Pillars of Pelvic Pain Management

Dr. Catherine Allaire – MDCM, FRCSC
Dr. Virginia McEwen – CCFP-FP
Rebecca Weaver - PT

VANCOUVER CONVENTION CENTRE

FMF Family Medicine Forum Forum en médecine familiale

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

1

Pillars of Chronic Pelvic Pain Management

November 6, 2024

2

Land Acknowledgment

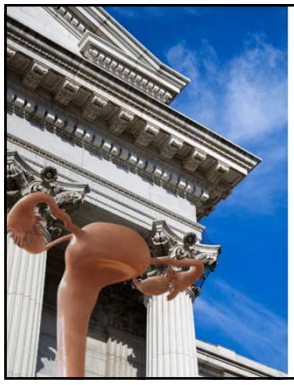
This land is the traditional land of the Coast Salish peoples. As a white settler, I am grateful for the land on which I live, work, and play. I am an uninvited guest on these lands that has much to give back to this community and its people, and humbly thank the Coast Salish peoples, this land and its creatures, and the Creator for their gifts. As guests on this land, I encourage us all to take a moment to reflect on how we may all can contribute to treating the land and all of its people with kindness and respect.

3

Disclosure of Financial Support

This program has received no external financial support.

4

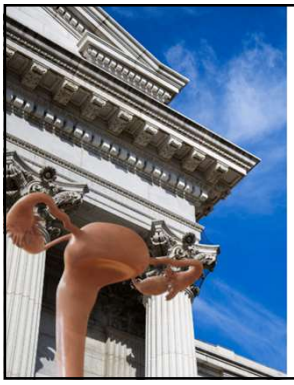


Objectives

After today's session, participants will be able to:

- identify relevant clinical diagnoses
- use a stepwise approach to addressing different facets of pelvic pain
- implement approaches to reduce inflammatory, central sensitization, and neuropathic pain burden comorbid in pelvic pain
- integrate multidisciplinary recommendations for pelvic floor physiotherapy and when to involve psychology

5



Part 1

Dr. Allaire MD MDCM FRCSC

Clinical Professor, UBC Department of Obstetrics and Gynaecology
Head, Division of Gynaecologic Specialties
Medical Director, BC Women's Centre for Pelvic Pain and Endometriosis
Director, UBC Advanced Training Program in Pelvic Pain, Endometriosis and Advanced Laparoscopy

6

Presenter Disclosure

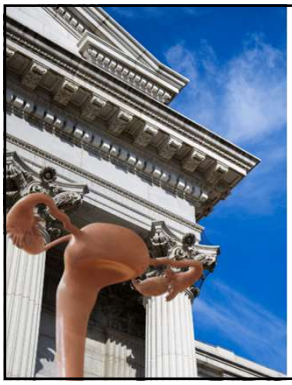
Presenter: Dr. Catherine Allaire

Relationships with financial sponsors:

Dr. Catherine Allaire has received financial compensation unrelated to this program for participating in:

- Advisory Board: Abbvie, Pfizer

7



Part 1 – Dr. Allaire

- Review definition and epidemiology/impact
- Clinical diagnosis
- Practical approach history and physical to identify pain contributors
- Hormonal management recommendations When is surgery now considered?

8

Chronic (Persistent) Pelvic Pain

- Pain lasting more than 3-6 months perceived to originate from pelvic organs/structures
- Associated with negative cognitive, behavioral, emotional and sexual consequences
- Associated with symptoms suggestive or lower urinary, sexual, bowel, pelvic floor, myofascial or gynecologic dysfunction

9

CPP: Societal Impact

- Affects 15% of female adults
- Accounts for ~ 10% of referrals to gynaecologists
- Primary indication for 40% of diagnostic laparoscopies
- Primary indication for 12% of hysterectomies
- Direct U.S. health care costs: $800 million/yr
  Combined U.S costs:
  $2 billion/year
- Patient experience:
  Suffering
  Decreased productivity
  Marital discord and divorce
  Complications from treatments

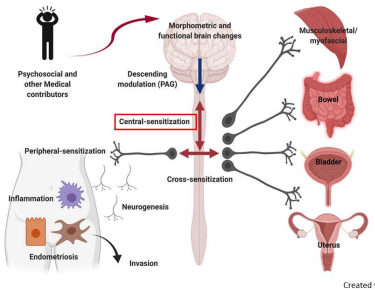
10

Pain Contributors

- **Gynecologic:** primary dysmenorrhea, endometriosis, adenomyosis, vulvo/vestibulodynia, pelvic venous disorders, chronic pelvic inflammatory disease, pelvic adhesions, adnexal masses, uterine fibroids, ovarian remnant.
- **Gastrointestinal:** Irritable Bowel Syndrome, chronic constipation, chronic appendicitis, inflammatory bowel disease
- **Urological:** Painful bladder syndrome/interstitial cystitis, recurrent urinary tract infection, chronic renal/bladder stones
- **Musculoskeletal and myofascial:** pelvic floor, abdominal wall, pelvic girdle, hip, and lumbosacral disorders, hernias, hypermobility syndromes
- **Neuropathic:** ilio-inguinal/ilio-hypogastric neuropathy, radiculopathy; entrapment/neuromas
- **Psychosocial Factors:** active trauma symptoms, anxiety, depression, insomnia, pain catastrophizing

11

Central sensitization



Increased excitability of the CNS so that normal inputs now evoke *exaggerated* responses

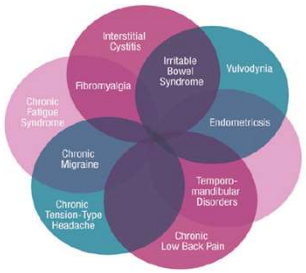
Woolf, 1983

Multiple studies show that CPP is associated with central changes

Brawn et al, Hum Reprod Update 2014
Kaya et al. Pain Physician 2013

12

Chronic Overlapping Pain Conditions (COPCS)



- NIH recognized condition 2015
- Pain conditions that occur in combination, mostly in women
- Altered neural, immune and endocrine mechanisms
- One disorder with multiple phenotypes

www.chronicpainresearch.org

13

RISK FACTORS FOR CS

Predisposing Factors

- Genetics
- Exaggerated stress-response
- History of depression, anxiety
- History of physical or psychological trauma at early age

Reinforcing Factors

- Sleep disturbance
- Anxiety, depression, fear-avoidance
- Operant learning: interpersonal and environmental reinforcements
- Repeated nociceptive exposure (wind-up)

Instituteforchronicpain.org

14

Essential components of CPP Assessment

- Build therapeutic relationship
- Assess psychosocial factors
- Thorough history and physical exar for peripheral nociceptors
- Identify CS

15

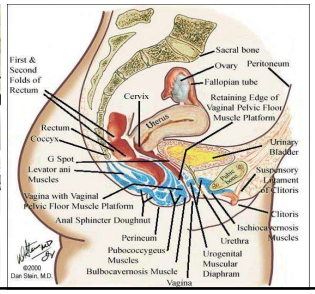
Table 2. Assessment of patients with chronic pelvic pain: clinical history

Assessment Techniques	Description
Building a therapeutic relationship	• Avoid pain stigma (e.g., pain is "all in the head" or caused by past sexual abuse) • Validate the pain (e.g., rather than saying "there's nothing there," provide a fuller explanation of the pain) • Active listening (i.e., let the patient tell her story then summarize back) • Empathy (e.g., "That must be very difficult"; "I am sorry you have experienced that")
Pain History (OPQRST)	• Onset: Initiating event (e.g., surgery, cyst rupture, miscarriage), duration and frequency • Provoking/palliating: Movement, intercourse, menstrual cycle, and medications • Quality: Sharp, cramping, and/or burning • Region/Radiation: Diffuse, localized, unilateral, and/or radiates to back, hip, groin, or vulva • Severity: Elicit numeric rating (0–10) for pain at specific times. • Treatment: What medications/surgeries/treatments have been tried and/or are currently using? What is the effectiveness and are there side effects? • History of pelvic surgeries: Targeted to pain (laparoscopy, -ectomies), duration of any relief; other pelvic surgeries and any temporal relation to pain onset
Psychosocial factors questions (FIFE)	• Function: Ask about pain impact (e.g., "How has this pain impacted your life?") • Ideas: Elicit beliefs about the pain (e.g., "What do you believe is causing this pain?") • Fears: Explore pain catastrophizing (e.g., "Do you have any anxious or worrisome thoughts about this pain?") • Expectations: Explore the hopes for this visit and treatment expectations (e.g., "What kind of results are you hoping to get from this treatment?")

Allaire et al. *Guideline No. 445: Management of Chronic Pelvic Pain, JOGC 2024*

16

Physical Examination



17

Table 3. Assessment of patients with chronic pelvic pain: physical examination

Assessment Techniques	Description
Overall	• Affect, gait, mobility, and pain behaviour
If tender area found, ask if it reproduces usual pain	
Back/pelvis	• Screen for pelvic girdle pain*, pelvic asymmetry, hip exam (e.g., FABER, FAIR)
Abdomen	• Scars (tender?), allodynia test with cotton swab* • Localized tender areas (Carnett's test to identify abdominal wall pain* • Look for masses or hernias
Pelvic exam	• Offer chaperone • Obtain permission (e.g., "Are you okay to have an internal exam now or at a future appointment"?) • Frequent check-ins during exam (e.g., "Are you okay? Can we continue with the exam?") • Vulvar skin examination for lesions or skin conditions • Cotton swab test for provoked vestibulodynia and dermatomal pain S2–S4 (vulvodynia) • Single digit vaginal exam of the pelvic floor muscles (Figure 1)*, anterior vagina for bladder tenderness, cervix, adnexae, cul-de-sac tenderness and/or nodularity • Bimanual exam of uterine size, position, tenderness, mobility, adnexal masses/tenderness • Rectovaginal exam if deep endometriosis of bowel is suspected or to determine extent of any cul-de-sac nodule palpated • Speculum exam (if bimanual exam tolerated) for the examination of the vagina, cervix, cuff, look for discharge, prolapse
Basic investigations	• Pelvic ultrasound (as an initial evaluation for pelvic pathology) • Urinalysis (if bladder symptoms) • Vaginal wet prep and cervical swabs (if infection suspected)

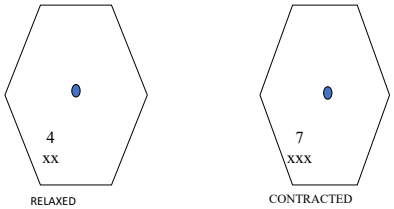
FABER: flexion, abduction, and external rotation; FAIR: flexion, adduction, internal rotation.
*see Supplementary videos in references 59 and 60.

18

Examination of the Abdominal Wall

Light touch/Q tip: allodynia

Localized tendernes/muscle twitch: Carnett's test



19

Therapeutic Plan for CPP

- GIVE PATIENT DIAGNOSIS/DIAGNOSES
- PROVIDE PAIN EDUCATION
- PATIENT-CENTERED GOALS: PARTNERING WITH PATIENT
- ADDRESS PERIPHERAL NOCICEPTORS
- MULTIDISCIPLINARY OR INTERDISCIPLINARY CARE FOR CS

20

Pain Education

- **Starts in the office with proper language**
  Explain Pain book/workshop
  Script/metaphor
- **Use short videos**
- **Books and websites (see Reference list)**
- **Improves readiness for change**

21

22

ENDOMETRIOSIS FACT AND FIGURES

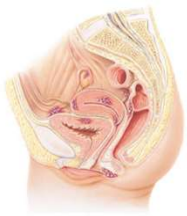
1 in 10 females suffer from endometriosis

- Ectopic endometrial tissue (glands and stroma)
- Estrogen-dependent chronic inflammatory process
- **8-10 years** delay between onset and diagnosis
- Up to **1 in 3** people with endometriosis have fertility problems

In Canada, the cost of endometriosis is **$1.8 billion** annually

23

Endometriosis lesions

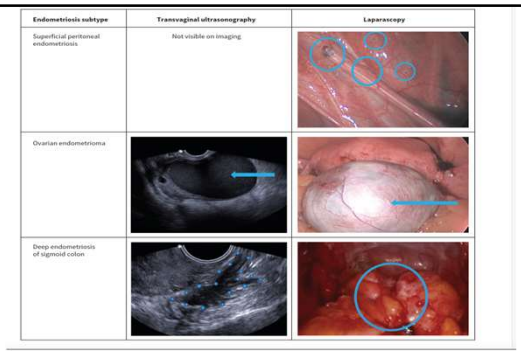


Common Pelvic Sites
- Peritoneum
- Ovaries
- US ligaments

Other Pelvic Sites
- Vagina
- Bowel
- Bladder
- Ureters

Rare Sites
- Incisions
- Umbilicus
- Diaphragm
- Lung

24



Allaire et al. Diagnosis and Management of Endometriosis. CMAJ, 2023

25

When to Suspect Endometriosis

Classic symptoms

- Severe dysmenorrhea
- Deep dyspareunia
- Chronic pelvic pain
- Infertility
- Dysuria (cyclic) ± hematuria*
- Dyschezia (cyclic) ± hematochezia*
- Cyclic SOB or chest pain, shoulder pain, hemoptysis, pneumothorax

Other nonspecific symptoms

- Abnormal uterine bleeding
- Low back pain
- Abdominal pain or bloating
- Fatigue

Signs

- Fixed retroverted uterus*
- Nodularity in posterior vaginal fornix*
- Tender posterior and lateral vaginal fornices
- Adnexal mass

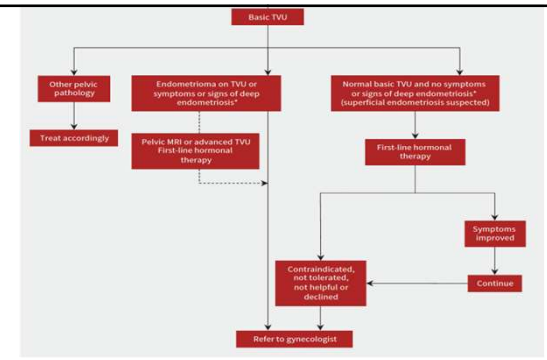
Risk factors

- First-degree relative with endometriosis
- Early menarche, heavy flows, short cycles
- Müllerian anomaly
- Nulliparity
- Low birth weight
- Low BMI

* Suspect deep endometriosis

Allaire et al. Diagnosis and Management of Endometriosis. CMAJ, 2023

26



Allaire et al. Diagnosis and Management of Endometriosis. CMAJ, 2023

27

FIRST-LINE THERAPIES

- Pre-emptive NSAIDs
- Cyclic CHCs

OVARIAN/MENSTRUAL SUPPRESSION

- Continuous CHCs: monophasic pill
- Progestins

LNG-IUS
norethindrone (0.35mg, 1-3 tabs/day)
drosperinone (4mg)
dienogest (2mg)
norethindrone acetate (5mg, 0.5-3 tabs/day)
medroxyprogesterone acetate (oral 10-20mg, Depot 150 mg IM q6-8 weeks)

28

Ovarian suppression

Cochrane database review: Oral contraceptives, MPA, Gestrinone, Danazol, GnRH agonists

- All equally effective (60-70%) and better than placebo
- Side-effect profile varies

Brown J., Farquhar C. Cochrane Reviews 2014

29

TIPS TO MANAGE BREAKTHROUGH BLEEDING

Discuss the risk of BTB prior to initiation

To reduce the risk of breakthrough bleeding:

- Consistent pill use, timing, and smoking cessation
- 3-day hormone-free interval rather than 7-day after a minimum of 21 days of CHC use

To manage BTB

- Switch to another CHC with a different type of progestin
- Short course of oral estrogen (e.g., 1.25 mg conjugated estrogen or 2 mg 17β-estradiol) daily for 7 days for BTB on progestins

Black et al. *JOGC* 2004; 143 (Part 2): 219-54.
Guilbert et al. SOGC 2007; 195: S1-S32.

30

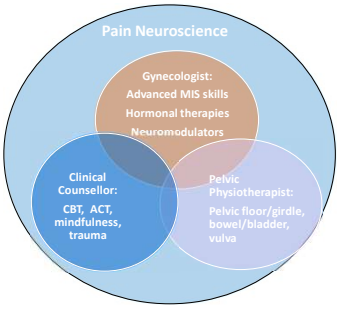
Conservative Endometriosis Surgery Outcomes

Cumulative pain recurrence	⟶	**20-40 %**
Reoperation rate at 5 years	⟶	**36 %**
Negative repeat surgeries	⟶	**38 %**

31

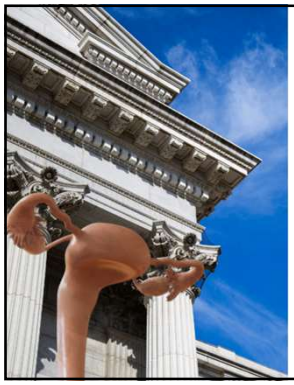
BC Women's Centre for Pelvic Pain and Endometriosis

BC WOMEN'S HOSPITAL+ HEALTH CENTRE



Allaire et al. Interdisciplinary Teams in Endometriosis Care. Sem Reprod Med 2020

32



Part 2

Dr. McEwen MD CCFP-FP

Pain Medicine
Chronic Pain Management Program, St. Joseph's Care Group
Interventional Pain Service, Thunder Bay Regional Health Sciences Centre
Assistant Professor, NOSM University

33

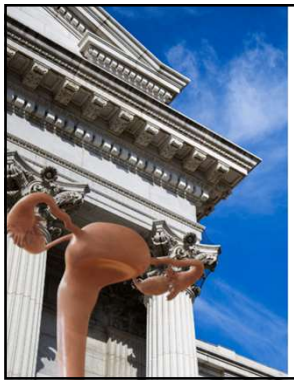
Presenter Disclosure

Presenter: Dr. Virginia McEwen

Relationships with financial sponsors:

- Any direct financial relationships, including receipt of honoraria: not applicable
- Membership on advisory boards or speakers' bureaus: not applicable
- Patents for drugs or devices: not applicable
- Other: not applicable

34



Conflicts of interest:
None to declare.

Caveat:
Medications used in chronic pain are largely off-label.

35

Overarching Caveats

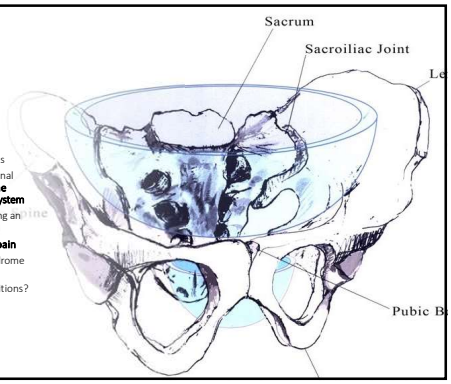
POWER OVER PAIN PORTAL

- Validation
- Pain education
  - Power Over Pain Portal https://poweroverpainportal.ca
- Multidisciplinary approaches:
  - Pelvic floor physiotherapy
  - Psychology
  - Lifestyle
- Autonomy/shared decision-making

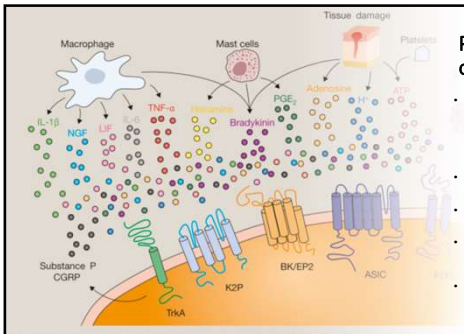
36

Common Discussions

- **Importance of hormonal control**
  - Progesterone-based treatments
- Endometriosis is not simply a hormonal problem, but also one that **affects the nervous system, MSK, and immune system**
- Concept of pelvis as a bowl containing an **inflammatory soup**
- **Central sensitization and nociplastic pain**
  - Comorbid Painful Bladder Syndrome or Irritable Bowel Syndrome?
  - Chronic overlapping pain conditions?



37



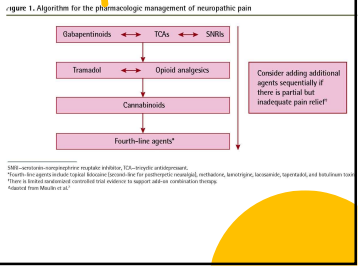
Pharmacological options - Inflammation

- Anti-inflammatories
  - Non-selective ex. Naproxen, ibuprofen
  - Cox-2 selective ex. Celecoxib, meloxicam, diclofenac/misoprostol
  - ASA
- Low-dose naltrexone
  - TLR4 receptor antagonist
- Fluvoxamine (SSRI)
  - Sigma 1 receptor antagonist
- Cannabis
  - CBD dominant – can be helpful in some patients
- Blocking other drivers of inflammation?
  - Estrogen related inflammation? Progesterone
  - Mast cell related inflammation? Ketotifen/Cromolyn

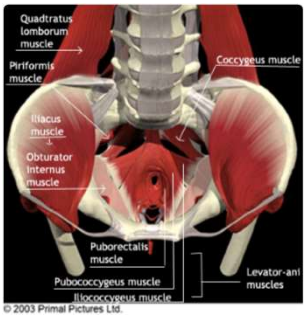
38

Pharmacological Options – Neuropathic Pain

- Tricyclic antidepressants
  - Amitriptyline most commonly prescribed
  - Consider nortriptyline instead, if sleep an issue, or desipramine, if fatigue is an issue
- Selective norepinephrine reuptake inhibitors
  - Duloxetine (especially if concurrent low back pain)
  - Venlafaxine (especially if concurrent migraines)
- Gabapentinoids
  - Pregabalin (especially if concurrent anxiety) or gabapentin
- Low-dose naltrexone
  - Glial cell modulator
- Cannabis
  - THC dominant - can be helpful in some patients



39



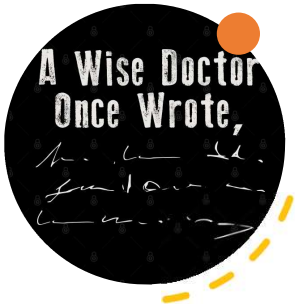
Pharmacological options – MSK pain

- Magnesium
- NSAIDs
- Baclofen
- Cyclobenzaprine
- Methocarbamol
- Tricyclic antidepressants
- Gabapentinoids

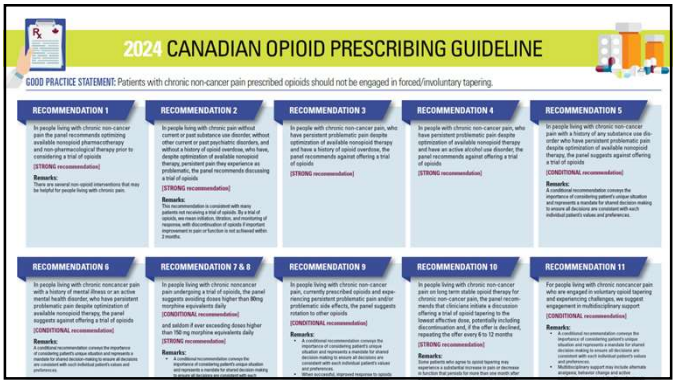
40

Pharmacological Options – Opioids

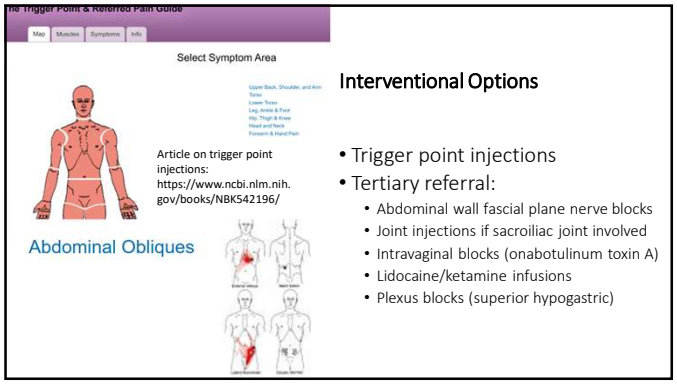
- Not first-line treatment
- However, still a possible part of the treatment plan, particularly with a focus on functional goals
- Try to stay within recommended watchful doses (80 – 150MMED)
- Consider opioid rotations before escalation to doses >150MMED
- Patient teaching around opioid-induced hyperalgesia
- New 2024 National Pain Centre Opioid Guidelines: 2024-Opioid-Prescribing-Guideline-Web.pdf (mcmaster.ca)



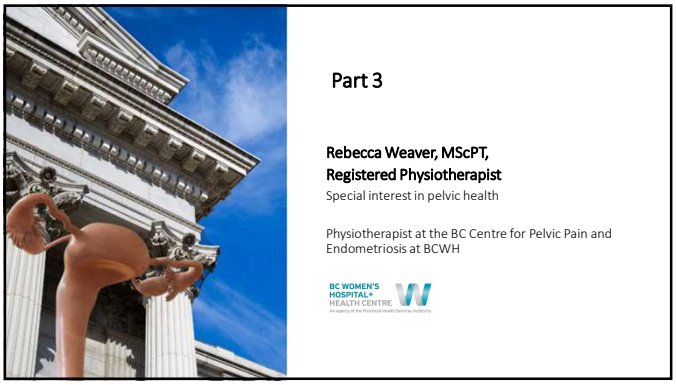
41



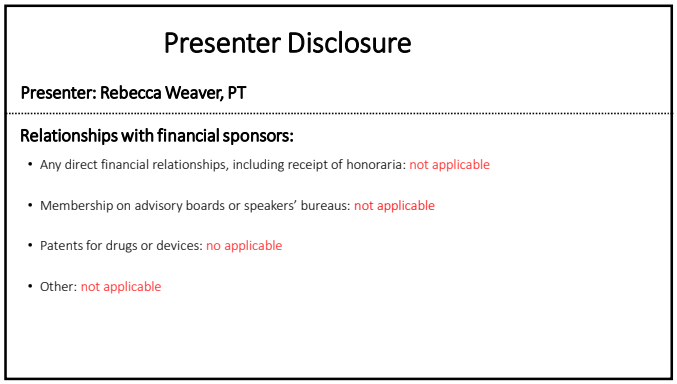
42



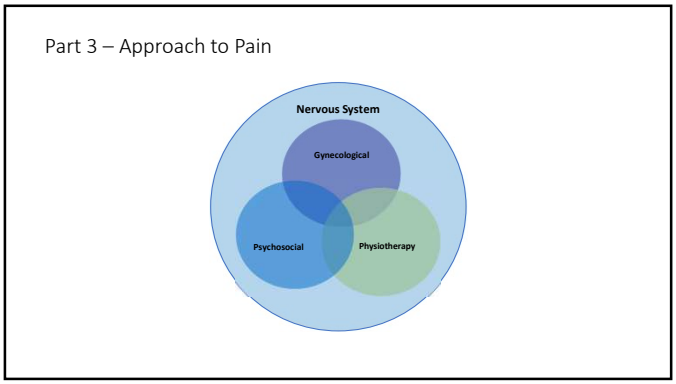
43



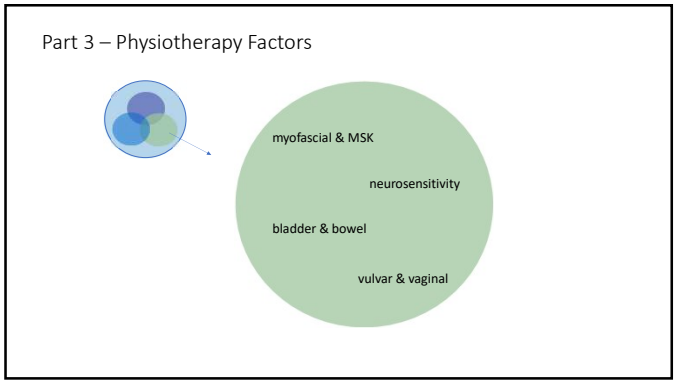
44



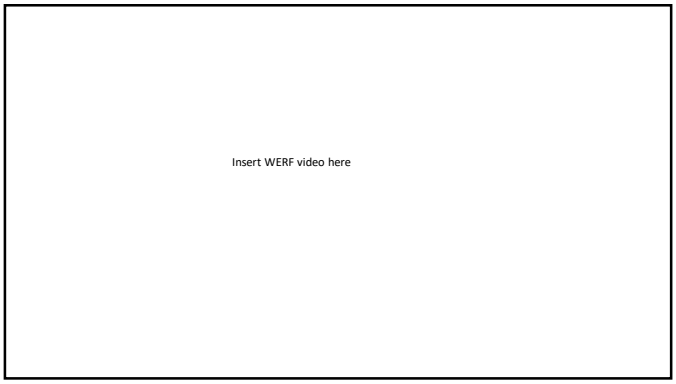
45



46



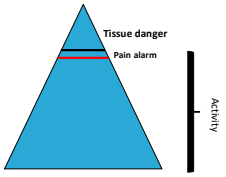
47



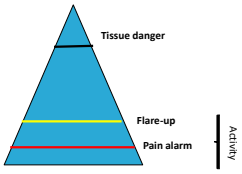
48

Part 3 – Approach to Movement

Non-sensitized pain response



Sensitized pain response



49

Part 3 – Physiotherapy Treatment

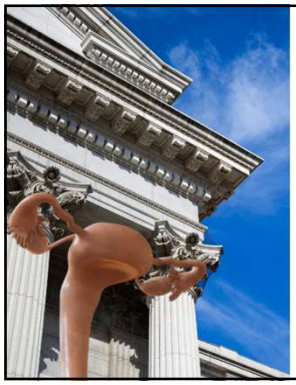
34-year-old patient with endometriosis, pelvic floor myalgia, dyspareunia, IBS, and central sensitization/nociplastic pain.

Foundation:
- Validation, reassurance, cognitive beliefs
- Pain neuroscience education – threats versus safeties
- Relaxation strategies for the pelvic floor (not Kegels!)
- Connecting to breath and the abdominal wall

Progressing:
- Graded exposure for dyspareunia – dilators
- Extra-pelvic factors driving pelvic floor tension – PGP? Thorax?
- Healthy bowel/bladder habits
- Reintegrating into activities, lived experience of moving without flaring

Independence:
- Expanding comfort zone
- Toolbox of self-management strategies
- Manage a flare independently
- Knows when to return to physio

50



Part 3 – Pelvic Pain Resources

Painbc.ca

Tamethebeast.org

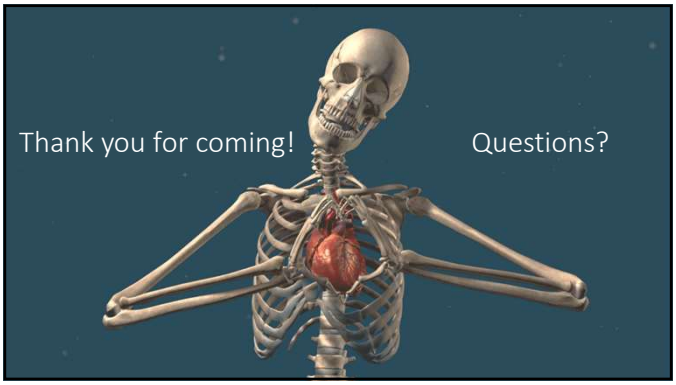
Endopain.endometriosis.org

liveplanbeplus.ca

pelvicpaineducation.com

Find-a-Physio on PABC, OPA

51



52

Thank you!

Please fill out your session evaluation now!

#myfmf

FamilyMedicineForum FamilyMedForum FamilyMedForum

53