The Beck Depression Inventory.

Women who have chronic pelvic pain also have periﬁrms or levator ani tenderness, according to a study presented by Dr. Frank Tu at a meeting sponsored by the International Pelvic Pain Society.

Musculoskeletal dysfunction—including tenderness and spasm of the levator ani and periﬁrms—has been reported as a treatable cause of chronic pelvic pain. The efﬁcacy of treatments such as manual therapies, electrical stimulation, injected medications, and surgeries ranges from 20% to 90%, according to the literature, which is mostly comprised of case studies.

Although musculoskeletal dysfunction is increasingly implicated as a cause of many pelvic pain conditions such as interstitial cystitis, we really don’t have much information about the diagnosis, evaluation, treatment, and epidemiology of this particular condition,” Dr. Tu said. “This is the ﬁrst study to look at the frequency of these disorders in a large referral clinic population.”

A retrospective study of 987 women referred to a pelvic pain clinic at the University of North Carolina, Chapel Hill, for chronic pelvic pain, found levator ani tenderness in 22% and periﬁrms tenderness in 13% of the 942 of patients evaluated for those conditions.

There were no differences between those with periﬁrms tenderness and those with levator ani tenderness in age (mean 30 years), pain duration, or sexual abuse history. Of the 987 women studied, 288 had a history of sexual abuse, said Dr. Tu, noting that the proportion of women with a history of abuse did not differ between the women with and without musculoskeletal dysfunction.

In all, 85% of patients had pain for at least 6 months, and most had daily pain. Two-thirds of the cohort had a diagnosis of depression, based on the Beck Depression Inventory.

Musculoskeletal Dysfunction Has Role in Pelvic Pain

BY PATRICIE WENDLING  Contributing Writer

CHICAGO — Up to one-fourth of women with chronic pelvic pain also have periﬁrms or levator ani tenderness, according to a study presented by Dr. Frank Tu at a meeting sponsored by the International Pelvic Pain Society.

Females who have vulvar disease should be asked speciﬁcally about bladder and bowel pain, and treated accordingly, Colleen M. Kennedy, M.D., advised. Such women are twice as likely as are general gynecology patients to have bladder pain and bowel pain. “We hypothesize that certain vulvar or vaginal diseases are not isolated clinical entities, but rather represent symptoms of a global or generalized pelvic ﬂoor disorder,” she said at the annual meeting of the Central Association of Obstetricians and Gynecologists.

Dr. Kennedy and her associates at the University of Iowa, Iowa City, assessed the rates of painful bladder syndrome (interstitial cystitis) and irritable bowel syndrome in 324 women who were being treated at a vulvar disease clinic, and compared them with the rates among a control subset attending a general gynecology clinic.

Of the women with vulvar disease, 12% reported bladder pain, vs. 6% of the controls. Similarly, 23% of those with vulvar disease had bowel pain, vs. 11% of controls.

The data showed that women with bladder pain were 2.2 times more likely than those without to have been treated for vulvar disease. Women with vulvar disease had a mean score of 20.3 on the Urinary Distress Inventory’s pain subscale, compared with 5.3 for women without vulvar disease.

Likewise, women with functional bowel disorders were 2.1 times more likely than those without such disorders to have been treated for vulvar disease.

The higher prevalence of painful bladder and painful bowel syndrome in women with vulvar disease may reﬂect a common etiology for all these disorders. The design of this study, however, did not allow the researchers to tease out whether there is a common etiology “or whether treatments for one disorder may exacerbate or cause the other disorders.”

“The diagnosis of vulvar disease is more reliably made if the patient’s score on that questionnaire—the Pelvic Pain and Urgency/Frequency (PUF) symptom pain scale—suggests interstitial cystitis (IC), then diagnostic tests are indicated,” she said.

A standardized abdominal exam was performed on all patients that included a single-digit intravaginal palpation of the levator ani and periﬁrms muscles, and either a Kegel contraction to iden- tify the levators or an external hip rotation to iden- tify the periﬁrms.

A visual analog score of 0-10 was assigned by the physician to rate the degree of clinically meaningful tenderness. Periﬁrms and levator ani tenderness was posi- tively associated with the number of painful abdominal pelvic locations reported, pain associ- ated with bowel movements, and higher Beck Depression Inventory and McGill Pain Question- nnaire scores.

Patients with levator ani tenderness reported 4.6 pain locations, compared with 3.7 locations for those without such tenderness; patients with and without periﬁrms tenderness reported 4.6 and 3.8 pain locations, respectively.

Pain with bowel movements was reported by 372 study patients, including 51% of those with levator ani tenderness 50% of those with periﬁrms tenderness.

Levator ani tenderness was positively associ- ated with a higher number of surgeries for pain. Of the 212 patients with levator ani tenderness, 23% had no previous surgeries, 61% had one-to-three surgeries, and 17% had more than three surgeries, compared with 30%, 60%, and 10%, respectively, of those without levator ani tenderness.

Levator ani tenderness was positively associ- ated with pain that worsened with intercourse, although there was a trend toward a higher proportion with periﬁrms tenderness.

The data suggest that the prevalence of periﬁrms and levator ani tenderness may be increased among women with more intense chronic pelvic pain, said Dr. Tu, director of the division of chronic pelvic pain, department of ob.gyn., Evanston (Ill.) Hospital. A possible association with dyschezia also may exist.

Chronic Pelvic Pain Could Signal Interstitial Cystitis

BY MIRIAM E. TUCKER  Senior Writer

SAN FRANCISCO — In a large majority of women presenting with chronic pelvic pain, the bladder is the pain generator, Edward J. Stanford, M.D., said at the annual meeting of the American Association of Gynecologic Laparoscopists.

In three studies involving almost 300 women with chronic pelvic pain, the prevalence of interstitial cystitis ranged from 70% to 82%, said Dr. Stanford of St. Mary’s Good Samaritan Medical Center, Centralia, Ill.

The higher prevalence of painful bladder and painful bowel syndrome in women with vulvar disease may reﬂect a common etiology for all these disorders. The design of this study, however, did not allow the researchers to tease out whether there is a common etiology “or whether treatments for one disorder may exacerbate or cause the other disorders.”

From a clinical point of view, it is clear that women with vulvar disease should be queried about bladder and bowel pain, and treated accordingly,” Dr. Kennedy said.

The study also showed that women with vulvar disease had nearly a fourfold higher risk of undergoing hysterectomy than did the general gynecology patients. “To our knowledge, ours is the ﬁrst large clinic comparison to re- port this association,” she said.

Despite alleviation of their uterine bleeding, both reported postoperative chronic pelvic pain, along with urinary urgency and frequency, dysuria, rectal pain, perineal pain, dysmenorrhea, decreased sexual intimacy, and decreased quality of life.

Choosing a review of their surgical pathology reports and examination of uterine shavings or laser-excised tissue strips to exclude subbasalis diagnoses, “pure” adenosomy was conﬁrmed in 48 (28%) of the women. Of them, 32 (67%) had a score greater than 6 on the PUF scale, suggesting IC. Of those 32, 27 (84%) had positive potassium sensitivity test scores.

With use of established criteria for cystoscopy/hydrodistention, IC was conﬁrmed in 25 (78%) of the 32 women, and in 6 (6%) of the 16 women with PUF scores less than 6.

Of the remaining 124 chronic pelvic pain patients who did not have IC, 54 were ran- domly selected for the same disease screening. Of those 54 (6%) who had a score greater than or equal to 6 on the PUF scale, 48 (85%) had symptoms consistent with IC. Of those 48 (85%), 45 (93%) were conﬁrmed in contrast to the total 60% (11%) who had a score of 6 or less on the PUF scale.