EAU GUIDELINES ON CHRONIC PELVIC PAIN

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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.

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 of chronic pelvic pain 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 Hip muscle	

	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

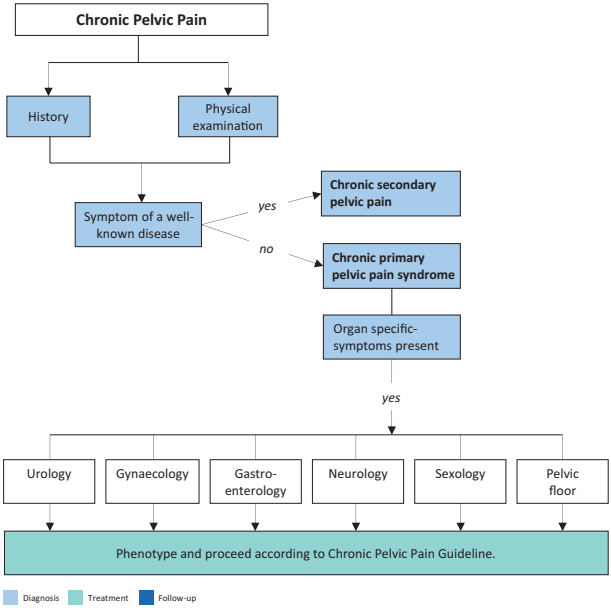
Epidemiology, Aetiology and Pathophysiology
Chronic visceral pain, pelvic pain and abdominal aspects of pelvic pain

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 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



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.

Figure 2: Phenotyping of pelvic 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 following complete urological evaluation if there is a clinical suspicion of a gynaecological cause for pain. 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 factors related to the pain, e.g., pain-related fear, anxiety and depressive symptoms.	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 management of chronic pelvic pain is based on a bio-psychosocial model. This is a holistic approach where patient engagement is fundamental. Communicating empathy and understanding is a prerequisite for patient engagement, which in turn facilitates treatment adherence and improves psychological well-being. Empathic communication should therefore be integrated at all stages in the management of chronic pelvic pain.

Single interventions, including psychology, physiotherapy, drugs and more invasive interventions need to be considered within a broader personalised management strategy, including self-management. All potential interventions should be

explored in collaboration with the patient, aiming for a shared understanding of the potential and realistic outcomes, where benefits, risks and efforts are weighed against each other, and against the possibility of no treatment.

Patient education

Communicating empathy, legitimisation and understanding is particularly important in patient education. Patient education, defined as learning about diseases, symptoms, comorbidities and their management to improve health, is a key component of treatment and should be provided at the very beginning of the treatment process in chronic pelvic pain. Exploring the patient's worries, questions and concerns, and establishing what the patient believes is the cause of pain, is the first step for personalising patient education according to needs.

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 longterm-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
Consider submucosal bladder wall and trigonal injection of botulinum toxin type 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 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 pudendal neuralgia	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 978-94-92671-29-5), available to all members of the European Association of Urology at their website, http://www.uroweb.org/guidelines/.