



Complete Summary

GUIDELINE TITLE

General treatment of chronic pelvic pain. In: Guidelines on chronic pelvic pain.

BIBLIOGRAPHIC SOURCE(S)

General treatment of chronic pelvic pain. In: Fall M, Baranowski AP, Elneil S, Engeler D, Hughes J, Messelink EJ, Oberpenning F, Williams AC. Guidelines on chronic pelvic pain. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. p. 84-97. [27 references]

GUIDELINE STATUS

This is the current release of the guideline.

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SCOPE

DISEASE/CONDITION(S)

Chronic pelvic pain

GUIDELINE CATEGORY

Treatment

CLINICAL SPECIALTY

Obstetrics and Gynecology
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To help urologists in the clinical decisions they make every day
- To provide access to the best contemporaneous consensus view on the most appropriate management currently available

TARGET POPULATION

Patients with chronic pelvic pain

INTERVENTIONS AND PRACTICES CONSIDERED

1. Simple analgesics (paracetamol, cyclooxygenase isoenzyme 2 [COX2] inhibitors, non-steroidal anti-inflammatory drugs [NSAIDs])
2. Neuropathic analgesics
 - Tricyclic antidepressants (amitriptyline, fluoxetine, dothiepin, imipramine, nortriptyline)
 - Anticonvulsants (gabapentin, carbamazepine)
 - N-methyl-D-aspartate antagonists (ketamine)
 - Sodium channel blockers (lidocaine)
 - Opioids and opioid-like agents (morphine, transdermal fentanyl, methadone, oxycodone [no recommendation], naloxone, buprenorphine, codeine, dihydrocodeine, tramadol)
3. Nerve blocks
4. Transcutaneous nerve stimulation (TENS)
5. Sacral neuromodulation

MAJOR OUTCOMES CONSIDERED

- Pain relief and control
- Quality of life
- Side effects of treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A structured literature search was performed but this search was limited to randomized controlled trials and meta-analyses, covering at least the past three years, or up until the date of the latest text update if this exceeds the three-year period. Other excellent sources to include were other high-level evidence,

Cochrane review and available high-quality guidelines produced by other expert groups or organizations. If there were no high-level data available, the only option was to include lower-level data. The choice of literature was guided by the expertise and knowledge of the Guidelines Working Group.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

1b Evidence obtained from at least one randomized trial

2a Evidence obtained from one well-designed controlled study without randomization

2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

- The first step in the European Association of Urology (EAU) guidelines procedure is to define the main topic.
- The second step is to establish a working group. The working groups comprise about 4 to 8 members, from several countries. Most of the working group members are academic urologists with a special interest in the topic. Specialists from other medical fields (pain medicine, psychology, radiotherapy, oncology, gynaecology, anaesthesiology, etc.) are included as full members of the working groups as needed. In general, general practitioners or patient representatives are not part of the working groups. Each member is appointed for a four-year period, renewable once. A chairman leads each group.
- The third step is to collect and evaluate the underlying evidence from the published literature.
- The fourth step is to structure and present the information. All main recommendations are summarized in boxes and the strength of the recommendation is clearly marked in three grades (A-C), depending on the evidence source upon which the recommendation is based. Every possible effort is made to make the linkage between the level of evidence and grade of recommendation as transparent as possible.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation

- A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
- B. Based on well-conducted clinical studies, but without randomized clinical studies
- C. Made despite the absence of directly applicable clinical studies of good quality

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Appraisal of Guidelines for Research and Evaluation (AGREE) instrument was used to analyse and assess a range of specific attributes contributing to the validity of a specific clinical guideline. The AGREE instrument, to be used by two to four appraisers, was developed by the AGREE collaboration (www.agreecollaboration.org) using referenced sources for the evaluation of specific guidelines. (See the "Availability of Companion Documents" field for further methodology information).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the level of evidence (**1-4**) and grade of recommendation (**A-C**) are provided at the end of the "Major Recommendations."

Guidelines for Use of Non-steroidal Anti-inflammatory Drugs (NSAIDs) and Cyclooxygenase Isoenzyme 2 (COX2) Selective Agents

- Non-selective, low potency NSAIDs should be used in the first instance. They are most likely to be of help if there is an inflammatory component to the pain. More potent NSAIDs should be reserved for those conditions in which the low potency drugs have been tried and failed to produce significant benefit.
- COX2 selective drugs should be used with caution as an alternative to the non-selective drugs where there is an increased risk of gastric complications. They should be avoided in patients with known cardiovascular disease.
- NSAIDs should be taken with food and consideration must be given to the use of gastric protective agents.
- The benefits of the NSAIDs must be demonstrated to outweigh the risks.
- All NSAIDs are contraindicated in active gastrointestinal ulceration/bleeding and renal disease. They may exacerbate asthma and produce fluid retention.
- Even if stronger analgesics such as opioids are added, the NSAIDs can be continued as they are likely to have a synergistic action improving pain control above and beyond that obtained with opioids alone.
- Paracetamol should be considered as an alternative to, or given with, NSAIDs as it is well tolerated with few side effects.

Neuropathic Analgesics

See Figure 8 in the original guideline document for guidelines for the use of neuropathic analgesics, including antidepressants and antiepileptics. N-methyl-D-aspartate (NMDA) antagonists and sodium channel blockers were considered but not recommended. They must be instigated by experts in the field.

Guidelines for the Use of Opioids in Chronic/Non-acute Urogenital Pain

- All other reasonable treatments must have been tried and failed.
- The decision to instigate long-term opioid therapy should be made by an appropriately trained specialist in consultation with another physician (preferably the patient's family doctor).
- Where there is a history or suspicion of drug abuse, a psychiatrist or psychologist with an interest in pain management and drug addiction should be involved.
- The patient should undergo a trial of opioids.
- The dose required needs to be calculated by careful titration.
- The patient should be made aware (and possibly give written consent):
 - That opioids are strong drugs and associated with addiction and dependency.

- The opioids will normally only be prescribed from one source (preferably the family doctor).
- The drugs will be prescribed for fixed periods of time and a new prescription will not be available until the end of that period.
- The patient will be subjected to spot urine and possibly blood checks to ensure that the drug is being taken as prescribed and that non-prescribed drugs are not being taken.
- Inappropriate aggressive behaviour associated with demanding the drug will not be accepted.
- Hospital specialist review will normally occur at least once a year.
- The patient may be requested to attend a psychiatric/psychology review.
- Failure to comply with the above may result in the patient being referred to a drug dependency agency and the use of therapeutic, analgesic opioids being stopped.
- Morphine is the first-line drug, unless there are contraindications to morphine or special indications for another drug. The drug should be prescribed in a slow-release/modified release form. Short-acting preparations are undesirable and should be avoided where possible. Parenteral dosing is undesirable and should be avoided where possible.

Morphine

There is no compelling evidence that one opiate is better than another. Morphine is the traditional gold standard and the opioid many physicians are most familiar with. In an acute situation, the daily morphine requirement may be calculated by titration of rapid-release morphine. In chronic pain situations, starting with a low dose of slow-release morphine and titrating the dose every 3 days to 1 week is adequate.

Transdermal Fentanyl

Transdermal fentanyl is used when oral absorption is restricted or when the patient suffers with intolerable side effects from other opioids. Patients with rapid bowel transit times (e.g., ileostomy) may find transdermal preparations beneficial. Patches are generally changed every 72 hours.

Methadone

A practitioner familiar with its use as an analgesic should prescribe methadone.

Other Opioids and Opioid-like Agents

Other opioids are available as slow- or modified-release preparations. They may be useful for opiate rotation if side effects or tolerance is a problem.

Buprenorphine and pentazocine both have agonist and antagonist properties and can induce withdrawal symptoms in patients used to opioids. Naloxone may only partly reverse respiratory depression. Buprenorphine topical patches are now available and may offer a similar advantage to topical fentanyl.

Codeine and dihydrocodeine are effective for the relief of mild-to-moderate pain. They are limited by side effects (notably constipation) and genetic variance of metabolism that affects analgesic efficacy.

Tramadol has fewer typical opioid side effects (especially less respiratory depression, less constipation and less addiction potential) and is available in a slow-release preparation. A Cochrane review suggests that there is a role for tramadol in neuropathic pain management.

General Treatment of CPP

Type of Pain	Level of Evidence	Grade of Recommendation	Comment
Paracetamol for somatic pain	1b	A	Benefit is limited and based on arthritic pain
cyclooxygenase (COX2) antagonists	1b	A	Avoid in patients with cardiovascular risk factors
Non-steroidal anti-inflammatory drug (NSAIDs) for dysmenorrhoea	1a	B	Better than placebo but unable to distinguish between agents
Tricyclic antidepressants	1a	A	Neuropathic pain
Tricyclic antidepressants	3	C	Evidence suggests pelvic pain is similar to neuropathic pain
Anticonvulsants Gabapentin	1a	A	For neuropathic pain
Opioids for chronic non-malignant pain	1a	A	Limited long-term data Should only be used by clinicians experienced in their use
Opioids for neuropathic pain	1a	A	Benefit is probably clinically significant Caution with use, as above

Nerve Blocks

Neural blockade for pain management is usually carried out by a consultant in pain medicine with an anaesthetic background. Textbooks have been written on the techniques employed, and individual specialists using neural blockade must be well versed in assessment of the patient, the indications for specific procedures,

and the general and specific risks associated with the procedures, as well as possible advantages.

Procedures may be performed for diagnostic reasons, therapeutic benefit or possibly both. Diagnostic blocks can be difficult to interpret and a clear understanding of the many mechanisms by which a block may be acting must be understood. Temporary but consistent responses to nerve blocks may lead a specialist to proceed with a neurolytic nerve block or to a pulsed radiofrequency neuromodulation procedure. Neurolytic nerve blocks are rarely indicated for a benign process, and to proceed with a neurolytic nerve block may result in disastrous results.

Published guidelines emphasize that all nerve blocks should be performed with appropriate attention to safety, including the presence of skilled support staff and appropriate monitoring and resuscitation equipment. The use of block needles, nerve location devices and imaging (i.e., X-ray image intensifier, ultrasound or computerized tomography) appropriate for the procedure is essential.

The evidence base for nerve blocks is not strong, but suggests that:

- Peripheral nerve blocks, such as ilioinguinal/iliohypogastric/genitofemoral, may be useful in the management of neuropathic pain associated with nerve damage, such as following hernia repairs.
- Blocks around the spermatic cord may be useful diagnostically prior to testicular denervation.
- Lumbar (L1) sympathetic blocks may be helpful in the management of testicular pain, renal pain and possibly a range of pelvic pain conditions with afferents that pass via the L1 level.
- Pudendal nerve blocks may be useful in the management of pudendal nerve injury related pain and possibly pelvic floor muscle spasm. Where pudendal neuralgia is suspected, pudendal nerve blocks may have a diagnostic role. Multiple other nerves close to the pudendal nerve may also be associated with neuropathic symptoms and differential nerve blocks using neurotracing may be of help in understanding the process.
- Pre-sacral blocks and the ganglion Impar block may have a role in the management of pelvic pathology, particularly cancer pain.
- Sacral root nerve blocks may be helpful in the diagnosis of those conditions that might respond to sacral root stimulation.

The above list is not exhaustive and readers are advised to look at the major textbooks in this area.

Transcutaneous Electrical Nerve Stimulation (TENS)

The rationale behind using surface electrical nerve stimulation to relieve pain is the stimulation of myelinated afferents and thus activation of segmental inhibitory circuits. Urinary frequency may also be reduced.

TENS involves the use of a pulse generator with an amplifier and electrodes. The pulses may be delivered continuously or as trains of varying duration. Continuous stimulation seems to be preferable when treating pain.

Counselling of the patient before the start of the treatment is necessary. A specially trained nurse with the time necessary to communicate the technical instructions is a good option. The patient should be confident with the feeling of strong stimulation and view self-treatment without fear. The induction time for TENS to produce analgesia varies widely. The effect is cumulative. Since onset and progression are usually rather slow in interstitial cystitis, the standard recommendation so far has been 0.5-2 hours of treatment twice daily. The duration of an individual treatment session depends on the severity of pain.

Sacral Neuromodulation in Pelvic Pain Syndromes

Sacral neuromodulation (SNS) has been shown to have benefits in patients with refractory motor urge incontinence, urinary retention, and chronic pelvic pain. Neuropathic pain and complex regional pain syndromes may also be treated successfully with neurostimulation applied to dorsal columns and peripheral nerves.

Definitions:

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

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CLINICAL ALGORITHM(S)

The original guideline document contains a clinical algorithm for the use of neuropathic analgesics.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for the tabulated recommendations (see the "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate use of pharmacologic agents in the treatment of chronic pelvic pain
- Appropriate use of nerve blocks, transcutaneous nerve stimulation (TENS), and sacral neuromodulation in the treatment of chronic pelvic pain
- Improved pain control
- Improved quality of life

POTENTIAL HARMS

Side effects of treatment

CONTRAINDICATIONS

CONTRAINDICATIONS

- Selective cyclooxygenase-2 (COX2) agents should not be prescribed in patients with increased risk of cardiovascular disease including congestive cardiac failure.
- All non-steroidal anti-inflammatory drugs (NSAIDs) are contraindicated in active gastrointestinal ulceration/bleeding and renal disease. They may exacerbate asthma and produce fluid retention.
- Antidepressants are contraindicated in cases of recent infarction, arrhythmias, or severe hepatic/renal disease.
- Relative contraindications to amitriptyline for which other antidepressants should be considered include the following situations: use in the elderly, when use of machinery or driving is important, dry mouth (e.g., with oral cancer).

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The European Association of Urology (EAU) believes that producing validated best practice in the field of urology is a very powerful and efficient tool in improving patient care. It is, however, the expertise of the clinician which should determine the needs of their patients. Individual patients may require individualized approaches which take into account all circumstances and treatment decisions often have to be made on a case-by-case basis.

- There are some very clear limitations on the use of the EAU Guidelines. These guidelines are specifically aimed at helping the practising urologist and will thus be of limited use to other health care providers or third party payers. These are limitations which we have accepted, given that the aim is to cover all of Europe and that such non-clinical questions are best covered locally. Another limitation is that the texts have no medico-legal status, nor are they intended to be used as such.
- The purpose of this text is not to be proscriptive in the way a clinician should treat a patient but rather to provide access to the best contemporaneous consensus view on the most appropriate management currently available. EAU guidelines are not meant to be legal documents but are produced with the ultimate aim to help urologists with their day-to-day practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The European Association of Urology (EAU) Guidelines long version (containing all 19 guidelines) is reprinted annually in one book. Each text is dated. This means that if the latest edition of the book is read, one will know that this is the most updated version available. The same text is also made available on a CD (with hyperlinks to PubMed for most references) and posted on the EAU websites Uroweb and Urosource (www.uroweb.org/professional-resources/guidelines/ & <http://www.urosource.com/diseases/>).

Condensed pocket versions, containing mainly flow-charts and summaries, are also printed annually. All of these publications are distributed free of charge to all (more than 10,000) members of the Association. Abridged versions of the guidelines are published in European Urology as original papers. Furthermore, many important websites list links to the relevant EAU guidelines sections on the association websites and all, or individual, guidelines have been translated to some 15 languages.

IMPLEMENTATION TOOLS

Clinical Algorithm
Pocket Guide/Reference Cards

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

General treatment of chronic pelvic pain. In: Fall M, Baranowski AP, Elneil S, Engeler D, Hughes J, Messelink EJ, Oberpenning F, Williams AC. Guidelines on chronic pelvic pain. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. p. 84-97. [27 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Mar

GUIDELINE DEVELOPER(S)

European Association of Urology - Medical Specialty Society

SOURCE(S) OF FUNDING

European Association of Urology

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Chronic Pelvic Pain guidelines writing panel have provided disclosure statements on all relationships that they have and that might be perceived as a potential source of conflict of interest. This information is kept on file in the European Association of Urology Central Office database. This guideline document was developed with the financial support of the European Association of Urology (EAU). No external sources of funding and support have been involved. The EAU is a non-profit organisation and funding is limited to administrative assistance, travel, and meeting expenses. No honoraria or other reimbursements have been provided.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [European Association of Urology Web site](#).

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- EAU guidelines office template. Arnhem, The Netherlands: European Association of Urology (EAU); 2007. 4 p.
- The European Association of Urology (EAU) guidelines methodology: a critical evaluation. Arnhem, The Netherlands: European Association of Urology (EAU); 18 p.

The following is also available:

- Guidelines on chronic pelvic pain. 2005, Ultra short pocket guidelines. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. 18 p.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

PATIENT RESOURCES

None available

NGC STATUS

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