Features of chronic pelvic pain verification in clinical orthopedic practice

Abstract. Chronic pelvic pain is a complex of pathological and biomechanical changes in the human body that requires a multidisciplinary approach to diagnosis and treatment, due to the high prevalence, underestimation and multifactorial development of this pathological condition. The article provides the overview information and a brief algorithm for chronic pelvic pain verification in men and women for clinical use in medical practice taking into account a comprehensive multidisciplinary approach by physicians of various specialties, including an orthopedist. Diagnostic features and key criteria for specific and nonspecific pelvic pain, pathophysiological mechanisms of chronic pain involving the central, peripheral and autonomic nervous systems, their relationship with the psycho-emotional disturbances are described. The special attention is paid to musculoskeletal pathology as a possible reason for pain and pelvic dysfunction, as well as its secondary changes against the background of gynecological, urological and proctological diseases. The participation of an orthopedist in the process of differentiation of both specific and non-specific pelvic pain is justified. The features of pelvic pain verification are based on international multidisciplinary protocols for its management indicating the pain syndromes according to II Classifcation of IASP Pain and possible classification diagnoses and codes, respectively, ICD-10.

Keywords: chronic pelvic pain; pelvic pain syndrome; “red flags”; musculoskeletal system; men; women; diagnostic algorithm; ICD-10

Chronic pelvic pain (CPP) has a significant effect on men and women of reproductive and non-reproductive age, disrupting their psychological, functional and behavioral status. According to various studies, the CPP prevalence among women varies between 5.6 to 30.9% [1] and among men — between 2 to 17% [2, 3]. The CPP affects women more often than men due to the genetic, hormonal, socio-cultural and other factors. Most CPP cases are accompanied by psychosocial adaptation disorders, worsening of mood, reduction of sexual activity and general life quality, cognitive-neurological disorders included [4].

According to some prognoses, chronic health problems, associated with pelvic pains, will increase to twice their number during the next 30 years due the increase of numbers of men and women over 65 years [5]. On the other hand, according to various sources, the CPP remains undiagnosed or underestimated in 55-70% of cases because of the irregular nature of the examined patient categories, insufficient standardization of terminology, patients’ concealing the symptoms because of the assumed intimate and sensitive nature of this information [5], as well as an inadequate understanding of risk factors, possible diagnostic options and treatment by the medical personnel [6]. Furthermore, one and the same patient may present various signs, for instance, pelvic pain, trigger points in the muscles, symptoms from the urinary tracts, prompting repeated visits to gynecologists and urologists, sometimes neurologists and sexologists, and very rarely to an orthopedist who may solve the problem of pain in a comprehensive manner [7].

Taking into account the multifactorial nature, high prevalence and an underestimated character of CPP, practitioners of the leading countries follow the unified multidisciplinary protocols of CPP management [8, 9, 10]. In the European countries, the foundation is laid by «The guidelines of European Association of Urology (EAU)» [11], developed according to the II IASP (International Association for the Study of Pain) Pain Classification. Regional guidelines on CPP management do not differ radically, and all of them require an orthopedist’s obligatory involvement at the stage of diagnostic decision making. Since the diagnostics of gynecological and/or urological conditions, with a pelvic pain as a symptom, does not pose difficulties for the specialists, we aim at presenting a review and short algorithm of CPP verification from the perspective of orthopedist-vertebrologist, listing pain syndromes according to the II IASP Pain
Classification and possible classifications of diagnosis and syndromes according to the ICD-10.

According to the II IASP Pain Classification, which makes the basis of the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) [12], the CPP is defined as a continuous, unremitted or persistent pain during no less than 6 months, subjectively experienced by a patient and determined by a physician (according to the objective and instrumental data) in the pelvic anatomical region [13] (Block F. Visceral and other syndromes of the trunk apart from spinal and radicular pain).

According to the «Guidelines of EAU» [11], chronic pelvic pain may be subdivided into conditions with a distinct classical pathology (for instance, infection or cancer (“specific, disease-associated pelvic pain”)) or no obvious pathology (non-specific, “syndrome of chronic pelvic pain”, CPPS).

Chronic pelvic pain is a chronic or constant pain, experienced in the structures associated with the pelvis either in men or in women, often associated with negative cognitive, behavioral, sexual and emotional disorders, as well as symptoms of the lower urinary tract dysfunction, reproductive organs, intestine, pelvic floor or gynecological disorders.

Specific pain syndrome is related to a principal complaint, namely:
- Determined pelvic organ pathology [«F: XXIV. Diseases of the bladder, uterus, ovaries, testis, and prostate, and their adnexa»];
- Peripheral nerve injuries (iliohypogastric, ilioinguinal, genitofemoral, genital), including the postsurgical ones [«F: XXV. Pain perceived in the rectum, perineum, and external genitalia of nociceptive or neuropathic cause»];
- Pathologies of sacrum and coccyx, including radicular syndromes, congenital diseases, traumas, tumors, fractures, bone and joint infections [«G: XXVII. Sacral spinal or radicular pain syndromes» and «G: XXVIII. Coccygeal pain syndromes»];
- Lumbar-sacral pain associated with a determined pathology of internal organs [«G: XXVII-8. Pain referred from abdominal or pelvic viscera or vessels perceived as sacral spinal pain» and «G: XXIX-5. Back pain of other visceral or neurological origin involving the spine»].

If the principal complaint is absent, unconfirmed by anamnesis, instrumental and/or laboratory methods, the pain syndrome is considered non-specific. Non-specific CPP, or chronic pelvic pain syndrome [CPPS; «F: XXIII. Chronic pelvic pain syndromes (CPPS)»] is a chronic pelvic pain without any confirmed or obvious local pathology, trauma or infection, potentially explaining the pain’s cause. The CPPS is attended by negative psychological, behavioral and sexual disorders, as well as symptoms of the lower urinary tract and intestinal dysfunction, reproductive disorders. The CPPS is always a part of CPP.

Conflicts of interests. Author declares the absence of any conflicts of interests and their own financial interest that might be construed to influence the results or interpretation of their manuscript.

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Information about author
Tatiana Orlyk, MD, PhD, Rheumatologist, Medical Center “Polі-Кlіnіка”, Kyiv, Ukraine

Орлік Т.В.
МЦ «Полі-Клініка», м. Київ, Україна

Особливості верифікації хронічного тазового болю в клінічній ортопедичній практиці

Резюме. Хронічний тазовий біль — комплекс патологічних і біомеханічних змін в організмі, що вимагає мультиспеціалістичного підходу до діагностики та лікування у зв'язку із значною поширеністю, недооціненістю та мультифакторністю розвитку цього патологічного стану. У статті наведені оглядова інформація та короткий алгоритм верифікації хронічного тазового болю у чоловіків і жінок для клінічного використання. У статті зазначено скелетно-м'язові патології як в основному, так і на фоні метаболічних, нейроенцефалічних, гонадних синдромів цієї ділянки, а також її вторинних змін на тлі гінекологічних, урологічних і проктологічних захворювань.


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49
Орлик Т.В.
МЦ «Поли-Клиника», г. Киев, Украина

Особенности верификации хронических тазовых болей в клинической ортопедической практике

Резюме. Хроническая тазовая боль — комплекс патологических и биомеханических изменений в организме, требующий мультидисциплинарного подхода к диагностике и лечению в связи с высокой распространенностью, недооцененностью и мультифакторностью развития этого патологического состояния. В статье представлены обзорная информация и краткий алгоритм верификации хронической тазовой боли у мужчин и женщин для клинического использования в медицинской практике врачей различных специальностей, в том числе ортопеда, с учетом комплексного мультидисциплинарного подхода. Описаны диагностические особенности и ключевые критерии специфической и неспецифической тазовой боли, патофизиологические механизмы хронизации болевого синдрома с вовлечением центральной, периферической и вегетативной нервной системы, их связь с нарушением психоэмоционального состояния. Особое внимание уделено скелетно-мышечной патологии как возможной причине развития дисфункции тазового региона и болевых синдромов этой области, а также ее вторичным изменениям на фоне гинекологических, урологических и проктологических заболеваний. Обосновано участие врача-ортопеда в процессе дифференциальной диагностики как специфической, так и неспецифической тазовой боли. Особенности верификации боли в регионе таза основаны на международных мультидисциплинарных протоколах менеджмента тазовых болей с указанием болевых синдромов согласно II классификации боли IASP и возможных классификационных диагнозов и кодов соответственно МКБ-10.

Ключевые слова: хроническая тазовая боль; синдром тазовой боли; «красные флажки»; скелетно-мышечная система; мужчины; женщины; алгоритм диагностики; МКБ-10