Plenary 6: Pain Issues

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Plenary 6: Pain Issues

Moderator: John L. Marlow
Co-Moderators: Bruce Kahn, John F. Steege

Faculty: Mario E. Castellanos, Austin D. Findley, Rebeca Sandoval, Frank F. Tu, Maya P. Yamamoto

Course Description

This session will provide education and a discussion of chronic pelvic pain. Pudendal neuralgia after vaginal wall surgery using mesh will be described. The long term experience after hysterectomy performed in a pelvic pain center will be presented. The presenters will discuss undiagnosed co-existing pain triggers contributing to pelvic pain in patients with endometriosis. An assessment of the education and training in chronic pelvic pain provided to current AAGL/SRS gynecologic surgery fellows will be provided.

Course Objectives

At the conclusion of this session, the participant will be able to: 1) Evaluate patients with pudendal neuralgia following vaginal wall surgery using mesh; 2) select patients with chronic pelvic pain who may benefit from hysterectomy; and 3) assess the credentials of surgeons trained in current AAGL/SRS fellowships.

Course Outline

12:05  Education and Experience in Chronic Pelvic Pain and Associated Co-Morbid Pain Conditions among AAGL/SRS Minimally Invasive Gynecologic Surgery Fellows  A.D. Findley

12:15  Enhanced Pain Sensitivity among Women with Chronic Pelvic Pain and Dysmenorrhea  F.F. Tu

12:25  Pudendal Neuralgia after Posterior Vaginal Wall Repair with Mesh Kits: An Anatomical Study and Case Series  M.E. Castellanos

12:35  Long Term Outcomes after a Hysterectomy for Chronic Pelvic Pain: A Pelvic Pain Center Experience  M.P. Yamamoto

12:45  Undiagnosed Co-Existing Pain Triggers Contributing to the Perpetuation of Pelvic Pain in Patients with Endometriosis  R. Sandoval

12:55  Discussion

1:05  Adjourn
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop and have no conflict of interest to disclose (in alphabetical order by last name).
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Frank D. Loffer, Executive Vice President/Medical Director, AAGL*
Linda Michels, Executive Director, AAGL*
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The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
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Grants/Research Support: Boston Scientific Corp. Inc.
Consultant: Omniguide
Speaker's Bureau: Warner Chillcott, Johnson & Johnson

Asterisk (*) denotes no financial relationships to disclose.
Education and Experience with Chronic Pelvic Pain and Associated Co-Morbid Pain Conditions Among AAGL/SRS MIGS Fellows

Austin Findley, MD
Erin Carey, MD MSCR
Matthew Siedhoff, MD MSCR
Denniz Zolnoun, MD MPH
John Steege, MD

LEARNING OBJECTIVES

• At the conclusion of this activity, participants will be able to specify:
  – the percent of women affected by chronic pelvic pain
  – the 3 most common pain conditions encountered by AAGL fellows
  – the proportion of fellows who receive didactic training in chronic pelvic pain

BACKGROUND

• Chronic pelvic pain (CPP): non-cyclical pain below the umbilicus for at least 6 months duration that impairs functional status
• Affects 15% of U.S. women
• 10% of all outpatient gynecology visits and primary indication for 20% of hysterectomies
• Annual health care costs >$2 billion
• Strongly associated with other pain conditions

BACKGROUND

Institute of Medicine Report

AAGL/SRS learning objectives:
“The fellow should be able to understand the diagnosis and management of musculoskeletal, neurologic, urological, and gastrointestinal causes of chronic pelvic pain.”

OBJECTIVE

• To assess the education and training experience with chronic pelvic pain and associated co-morbid pain conditions among current AAGL/SRS minimally invasive gynecologic surgery fellows

DISCLOSURES

• I have no financial relationships to disclose.
METHODS

• 13 question, internet-based survey sent to all current AAGL/SRS MIGS fellows in training
• February 2012
• Fellows queried about their education, training, and comfort in treating CPP and other associated pain conditions
• 39/61 (64%) completed survey

RESULTS

Most Comfortable Managing
• Chronic Pelvic Pain
• Endometriosis
• Pelvic Floor Tension Myalgia
• Vulvodynia

Least Comfortable Managing
• Temporomandibular Jaw Disorder
• Fibromyalgia
• Neuralgia
• Migraines
• Low Back Pain
• Interstitial Cystitis
• Irritable Bowel Syndrome

RESULTS

• 27/39 (69%): residency prepared them a little or not at all to treat CPP
• 28/39 (72%): fellowship moderately prepares them or prepares them well to treat CPP
• 14/39 (36%) receive formal didactic training on the evaluation and treatment of CPP in fellowship
• CME courses and formal didactic training most likely method to improve understanding and confidence in treating CPP

CONCLUSIONS

• Commonly encountered by AAGL/SRS MIGS fellows
• Many not comfortable managing common pain conditions
• Formal, structured education lacking in most fellowship programs
• Additional evidence-based didactic training to enhance knowledge and confidence in treating

REFERENCES

Reduced Pain Thresholds Among Women with Chronic Pelvic Pain and Dysmenorrhea

Frank F Tu, MD, MPH; Kevin M Hellman, PhD; Julia J Resnick, MPH; Peter Y Yu; Kristen E Pozolo

Introduction

- Chronic pelvic pain (CPP) and dysmenorrhea are widespread public health problems with poorly understood antecedents.
- Menstrual pain is a known risk factor for chronic pelvic pain disorders such as endometriosis-associated pelvic pain, painful bladder syndrome/interstitial cystitis, and irritable bowel syndrome.
- Somatic pain such as pelvic floor pain syndromes are comorbid in many CPP states suggesting that neural mechanisms of pelvic mechanoreception are heightened in these conditions.

Methods

- Using data from an ongoing study of the physiological determinants of chronic pelvic and bladder pain, we studied 40 non-pregnant women.
- Participants were profiled for demographics and Patient Reported Outcome Measurement Information System (PROMIS) web-based computer adaptive assessments for fatigue, depression, anxiety, pain behavior, pain interference, and sleep disturbance.
- Dysmenorrhea was defined by participant self-reported average menstrual pain ≥ 4 on a numeric rating scale (0-10).
- Participants underwent pressure-pain testing on pelvic floor (right and left iliooccygeus, anterior and posterior vaginal surfaces, and external sites [forehead and right trochanter, hip, and medial knee fat pad, respectively]) in a controlled setting using a 1 cm² contact area custom-built pressure transducer.

Disclosures

- Consultant: Ethicon Endo-Surgery

Introduction

- Work by our group and others has focused on quantifying this pain sensitivity via transvaginal pressure-pain testing (PPT).1,2
- The relative contribution of psychological, visceral, and central neurological factors to the transition from acute to chronic pelvic pain needs to be characterized.
- The present study seeks to determine whether pelvic and global mechanoreception is altered in dysmenorrhea as a contributing factor in the development of CPP.

Methods

- Kruskal-Wallis tests were used to confirm differences between subjects with dysmenorrhea or chronic pain and subjects without dysmenorrhea and chronic pain.
- Spearman correlations were used to compare PROMIS profile responses and pelvic floor PPTs.
- We explored the combined influence of chronic pelvic pain status and dysmenorrhea on experimental PPTs.
- In this preliminary analysis, Kruskal-Wallis and Wilcoxon rank-sum tests were used to identify effects on mechanical pain sensitivity of the primary factors (dysmenorrhea, CPP).
Psychosocial Profiles of Participants

Results

• Age, education and race do not consistently predict internal or external PPTs.
• Fatigue (spearman $\rho = -0.34 - -0.53$), anxiety ($\rho = -0.32 - -0.40$), pain behavior ($\rho = -0.39 - -0.59$) and pain interference ($\rho = -0.39 - -0.58$) are consistently negatively associated with internal PPTs; physical functioning was positively associated with internal PPTs ($0.41 - 0.60$); only social functioning ($\rho = 0.33 - 0.39$) was consistently positively associated with external PPTs (all $p < 0.05$).
• Subjects with chronic pelvic pain were more likely to have dysmenorrhea (chi square $p < 0.05$).
• Non-chronic pain subjects with dysmenorrhea have more depression, anxiety and fatigue compared to subjects without dysmenorrhea ($p's < 0.05$).
• Subjects with chronic pain also have additional alterations in pain behavior, pain interference and sleep disturbance compared to healthy controls ($p's < 0.01$).

Mean PPTs (kg/cm$^2$) for external and pelvic floor sites

Results

• Wilcoxon rank-sum tests on grouped subjects (with and without chronic pain) revealed that dysmenorrhea lowered external mechanical PPTs ($p < 0.01$), with a less robust effect on pelvic floor PPTs ($p = 0.06$).
• In contrast, chronic pain subjects had reductions in external thresholds ($p = 0.02$) and robust reductions in pelvic floor thresholds ($p < 0.001$).
• While preliminary data obtained within individual groups for interactions was insufficient for statistical analysis, a consistent pattern was observed. Non-chronic pain subjects with dysmenorrhea had 38% reduced external thresholds compared to controls, though pelvic thresholds were only 14% lower. In contrast, subjects with chronic pelvic pain had both reduced external (30%) and pelvic floor (41%) thresholds.
Conclusions

• While chronic pelvic pain is associated with both enhanced external and pelvic floor pressure-pain sensitivity, reduced thresholds in dysmenorrhea appear concentrated in sites outside the pelvic floor. Plausibly, aberrant central pain circuits contribute more to the underlying etiology of dysmenorrhea than regional somatic innervation.
• In contrast, the heterogeneous nature of CPP presentation could reflect combined influences of aberrant neuropathic pudendal afferent signaling in addition to deficits in central pain modulation.
• Further modeling of this dataset will accommodate the collective influence of psychological, somatic, and neurological factors on chronic pelvic pain distress.
Pudendal neuralgia after mesh kit placement for posterior vaginal wall repair: An anatomical study and case series.

Mario E. Castellanos, MD1
Johnny Yi, MD2
Okana Akashino, MD1
Nita Decsi, MD1
Michael Hibner, MD PhD1

1. University of Creighton School of Medicine. St. Joseph’s Hospital and Medical Center, Phoenix, AZ
2. Mayo Clinic, Scottsdale, AZ

Disclosures
- No financial relationships to disclose

Background
- Pelvic pain after mesh placement occurs in 1 percent of patients
- Causes of pain include
  - Mesh erosion
  - Pelvic floor tension myalgia
  - Neuralgias
    - Obturator neuralgia
    - Pudendal Neuralgia

Vaginal mesh removal
- Removal of mesh kits vaginally has b

Objectives
- To evaluate how a patient may acquire pudendal nerve injury from placement of the Gynecare Prolift® Posterior Pelvic Floor Repair System
- To review treatments and clinical outcomes of these patients in our practice
Setting

- Academic surgical and chronic pelvic pain practice at the University of Arizona, St. Joseph’s Hospital and Medical Center in Phoenix, Arizona and academic gynecologic surgery practice at the Mayo Clinic, Scottsdale, Arizona

Study Design - Anatomical

- Three unembalmed female cadavers
- Gynecare Prolift® trocars were placed bilaterally according to manufacture’s instructions
- Polyester string was then threaded through the trocar and the trocar removed.
- Cadaveric dissection was performed and the pudendal nerve and string identified
- The closest distance from the trunk of the pudendal nerve and inferior rectal branch to the twine were measured twice by 2 different observers
- 12 total measurements per nerve were recorded (6 sides X 2 observations) and the average and standard deviation were reported

Study design – Case review

- From January 2008 to December 2010, 4 patients were identified who developed symptoms of pudendal neuralgia after Gynecare Prolift® Posterior Pelvic Floor Repair System placement
- Clinical history, treatments, and outcomes were recorded

Results – Anatomical dissection

Results – Rectal nerve dissection

<table>
<thead>
<tr>
<th></th>
<th>Pudendal Nerve</th>
<th>Rectal Nerve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average distance to</td>
<td>16.8</td>
<td>9.7</td>
</tr>
<tr>
<td>trocar in mm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>2.9</td>
<td>2.5</td>
</tr>
</tbody>
</table>
### Results – Chart review

<table>
<thead>
<tr>
<th>Location of pain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient 1</strong></td>
</tr>
<tr>
<td>Right: Clitoris, Perineum, Rectum</td>
</tr>
<tr>
<td><strong>Patient 2</strong></td>
</tr>
<tr>
<td>Left: Perineum, Rectum</td>
</tr>
<tr>
<td><strong>Patient 3</strong></td>
</tr>
<tr>
<td>Left: Perineum, Rectum</td>
</tr>
<tr>
<td><strong>Patient 4</strong></td>
</tr>
<tr>
<td>Right: Perineum, Ischial tuberosity</td>
</tr>
</tbody>
</table>

### Results – Outcomes

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Outcome at 12 month follow up</th>
<th>Intraoperative findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient 1</strong></td>
<td>Physical Therapy</td>
<td>Significant improvement</td>
</tr>
<tr>
<td><strong>Patient 2</strong></td>
<td>Transgluteal pudendal nerve</td>
<td>Significant improvement</td>
</tr>
<tr>
<td><strong>Patient 3</strong></td>
<td>Transgluteal pudendal nerve</td>
<td>Significant improvement</td>
</tr>
<tr>
<td><strong>Patient 4</strong></td>
<td>Transgluteal pudendal nerve</td>
<td>Significant improvement</td>
</tr>
</tbody>
</table>

Patients 2, 3, and 4 presented to our office after undergoing vaginal mesh removal without any improvement

### Conclusions

- The inferior rectal nerve runs in close proximity to the pathway of the Prolift trocar and may be susceptible to injury
- Persistent pelvic pain after vaginal mesh removal may be an indication of pudendal nerve entrapment
- Access to the pudendal nerve via a transgluteal incision allows for nerve decompression and removal of mesh that is otherwise not accessible vaginally

### References

Long Term Outcomes after Hysterectomy for Chronic Pelvic Pain: A Pelvic Pain Center Experience

Miya P. Yamamoto MD, Kaiser Permanente
Katina Foster MD, University of Rochester
Fred M. Howard MD, University of Rochester

Objective:
At the conclusion of this talk, the participants should be able to describe which patient characteristics are associated with higher likelihood of poor long-term outcomes after a hysterectomy for chronic pelvic pain.

Significance of Chronic Pelvic Pain (CPP)

- The “Pandora’s Box” of gynecology
- Affects between 4-15% of women with significant cost to the health care system
- Multi-factorial; difficult to diagnose and treat; no “magic bullet” exists....

Hysterectomy as treatment for CPP: How effective is it?

- 600,000 hysterectomies performed yearly in the US
- Most common indications: symptomatic fibroids, heavy/irregular bleeding, endometriosis, pelvic organ prolapse....
- CPP is the indication in 12-18%

Diagnosis Specific Pelvic Pain

- 1990 Stovall, uterine pain, 21 months, n=99, 22% persistent pain
- 1991 Beard, Pelvic Congestion Syndrome, n=36 women, 12 months, 33% persistent pain

Hysterectomy for CPP

- Hillis 1995, 12 months, n=279, 26% persistent pain
- Hartmann 2004, 24 months, n=359, 14% persistent pain
Risk factors associated with poor Outcomes after Hysterectomy for CPP

- Age < 30 (MacDonald et al. 1999)
- Low income < $35,000, BSO, Therapy for emotional problems (MacDonald et al. 2004)
- Normal histology, age < 30, no pelvic disease, economically disadvantaged, > 2 pregnancies, history of PID (Kjerluff et al. 2000)
- Depression with pain, moderate to severe pain levels, depression (Kjerluff et al. 2000)

Results:

- 106 women underwent a hysterectomy for CPP
- 80 patients had a completed initial intake visit
  - 49 patients had follow-up for ≥ 24 months, average of 46 months
  - 31 patients had follow up for < 24 months, average 6.5 months

Results: Comparison of <24 vs ≥ 24 months

<table>
<thead>
<tr>
<th></th>
<th>Median Income</th>
<th>Age at initial pain</th>
<th>Age at Hysterectomy</th>
<th># Prior surgeries</th>
<th>Parity</th>
<th>Initial Pain Score</th>
<th>Beck Depression Score</th>
<th>McGill Pain Score</th>
<th>No. of CPP diagnoses</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 24 months (n=49)</td>
<td>44,904</td>
<td>27.5</td>
<td>36.9</td>
<td>2.9</td>
<td>8.8</td>
<td>6.2</td>
<td>16</td>
<td>23.8</td>
<td>2.5</td>
<td>0.736</td>
</tr>
<tr>
<td>&lt;24 months (n=31)</td>
<td>45,914</td>
<td>26.6</td>
<td>37.7</td>
<td>2.9</td>
<td>5.6</td>
<td>14.7</td>
<td>18.2</td>
<td>3.5</td>
<td>0.753</td>
<td></td>
</tr>
<tr>
<td>P-value</td>
<td>0.736</td>
<td>0.753</td>
<td>0.635</td>
<td>0.991</td>
<td>0.512</td>
<td>0.002</td>
<td>0.102</td>
<td>0.005</td>
<td>0.889</td>
<td></td>
</tr>
</tbody>
</table>

Results: ≥50% Improvement vs <50%

<table>
<thead>
<tr>
<th></th>
<th>Median Income</th>
<th>Age at initial pain</th>
<th>Age at Hysterectomy</th>
<th># Prior surgeries</th>
<th>Parity</th>
<th>Initial Pain Score</th>
<th>Beck Depression Score</th>
<th>McGill Pain Score</th>
<th>No. of CPP diagnoses</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 50% (33)</td>
<td>47,857</td>
<td>29</td>
<td>38</td>
<td>2.6</td>
<td>1.7</td>
<td>6</td>
<td>13</td>
<td>23</td>
<td>2.5</td>
<td>0.035</td>
</tr>
<tr>
<td>&lt;50% (16)</td>
<td>39,486</td>
<td>27</td>
<td>35</td>
<td>3.5</td>
<td>2.3</td>
<td>6</td>
<td>20</td>
<td>25</td>
<td>2.5</td>
<td>0.422</td>
</tr>
<tr>
<td>P-value</td>
<td>0.035</td>
<td>0.798</td>
<td>0.107</td>
<td>0.052</td>
<td>0.196</td>
<td>0.847</td>
<td>0.019</td>
<td>0.422</td>
<td>0.209</td>
<td></td>
</tr>
</tbody>
</table>
Results: ≥ 50% Improvement vs <50%

<table>
<thead>
<tr>
<th>≥ 50% (33)</th>
<th>≤ 50% (16)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
<td>3.1</td>
<td>≤ 0.001</td>
</tr>
<tr>
<td>1.5</td>
<td>63%</td>
<td>0.305</td>
</tr>
<tr>
<td>70%</td>
<td>36%</td>
<td>0.614</td>
</tr>
<tr>
<td>18%</td>
<td>19%</td>
<td>0.249</td>
</tr>
<tr>
<td>33%</td>
<td>13%</td>
<td>0.108</td>
</tr>
<tr>
<td>33%</td>
<td>44%</td>
<td>0.478</td>
</tr>
<tr>
<td>87 gm</td>
<td>99 gm</td>
<td>0.261</td>
</tr>
</tbody>
</table>

Conclusion:

- At 46 months of follow up after hysterectomy for CPP, 67% (33/49) of patients had a clinically significant improvement in pain levels (≥ 50%)
- 33% (16/49) of patients did not have clinically significant improvement in their pain level
- 4/49 of patients had their pain worsen (8%)

Weaknesses

- Majority patients Caucasian
- Not able evaluate pain scores at 24 months due to lack of visit/documentation
- Abuse score did not give more weight to sexual abuse or physical abuse, not a validated questionnaire
- Retrospective study
- No control cohort of CPP without hysterectomy...

Conclusion:

- Patients who did not have ≥ 50% improvement had statistically significant:
  - Higher Beck Depression Scores which were clinically significant as well (moderate symptoms vs minor symptoms)
  - Higher total abuse scores
  - Lower incomes and rate of proven endometriosis
- But: No difference for presence of dense adhesions or number of initial CPP diagnoses

Thank you:

- Hua He and Xiao Zhang
- Katina Foster, MD
- Fred Howard, MD

Future studies: Comparison of control non-hysterectomy CPP to hysterectomy for CPP

References


References


Undiagnosed co-existing pain triggers contributing to the perpetuation of pelvic pain in patients with endometriosis

Rebeca Sandoval, MD
Alfredo Nieves-Gonzalez, MD
Pelvic Pain and Reconstructive Surgery Center – Chattanooga, TN
University of Tennessee COM-Chattanooga
Department of Obstetrics and Gynecology

Study Objectives

- To identify undiagnosed neuropathic and myopathic conditions in patients with endometriosis and pelvic pain refractory to surgical and conventional pharmacologic therapy.

Study Design

- As part of intake assessment, all patients underwent standardized and validated pain questionnaires.
- Pain diagnoses of interests included:
  - Endometriosis - As per patient history, medical records &/or pathology
  - Chronic Pelvic Pain - Pain > 6 months without evidence of other disease
  - PBS - NIDDK Diagnostic Criteria
  - PFTM - Positive trigger point findings on pelvic examination
  - Vulvodynia - Diagnosed using Friedrich’s Criteria
  - Pudendal Neuralgia - Allodynia along the distribution of the Pudendal nerve
  - Chronic Pain Syndrome - Pain >3 months, impaired function, incomplete relief despite treatment, signs of depression, altered roles

Study Design

- Retrospective study reviewing records over a 5 year period of patients referred to the “Pelvic Pain and Reconstructive Surgery Center”
- Computer search of Electronic Medical Billing Records between 2006 and 2011 was used to identify patients with endometriosis and coexisting pelvic visceral and somatic pain diagnoses.
- Identified charts were thoroughly reviewed to confirm diagnoses and inclusion criteria.
- Endometriosis and co-existing physical exam findings identified by pelvic pain specialist were reported (ie. pudendal neuralgia, vulvodynia, pelvic floor myalgia, and painful bladder)

Inclusion Criteria

- Patients who have failed conventional therapy for endometriosis-related pelvic pain by prior provider.
- Women between the ages of 18-65 with history of pelvic pain and endometriosis.
- Patients will have a history of medical and/or surgical therapy for endometriosis, and complaints of persistent or recurrent pelvic pain despite treatment.

Disclosures:

- I have no financial relationships to disclose.
Preliminary Results

- As per billing data, a total of 347 patients with the diagnosis of endometriosis were seen at the PPSC between 4/1/2006 to 4/5/2012.
- The following data represents preliminary findings after reviewing 25% (86) of identified charts.
- The co-existing visceral and somatic pain diagnoses are shown in order of most to least common.

---

**Diagnosis** | **Total # Patients w Diagnosis** | **% Endometriosis + Specific Pain Dx**
--- | --- | ---
Endometriosis | 86 | --
Chronic Pelvic Pain | 84 | 97.7%
Painful Bladder Syndrome | 73 | 84.9%
Pelvic Floor Myalgia | 54 | 62.8%
Vulvodynia | 45 | 53.3%
Pudendal Neuralgia | 27 | 31.4%
Chronic Pain Syndrome | 89 | .3%

---

**Number of Additional Painful Triggers** | **Number of Patients** | **Percent (of 86 Endometriosis Patients)**
--- | --- | ---
0 | 2 | 2%
1 | 4 | 5%
2 | 53 | 27%
3 | 10 | 12%
4 | 26 | 30%
5 | 10 | 22%
6 | 2 | 2%

- Of 86 charts, only 2 patients had Endometriosis as the only diagnosis = 2%
- 49% had Endometriosis and 2 additional pain diagnoses

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Existing Literature:

- "Finding minimal or no endometriosis in re-operation patients with continuing or recurrent pain suggest that endometriosis is not the only cause of pain..." - Redwine DB. Fert&Ster 1991
- "The definition of chronic pelvic pain and its physical examination criteria need to be revised to exclude obvious causes of pain such as IBS, PFS, and PFMs...to determine which patients will respond preferentially to specific treatments..." - Lamvu G. ACOG 2011

- With either a history of or active endometriosis, 96.4% were also found to have interstitial cystitis on cystoscopy and hydrodistention - Chung MK et al. JSLS 2002
- "Among the 134 patient with endometriosis, 86% were also diagnosed with IC." - Prospective Chung M.D. et al. JSLS 2005
- "In 107 (66%) patients, both endometriosis and interstitial cystitis were found at the same time." - Prospective Pauken D.B. et al. JSLS 2007
- "Interstitial cystitis and painful bladder syndrome was the most common coexistent diagnosis in patients with endometriosis (32%), vulvar vestibulitis (36%), myo-fascial pain syndrome (31%), adhesive disease (36%), and pelvic floor tension myalgia (36%)." - Prospective Prospective J. Rebound & F. 2006.2010

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Weaknesses & Strengths

- Biased in that only 1 physician made diagnosis of major pain triggers
- Performed at a referral center so may not represent finding in general Gyn population
- Self reported history included
- Scarce literature in endometriosis and co-existing pain diagnoses.
- Patient assessment in single facility and by single provider.
- All patients undergo a standardized pain questionnaire and fully documented H&P
Future Studies:

- Most commonly missed diagnoses
- The effect of treating underlying pain conditions
  - Pain improvement - Short and long term
  - Failure rate and need for re-operation/invasive procedures

Conclusion:

- Women who suffer from endometriosis related pelvic pain refractory to conventional therapy may have co-existing and undiagnosed pain triggers contributing to the perpetuation of their symptoms.
- Identifying such conditions can re-direct and expand treatment options.
- Tailoring treatment to include underlying conditions may improve pain symptoms plus decrease the chances of undergoing additional invasive procedures.

Bibliography

- Drez J, Howard F. Use of Short-Form McGill Pain Questionnaire as a Diagnostic Tool in Women with Chronic Pelvic Pain. JMBG. Vol 18. No 2. March/April 2011
CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.