Endometriosis is often only part of the problem.

PERSISTENT PELVIC PAIN

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Diagnosing the cause of this common disorder is often delayed as there is no good diagnostic test.

PERSISTENT pelvic pain (PPP), also referred to as chronic pelvic pain (CPP), is estimated to affect 15-25% of women worldwide and may cost the Australian economy upwards of $6 billion annually.

It is diagnosed when pelvic pain has been present on most days for more than 3-6 months.

While many women with pelvic pain have had, or will have, a diagnosis of endometriosis made at some time, this is frequently only part of their persistent pain problem.

The symptoms they present with may be due to any one of several comorbidities often found in women with endometriosis.

These comorbidities might include:

- Painful bladder syndrome (frequency, nocturia, urgency)
- Irritable bowel syndrome with food sensitivities
- Pelvic muscle pain (stabbing or aching pains, dyspareunia)
- Uterine pain
- Recurrent candidiasis
- Provoked vulvar vestibulodynia (sensitivity of the skin at the opening of the vagina).

DELAYED DIAGNOSIS

None of these usually show on ultrasound examination or laparoscopy, so diagnosis is frequently delayed.

In addition, the patient may have fatigue, anxiety, low mood, nausea, dizziness, sweating and headaches, which are commonly found in conjunction with persistent pain and considered to represent aspects of central and peripheral sensitisation.

With so many types of pain that can't be seen at a laparoscopy, and a mix of seemingly unrelated symptoms, it's not surprising that women find getting a diagnosis for their pain and appropriate management so frustrating.

CLINICAL ASSESSMENT

Q1. What was your health like before your periods began and what was your first pain symptom?

This helps determine which pain condition started the problem. While painful periods are a common first symptom, an irritable bowel, non-specific abdominal pain, migraine headaches or a painful bladder are also common.

Q2. What were your periods like as a teenager?

Where periods were painful as a teen, and particularly where there is a family history of endometriosis or pain does not resolve with the oral contraceptive pill, then endometriosis is commonly present.

Q3. How many days a month do you have pelvic pain of any kind?

If there has been pain on most days for more than 3-6 months, then central or peripheral sensitisation is likely to be present.

CASE STUDY

Marie, aged 16, came with her mother to discuss her severe pelvic pain. Periods had been painful and heavy from when they started, but for the last year she'd had pain on more days and new types of pain. All of her pain symptoms were discussed, which included period pain for seven days each month (despite taking the contraceptive pill), pain on movement with some stabbing pain that she considered her worst pain (pelvic muscle spasm); an overactive bladder with nocturia (bladder pain syndrome); migraines with periods; a headache of some kind on most days; and constipation.

Marie was missing school, felt disconnected from her friends and had begun to self-harm. Marie's mother knew how bad these pains were. She'd had endometriosis herself and didn't want her daughter suffering as she had.

Laparoscopy showed the typical tiny clear lesions of endometriosis so common in teenagers, and so easily missed, which were completely excised.

However, with a complex clinical picture such as this, surgery alone will not be sufficient. We made the following plan:

- Mirena IUD in combination with a continuous low-dose oral contraceptive to achieve amenorrhoea.
- Pelvic physiotherapy to teach pelvic muscle downtraining, relaxation and encourage regular gentle exercise. While core exercise can exacerbate pelvic muscle spasm in this situation, regular exercise should be considered essential.
- Amitriptyline in low-dose 10mg for her background headache, poor sleep and central sensitisation. In those with a painful bladder, higher doses may be required. Should this be too sedating, nortriptyline would be an option, or alternatively, duloxetine with its SNRI effect.
- Pain psychology to aid her return to school, approach to pain, and re-engagement with peers.
- Dietary advice for her constipation and irritable bowel.
- Diclofenac 100mg suppositories or imigran for severe headaches if they occur.

At review two years later, she was back at school, socially reconnected and well, apart from recurrent vaginal candidiasis which was managed with oral fluconazole.

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