W27: ICS Institute - School of Pelvic Pain: Approach to Chronic Pelvic Pain and Sexual Dysfunction

Workshop Chair: Kristene Whitmore, United States

05 September 2019 09:30 - 11:00

Start	End	Topic	Speakers
09:30	09:50	Overview of Chronic Pelvic Pain Syndromes/ Central Sensitization	Mauro Cervigni, M.D.
09:50	10:10	Sexual health and function/ Physical Therapy	Kristene Whitmore, M.D.
10:10	10:30	Integrative Approach with Complementary and Alternative Medicine	Karolynn Echols, M.D.
10:30	10:50	Patient's perspective	Jane Meijlink
10:50	11:00	Questions	Panel

Aims of Workshop

Overview of chronic pelvic pain (CPP) and complex of syndromes (lower urinary tract, genital pain, gastro-intestinal pain, musculoskeletal pain, neurological, psychological, and sexual)

- Evaluation of CPP – complete history and physical to identify
- Discuss implications of CPP with sexual dysfunction
- Overview of female sexual dysfunction
- Management of CPP and sexual dysfunction- an overview of multi-modal treatment approach with the emphasis on an individualized approach, including therapies that are easily available and low budget.
- Discuss complementary medicine and pelvic floor physical therapy and its role in CPP/sexual dysfunction
- Interactive discussion time

Learning Objectives

Overview of chronic pelvic pain (CPP) and complex of syndromes (lower urinary tract, genital pain, gastro-intestinal pain, musculoskeletal pain, neurological, psychological, and sexual)

Target Audience

Urogynecology, Conservative Management

Advanced/Basic

Basic

Suggested Learning before Workshop Attendance

1. Bo, Kari, et al. "An International Urogynecological Association (IUGA)/International Continence Society (ICS) Joint Report on the Terminology for the Conservative and Nonpharmacological Management of Female Pelvic Floor Dysfunction." International Urogynecology Journal, vol. 28, no. 2, 2017, pp. 191-213.

2. Doggweiler, Regula, et al. "A Standard for Terminology in Chronic Pelvic Pain Syndromes: A Report from the Chronic Pelvic Pain Working Group of the International Continence Society." Neurourology and Urodynamics, vol. 36, no. 4, 2017, pp. 984-1008.

3. An International Urogynecological Association (IUGA)/ International Continence Society (ICS) Joint Report on the terminology for the assessment of sexual health of women with female pelvic floor dysfunction

Mauro Cervigni, MD

Italy

Overview of chronic pelvic pain and central sensitization

Chronic pelvic pain (CPP) is defined as non-cyclical pain of at least six months duration that leads to decreased quality of life and physical performance. It can be located in the pelvis, lower abdomen, inguinal region, or low back and may be described as a sharp, burning, pressure, or throbbing discomfort. The pain can be complex in nature with possible gynecologic, urologic, gastrointestinal, musculoskeletal, neurologic, rheumatologic factors, and/or psycho-social attributes. As such, CPP syndromes require multidisciplinary approach to the evaluation and treatment.

Given its complex nature with various pain generators, CPP may also be the result of central sensitization in some patients. In this, the pathogenesis of CPP could be related to an enhanced response of the neurons in nociceptive pathways. This heightened response may persist after the nociceptive input has been removed because of structural or phenotypic changes to the neuron itself contributing to the difficulty of treating CPP. Providers should have a thorough understanding of the various causes of CPP and to be able to counsel patients on in the multi-modal approach to its treatment.

Workshop attendees will gain an overview of chronic pelvic pain syndromes, including the various etiologies, the evaluation and management and the role of central sensitization.

References and useful reading:

1. Doggweiler, Regula, et al. "A Standard for Terminology in Chronic Pelvic Pain Syndromes: A Report from the Chronic Pelvic Pain Working Group of the International Continence Society." Neurourology and Urodynamics, vol. 36, no. 4, 2017, pp. 984-1008.
2. Steege JF, Siedhoff MT. Chronic pelvic pain. *Obstetrics and gynecology.* 2014; 124:616-629.
3. Fenton BW, Schmitt JJ, von Gruenigen V. Central sensitization in chronic pelvic pain syndrome. *Journal of Minimally invasive gynecology, The.* 2011; 18:S9-S9.

Kristene Whitmore, MD

USA

Physical Therapy treatment for chronic pelvic pain and sexual dysfunction

Chronic pelvic pain has a potential multifactorial etiology and a systematic approach is necessary in the evaluation of the patient. It is important to perform a detailed history including any pertinent medical comorbidities, laboratory results, imaging, and prior surgical procedures. The investigation should look into the factors that may alleviate and/or worsen the symptoms including temporality with other events that may surround the pain, the description of the quality of the pain, and any radiation of the pain. A thorough physical examination is crucial and should be comprehensive with particular attention placed in a systems-based approach including the abdomen, back, and pelvis in standing, supine, and lithotomy positions to evaluate the skin, muscles, neurologic response, and internal organs.

Physical therapy evaluation and treatment is also an integral component in the care of chronic pelvic pain patients. Many patients with CPP have associated diagnoses of spinal and or other musculoskeletal dysfunction. Pelvic musculoskeletal imbalance can cause or augment urologic and gynecologic symptoms.

Given the association of CPP with depression and anxiety, providers should also assess the patients' mental health and discuss interpersonal relationships to identify potential psychosocial factors. Chronic pelvic pain may result in dyspareunia or sexual dysfunction that can have psychological implications for the patient. The patient and partner may benefit from counselling to address any underlying issues as well.

This workshop will provide an overview of the chronic pelvic pain syndrome, the multifactorial etiologies that may attribute to it, and a stepwise approach to the patient. Attendants of this workshop will also gain understanding of the musculoskeletal imbalances commonly found in the CPP population. Participants will gain insight as to the process and theories behind successful manual physical therapy rehabilitation of the CPP population.

References and useful reading:

4. Bo, Kari, et al. "An International Urogynecological Association (IUGA)/International Continence Society (ICS) Joint Report on the Terminology for the Conservative and Nonpharmacological Management of Female Pelvic Floor Dysfunction." International Urogynecology Journal, vol. 28, no. 2, 2017, pp. 191-213.

5. Doggweiler, Regula, et al. "A Standard for Terminology in Chronic Pelvic Pain Syndromes: A Report from the Chronic Pelvic Pain Working Group of the International Continence Society." Neurourology and Urodynamics, vol. 36, no. 4, 2017, pp. 984-1008.
6. Baker et al, Musculoskeletal origins of chronic pelvic pain: diagnosis and treatment. Obstetrics and Gynecology Clinics of North America, vol 20,WB Saunders, Philadelphia, PA, 1993PK..
7. Lukban J, Whitmore K, Kellogg-Spadt S, Bologna R, Lesher A, Fletcher E: The effect of manual physical therapy in patients diagnosed with interstitial cystitis, high tone pelvic floor dysfunction and sacroiliac dysfunction. Urol 57(6suppll):121-2, 2001.
8. Moldwin, RM. Interstitial cystitis and pelvic floor dysfunction: The expanding role of the physical therapy. Combined Sections Meeting, APTA Boston, MA, 2002.

Karolynn Echols, MD
USA

An Integrative Approach with complimentary medicine

Pelvic pain and sexual dysfunction are dilemmas that can frustrate even the most patient of providers. Managing these conditions can be even more bewildering as they require a multidisciplinary approach in most cases.

Interstitial Cystitis (IC) is a condition that results in recurring discomfort or pain in the bladder and the surrounding pelvic area, and is often associated with urinary urgency and frequency. The prevalence has been reported as high as almost 13%.

Vulvodynia is defined as vulvar discomfort in the absence of clinically identifiable or laboratory findings. Its incidence is 17% and prevalence has been reported as high as 25%. Women describe it as vulvar irritation, soreness, tearing sensation, burning, rawness or stinging, infrequently accompanied by an itching sensation and almost always accompanied by painful intercourse.

There is no one single cause for vulvodynia although genetic, immune or embryologic factors, inflammation, infection, neuropathic changes or increased urinary oxalates have been suggested.

Myofascial pain or high tone pelvic floor dysfunction is defined as trigger point pain due to short tight and weak pelvic floor muscles. The pain can range from the vulva, vagina to the uterus, rectum, urethra and bladder.

Sexual dysfunction is the departure from normal sensations and/or function experienced by a woman during sexual activity. Promotion of sexual health can be challenging and thus a multimodal approach is usually required.

Integrative Medicine (IM) is the scope of medical practice that considers the patient as a whole: mind, body, and soul, community and way of life. It utilizes all appropriate evidence-based resources and therapeutic options: conventional and complimentary alternative medicine (CAM). Therefore when practicing IM, which continues to grow significantly in popularity, it is necessary to identify the multidimensional aspects of what makes a person healthy. According to the 2007 National Health Statistics Survey almost 4 out of 10 adults had used CAM therapy within the past year most commonly being medicinal herbs and other natural products and mind-body therapies i.e. meditation, deep-breathing exercises, yoga and manual medicine i.e. chiropractic and osteopathic manipulation. Although Urology and FPMRS are predominantly surgical subspecialties, utilizing IM is not only beneficial in the perioperative period but more importantly it is beneficial in the various nonsurgical conditions including chronic pelvic pain and sexual health.

Diet and lifestyle modifications in addition to physical therapy, biofeedback, medications, surgery and integrative medicine modalities such as manual medicine, nutriceuticals, yoga, acupuncture, aromatherapy and energy medicine can be used alone or in combination to relieve symptoms and should be individualized after proper evaluation and diagnosis(es).

At the end of this workshop the provider should be able to define the basics of Integrative Medicine relevant to FPMRS, develop a basic understanding of common botanicals and medicinal herbs, minerals and supplements that can be utilized in the patient with CPP and sexual dysfunction and learn how other available treatment options in Integrative Medicine can supplement conventional therapy in the refractory urogynecologic patient.

References and useful reading:

1. “Mediterranean diet pyramid: a cultural model for healthy eating” Am J of Clin Nutr, 1995; 61(suppl): 1402S-6S
2. www.Dr.Weil.com
3. FDA Drug Safety Communication: Low magnesium levels can be associated with long-term use of Proton Pump Inhibitor drugs (PPIs).

4. Heidelbaugh, Joel J. “Proton Pump Inhibitors and Risk of Vitamin and Mineral Deficiency: Evidence and Clinical Implications.” Therapeutic Advances in Drug Safety 4.3 (2013): 125–133. PMC. Web. 13 Oct. 2015.
5. Deichmann R, Lavie C, Andrews S. Coenzyme Q10 and Statin-Induced Mitochondrial Dysfunction. The Ochsner Journal. 2010; 10(1):16-21.
6. www.ewg.org
7. Ripoll E, Mahowald D. Hatha Yoga therapy management of urologic disorders. World J Urol. 2002; 20: 306–309.)
8. Katayama et al. “Effectiveness of acupuncture and moxibustion therapy for the treatment of refractory interstitial cystitis” Hinyokika Kiyo. 2013 May; 59(5): 265-9.

Jane Meijlink
Netherlands
The Patient Perspective

Interstitial Cystitis/Bladder Pain Syndrome and Hunner Lesion Disease rank amongst the most unpleasant forms of chronic pelvic pain, even in their mildest form. These painful bladder conditions have far-reaching consequences which include a frequent or persistent need to urinate day and night and an often overwhelming urgent need to find a toilet immediately. A similar situation may be found in patients with a painful bladder and/or lesions from other identifiable causes such as drug- or chemical-induced cystitis including street ketamine cystitis; radiation cystitis; haemorrhagic cystitis and chronic recurrent urinary tract infection. Night-time frequency, which may include being unable to sleep for hours every night or during flares, or very disturbed patterns of sleep due to continually waking with pain or discomfort in the bladder and urethra, has debilitating physical and psychological consequences on the patient. Add to this the anxiety and stress caused by worrying about whether or not they are going to find a toilet in time when away from the safety of their own home, the stress of sexual intimacy problems caused by the pain and the resultant relationship problems, plus anxiety about their job and financial consequences, you then have patients who are anxious, stressed, exhausted, unable to relax due to the persistent nagging pain and often simply struggling to cope from day to day. Urogenital disorders are still taboo in today’s world and make sufferers feel stigmatized and socially isolated. These problems and anxieties are compounded in patients with multiple comorbidities and since IC/BPS patients are generally treated by a urologist or urogynecologist, there is always a risk that some of these comorbidities may go unidentified and untreated, causing the patient even more stress. These patients need support and empathy. And this support aspect - whether it comes from health providers on the one hand or family, partner and environment on the other - may be key to coping. One of the big problems with treatment is that every patient is different and needs a personalized treatment approach. Meaningful phenotyping is urgently needed for both non-lesion and lesion disease. This may help to pinpoint the best treatment per patient. Comorbidities should always be taken into account and often make treatment very challenging. This underlines the need for a coordinated multi-disciplinary and multi-specialist approach. However, the best treatment in the world is of little use if patients either have no access to it or cannot afford it due to refusal by health authorities to reimburse many treatments for IC/BPS. It is inhumane to expect sick patients to go to court repeatedly to challenge these unfair decisions or for patient support groups to use their limited resources in battling authorities. The solutions lie with the medical researchers who must now produce better scientific studies – with internationally accepted terminology and definitions - which will be acceptable to the relevant authorities and convince them to approve and reimburse the treatments.