Interventions for treating chronic pelvic pain in women

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The progestogen medroxyprogesterone acetate is associated with a reduction of pain at the end of treatment, but the benefit is not sustained nine months post treatment. Counseling supported by ultrasound scanning is associated with reduced pain and improvement in mood.

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1. EVIDENCE SUMMARY

This review concludes that the progestogen, medroxyprogesterone acetate, is associated with a reduction of pain at the end of treatment, but the benefit is not sustained nine months post treatment. One trial comparing goserelin with progesterone suggests possible beneficial effects for goserelin up to one year. Counseling supported by ultrasound scanning is associated with reduced pain and improvement in mood. A multidisciplinary approach is beneficial only for some outcome measures. Dihydroergotamine and adhesiolysis do not result in an improved outcome, although the former is not a current therapy.

The review methodology was sound and it included a wide range of available studies. For treatment with medroxyprogesterone acetate two studies were included, but for the other interventions only single studies were identified. It was surprising to see the small number of subjects in the studies and the limited number of studies available on this subject. The quality of some of the studies was inadequate. As noted by the reviewers, the small number of studies and the small number of participants in these trials were a major limitation of the review.

2. RELEVANCE TO UNDER-RESOURCED SETTINGS

2.1. Magnitude of the problem

Chronic pelvic pain is common in women in the reproductive age group both in developed and developing countries (1). According to a population-based estimate, chronic pelvic pain affects approximately 15% of women aged 18-50 (3). The psychosocial impact of chronic pelvic pain is reflected in mood disturbance, disruption of normal activity and relationships as well as pain (2). Chronic pelvic pain is an important cause of attendance at gynaecology clinics and is associated with significant costs to the health system (4).
2.2. Feasibility of the intervention

Apart from the cost of the interventions, varying from one country to another, the progestogen medroxyprogesterone acetate represents the therapy of choice for chronic pelvic pain. It has the additional advantage that it needs to be administered every three months in the form of a single injection. Counseling supported by ultrasound scanning would not be feasible because of financial constraints in under-resourced settings.

2.3. Applicability of the results of the Cochrane Review

The trials that met the inclusion criteria were conducted in New Zealand, the United Kingdom, the USA, the Netherlands and Turkey. Since all the studies were small, the conclusions of the review are not generally applicable in both developed as well as developing countries. Another limitation in terms of applicability of the findings is the cost of treatments and equipment. Ultrasound scanning is not available in many settings in developing countries, and the routine use of medroxyprogesterone acetate or goserelin for chronic pelvic pain may not be affordable because of its cost, especially in the absence of substantial benefit.

2.4. Implementation of the intervention

The administration of medroxyprogesterone acetate would not need any special training for health staff. On the other hand, counseling with ultrasound reassurance and multidisciplinary approaches may require training of staff where trained staff is not available. However, the evidence from the review is not compelling enough to justify allocating resources for either of these interventions.

2.5. Research

The studies included in this review did not have adequate number of women to allow drawing meaningful conclusions. Moreover the number of interventions for chronic pelvic pain covered in this review was limited. Further research is needed in order to test the effectiveness of promising interventions. As the reviewers state, the pathogenesis of chronic pelvic pain is poorly understood and could be associated with both non-detected organic and psychosocial disorders, including the relationship between the woman and her environment and between the woman and her partner. Therefore, a single intervention may not be sufficient to obtain the desired results in all cases. A combination of therapies could be tested, e.g. use of antidepressants (4) combined with different kind of analgesics and diuretics (5), or with progestins (such as medroxyprogesterone acetate). The latter seems to be beneficial at least during the course of therapy. Some other interventions have arisen in the last years, but these have not been tested in methodologically adequate trials. They include ovarian and internal iliac vein embolization (6), laparoscopic plication and suspension of the round ligament for chronic pelvic pain and dyspareunia (7), the use of a vasopressin antagonist (Atosiban) (8, 9), adhesiolysis (10) and anti-leukotrienes (11), as well as an interdisciplinary approach orientated towards psychosomatic disorders (12, 13). Finally, there are some other possible interventions to be tested in both developing and industrialized countries, e.g. natural and traditional therapies such as acupuncture and diet (14, 15), alone or in combination with other therapies. Natural and traditional therapies are potentially promising as they are inexpensive and may be provided by non-medical health care workers.

References

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