Complete Summary

GUIDELINE TITLE

Chronic pelvic pain.

BIBLIOGRAPHIC SOURCE(S)

American College of Obstetricians and Gynecologists (ACOG). Chronic pelvic pain. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 2004 Mar. 17 p. (ACOG practice bulletin; no. 51). [150 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.

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SCOPE

DISEASE/CONDITION(S)

Chronic pelvic pain*, including pain thought to be related to:

- Physical and sexual abuse
- Pelvic inflammatory disease
- Endometriosis
- Interstitial cystitis
- Irritable bowel syndrome
- Obstetric history
- Past surgery
- Musculoskeletal disorders

***Chronic pelvic pain** is defined as noncyclic pain of 6 or more months' duration that localizes to the anatomic pelvis, anterior abdominal wall at or below the umbilicus, the lumbosacral back, or the buttocks and is of sufficient severity to cause functional disability or lead to medical care.

GUIDELINE CATEGORY

Diagnosis
Management
Treatment

CLINICAL SPECIALTY

Internal Medicine
Obstetrics and Gynecology
Pediatrics

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To aid practitioners in making decisions about appropriate obstetric and gynecologic care
- To provide information on the differential diagnosis of chronic pelvic pain and review the available evidence on treatment options for women with chronic pelvic pain

TARGET POPULATION

Women and adolescent girls who experience chronic pelvic pain

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Patient history and physical examination
2. Differential diagnosis
3. Imaging (transvaginal ultrasonography, magnetic resonance imaging, computed tomography)
4. Laparoscopy
5. Intravesical potassium sensitivity testing
6. Intrastitial cystitis symptom index
7. Cystoscopy

Management

1. Mental health referral
2. Multidisciplinary treatment

Treatment

1. Antidepressants - tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRI)
2. Local anesthetic injection
3. Analgesics – cyclooxygenase isoenzyme 2 (COX-2) agents, nonsteroidal anti-inflammatory drugs (NSAIDs), opioids
4. Combination oral contraceptives
5. Gonadotropin-releasing hormone (GnRH) agonists
6. Progestins
7. Exercise
8. Physical therapy
9. Dietary modifications
10. Surgical approaches, including:
    - Excision or destruction of endometriotic tissue
    - Hysterectomy
    - Adhesiolysis
    - Sacral nerve stimulation
    - Presacral neurectomy
    - Uterine nerve ablation
11. Psychotherapy (cognitive therapy, operant conditioning, behavioral modification)
12. Complementary or alternative medicine, including:
    - Herbal and nutritional therapy
    - Magnetic field therapy
    - Acupuncture, acupressure, and transcutaneous nerve stimulation

MAJOR OUTCOMES CONSIDERED

- Rate of reported reduction in pelvic pain
- Duration of pain reduction
- Relapse rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The MEDLINE database, the Cochrane Library, and the American College of Obstetricians and Gynecologists' own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 1985 and November 2003. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles.

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

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.

II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

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

Analysis of available evidence was given priority in formulating recommendations. When reliable research was not available, expert opinions from obstetrician–gynecologists were used. See also the "Rating Scheme for the Strength of Recommendations" field regarding Grade C recommendations.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Practice Bulletins are validated by two internal clinical review panels composed of practicing obstetrician-gynecologists generalists and sub-specialists. The final guidelines are also reviewed and approved by the American College of Obstetricians and Gynecologists (ACOG) Executive Board.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of evidence (I-III) and levels of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

The following recommendations are based on good and consistent scientific evidence (Level A):

- Combined oral contraceptives should be considered as a treatment option to decrease pain from primary dysmenorrhea.
- Gonadotropin-releasing hormone (GnRH) agonists are effective in relieving pelvic pain associated with endometriosis and irritable bowel syndrome, as well as in women with symptoms consistent with endometriosis who do not have endometriosis. Thus, empiric treatment with GnRH agonists without laparoscopy should be considered as an acceptable approach to treatment.
- Nonsteroidal antiinflammatory drugs, including cyclooxygenase isoenzyme 2 (COX-2) inhibitors, should be considered for moderate pain and are particularly effective for dysmenorrhea.
- Progestins in daily, high doses should be considered as an effective treatment of chronic pelvic pain associated with endometriosis and pelvic congestion syndrome.
- Laparoscopic surgical destruction of endometriosis lesions should be considered to decrease pelvic pain associated with stages I to III endometriosis.
- Presacral neurectomy may be considered for treatment of centrally located dysmenorrhea but has limited efficacy for chronic pelvic pain or pain that is not central in its location. Uterine nerve ablation or transection of the uterosacral ligament also can be considered for centrally located dysmenorrhea, but it appears to be less effective than presacral neurectomy. Combining uterine nerve ablation or presacral neurectomy with surgical treatment of endometriosis does not further improve overall pain relief.
- Adding psychotherapy to medical treatment of chronic pelvic pain appears to improve response over that of medical treatment alone and should be considered.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- GnRH agonists should be considered as a treatment option for chronic pelvic pain because they have been shown to relieve endometriosis-associated pelvic pain.
- Surgical adhesiolysis should be considered to decrease pain in women with dense adhesions involving the bowel, but it is unclear if lysis of other types of adhesions is effective.
- Hysterectomy is an effective treatment for chronic pelvic pain associated with reproductive tract symptoms that results in pain relief in 75 to 95% of women and should be considered.
- Sacral nerve stimulation may decrease pain in up to 60% of women with chronic pelvic pain and should be considered as a treatment option.
- Various physical therapy modalities appear to be helpful in the treatment of chronic pelvic pain and should be considered as a treatment option.
- Nutritional supplementation with vitamin B_1 or magnesium may be recommended to decrease pain of dysmenorrhea.

- Injection of trigger points of the abdominal wall, vagina, and sacrum with local anesthetic may provide temporary or prolonged relief of chronic pelvic pain and should be considered.
- Treatment of abdominal trigger points by the application of magnets to the trigger points may be recommended to improve disability and reduce pain.
- Acupuncture, acupressure, and transcutaneous nerve stimulation therapies should be considered to decrease pain of primary dysmenorrhea.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- A detailed history and physical examination are the basis for differential diagnosis of chronic pelvic pain and should be used to determine appropriate diagnostic studies.
- Antidepressants may be helpful in the treatment of chronic pelvic pain.
- Opioid analgesics can be used to provide effective relief of severe pain with a low risk of addiction but do not necessarily improve functional or psychologic status and are not well studied in patients with chronic pelvic pain.

Definitions:

Grades of Evidence

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.

II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Levels of Recommendations

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

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

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and management of chronic pelvic pain in women and adolescent girls

POTENTIAL HARMS

Drug treatment side effects

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Patient Resources

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

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

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

DATE RELEASED

2004 Mar

GUIDELINE DEVELOPER(S)

American College of Obstetricians and Gynecologists - Medical Specialty Society

SOURCE(S) OF FUNDING

American College of Obstetricians and Gynecologists (ACOG)

GUIDELINE COMMITTEE

American College of Obstetricians and Gynecologists (ACOG) Committee on Practice Bulletins-Gynecology

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: None available

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 4500, Kearneysville, WV 25430-4500; telephone, 800-762-2264, ext. 192; e-mail: sales@acog.org. The ACOG Bookstore is available online at the ACOG Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

The following is available:

- Pelvic pain. Atlanta (GA): American College of Obstetricians and Gynecologists (ACOG); 2006.

Electronic copies: Available from the American College of Obstetricians and Gynecologists (ACOG) Web site.

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 4500, Kearneysville, WV 25430-4500; telephone, 800-762-2264, ext. 192; e-mail: sales@acog.org. The ACOG Bookstore is available online at the ACOG Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI Institute on October 11, 2007. The information was verified by the guideline developer on December 3, 2007.

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