OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Pain: Acute on chronic pelvic pain management

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Emergency Centre KEMH

This document should be read in conjunction with this Disclaimer

Contents

Aim

To provide guidance on the management of patients presenting with an acute exacerbation of chronic pelvic pain to the Emergency Centre (EC). Frequently, in the absence of acute pathology, these patients can be managed without admission to hospital, thereby reducing the rate of unnecessary admissions.

Background

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage.[1, 2] Five main components exist, namely end organ pain generation, musculoskeletal, central nervous system, psychological and other contributing factors. Frequently, however, there is more than one contributory component. The experience of pain is inevitably affected by physical, psychological and social factors.

Chronic pelvic pain (CPP) is defined as, 'intermittent or constant pain in the lower abdomen or pelvis of a patient, present on most days, of at least 3 months in duration, not occurring exclusively with menstruation or intercourse and not associated with pregnancy' [3]. It is caused by a complex combination of visceral and musculoskeletal pain, central sensitisation and pelvic floor hypertonicity, often accompanied by evolving psychological dysfunction.

In Australia, approximately 7% of the general female population is affected by CPP; 15% in the reproductive age group. Approximately 20% of hysterectomies and 40% of laparoscopies are performed for CPP. Chronic pelvic pain has been estimated to cost Australians more than $6 billion annually in both direct and indirect costs.[4, 5]

Acute flares of CPP

Although patients with CPP experience pain on most days, occasionally a 'flare' will occur resulting in an exacerbation of pain and presentation to the emergency department. Common causes include:

Gynaecological:

- Ovulation pain, ovarian cyst accident including rupture, haemorrhage or torsion
- Dysmenorrhoea, primary or secondary
- Penetrative intercourse when prolonged, lubrication inadequate or well-endowed partner
- Acute episode, or acute-on-chronic exacerbation, of PID

Gastrointestinal:

- Appendicitis
- Gastroenteritis
- Diverticulitis

Urinary:

- Urinary tract infection
- Interstitial cystitis
- Renal tract stones

Musculoskeletal:

- Pelvic muscle spasm
- Trauma (physical)
- Recent surgery with late onset of neural injury pain (abdominal wall, pelvic or perineal)
- Postoperative complication e.g. haematoma causing pressure and pain

Psychological

- Trauma or re-triggering of past trauma
- Recent severe stress or stressful event

Management of emergency presentations

Principles

- **Avoid admission to hospital where acute pathology has been excluded, as admission is unlikely to be advantageous over going home**

- Confirm symptoms consistent with an exacerbation of chronic pain
- Exclude acute abdominal or pelvic pathology (or other acute cause of pain)
- Recognise and manage the likely trigger for the recent flare of pain
- Prescribe appropriate analgesia, with avoidance of opioids
- Assessment of psychological stressors and risk of self-harm
- Reassurance and acknowledgement of the patient's pain, despite normal investigations
- Arrange and encourage appropriate follow up in either gynaecology outpatient clinic, pelvic pain clinic or with the patients regular General Practitioner (GP)
    - Referral should reflect the complexity of their condition, written or otherwise
- Education and emphasis on self-management

History

- Comprehensive history is very useful including biological, social, sexual and psychological history
    - Based on **trauma-informed care principles** including:
        - Seek consent for interview and assessment
        - Validate patient's pain experience
            - empathetic responses, provision of options, offer control to the patient
        - Enquire regarding past trauma and dissociation
            - "Anything in your history that makes having a physical examination difficult?"
        - Offer explanation

Examination

- Observe gait and demeanour
- Appropriate and non-provocative examination including observations, abdominal palpation, bimanual examination and speculum examination (if indicated)
- Pelvic floor examination
  - Pelvic floor hypertonicity will be evident in most women with CPP
  - Acute spasm of these muscles contributes significantly to pain flares
  - Directed examination of the superficial perineal muscles and the deeper muscles (pubococcygeus, puborectalis, piriformis and obturator internus) can localise the causative muscle group and replicate the patient's pain
    - Avoid internal examination, if it is not going to be beneficial, in a patient with documented levator ani dysfunction, or consider one-digit examination
    - Ideally this should be undertaken by a clinician experienced in pelvic floor examination

Investigations

- Urinalysis +/- urine MCS to exclude renal tract pathology
- Urinary BhCG to exclude pregnancy
- High vaginal and endocervical swabs to exclude infection
- Cervical screening test as an opportunistic intervention, if indicated
- Blood tests including FBC, UEC, LFTs, CRP to aid exclusion of acute and inflammatory causes
- Transvaginal pelvic ultrasound scan
- Laparoscopy, if indicated, in the acute setting (signs of peritonism)
  - Should be avoided in patients with normal observations, bloods and pelvic USS
  - Repeat laparoscopies increase the risk of
    - Exacerbation of central sensitisation
    - Surgical complications [4]

Management of pelvic pain 'flares' in absence of acute surgical cause

General

- Treat acute pathology, if indicated
- Consider and address reversible causes e.g. constipation (Movicol), UTI (oral antibiotics), dysmenorrhoea (NSAID's)
- Exclude sinister causes
- Reassure patient
- Offer an explanation for the cause of the exacerbation and likely trigger for flare (if known)
    - Patients frequently worried that the increased pain has been caused by something 'serious'
- Identification and elimination of triggers for pain flares
- Relaxation/breathing techniques
- Regular gentle exercise e.g. walking, yoga, swimming, Thai Chi
- Sleep hygiene
- Trial of low FODMAP or healthier diet

Hormonal treatment

- All equally effective and can be commenced in the acute setting, if appropriate
    - Cost and side effects vary
- Encourage use of hormonal suppression of ovulation, especially in patients with cyclical pain, endometriosis +/- dysmenorrhoea
    - Combined oral contraceptive pill (COCP) - continuous or tricycle
    - Drospirenone (Slinda) - unlike other low dose progesterones, suppresses ovulation
    - Not all hormonal preparations suppress ovulation, but may have other benefits
- Progestogenic agents cause:
    - Regression of endometriosis at a cellular level
    - Endometrial atrophy and decidualisation, +/- amenorrhoea

  Examples:
    - Oral progesterones:
        - Levonorgestrel (Microlut Minipill)
        - Drospirenone (Slinda) 4mg daily PO
        - Dienogest (Visanne) 2mg daily PO - an effective therapy for endometriosis
            - Not licenced as a contraceptive unlike COCP, LARCs
    - Long Acting Reversible Contraceptives (LARC):
        - Implanon, Depo-Provera, Mirena IUS

Pharmacological treatment

- Simple stepwise analgesia:
  - Regular paracetamol 1g PO QID

    AND
  - NSAID e.g. Ibuprofen 400mg PO TDS or mefenamic acid (e.g. Ponstan) 250mg PO TDS or Ketorolac 10-30mg IM 4-6 hourly (maximum daily dose 90mg, caution >65 years, <50kg)

    OR
  - COX 2 inhibitors e.g. Celecoxib 100 to 200mg PO BD for 5 days

- Neuropathic medications, starting with low dose and increasing slowly:
  - Nortriptyline (Allegron) 10mg PO nocte, 5mg if side effects e.g. drowsiness
    - Take 2 hours before bedtime
    - Can increase by 5-10 mg increments weekly to get the desired effect (max 25mg) at GP
    - Enquire re contraindications e.g. arrhythmias, glaucoma, voiding difficulties

    OR
  - Amitriptyline (Endep) 10mg PO nocte
    - side effects more common compared to Nortriptyline

    OR
  - Duloxetine (Cymbalta) 30mg PO daily, can be increased to 60mg after 2 weeks (at GP)

    OR
  - Gabapentin (Neurontin) 900-1800mg PO daily in 3 divided doses, 300mg daily for first week and then increase by 300mg incremental doses every 7 days

    OR
  - Pregabalin (Lyrica) commence 75mg PO nocte and increase to 75mg PO BD; maximum dose 300mg PO daily in divided doses (150mg BD)
    - Gauge benefit once on highest tolerated dose for 4 weeks
    - When stopping Lyrica, stop morning dose, then alternate days for few weeks
    - Category D, contraindicated in pregnancy

Advise patient to see GP 2 weeks later for medication review.

- If above inadequate, consider adjunct medications (seek pain specialist advice prior to starting) and treatments:
    - Clonidine 25 to 100microg PO as indicated for anxiety, autonomic symptoms and pain
    - Capsaicin creams
        - Can cause localised burning of skin
    - Lidocaine (Lignocaine)
        - 5% Patch for superficial neuropathic pain (post trauma/surgery/shingles)
        - Lidocaine (Lignocaine) Infusion in hospital setting
    - Calcitonin subcut injections
    - Medically prescribed THC/cannabinoids (**not** for prescription in the Emergency Centre)
        - Currently no clear evidence to support use for acute or chronic pelvic pain
        - Can interact significantly with other medications

- **Avoid opioid medications wherever possible**. However, if stronger options for pain relief required, the following may be considered in the Emergency Centre (Note- ensure limited supply and GP review in 1-2 weeks if pain control inadequate):
    - Short course of Tapentadol SR (Palexia) 50 to 100mg PO BD for 5 days

      AND / OR
    - Tramadol Immediate Release (IR) 50mg PO or IV every 4 hours (max 300mg in 24 hours)

      AND / OR
    - Buprenorphine 100 to 200microg subling 4 hourly for breakthrough pain in the short term (max 10 x 200microg tablets)

Complementary and alternative therapies

- Palmitoyl Ethanol Amide (PEA) 600mg PO BD
- Fish oil 5g PO daily
- Curcumin 600mg PO daily
- Peppermint Oil 1 capsule PO TDS
- Melatonin 2mg PO nocte

These therapies are not listed in the Hospital Formulary (external website) in WA. IPA approval must be sought and approved prior to use via WAH Individual Patient Approval (IPA) PROD (external website). See also NMHS Complementary and Alternative Medicines Policy.

Provision of patient education resources

- Reputable online resources:
  - Susan Evans' eBook: Pelvic Pain 2017: An Introduction to Pelvic Pain for Women (external website)
  - Online sessions from UniNSW "This Way Up"
    - https://thiswayup.org.au (external website)
- Information sheets found at:
  - www.pelvicpain.org.au (external website)
  - https://pelvicpain.org (external website)
  - https://www.endometriosisaustralia.org (external website)
  - https://jeanhailes.org.au (external website)

Follow-up

Follow-up appointment with GP for review at 1-2 weeks. Consider for Chronic Pain Clinic (CPC) referral.

Multidisciplinary management

There is good evidence to support the benefit of multidisciplinary care in the management of chronic pelvic pain. This service can be accessed by referring patients to the KEMH Pelvic Pain Clinic. There is currently no gynaecologist available at the KEMH CPP clinic, therefore gynaecological review is required prior to referral to the clinic.

Serotonin Syndrome can occur when either the dose of a medication that affects Serotonin in the body is increased, or another medication that affects Serotonin is added. It is rare when using either low dose Amitriptyline or an SNRI, and still quite uncommon when these drugs are used together. However, adding a further medication that affects Serotonin to the combination of Amitriptyline and an SNRI medication makes Serotonin Syndrome more likely. Symptoms of Serotonin Syndrome include agitation, confusion, headache, shivering, sweating, diarrhoea, high BP, rapid HR, muscle rigidity, twitching and dilated pupils. If you are unsure, refer to AMH Adverse effects of antidepressants: 'Table – Drugs that may contribute to serotonin toxicity' (external website; WNHS staff access through WNHS library login) or check with the pharmacy department.

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5. Faculty of Pain Medicine ANZCA. Pelvic pain report: The $6 billion woman and the $600 million girl 2011.

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Related NMHS and WNHS policies, guidelines and procedures

WNHS clinical guidelines:

- Anaesthesia and Pain Medicine guidelines (available to WA Health employees through HealthPoint)
- Obstetrics and Gynaecology: Cervical Screening Test ; Gynaecology (Non-oncological); Pain Management in Adults ; Palliative Care; Sexually Transmitted Infections (STI) ; Vaginal Procedures

NMHS Complementary and Alternative Medicines Policy

Useful resources and related forms

See section for 'Provision of Patient Education Resources'

KEMH website:

- For Health Professionals: Pelvic Pain Clinic ; Chronic Pain Clinic
- Women's Health: Physiotherapy: Persistent Pelvic Pain

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Version history

Version number	Date	Summary
1	Apr 2023	First version
2	May 2024	Minor amendment. Alert box added - manage as outpatients wherever possible. ‘Avoid admission to hospital where acute pathology has been excluded, as admission is unlikely to be advantageous over going home.’

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