Chronic Pelvic Pain

Idiopathic Pelvic Pain, Depression, and Body Image

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Pain is a complex and subjective experience which derives from physical, psychological, and environmental factors. When pain is chronic (usually lasting more than 6 months) it frequently happens that the subjective intensity of the painful sensation and its consequences on the patient’s life are not necessarily proportionate to the extent of the detected lesions. Moreover, in several patients it is not possible to demonstrate any objective organic lesion.

In such cases it has been hypothesized that psychological and environmental factors could play an important role. The problem is, however, extremely complex because psychosocial factors might contribute directly to the onset of the pain but also represent a set of secondary changes due to the persistence of a chronic (organic) symptomatology, taking part (or not) in its maintenance. Sometimes they could represent an independent phenomenon which can evolve separately from the main, initial cause.

Chronic pelvic pain is a rather frequent gynecological complaint in both young and adult women.

When “objective” clinical data are available diagnosis may be accurate enough, but in some cases a specific organic pathology cannot be found. Sometimes, if an organic abnormality is noticed, it is difficult to ascribe it the responsibility for the pain symptomatology.

The introduction of laparoscopy as a diagnostic aid has recently allowed a clear distinction between organic and so-called “psychosomatic” cases, becoming a fundamental diagnostic procedure in uncertain cases with insufficient clinical findings.

A measure of the phenomenon is given by the fact that more than 10,000 laparoscopies were performed in the United Kingdom during 1978. Chronic pelvic pain (CPP) represents the most common reason for this procedure [1].

The incidence and prevalence of CPP in the general population are not known. In a recent survey about pain as the main cause of patient-doctor contact among 26 general practitioners in a Danish town, it emerged that genitourinary pain represented the third reason for consultation due to pain of visceral origin and accounted for about 12 contacts/1000. The majority of
subjects (81%) were aged between 16 and 65 years, with a male/female ratio of 1/4. Chronic pain was clearly more frequent than acute pain [2].

Chronic pelvic pain can have several genital and extragenital organic causes [3]. This paper will deal with CPP with no obvious organic lesions (idiopathic). According to the International Association for the Study of Pain [3], this diagnosis should only be considered if: (a) the patient’s symptoms are not due to any gynecological cause; (b) the pain has the features of gynecological pain; and (c) the syndrome is not due to one of the acknowledged causes of gynecological pain which supposes that the patient underwent laparoscopy.

The disturbance is relatively frequent, at least in hospital samples: the percentage of subjects with pelvic pain but a normal pelvis in the 1194 women of Cunannan et al.’s [4] sample was the highest ($n = 355$). This is in agreement with some other studies [5], whereas a lower prevalence was found in a group of 109 adolescent girls [6].

Several authors have emphasized the importance of psychological factors in the onset and/or maintenance of idiopathic CPP.

Duncan and Taylor, in a pioneering study, suggested it was due to the physiopathological mechanism of pelvic congestion and developed in women who had had a difficult childhood, unable to live their femininity adequately (as mothers or partners). Symptomatology in their sample was often temporarily related to stressful events (66% of cases) and frigidity was present in the great majority of cases (>90%) [7].

More recent papers, written by authors using laparoscopy as a diagnostic aid, have reported higher neuroticism in the idiopathic group [8] when compared with the organic group (used as control). Other authors have pointed out in these patients the presence of personality disorders (in particular the borderline personality disorder) and of sexual abuse [9].

However, it is worth remembering that some studies found no significant differences between samples of women with chronic organic and idiopathic pelvic pain, demonstrating that both differed from control groups of healthy subjects [10]. This has led researchers to conclude that chronic pain, regardless of its etiology, may determine neurotic-type psychological reactions.

I and my group have been involved in various research, specifically dealing with the relationship between pelvic pain and affective disorders.

Chronic pain is frequently linked with depression and the recurrent association of these two disturbances in clinical practice has led many authors to postulate that pain in the absence of a demonstrable organic lesion may express an underlying depressive disturbance, which is made manifest in a somatic form through the symptom of pain [11]. However, other authors have observed a very low prevalence (around 10%) of depression in patients with chronic pain and it has been reported that depression may frequently be secondary to the occurrence and persistence of the pain symptom. There is, therefore, considerable controversy over the nature and intensity of this relationship [12].