

# Chronic non-visceral pelvic pain: multidisciplinary management. Case report\*

## *Dor pélvica crônica não visceral: tratamento multidisciplinar. Relato de caso*

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### ABSTRACT

**BACKGROUND AND OBJECTIVES:** The prevalence of chronic pelvic pain among females is approximately 4%, similar to the prevalence of migraine (2.1%), asthma (3.7%) and low back pain (4.1%). Its diagnosis and management are major challenges for the health team. This report aimed at showing the difficulty of diagnosing and managing chronic pelvic pain and the importance of the multidisciplinary team for pain relief.

**CASE REPORT:** Forty-five years old patient with pelviperineal pain for six years after hysteroscopy and uterine polyp excision. Severe pain, starting in the immediate postoperative period has evolved along this period without improvement, leading her to look for the Chronic Abdominal, Pelvic and Perineal Pain Out-patient Clinic of the Interdisciplinary Pain Center, Clinicas Hospital, School of Medicine, University of São Paulo.

**CONCLUSION:** Multidisciplinary management, involving drugs, inactivation of trigger-points (anesthetic infiltration, dry needling, acupuncture), physiotherapy, postural reeducation and psychosocial support, has provided patient's significant pain relief and improved quality of life.

**Keywords:** Multidisciplinary management, Myofascial pain, Pelviperineal pain, Quality of Life, Trigger-points.

### RESUMO

**JUSTIFICATIVA E OBJETIVOS:** A prevalência de dor pélvica crônica no sexo feminino é de aproximadamente 4%, similar à prevalência da enxaqueca (2,1%), asma (3,7%) e dor lombar (4,1%). Seu diagnóstico e tratamento constitui um grande desafio para a

equipe de saúde. Este estudo teve por objetivo mostrar a dificuldade no diagnóstico e tratamento de dor pélvica crônica e a importância da equipe multidisciplinar no alívio do quadro doloroso.

**RELATO DO CASO:** Paciente de 45 anos, com quadro de dor pelviperineal há 6 anos, após histeroscopia para exérese de pólipos uterino. A dor que iniciou no pós-operatório imediato, de forte intensidade, evoluiu ao longo deste período sem melhora e motivou-a a buscar o Ambulatório de Dor Abdominal, Pélvica e Perineal Crônica do Centro Interdisciplinar de Dor do Hospital de Clínicas da Faculdade de Medicina da Universidade de São Paulo.

**CONCLUSÃO:** O tratamento multidisciplinar que abrangeu o uso de fármacos, inativação dos pontos-gatilho (infiltração com anestésicos, agulhamento seco, acupuntura), fisioterapia, reeducação postural e suporte psicossocial, proporcionou melhora significativa da dor e da qualidade de vida da paciente.

**Descritores:** Dor miofascial, Dor pelviperineal, Pontos-gatilho, Qualidade de vida, Tratamento multidisciplinar.

### INTRODUCTION

Chronic pelvic pain (CPP) is a non-cyclic pain located in the pelvis, abdominal wall anterior and inferior to umbilicus, lumbar and gluteus regions. Chronic pelvic pain courses without specific visceral or identifiable disease, generates physical and emotional incapacity and in general is refractory to treatment<sup>1,2</sup>.

In Brazil, pelviperineal pain is responsible for 10% of gynecological consultations, 17% of hysterectomies and 40% of laparoscopies and its prevalence is estimated to be higher than that found in developed countries<sup>3</sup>.

The diversity of pelvic structures and the broad musculoskeletal framework which involves and supports them, associated to multifactorial, genitourinary, gastrointestinal, neurological and musculoskeletal etiology, make difficult CPP evaluation and diagnosis<sup>4</sup>.

Most frequent cause of non-visceral CPP is the myofascial pain syndrome of musculus levator ani and transversus perinei superficialis and profundus<sup>3,5</sup>. Peripheral nervous system (PNS) and central nervous system (CNS) structures lesions may also induce pelviperineal pain<sup>6</sup>.

The integrated model of multidisciplinary management with simultaneous or sequential therapeutic interventions to rescue physical-psychosocial interaction, associated to analgesics and adjuvants, rehabilitation, anesthetic and neurosurgical procedures, occupational therapy, acupuncture and psychotherapy, when rationally applied, may relieve symptoms and improve quality of life<sup>3,7</sup>.

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This study aimed at showing the difficulty of diagnosing and managing chronic pelvic pain and the importance of the multi-disciplinary team to relieve pain.

## CASE REPORT

Female patient, 45 years old, single, fashion designer, with pain starting in the postoperative period of hysteroscopy for uterine polyp removal. A vaginal septum was "cut" during the procedure (which has never bothered) with vaginal perforation toward the rectum and formation of a vaginal-rectal fistula. She presented repetition urinary infections and vulvovaginitis being treated with antibiotics, vaginal creams, analgesics and anti-inflammatory drugs. Patient was treated by more than 20 physicians without any pain improvement. Today, she no longer has the fistula or menstrual problems, but the same pain persists. She has taken several drugs, however without success. Currently she is under dipirone (2 g/day) and muscle relaxant when pain becomes unbearable, with mild improvement.

Pain was described as throbbing and burning, with constant duration and severe intensity, with visual analog scale (VAS) = 10, and would worsen with movements, staying a long time the orthostatic or sitting position, post-evacuation, post-intercourse, in cold days, in pre-menstrual phase, during moments of tension and anxiety. Improvement factors are local heat, lying in the lateral position, massage, relaxation and muscle relaxant drugs. Sleep is poor and not repairing, being interrupted by pain.

At static evaluation, patient presented cervical kyphosis, lumbar hyperlordosis, hip anteversion, knees hyperextension (typical pelvic pain posture). She also presented systemic ligamentous laxity, hip misalignment (higher right iliac), predominance of right leg support and knees internal rotation. Trigger-points (TP) were bilaterally identified in muscles: superior and inferior rectus abdominis, iliopsoas, gluteus maximus and medius, piriformis, adductor longus and brevis and ischiotibial.

At vaginal touch: uterus of normal size, annexa without abnormalities and presence of TP in musculus transversus perinei superficialis and profundus, bilaterally and more to the right. Rectal touch has identified TP in rectus muscle of levator ani and coccygeus, also more to the right.

Diagnosis was myofascial pain syndrome in the pelvipereineal region and pharmacological treatment was immediately started with amitriptyline (25 mg), tramadol (50 mg) 6/6 h associated to dipirone (1 g) 6/6 h and patient was referred to physiotherapy, psychotherapy and acupuncture.

The physiotherapy team has oriented her on how to sleep, correct sitting, orthostatic and car driving positions. They deactivated TPs with digital pressure, muscle stretching, lower limbs muscles and pelvic girdle rebalancing exercises.

Simultaneously, the medical team performed dry needling in superior and inferior rectus abdominis, iliopsoas, gluteus maximus and medius, piriformis, adductor, ischiotibial, transversus perinei superficialis and profundus, levator ani and coccygeus muscles, and lidocaine infiltration of gluteus maximus and medius, piriformis, adductor, levator ani and coccygeus muscles. Dry needling and TPs infiltration have acted as facilitators for physical rehabilitation.

During two years of clinical follow up, amitriptyline dose was increased to 75 mg, 4% chlorpromazine (5 mg) 3 times a day and pregabalin (150 mg/day) were introduced.

Psychotherapy has applied the projective test, portrait of pain and analysis of stressor factors, in addition to cognitive-behavioral techniques.

Patient is currently asymptomatic with mild pain episodes and VAS between 0 and 2, has normalized her professional and personal life, is no longer using drugs, maintains postural care during daily life activities, and practices regular and continuous physical activities with psychotherapeutic follow up.

## DISCUSSION

The prevalence of CPP in females is approximately 4% and similar to the prevalence of migraine (2.1%), asthma (3.7%) and low back pain (4.1%). Among females aged from 18 to 50 years, approximately 15% to 20% have CPP for more than one year<sup>9,10</sup>. CPP intensity and characteristics may change due to external and internal stimuli, such as ovulation and menstruation, premenstrual syndrome, evacuation, micturition, coitus, systemic diseases, weather, emotions etc. Visceral, non-visceral and neuropathic pain may be superficial or deep, localized, generalized or referred to anterior or posterior thigh, gluteus and abdominal regions<sup>3,11,12</sup>.

Visceral nociceptive stimuli and emotional stress may cause, as visceral-somatic reflex reaction, hyperactivity and tension of muscles of the abdominal wall, thoracolumbar, gluteus, perineal and lower limbs, resulting in regional myofascial pain<sup>3,8,13</sup>.

Triggering and perpetuating factors should be evaluated during anamnesis, as well as previous clinical and surgical interventions, levels of anxiety and depression, panic syndrome symptoms, physical, emotional and sexual violence episodes, which often contribute for pelvic pain chronicity.

During physical exam, one should evaluate reproductive, gastrointestinal, urologic, musculoskeletal and neurologic systems, try to identify the anatomic pain site, the presence of painful points and, whenever possible, correlate them with the painful area<sup>3,14</sup>. Static and dynamic physical evaluation is important in the orthostatic, sitting and lying positions.

Vaginal and rectal touch and digital pressure of lumbar, abdominal, pelvic and perineal regions should be performed to identify TPs. Global neurological exam allows for the evaluation of sensory, motor and neurovegetative systems to help diagnosing neurological diseases. It is critical to evaluate orthostatism and gait to check limbs asymmetry, antalgic and compensatory postures, among others, and to perform vaginal and rectal touch and digital pressure of lumbar abdominal, pelvic and perineal regions to identify myofascial trigger-points. Unidigital examination of pelvic floor muscles allows for the evaluation of local tone, spasm and sensitivity<sup>15</sup>. During pelvic floor palpation one may reproduce, trigger or worsen patient's pain<sup>3,8</sup>.

So, clinical diagnosis is based on anamnesis and physical evaluation, and supplementary exams should be requested and interpreted by validating congruence cases between findings and semiological data.

This case has shown the difficulty of diagnosing and treating CPP (20 physicians) and the need for a multidisciplinary approach to relieve pain and improve patient's quality of life.

## CONCLUSION

Pelvic and perineal myofascial pain syndrome is still poorly known and adequately diagnosed in Brazil, which leads to delay in diagnosis and implementation of adequate therapy, with significant impact on patients' lives.

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