EAU GUIDELINES ON CHRONIC PELVIC PAIN

(Limited text update March 2021)

D. Engeler (Chair), A.P. Baranowski, B. Berghmans, J. Borovicka, A.M. Cottrell, P. Dinis-Oliveira, S. Elneil, J. Hughes, E.J. Messelink (Vice-chair), A.C. de C. Williams
Guidelines Associates: B. Parsons, S. Goonewardene, P. Abreu-Mendes, V. Zumstein

Introduction

The EAU Guideline for Chronic Pelvic Pain plays an important role in the process of consolidation and improvement of care for patients with abdominal and pelvic pain. From both literature and daily practice it has become clear that abdominal and pelvic pain are areas still under development. The EAU Guideline aims to expand the awareness of caregivers in the field of abdominal and pelvic pain and to assist those who treat patients with abdominal and pelvic pain in their daily practice. The guideline is a useful instrument not only for urologists, but also for gynaecologists, surgeons, physiotherapists, psychologists and pain doctors.

This pocket version aims to synthesise the important clinical messages described in the full text and is presented as a series of 'strength rated recommendations', which follow the standard for levels of evidence used by the EAU (see Introduction chapter of the EAU Guidelines book and online at the EAU website http://www.uroweb.org/guideline/).

Chronic pelvic pain syndromes

Classification

Much debate over the classification of chronic pelvic pain has occurred, is ongoing and will continue in the future. Classification involves three aspects of defining a condition: phenotyping, terminology and taxonomy.

Definition of chronic pelvic pain

Chronic pelvic pain is chronic or persistent pain perceived* in structures related to the pelvis of either men or women. It is often associated with negative cognitive, behavioural, sexual and emotional consequences as well as with symptoms suggestive of lower urinary tract, sexual, bowel, pelvic floor or gynaecological dysfunction.

*(*Perceived indicates that the patient and clinician, to the best of their ability from the history, examination and investigations (where appropriate) have localised the pain as being perceived in the specified anatomical pelvic area).*

Definition of CPPPS

Chronic primary pelvic pain syndrome (CPPPS) is the occurrence of chronic pelvic pain when there is no proven infection or other obvious local pathology that may account for the pain. It is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. CPPPS is a sub-division of chronic pelvic pain.

Table 1: Classification of chronic pelvic pain syndromes

Axis I Region		Axis II System	Axis III End-organ as pain syndrome as identified from Hx, Ex and Ix	
Chronic pelvic pain	Chronic secondary pelvic pain syndrome, formally known as specific disease associated pelvic pain OR Chronic primary pelvic pain syndrome, formally known as pelvic pain syndrome	Urological	Prostate	
			Bladder	
			Scrotal Testicular Epididymal	
			Penile Urethral	
			Post-vasectomy	
		Gynaecological	Vulvar Vestibular Clitoral	
			Endometriosis associated	
			CPPPS with cyclical exacerbations	
			Dysmenorrhoea	
		Gastrointestinal	Irritable bowel	
			Chronic anal	
			Intermittent chronic anal	
		Peripheral nerves	Pudendal pain syndrome	
		Sexological	Dyspareunia	
			Pelvic pain with sexual dysfunction	
		Psychological	Any pelvic organ	
		Musculo-skeletal	Pelvic floor muscle Abdominal muscle Spinal	
			Coccyx	

	Axis IV Referral character-istics	AAxis V Temporal characteristics	Axis VI Character	Axis VII Associated symptoms	Axis VIII Psychological symptoms
	Suprapubic Inguinal Urethral Penile/clitoral Perineal Rectal Back Buttocks Thighs	ONSET Acute Chronic ONGOING Sporadic Cyclical Continuous TIME Filling Emptying Immediate post Late post TRIGGER Provoked Spontaneous	Aching Burning Stabbing Electric	UROLOGICAL Frequency Nocturia Hesitance Dysfunctional flow Urgency Incontinence GYNAECOLOGICAL Menstrual Menopause GASTROINTESTINAL Constipation Diarrhoea Bloatedness Urgency Incontinence NEUROLOGICAL Dysaesthesia Hyperaesthesia Allodynia Hyperalegesie SEXUOLOGICAL Satisfaction Female dyspareunia Sexual avoidance Erectile dysfunction Medication MUSCLE Function impairment Fasciculation CUTANEOUS Trophic changes Sensory changes	ANXIETY About pain or putative cause of pain Catastrophic thinking about Pain DEPRESSION Attributed to pain or impact of pain Attributed to other causes Unattributed PTSD SYMPTOMS Re-experiencing Avoidance

Table 2: Chronic Primary Pelvic Pain Syndromes

Primary Urological Pain Syndromes	
Primary prostate pain syndrome	Primary prostate pain syndrome (PPPS) is the occurrence of persistent or recurrent episodic pain (which is convincingly reproduced by prostate palpation). There is no proven infection or other obvious local pathology. PPPS is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction. The term "chronic prostatitis" continues to be equated with that of PPPS. In the authors' and others' opinion, this is an inappropriate term, although it is recognised that it has a long history of use. The National Institutes of Health (NIH) consensus includes infection (types I and II), which the authors feel should not be considered under PPPS, but as specific disease-associated pelvic pain. The term prostadynia has also been used in the past but is no longer recommended by the expert panel. Please note that some of the authors of the IASP document disagree with this term and suggest that CPPPS of the male is used instead of PPPS, which has been agreed by the majority.

Primary bladder pain syndrome	Primary bladder pain syndrome (PBPS) is the occurrence of persistent or recurrent pain perceived in the urinary bladder region, accompanied by at least one other symptom, such as pain worsening with bladder filling and day-time and/or night-time urinary frequency. There is no proven infection or other obvious local pathology. PBPS is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction. PBPS is believed to represent a heterogeneous spectrum of disorders. There may be specific types of inflammation as a feature in subsets of patients. Localisation of the pain can be difficult by examination, and consequently, another localising symptom is required. Cystoscopy with hydrodistension and biopsy may be indicated to define phenotypes. Recently, ESSIC has suggested a standardised scheme of sub-classifications to acknowledge differences and make it easier to compare various studies. Other terms that have been used include "interstitial cystitis", "painful bladder syndrome", and "PBS/IC" or "BPS/IC". These terms are no longer recommended.
Primary scrotal pain syndrome	Primary scrotal pain syndrome is the occurrence of persistent or recurrent episodic pain localised to the scrotum or a structure within it, and may be associated with symptoms suggestive of lower urinary tract or sexual dysfunction. There is no proven infection or other obvious local pathology. Primary scrotal pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences. Primary scrotal pain syndrome is a generic term and is used when the site of the pain is not clearly testicular or epididymal. The pain is not in the skin of the scrotum as such, but perceived within its contents, in a similar way to idiopathic chest pain.

Primary testicular pain syndrome	Primary testicular pain syndrome is the occurrence of persistent or recurrent episodic pain perceived in the testes, and may be associated with symptoms suggestive of lower urinary tract or sexual dysfunction. There is no proven infection or other obvious local pathology. Primary testicular pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences. Previous terms have included orchitis, orchialgia and orchiodynia. These terms are no longer recommended.
Primary epididymal pain syndrome	Primary epididymal pain syndrome is the occurrence of persistent or recurrent episodic pain perceived in the epididymis, and may be associated with symptoms suggestive of lower urinary tract or sexual dysfunction. There is no proven infection or other obvious local pathology. Epididymal pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences.
Primary penile pain syndrome	Primary penile pain syndrome is the occurrence of pain within the penis that is not primarily in the urethra, in the absence of proven infection or other obvious local pathology. Primary penile pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction.
Primary urethral pain syndrome	Primary urethral pain syndrome is the occurrence of chronic or recurrent episodic pain perceived in the urethra, in the absence of proven infection or other obvious local pathology. Primary urethral pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. Primary urethral pain syndrome may occur in men and women.

Post-vasectomy scrotal pain syndrome	Post-vasectomy scrotal pain syndrome is a scrotal pain syndrome that follows vasectomy. Post-vasectomy scrotal pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction. Post-vasectomy pain may be as frequent as 1% following vasectomy, possibly more frequent. The mechanisms are poorly understood and for that reason it is considered by some a special form of primary scrotal pain syndrome.
Primary Gynaecological Pain Syndromes: External Genitalia	
Primary vulvar pain syndrome	Primary vulvar pain syndrome is the occurrence of persistent or recurrent episodic vulvar pain. There is no proven infection or other local obvious pathology. It is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. Although pain perceived in the vulva was included under sexual disorders in the DSM-IV-R manual for classifying psychiatric disorders, there is no scientific basis for this classification, and pain perceived in the vulva is best understood as a pain problem that usually has psychological consequences. There is no evidence for its classification as a psychiatric disorder. The International Society for the Study of Vulvovaginal Disease (ISSVD) has used the term vulvodynia, where the panel use the term primary vulvar pain syndrome. According to the ISSVD, vulvodynia is vulvar pain that is not accounted for by any physical findings. The ISSVD has defined vulvodynia as "vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder". If physical findings are present, the patient is said to have vulvar pain due to a specified cause. The ISSVD has sub-divided vulvodynia based on pain location and temporal characteristics of the pain (e.g., provoked or unprovoked). The following definitions are based on that approach.

Primary generalised vulvar pain syndrome	Primary generalised vulvar pain syndrome refers to a vulvar pain syndrome in which the pain/burning cannot be consistently and precisely localised by point-pressure mapping via probing with a cotton-tipped applicator or similar instrument. Rather, the pain is diffuse and affects all parts of the vulva. The vulvar vestibule (the part that lies between the labia minora into which the urethral meatus and vaginal introitus open) may be involved but the discomfort is not limited to the vestibule. This pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences. Previous terms have included "dysesthetic vulvodynia" and "essential vulvodynia", but are no longer recommended.
Primary localised vulvar pain syndrome	Primary localised vulvar pain syndrome refers to pain that can be consistently and precisely localised by point-pressure mapping to one or more portions of the vulva. Clinically, the pain usually occurs as a result of provocation (touch, pressure or friction). Primary localised vulvar pain syndrome can be sub-divided into primary vestibular pain syndrome and primary clitoral pain syndrome.
Primary vestibular pain syndrome	Primary vestibular pain syndrome refers to pain that can be localised by point-pressure mapping to the vestibule or is well perceived in the area of the vestibule.
Primary clitoral pain syndrome	Primary clitoral pain syndrome refers to pain that can be localised by point-pressure mapping to the clitoris or is well-perceived in the area of the clitoris.

Gynaecological System: internal pelvic pain syndromes	
Endometriosis associated pain syndrome	Endometriosis-associated pain syndrome is chronic or recurrent pelvic pain in patients with laparoscopically confirmed endometriosis, and the term is used when the symptoms persist despite adequate endometriosis treatment. It is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. Many patients have pain above and beyond the endometriotic lesions; this term is used to cover that group of patients. Endometriosis may be an incidental finding, is not always painful, and the degree of disease seen laparoscopically does not correlate with severity of symptoms. As with other patients, they often have more than one end-organ involved. It has been suggested that this phenotype should be removed from the classification because the endometriosis may be irrelevant.
Chronic primary pelvic pain syndrome with cyclical exacerbations	Chronic primary pelvic pain syndrome with cyclical exacerbations covers the non-gynaecological organ pain that frequently shows cyclical exacerbations (e.g., IBS or BPS) as well as pain similar to that associated with endometriosis/adenomyosis but where no pathology is identified. This condition is different from dysmenorrhoea, in which pain is only present with menstruation.
Primary dysmenorrhoea	Primary dysmenorrhoea is pain with menstruation that is not associated with well-defined pathology. Dysmenorrhoea needs to be considered as a chronic primary pain syndrome if it is persistent and associated with negative cognitive, behavioural, sexual or emotional consequences.

Gastrointestinal Pelvic Pain Syndromes	
Irritable bowel syndrome (IBS)	IBS is the occurrence of chronic or recurrent episodic pain perceived in the bowel, in the absence of proven infection or other obvious local pathology. Bowel dysfunction is frequent. IBS is often associated with worry and pre-occupation about bowel function, and negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract or gynaecological dysfunction. The above classification is based upon the Rome III Criteria: three months of continuous or recurring symptoms of abdominal pain or irritation that may be relieved with a bowel movement, may be coupled with a change in frequency, or may be related to a change in stool consistency. Two or more of the following are present at least 25% of the time: change in stool frequency (> three bowel movements per day or < three per week); noticeable difference in stool form (hard, loose, watery or poorly formed stools); passage of mucus in stools; bloating or feeling of abdominal distension; or altered stool passage (e.g., sensation of incomplete evacuation, straining, or urgency). Extra-intestinal symptoms include: nausea, fatigue, full sensation after even a small meal, and vomiting.
Chronic primary anal pain syndrome	Chronic primary anal pain syndrome is the occurrence of chronic or recurrent episodic pain perceived in the anus, in the absence of proven infection or other obvious local pathology. Chronic primary anal pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction.

Intermittent chronic primary anal pain syndrome	Intermittent chronic primary anal pain syndrome refers to severe, brief, episodic pain that seems to arise in the rectum or anal canal and occurs at irregular intervals. This is unrelated to the need to, or the process of defecation. It may be considered a sub-group of the chronic primary anal pain syndromes. It was previously known as "proctalgia fugax" but this term is no longer recommended.
Musculoskeletal System	
Primary pelvic floor muscle pain syndrome	Primary pelvic floor muscle pain syndrome is the occurrence of persistent or recurrent episodic pelvic floor pain. There is no proven well-defined local pathology. It is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. This syndrome may be associated with over-activity of, or trigger points within the pelvic floor muscles. Trigger points may also be found in several muscles, such as the abdominal, thigh and paraspinal muscles and even those not directly related to the pelvis.
Primary coccyx pain syndrome	Primary coccyx pain syndrome is the occurrence of chronic or recurrent episodic pain perceived in the region of the coccyx, in the absence of proven infection or other obvious local pathology. Primary coccyx pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynaecological dysfunction. The term "coccydynia" was used but is no longer recommended.
Chronic Pain Post Surgery	
Chronic post-surgical pain syndrome	The definition of chronic post-surgical pain is chronic pain that develops or increases in intensity after a surgical procedure and persists beyond the healing process, i.e., at least three months after the surgery. There is a separate category for this in the ICD-11 classification.

Epidemiology, Aetiology and Pathophysiology
Chronic visceral pain, pelvic pain and abdominal aspects of pelvic pain

Recommendations	Strength rating
All of those involved in the management of chronic pelvic pain should have knowledge of peripheral and central pain mechanisms.	Strong
The early assessment of patients with chronic pelvic pain should involve investigations aimed at excluding disease-associated pelvic pain.	Strong
Assess functional, emotional, behavioural, sexual and other quality of life issues, such as effect on work and socialisation, early in patients with chronic pelvic pain and address these issues as well as the pain.	Strong
Build up relations with colleagues so as to be able to manage Chronic Primary Pelvic Pain Syndrome comprehensively in a multi-specialty and multi-disciplinary environment with consideration of all their symptoms.	Strong

Diagnostic Evaluation
History and physical examination
History is very important for the evaluation of patients with chronic pelvic pain. Pain syndromes are symptomatic diagnoses which are derived from a history of pain perceived in the region of the pelvis, and absence of other pathology, for a minimum of three out of the past six months. This implies that specific disease-associated pelvic pain caused by bacterial infection, cancer, primary anatomical or functional disease of the pelvic organs, and neurogenic disease must be

ruled out. The history should be comprehensive covering functional as well as pain related symptoms. The clinical examination often serves to confirm or refute the initial impressions gained from a good history. The examination should be aimed at specific questions where the outcome of the examination may change management. As well as a local examination, a general musculoskeletal and neurological examination should be considered an integral part of the assessment and be undertaken, if appropriate.

Figure 1: Diagnosing chronic pelvic pain

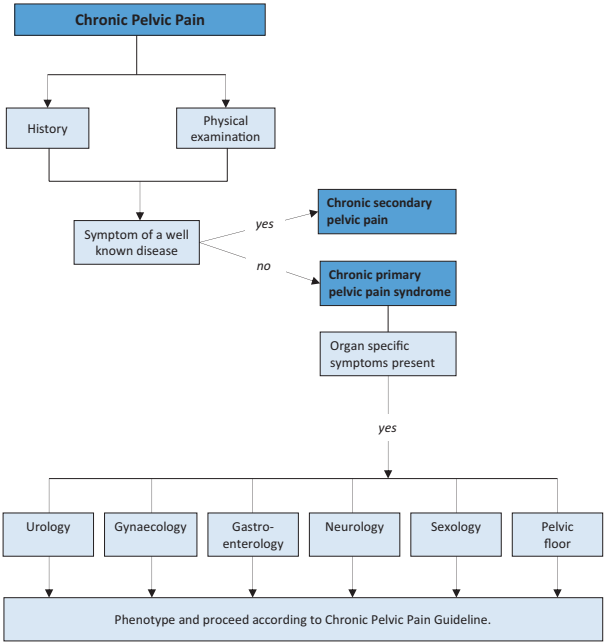

Figure 2: Phenotyping of pelvic pain

Phenotyping	Assessment
Urology	Urinary flow, micturition diary, cystoscopy, ultrasound, uroflowmetry.
Psychology	Anxiety about pain, depression and loss of function, history of negative sexual experiences.
Organ specific	Ask for gynaecological, gastro-intestinal, ano-rectal, sexological complaints. Gynaecological examination, rectal examination.
Infection	Semen culture and urine culture, vaginal swab, stool culture.
Neurological	Ask for neurological complaints (sensory loss, dysaesthesia). Neurological testing during physical examination: sensory problems, sacral reflexes and muscular function.
Tender muscle	Palpation of the pelvic floor muscles, the abdominal muscles and the gluteal muscles.
Sexological	Erectile function, ejaculatory function, post-orgasmic pain.

Recommendations for diagnostic evaluation

Recommendation – general	Strength rating
Take a full history and evaluate to rule out a treatable cause in all patients with chronic pelvic pain.	Strong

Recommendations for the diagnostic evaluation of Primary Prostate Pain Syndrome	Strength rating
Adapt diagnostic procedures to the patient. Exclude specific diseases with similar symptoms.	Strong
Use a validated symptom and quality of life scoring instrument, such as the National Institutes of Health Chronic Prostatitis Symptom Index, for initial assessment and follow-up.	Strong

Assess primary prostate pain syndrome associated negative cognitive, behavioural, sexual, or emotional consequences, as well as symptoms of lower urinary tract and sexual dysfunctions.	Strong

Recommendations for the diagnostic evaluation of Primary Bladder Pain Syndrome	**Strength rating**
Perform general anaesthetic rigid cystoscopy in patients with bladder pain to subtype and rule out confusable disease.	Strong
Diagnose patients with symptoms according to the EAU definition, after primary exclusion of specific diseases, with primary bladder pain syndrome (PBPS) by subtype and phenotype.	Strong
Assess PBPS associated non-bladder diseases systematically.	Strong
Assess PBPS associated negative cognitive, behavioural, sexual, or emotional consequences.	Strong
Use a validated symptom and quality of life scoring instrument for initial assessment and follow-up.	Strong

Recommendations for the diagnostic evaluation of gynaecological aspects of chronic pelvic pain	**Strength rating**
Take a full uro-gynaecological history in those who have had a continence or prolapse non-absorbable mesh inserted and consider specialised imaging of the mesh.	Strong

Refer to a gynaecologist if clinical suspicion of a gynaecological cause for pain following complete urological evaluation. Laparoscopy should be undertaken in accordance with gynaecological guidelines.	Strong

Recommendation for the diagnostic evaluation of Anorectal Pain Syndrome	**Strength rating**
Anorectal function tests are recommended in patients with anorectal pain.	Strong

Recommendations for the diagnostic evaluation of nerves to the pelvis	**Strength rating**
Rule out confusable diseases, such as neoplastic disease, infection, trauma and spinal pathology.	Strong
If a peripheral nerve pain syndrome is suspected, refer early to an expert in the field, working within a multi-disciplinary team environment.	Weak
Imaging and neurophysiology help diagnosis but image and nerve locator guided local anaesthetic injection is preferable.	Weak

Recommendation for the diagnostic evaluation of sexological aspects in CPP	**Strength rating**
Screen patients presenting with symptoms suggestive for chronic pelvic pain syndrome for abuse, without suggesting a causal relation with the pain.	Weak

Recommendations for the diagnostic evaluation of psychological aspects of CPP	Strength rating
Assess patient psychological distress in relation to their pain.	Strong
Ask patients what they think is the cause of their pain and other symptoms to allow the opportunity to inform and reassure.	Strong

Recommendations for the diagnostic evaluation of pelvic floor function	Strength rating
Use the International Continence Society classification for pelvic floor muscle function and dysfunction.	Strong
In patients with chronic primary pelvic pain syndrome, it is recommended to actively look for the presence of myofascial trigger points.	Weak

Management

The philosophy for the management of CPP is based on a bio-psychosocial model. This is a holistic approach with the patients' active involvement. Single interventions rarely work in isolation and need to be considered within a broader personalised management strategy. The management strategy may well have elements of self-management. Pharmacological and non-pharmacological interventions should be considered with a clear understanding of the potential outcomes and end points. These may include: psychology, physiotherapy, drugs and more invasive interventions. Providing information that is personalised and responsive to the patient's problems, conveying belief and concern, is a powerful way to allay anxiety. Additional written information or direction to reliable sources is useful; practitioners tend to rely on locally

produced material or pharmaceutical products of variable quality while endorsing the need for independent materials for patients.

Recommendations for management

Recommendations for the management of Primary Prostate Pain Syndrome	Strength rating
Offer multimodal and phenotypically directed treatment options for Primary Prostate Pain Syndrome (PPPS).	Weak
Use antimicrobial therapy (quinolones or tetracyclines) over a minimum of six weeks in treatment-naïve patients with a duration of PPPS less than one year.	Strong
Use α-blockers for patients with a duration of PPPS less than one year.	Strong
Offer high-dose oral pentosane polysulphate in PPPS.	Weak
Offer acupuncture in PPPS.	Strong
Offer non-steroidal anti-inflammatory drugs in PPPS, but long-term side-effects have to be considered.	Weak

Recommendations for the management of Primary Bladder Pain Syndrome	Strength rating
Offer subtype and phenotype-oriented therapy for the treatment of Primary Bladder Pain Syndrome (PBPS).	Strong
Always consider offering multimodal behavioural, physical and psychological techniques alongside oral or invasive treatments of PBPS.	Strong

Offer dietary advice.	Weak
Administer amitriptyline for treatment of PBPS.	Strong
Offer oral pentosane polysulphate for the treatment of PBPS.	Strong
Offer oral pentosane polysulphate plus subcutaneous heparin in low responders to pentosane polysulphate alone.	Weak
Do not recommend oral corticosteroids for long-term treatment.	Strong
Offer intravesical hyaluronic acid or chondroitin sulphate before more invasive measures.	Weak
Offer intravesical lidocaine plus sodium bicarbonate prior to more invasive methods.	Weak
Offer intravesical heparin before more invasive measures alone or in combination treatment.	Weak
Do not use bladder distension alone as a treatment of PBPS.	Weak
Offer submucosal bladder wall and trigonal injection of botulinum toxin type A (BTX-A) plus hydrodistension if intravesical instillation therapies have failed.	Strong
Offer neuromodulation before more invasive interventions.	Weak
Only undertake ablative and/or reconstructive surgery as the last resort and only by experienced and PBPS-knowledgeable surgeons, following a multi-disciplinary assessment including pain management.	Strong

Offer transurethral resection (or coagulation or laser) of bladder lesions, but in PBPS type 3 C only.	Strong

Recommendations for the management of Scrotal Pain Syndrome	**Strength rating**
Inform about the risk of post-vasectomy pain when counselling patients planned for vasectomy.	Strong
Do open instead of laparoscopic inguinal hernia repair, to reduce the risk of scrotal pain.	Strong
In patients with testicular pain improving after spermatic block, offer microsurgical denervation of the spermatic cord.	Weak

Recommendations for the management of gynaecological aspects of chronic pelvic pain	**Strength rating**
Involve a gynaecologist to provide therapeutic options such as hormonal therapy or surgery in well-defined disease states.	Strong
Provide a multi-disciplinary approach to pain management in persistent disease states.	Strong
All patients who have developed complications after mesh insertion should be referred to a multi-disciplinary service (incorporating pain medicine and surgery).	Strong

Recommendations for functional anorectal pain	Strength rating
Undertake biofeedback treatment in patients with chronic anal pain.	Strong
Offer Botulinum toxin type A in chronic primary anal pain syndrome.	Weak
Offer percutaneous tibial nerve stimulation in chronic primary anal pain syndrome.	Weak
Offer sacral neuromodulation in chronic primary anal pain syndrome.	Weak
Offer inhaled salbutamol in intermittent chronic primary anal pain syndrome.	Weak

Recommendation for the management of nerves to the pelvis	Strength rating
Neuropathic pain guidelines are well-established. Use standard approaches to management of neuropathic pain.	Strong

Recommendations for the management of sexological aspects in chronic pelvic pain	Strength rating
Offer behavioural strategies to the patient and his/her partner to reduce sexual dysfunctions.	Weak
Offer pelvic floor muscle therapy as part of the treatment plan to improve quality of life and sexual function.	Weak

Recommendation for the management of psychological aspects in chronic pelvic pain	Strength rating
For chronic pelvic pain with significant psychological distress, refer patient for chronic pelvic pain-focused psychological treatment.	Strong

Recommendations for the management of pelvic floor dysfunction	Strength rating
Apply myofascial treatment as first-line treatment.	Weak
Offer biofeedback as therapy adjuvant to muscle exercises, in patients with anal pain due to an overactive pelvic floor.	Strong

Recommendations for the management of chronic/non-acute urogenital pain by opioids	Strength rating
Opioids and other drugs of addiction/ dependency should only be prescribed following multi-disciplinary assessment and only after other reasonable treatments have been tried and failed.	Strong
The decision to instigate long-term opioid therapy should be made by an appropriately trained specialist in consultation with the patient and their family doctor.	Strong
Where there is a history or suspicion of drug abuse, involve a psychiatrist or psychologist with an interest in pain management and drug addiction.	Strong

This short booklet is based on the more comprehensive EAU Guidelines (ISBN 978-94-92671-13-4, available to all members of the European Association of Urology at their website, http://www.uroweb.org/guidelines/.