful in the assessment of palpable nodules in the pelvis or when symptoms suggest the presence of rectovaginal disease. It may also reveal rare pathology. [Evidence level III]

Therapeutic Options

A - Women with cyclical pain should be offered a therapeutic trial using the combined oral contraceptive pill or a GNRH agonist for a period of 3-6 months before having a diagnostic laparoscopy. The levonorgestrel-releasing intrauterine system could also be considered.

A - Women with irritable bowel syndrome should be offered a trial of antispasmodics.

B - Women with irritable bowel syndrome should try amending their diet to control symptoms.

Summary

Chronic pelvic pain is common affecting perhaps one in six of the adult female population. Much remains unclear about its aetiology but chronic pelvic pain should be seen as a symptom with a number of contributory factors rather than as a diagnosis in itself. As with all chronic pain, it is important to consider psychological and social factors as well as physical causes of pain. Many non-gynaecological conditions, such as nerve entrapment or irritable bowel syndrome, may be relevant. Women often present because they seek an explanation for their pain.

The assessment process should allow enough time for the woman to be able to tell her story. This may be therapeutic in itself. A pain diary may be helpful in tracking symptoms or activities associated with the pain.

Where pain is strikingly cyclical and no abnormality is palpable at vaginal examination, a therapeutic trial of a GnRH agonist may be more helpful than a diagnostic laparoscopy. Other conditions, such as irritable bowel syndrome, require specific treatment. Even if no explanation for the pain can be found initially, attempts should be made to treat the pain empirically and to develop a management plan in partnership with the woman.

Definitions:

Grading of Recommendations

Grade A - Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence levels Ia, Ib)

Grade B - Requires the availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendations (evidence levels IIa, IIb, III)

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Levels of Evidence

Ia: Evidence obtained from meta-analysis of randomised controlled trials

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IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

CLINICAL ALGORITHM(S)

A clinical algorithm for the Management of Chronic Pelvic Pain is provided in the original guideline document.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Living with any chronic pain carries a heavy economic and social price. Aiming for accurate diagnosis and effective management from the first presentation may help to reduce the disruption of the woman's life and may avoid an endless succession of referrals, investigations and operations.

POTENTIAL HARMS

- Diagnostic laparoscopy carries significant risks: an estimated risk of death of approximately 1.0/10,000 and a risk of injury to bowel, bladder, or blood vessel of approximately 2.4/1,000, of whom two-thirds will require laparotomy.
- The consequences of a negative laparoscopy have not been well studied but many women feel let down and that their doctor now thinks that "the problem is all in my head."
- Side effects of ovarian suppression and other pharmacological therapy

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Clinical guidelines are "systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions." Each guideline is systematically developed using a standardised methodology. Exact details of this process can be found in Clinical Governance Advice No. 1: *Guidance for the Development of Royal College of Obstetricians & Gynaecologists (RCOG) Green-top Guidelines*.
- These recommendations are not intended to dictate an exclusive course of management or treatment. They must be evaluated with reference to individual patient needs, resources and limitations unique to the institution and variations in local populations. It is hoped that this process of local ownership will help to incorporate these guidelines into routine practice. Attention is drawn to areas of clinical uncertainty where further research may be indicated.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Clinical Algorithm

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Royal College of Obstetricians and Gynaecologists (RCOG). The initial management of chronic pelvic pain. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2005 Apr. 12 p. (Guideline; no. 41). [60 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Apr

GUIDELINE DEVELOPER(S)

Royal College of Obstetricians and Gynaecologists - Medical Specialty Society

SOURCE(S) OF FUNDING

Royal College of Obstetricians and Gynaecologists

GUIDELINE COMMITTEE

Guidelines and Audit Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Professor Deirdre J Murphy, MRCOG (Chair); Lizzy Dijeh (Secretary); Ms Toni Belfield, Consumers' Representative; Professor P R Braude, FRCOG, Chairman, Scientific Advisory Committee; Mrs C Dhillon, Head of Clinical Governance and Standards Dept.; Dr Martin Dougherty, A. Director NCC-WCH; Miss L M M Duley, FRCOG, Chairman, Patient Information Subgroup; Mr Alan S Evans, FRCOG; Dr Mehmet R Gazvani, MRCOG; Dr Rhona G Hughes, FRCOG; Mr Anthony J Kelly MRCOG; Dr Gwyneth Lewis, FRCOG, Department of Health; Dr Mary A C Macintosh, MRCOG, CEMACH; Dr Tahir A Mahmood, FRCOG; Mrs Caroline E Overton, MRCOG, Reproductive medicine; Dr David Parkin, FRCOG; Oncology; Ms Wendy Riches, NICE; Mr Mark C Slack, MRCOG, Urogynaecology; Mr Stephen A Walkinshaw, FRCOG, Maternal and Fetal Medicine; Dr Eleni Mavrides, Trainees Representative

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Guideline authors are required to complete a "declaration of interests" form.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Royal College of Obstetricians and Gynaecologists \(RCOG\) Web site](#).

Print copies: Available from the Royal College of Obstetricians and Gynaecologists (RCOG) Bookshop, 27 Sussex Place, Regent's Park, London NW1 4RG; Telephone: +44 020 7772 6276; Fax, +44 020 7772 5991; e-mail: bookshop@rcog.org.uk. A listing and order form are available from the [RCOG Web site](#).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Guidance for the development of RCOG green-top guidelines. Clinical Governance Advice No 1. 2000 Jan. Available from the [Royal College of Obstetricians and Gynaecologists \(RCOG\) Web site](#).
- Searching for evidence. Clinical Governance Advice No 3. 2001 Oct. Available from the [Royal College of Obstetricians and Gynaecologists \(RCOG\) Web site](#).

PATIENT RESOURCES

None available

NGC STATUS

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