Pelvic Floor Pain Syndrome in Chronic Pelvic Pain

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In the genitourinary world, chronic pelvic pain (CPP) is one of the most complex and difficult conditions to diagnose and treat. The pain is rarely limited to one organ; it often involves multiple systems and is further complicated by the subjectivity of pain and individual variation in pain tolerance. Definitions of the condition vary. The American College of Obstetricians and Gynecologists defines CPP as “noncyclical pain of at least 6 months’ duration that localizes to the anatomic pelvis, lumbosacral back, buttocks, or anterior abdominal wall at or below the umbilicus and that is severe enough to cause functional disability or lead to medical care.” Although CPP is typically attributed to a pathologic process in peripheral (somatic or visceral) as opposed to central nervous system dysfunction or psychogenic mechanism, it is at work. This is especially true in cases of trauma to the pelvic region and with respect to the body’s cumulative inflammatory response. More research about causalfactors is needed to improve diagnostic accuracy and thus treatment. Today’s clinician must approach patients via differential diagnosis, systematically comparing clinical findings.

CPP is believed to be more common than is generally recognized or documented. A UK study of nearly 300,000 women ages 12 to 70 years found a prevalence of 38.3 per 1,000. However, pain due to chronic inflammatory bowel diseases or pain that occurred only during menstruation or sexual intercourse was excluded, so many think these findings are greatly underestimated. A US Gallup study of nearly 16% of women ages 18 to 50 years self-reported CPP. Several other surveys estimate much higher prevalence but do not constitute level-A evidence. About one fifth of diagnoses are considered gynecological, cyclical endometriosis is the number one causal disorder or associated condition.

Pelvic floor pain syndrome, a musculoskeletal system disorder also referred to as pelvic tension myalgia or levator ani syndrome, is a noncyclical condition. It is described as spasms induced by stressed pelvic floor muscles (the levator ani muscles that support pelvic viscera, the coccygeus muscle that aids in raising and supporting the pelvic floor, and the piriformis muscle that rotates the thigh laterally). Symptoms may include CPP, including pain in the perineum, vagina, or buttocks and down the back of the leg not unlike sciatica; dyspareunia; pain during intercourse; inability to fully empty the bowels; and urinary frequency with urgency. Causes include posttrauma such as rape, interstitial cystitis, chronic constipation, vulvodynia, untreated urinary tract infections, and trauma and damage to the pelvic floor muscles during labor and vaginal delivery. The syndrome often is accompanied by irritable bowel syndrome, endometriosis, and vulvar vestibulitis. Although most patients are women, clinicians should remember men have pelvic floor muscles and therefore may experience this syndrome (and thus CPP) for nonobstetrical reasons.

Pelvic floor pain syndrome treatment involves behavioral therapy techniques and technologies. Aspecially trained physical therapist typically addresses neuromuscular re-education of the pelvic floor muscles using computerized feedback to reduce the spasms and pain, not unlike bladder retraining used to address classic symptoms of overactive bladder, including urgency and frequency. Transcutaneous electrical nerve stimulation may be used, as well as manual therapies using a lubricant and dilator to stretch the stressed, tense muscles. A patient’s sexual partner may be invited to assist in therapy. On her own, a patient is encouraged to perform breathing exercises to relax and perform pelvic floor muscle exercises at home to supplement clinic protocol. Heat packs and warm baths for relaxation therapy and nutrition, emphasizing a diet of low-fat foods, fresh fruits, and vegetables, are also part of the remedy.

Contidence nurses should be attuned to complaints of CPP and refer patients to trained experts. Pelvic floor pain syndrome may be just one factor in CPP. Addressing CPP requires careful listening, patience, understanding, and collaborative efforts by several clinicians because of the frequent involvement of multisystem symptoms associated with the reproductive tract, urinary tract, gastrointestinal tract, musculoskeletal system, and psychological realms. Because of the number of people affected, clinicians should consider becoming vocal advocates for ongoing research to enrich the knowledge of CPP etiology, diagnosis, and treatment pathways to improve the quality of life for those affected. Ultimately, addressing CPP must be the highest of priorities.

References

Dr. Muller is the Executive Director, National Association For Continence (NAFC). The NAFC is a national, private, nonprofit organization dedicated to improving the quality of life of people with incontinence. The NAFC’s purpose is to be the leading source for public education and advocacy about the causes, prevention, diagnosis, treatments, and management alternatives for incontinence. This article was not subject to the Ostomy Wound Management peer-review process.