MANAGEMENT:
The philosophy for the management of chronic pelvic pain (CPP) is based on a bio-psychosocial model. This is a holistic approach with patients’ active involvement. Single interventions rarely work in isolation and need to be considered within a broader personalised management strategy, including self-management.

Conservative management

Pain education: Information improves adherence to treatment and underpins self-management. Physical therapy: the physiotherapist is part of the pain management team (including doctors, psychologists and nurses). Physiotherapists can either specifically treat the pathology of the pelvic floor muscles, or more generally treat myofascial pain if it is part of the pelvic pain syndrome.

Psychological therapy: Psychological interventions may be directed at pain itself or at adjustment to pain in terms of function and mood and reduced health-care use, with or without pain reduction.

Dietary treatment: Scientific data are limited and dietary restriction alone does not produce significant symptomatic relief.

Management of primary prostate pain syndrome (PPPS)

Summary of evidence

LE

Pharmacologically directed treatment may improve treatment success.
3a

ω-blockers have moderate treatment effect regarding total pain, voiding, and QoL scores in PPPS.
3a

Antidepressant therapy has a moderate effect on total pain, voiding, and QoL scores in PPPS.
1a

Non-steroidal anti-inflammatory drugs have moderate overall treatment effects on PPPS.
1a

Psychotherapy has some beneficial effect on pain and overall favourable treatment response in PPPS.
1a

Pentosane polysulphate improves global assessment and QoL score in PPPS.
1b

There are insufficient data on the effectiveness of muscle relaxants in PPPS.
2b

Pregabalin is not effective for the treatment of PPPS.
2b

Botulinum toxin type A injection into the pelvic floor (or prostate) may have a modest effect in PPPS.
2b

Acupuncture is superior to sham acupuncture in improving symptoms and QoL.
3a

Posterior talus nerve stimulation is probably effective for the treatment of PPPS.
1b

Extracorporeal shock wave therapy is probably effective over the short term.
1b

There are insufficient data supporting the use of other surgical treatments, such as transurethral incision of the bladder neck, transurethral resection of the prostate, or radical prostatectomy in patients with PPPS.
3a

Cognitive behavioral therapy designed for PPPS may improve pain and QoL.
3a

Recommendations

Strength rating

Offer multimodal and phenotype-oriented directed treatment options for Primary Prostate Pain Syndrome (PPPS).
Weak

Use an anticoagulant (quinolones or tetracyclines) over a minimum of six weeks in treatment-refractory patients with a duration of PPPS less than one year.
Strong

Use ω-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.
Weak

Offer non-steroidal anti-inflammatory drugs (NSAIDs) in PPPS, but long-term side-effects have to be weighed.
Weak

Management of primary bladder pain syndrome (PBPS)

Summary of evidence

LE

There is insufficient evidence for the long-term use of corticosteroids.
3b

Limited data exist on effectiveness of corticosteroids.
3a

Amphetamine is effective for pain and related symptoms of PBPS.
1b

Oral pentosane polysulphate is effective for pain and related symptoms of PBPS.
1a

Oral pentosane polysulphate plus subcutaneous heparin is effective for pain and related symptoms of PBPS, especially in initially low responders to pentosane polysulphate alone.
1b

Intravesical lidocaine plus sodium bicarbonate is effective in the short term.
1b

Intravesical pentosane polysulphate is effective, based on limited data, and may enhance oral treatment.
3b

There are limited data on the effectiveness of intravesical heparin.
3a

Intravesical chondroitin sulphate may be effective.
2b

There is insufficient data for the use of bladder distension as a therapeutic intervention.
3a

Hydrodistention plus BTX-A is superior to hydrodistention alone.
1b

Intravesical BCG is not effective in PBPS.
1b

Transurethral resection (irrigation and laser) may be effective in PBPS type 3 C.
1b

Sacral neuromodulation may be effective in PBPS.
3b

Pudendal nerve stimulation is superior to sacral neuromodulation for treatment of PBPS.
1b

Avoidance of certain foods and drinks may reduce symptoms.
3a

Outcome of cytotoxicity for PBPS is variable.
3a

Recommendations

Strength rating

Offer sub-type and phenotype-oriented therapy for the treatment of Primary Bladder Pain Syndrome (PBPS).
Strong

Always consider offering multimodal, physical and psychological techniques alongside oral or invasive treatments of PBPS.
Strong

Offer dietary advice.
Weak

Administer amphetamine for treatment of PBPS.
Weak

Offer oral pentosane polysulphate for the treatment of PBPS.
Weak

Offer oral pentosane polysulphate plus subcutaneous heparin to 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

Consider submucosal bladder wall and trigonal injection of botulinum toxin type A plus hydrodistention if invasive 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

Management of scrotal pain syndrome

Summary of evidence

LE

Mesorectal denervation of the spermatic cord is an effective therapy for primary scrotal pain syndrome.
2b

Vasectomy is effective in post-vasectomy pain.
2b

Recommendations

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 mesorectal denervation of the spermatic cord.
Strong

Management of anorectal pain syndrome

Summary of evidence

LE

Biofeedback is the preferred treatment for Chronic Primary Anal Pain Syndrome.
1a

Electro-galvanic stimulation is less effective than biofeedback.
1b

Available evidence fails to confirm effectiveness of BTX-A in management of Chronic Primary Ano-Rectal Pain Syndrome.
3a

Perirectal intrapelvic nerve stimulation is effective in anal pain.
3a

Sacral neuromodulation is effective in anal pain.
3a

Inhaled salbutamol is effective in intermittent Chronic Primary Ano-Rectal Pain Syndrome.
3a

Recommendations

Strength rating

Undertake biofeedback treatment in patients with chronic anal pain.
Strong

Offer percutaneous intrapelvic 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

Recommendations

Strength rating

Involving 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

Management of gynaecological aspects of chronic pelvic pain:

Management of sexological aspects in chronic pelvic pain:

Recommendations

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

Management of pelvic floor dysfunction:

Recommendations

Strength rating

Apply myofascial treatment as first-line treatment.
Weak

Offer biofeedback as therapy adjunctive to muscle exercises, in patients with anal pain due to an ineradicable pelvic floor.
Strong