11. Assessment of Chronic Pelvic Pain

Patients may present with a focus on an end organ, such as bladder, prostate or uterus, but also have associated sexual dysfunction, urogenital complications, resultant isolation, and concomitant effect on mood, emotions, and behaviour.

History

- General history of pain duration, cause (if known), development over time, location and radiation, impact on activities of daily living, easing and exacerbating features, severity and variation.
- Review what the patient avoids or is prevented from doing due to the pain.
- Note any difficulties or anxieties and ask about any anxieties related to health or work.
- Review the effects of past medical history, eg frequency of UTIs, thrush, STDs, congenital anomalies, and whether these episodes were proven or implied.
- Assess bladder, bowel and menstrual symptoms.
- Assess the effect pain is having on sexual function, feelings, and activity, including avoidance and refer to counselling if indicated.

Tools for the assessment of pain intensity and impact: *(click on text below)*
Chronic pain grade
Pain disability index
Brief pain inventory

Examination
It may be appropriate to defer or delay an examination if it will not add to the clinical picture or if it is not possible within the time constraints of the initial consultation:

- Assess posture (standing and sitting), effect of movement on pain and the function and range of movement in the lumbar spine and hips.

Where relevant, assess:

- skin changes, infection, damage
- the area the patient localises for the pain
- CNS assessment including light touch and pin prick as appropriate
- internal assessment vaginal and/or rectal
- bi-manual examination to exclude masses or bartolin cysts
- tip assessment for vulvodynia
- basic pelvic floor assessment for trigger points