EDITORIAL

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CHRONIC PELVIC PAIN, AN UNMET NEED THAT REQUIRES TRAINED GYNECOLOGISTS

The American College of Obstetricians and Gynecologists (ACOG) proposed the following definition of chronic pelvic pain: *"Non-cyclical pain of at least 6 months duration located in the anatomical pelvis, lumbosacral area, buttocks, abdominal wall anterior or infraumbilical, severe enough to cause functional disability or seek medical attention."* This ailment is currently of utmost importance, first, because of its great impact on the state of personal health (a prevalence of 15% of the female population of reproductive age is affected), and second, because of its multilevel repercussions, e.g. in the workplace, on family responsibilities or on personal relationships. In addition, it has a high economic cost for different healthcare organizations. Therefore, given the complexity of the problem, gynecologists may consider the issue time-consuming, challenging and less rewarding than the usually successful obstetrical and gynecological endeavors [1].

Chronic or serious illness transcends the organic, and becomes a vital process that affects emotions, relationships, activities and the existential and spiritual convictions of the patient. Situations of vulnerability, helplessness or dependence, life threat or intense suffering are generated, therefore the relationship between a doctor / a healthcare team and a patient should not be a neutral or an indifferent relation, but rather a deep interpersonal connection. It is the responsibility of the expert medical team to transmit to the trainee medical team the importance of empathy towards people who are in pain so that it is an aspect that runs parallel to the technical advance of diagnostic tests. Talk and let people talk, maintain eye contact with the patient, listen actively, take the necessary time for each individual case. The doctor-patient interaction must transcend the pain symptom and encompass the bio-psycho-social sphere of each patient. An individual with pain is a difficult patient. Anyone can be a "difficult" patient when they are subjected to unpleasant circumstances.

The figure of the doctor specializing in chronic pain entails the organization of rapid care circuits for acute pain that avoid chronicity and its neuropsychological repercussion with phenomena of centralization, pain memory and pain synergies between different organs and systems.

The doctor who cares for a patient with chronic pelvic pain should be knowledgeable about the physical/emotional aspects of pain, try to personalize their attitude towards each patient, have an empathetic and accessible approach, with non-dominant communicative skills and be able to respond quickly.

The origin or the trigger of chronic pelvic pain is not always identified, but the coexistence of pathologies of organic origin (e.g. urological, gynecological, gastroenterological, musculoskeletal) is characteristic over time, so the doctor who treats pain must be part of a multidisciplinary team with multisystem management capacities [2].

Chronicity alters pain signaling, giving rise to neuronal hyperexcitability and the alteration of the modulation of the pain signal at the level of the posterior spinal cord where the pain signal is received and conveyed to the brain. All of this can translate at a clinical level into the development of neuropathic symptoms such as hyperalgesia, dysesthesia, allodynia, in many cases a long time after the initial tissue damage has healed.

The development of central sensitization to pain represents a therapeutic challenge of utmost importance for the patient, who sometimes cannot deal with it if an adequate managment of such a situation has not previously been performed. This is where clinical suspicion and expertise based on knowledge of the pathophysiology of pain have their greatest value.

The following clinical conditions may produce pelvic pain: deep endometriosis, pain originating from adhesion processes / chronic pelvic inflammatory disease, vulvodynia, dyspareunia or perineal pain, myofascial syndromes, post-surgical neuropathic pain, painful bladder syndrome / interstitial cystitis or irritable bowel syndrome. Once diagnosis is suspected, it should be confirmed as soon as possible and immediate therapeutic measures be undertaken to avoid chronic pain.

Perhaps if patients could easily find the path to healing, those with chronic pain would undoubtedly be in the lead. Unfortunately, some healthcare structures do not always facilitate primary or secondary prevention. Hence, let's change the paradigm, let's support pain quality training and act quickly!!!

References

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2. Williams RE, Hartmann KE, Steege JF. Documenting the current definitions of chronic pelvic pain: implications for research. Obstet Gynecol. 2004;103(4):686-691.