A Woman Who Suffers Always and Forever: Management of Chronic Pelvic Pain

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11.1 Introduction and Aims

Chronic pelvic pain (CPP) in women affects about a quarter of women in the general population. The pathogenesis is poorly understood. The aim of this chapter is to provide insight into the role of various somatic factors and psychosocial variables as possible causal or contributing factors to pelvic pain. Cognitive behavioral approach of CPP women is advocated and illustrated.

11.2 Definition in Lay Terms

Chronic pelvic pain (CPP) in women is commonly described as a continuous or intermittent pain in the lower abdomen not exclusively related to menstrual period (dysmenorrhea) or sexual intercourse (dyspareunia) and which lasts for at least 3 months [1]. This description does not go into what the experience of pain might be. Fortunately, the definition of *chronic pain* by the International Association for the Study of Pain (IASP) gives some more information, as chronic pain is characterized as *an unpleasant sensory and emotional experience* associated with actual or potential tissue damage or described in terms of such damage.

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11.3 Didactic Goals

After reading this chapter, you:

- Will be familiar with the definition of chronic pelvic pain and chronic pain
- Will be familiar with the epidemiology of chronic pelvic pain in women
- Will be familiar with the etiologies of chronic pelvic pain in women
- Will be familiar with the results of different treatment modalities and its effectiveness in women with CPP
- Will be familiar with a structured interview according to the "model of consequences" to address the complaint and its impact in everyday life
- Will be familiar with those specific conversational skills to motivate a CPP patient for pain management

Case History

Renata Emerald is 43 years old and has suffered from pelvic pain for 2 years. She lives with her husband and two daughters, 11 and 9 years old. The complaint started following a common urinary tract infection. Pain persisted despite two additional courses of antibiotics. Renata consulted three medical professionals: urologist, gastroenterologist, and gynecologist. Blood and urine analyses were done as well as abdominal and vaginal ultrasound, cystoscopy, laparoscopy, coloscopy, gastroscopy, computed tomography (CT) scan, and magnetic resonance imaging (MRI) with contrast. So far, these investigations have not shown any abnormality that could be associated with the complaint. Only a small uterus myomatosus was found.

Now, Renata asks for a second opinion because she wants a hysterectomy to solve her chronic pelvic pain.

11.4 Facts and Figures: Definitions, Classification, and Prevalence

Pelvic pain is a common experience for most women of reproductive age. However, 5–26 % of women in the general population report that they suffer long-lasting pelvic pain complaints [2]. Studies on the prevalence rates in less and least developed countries are scarce but show similar data. The variation in rates of CPP worldwide was found to be due to variable study quality. Of these women in the general population, a minority asks for help from the general practitioner. For instance, in the United Kingdom with a prevalence rate of CPP in women in the general population of 24 %, an annual incidence rate of 3.7 % is

found in primary care, which is comparable with figures for asthma (3.8 %) and back pain (4.1 %). About 40 % of these CPP women are referred to secondary or tertiary care for further investigations and treatment. In the UK studies, chronic pelvic pain was defined as a recurrent or constant pelvic pain of at least 6 months' duration, unrelated to periods, intercourse, or pregnancy. These figures indicate that gynecologists as well as other medical specialists are likely to be confronted with a selected group of all women suffering from CPP. Moreover, CPP is a costly condition since it results in frequent use of healthcare resources and absence from work.

11.4.1 The Course of Chronic Pelvic Pain

No studies describe the *natural* course of chronic pelvic pain. Four uncontrolled follow-up studies investigated the *clinical* course of CPP [3–6]. In these studies, the chronicity of symptoms was confirmed. Risks for pain persistence, such as sociodemographic variables, complaint characteristics (i.e., duration and severity of pain), or the kind of treatment provided (surgical or nonsurgical) could not be identified. However, it was demonstrated that severe catastrophizing at baseline predicted less improvement at 1-year follow-up in women suffering pelvic pain associated with endometriosis. In women with CPP not specifically related to endometriosis, a reduction in pain catastrophizing was related to a decrease in pain intensity over a 3-year period. These findings concur with results of studies in other chronic pain conditions that demonstrated the important role of catastrophizing and its often negative effect on pain-related outcomes [7, 8]. Pain catastrophizing is characterized by the tendency to magnify the threat value of the pain stimulus and to feel helplessness in the context of the pain and by a relative inability to inhibit pain-related thoughts in anticipation of, during, or following a painful encounter.

Examples are: "I cannot bear this pain any longer," "I keep thinking how much it hurts…," or "Something has to be done, I am feeling so desperate…."

11.4.2 Pain Persistence

Recent data show that persistence of pain following diagnosis and treatment because of *acute* abdominal pain occurs in nearly one-third of those women who visited an emergency department about 2 years previously. Low educational level and a history of sexual abuse at younger age were shown to be significant risk factors. This result concurs with findings of other studies on persistence of pain complaints following an acute episode [9]. More research is warranted because increased knowledge about these factors may lead to early identification of patients at risk for the development of chronic pain and might, through early and appropriate intervention, reduce this risk.

11.5 Etiology and Pathogenesis

The pathogenesis of CPP is poorly understood. At the same time, it has become apparent that somatic, psychological, and social factors are intertwined. Although being discussed separately for didactical reasons, these factors cannot be treated as isolated entities.

11.5.1 Somatic Factors

A laparoscopy is considered an essential tool to diagnose abdominal and pelvic pathology. However, in about 40 % of the laparoscopies in women with CPP, no somatic explanation can be demonstrated. Even if an (gynecological) abnormality—such as endometriosis, adhesions, ovarian cysts, myoma uteri, or pelvic congestion—is observed, the association between pathology and the site or severity of the pain is not significant. What is more, the same type of pathology is also noted in pain-free women. If pathology is identified, it may be coincidental rather than causal.

In women with CPP, comorbid (pain) symptoms, such as dysmenorrhea and dyspareunia, as well as comorbid syndromes, such as irritable bowel syndrome, interstitial cystitis, chronic fatigue syndrome, and fibromyalgia, are frequently observed.

11.5.2 Psychological Factors

CPP can have a significant impact on the physical and mental health of the affected women and results in an impaired quality of life, specifically in those women who are seen in secondary or tertiary medical care centers. For instance, most CPP women suffer from higher levels of anxiety and depression, are disabled, and have more sexual problems than pain-free controls. Furthermore, as in other chronic pain conditions, CPP women are more likely to have a history of physical and especially sexual abuse than women without CPP. So far, the underlying processes that could explain an association between a history of sexual abuse and chronic (pelvic) pain are unclear.

11.5.3 A Biopsychosocial View

From clinical, experimental, as well as brain imaging studies that focus on chronic pain, a growing body of evidence emerges that demonstrates how somatic, psychological, and social factors can interact—partly mediated by various brain processes involved in chronic pain [10]. Also chronic pelvic pain is associated with alterations in the behavioral and central responses to noxious stimulation, changes in

brain structure, and altered activity of both the hypothalamic-pituitary-adrenal axis and the autonomic nervous system and psychological distress [11]. Further studies are needed to be able to explain, for instance, the experience of pain in the absence of peripheral pathology, and also to understand the discrepancy between the amount of tissue damage and the level of pain and disability as experienced by CPP women.

In clinical practice, study findings are reflected in a biopsychosocial view on chronic pelvic pain resulting in specific steps for diagnosis and treatment [10]. CPP women will benefit if attention is paid to the somatic factors as well as to the psychosocial aspects associated with the experience of pelvic pain, such as pain adjustment (i.e., anxiety and depression and health-related quality of life) to pain appraisals (i.e., attributions and expectancies about pain, catastrophizing) and pain-coping strategies (i.e., increase or decrease activity in response to pain, diverting attention, relaxation). By paying attention to these different aspects, the patient feels that her pain is taken seriously and is validated because not only the physical aspects are addressed but also her concerns, her thoughts, and her ways of coping with pain.

11.6 Specific Diagnostic Aspects

Women suffering from CPP are difficult to treat for healthcare professionals. At the same time, many women with CPP feel dissatisfied with the management of their symptoms. In their opinion, healthcare professionals have no genuine interest in them and dismiss or do not believe their complaints [12]. A cognitive behavioral (CB)-based "model of consequences" for the assessment, as explained briefly above, will meet these difficulties.

The first steps of treatment comprise a systematic and detailed interview with the patient about her pain, her ideas about pain, and the way she is coping with her pain in day-to-day life (i.e., step 1 and step 2).

11.6.1 Step 1: Pain History

History taking starts with an account of the patient's pain. As in other pain conditions, the characteristics, location, and description of current pain and the pattern of pain severity during the day, week, and month need full attention. Current pain can be recorded using a visual analogue scale (VAS) score on a scale from 0 to 10 (0 = no pain at all, 10 = worst pain imaginable). Also, comorbid symptoms such as dyspareunia and/or dysmenorrhea, associated bowel and urinary problems, as well as other chronic (pain) conditions are assessed. Apart from pain history, all diagnostics and treatments by previous medical specialists as well as complementary or alternative care providers are recapitulated. The effects of these interventions on pain and on other complaints are addressed.

11.6.1.1 What Should Be Known About Pain When a Patient Presents with the Complaint of Chronic Pelvic Pain?

Case History: Continued

The pain started with a urinary tract infection about 2 years ago. Renata Emerald describes the pain as a nagging pain located in her lower pelvis, which typically increases during the day and coincides with a bloating of the abdomen. At unexpected moments, the pain can grow worse, about 3 times a week for 1–5 h, sometimes for a whole day. On average, Renata is without pain for only 6 days a month. Changes in the severity of the pain are not related to an uncomplicated micturition, defecation, menstrual period, or sexual intercourse.

Up till now, all investigations done by different specialists did not reveal a specific abnormality, except for a small uterus myomatosus. Her gynecologist prescribed prostagens for 6 months, which initially resulted in some pain relief. However, after 3 months, Renata stopped taking this medication because she disliked a weight gain of 10 lb, because this increased her low self-esteem.

11.6.2 Step 2: Ideas About Pain and Coping with Pain

The patient is explicitly asked about those factors that, as she presumes, cause her chronic pelvic pain complaints. Later on, this information can be used to give a further explanation about a potential association between abnormalities and pain complaints. Thereafter, the patient's usual way of dealing with an increase or decrease in symptoms, determined by pain appraisals and pain-coping strategies, needs explicit attention. The term "pain appraisals" refers to a patient's opinions and beliefs about pain. Examples are "pain can cause damage," "activity should be avoided," "pain leads to disability," and/or "pain is uncontrollable." The term "pain coping" covers intended behavior or cognitions for dealing with pain, such as pain medication use, diverting attention from pain, increasing or decreasing activity, relaxation, or praying. The previously discussed "catastrophizing" of pain is an important psychological factor that is related to various levels of pain severity, distress, and disability.

11.6.2.1 What Are the Questions to Address a Patient's View on Pain and the Way She Is Coping with Pain When a Patient Presents with the Complaint of Chronic Pelvic Pain?

Case History: Continued

Renata Emerald is convinced that her uterus is the cause of her pain. Therefore, she argues that she wants a hysterectomy; she wants "…to get rid of this useless organ."

She does not take any pain killers because she experiences no pain relief when using these on a regular basis. Only when the pain is getting really worse and she starts sweating and feeling feverish, she will take an opioid. Thereafter, she sleeps for hours and has to recuperate for days. Such an episode occurs once every 2 weeks. Renata does not know which factors contribute to this deterioration of her pain. About 1 year ago, she had to go on sick leave because she could not concentrate on her job as the increase of pain and the time needed for recovery were so unpredictable.

During the next step (step 3) of the interview with the patient, the consequences of having to live in pain are addressed and elaborated. The healthcare professional will understand the impact of pain for this particular patient. The patient recognizes the genuine interest of the professional. She gets the feeling of being understood.

11.6.3 Step 3: Consequences

A variety of sequelae of "living in pain" are uncovered if the cognitive, emotional, behavioral, physical, and social consequences are addressed. Examples of the questions that should be asked are shown in Table 11.1. The consequences of living in pain might prolong and even worsen the complaint and become linked in self-perpetuating vicious circles. Specific patterns of associations between specific beliefs, emotions, and specific behavior can be recognized in each woman suffering from CPP, even though these patterns might be subject to fluctuation within one person.

11.6.3.1 What Are the Questions to Address the Cognitive, Emotional, Behavioral, Physical, and Social Consequences of Living in Pain?

Case History: Continued

When asked for, Renata Emerald mentions some of the consequences of her pain, which in turn lead to more pain. She is feeling really desperate at some times. When she experiences more severe pain she feels burdened by her pain. She cannot accept that the pain influences her everyday life to such an extent, and as a result, she gets angry. In its turn, this anger causes tension everywhere in her body. She recognizes that this increased bodily tension might have a negative effect on the level of experienced pain.

With great effort, she succeeds in fulfilling her regular household duties, but still she is convinced that she fails as a partner and mother. When the pain obliges her to rest, she blames herself for her inactivity. As soon as the symptoms improve, she resumes her activities and tries to catch up on lost time. Subsequently, the pain might increase as a result of overexertion. A vicious

circle can be drawn and illustrates a pattern that emerges when someone has "nonaccepting thoughts about pain" (Fig. 11.1).

Moreover, since she had to go on sick leave, contacts with her former colleagues are becoming less and less over time. This increases her feelings of despair.

Another example of a vicious circle is shown in Fig. 11.2. Catastrophizing appraisals and cognitions may maintain and even increase pain.

Table 11.1 Assessment question guide for women with chronic pelvic pain

Pain complaint	
Intensity of pain at this moment on a scale of 10 (0=no pain, 10=excruciating pain)	
Location of pain, with radiation	
Description of pain, kind of pain	
Course of pain during the day	
Chronicity of pain (continuous, intermittent, exact duration)	
History of pain	
Since when have you had pain complaints?	
Previous diagnostic tests by a doctor?	
If so, what were the results?	
Previous treatment?	
If so, what were the results?	
Ideas about pain	
What is in your opinion the cause of your pelvic pain?	
Pain-coping strategies	
What do you do when the pain increases?	
What do you do to prevent the pain increasing (medication, taking rest)?	
What do you do when the pain has decreased, when you are improving?	
Consequences	
Cognitive	What are your thoughts when pain exacerbates? Do you worry about (the (consequences of) your pain? To what extent do you feel able to influence pain? Do you feel helpless regarding your pain?
Emotional	Do you feel anxious, depressed, irritated, annoyed, distressed, or unhappy?
Behavioral	Do you go on with your activities despite pain or do you stop because of pain? How many prescribed and nonprescribed drugs do you use and what is the effect on pain? Current or past alcohol abuse and use of other psychoactive drugs? Do you visit complementary healthcare providers?
Physical	Do you experience accompanying symptoms such as sweating, nausea, and a high heart rate? Do you feel tired or exhausted? Do you experience muscle tension? Is your participation in physical exercise and/or sexual functioning affected by pain experience? Can you fulfill your household duties?
Social	Do you experience problems in your relationship with your partner, relatives, or friends and/or in your job? Does pain affect your participation in pleasurable activities, going on vacation?

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The most difficult but also the most essential step during this interview is the next step (step 4) because the patient is encouraged to change her biomedical view on pain into a biopsychosocial perspective.

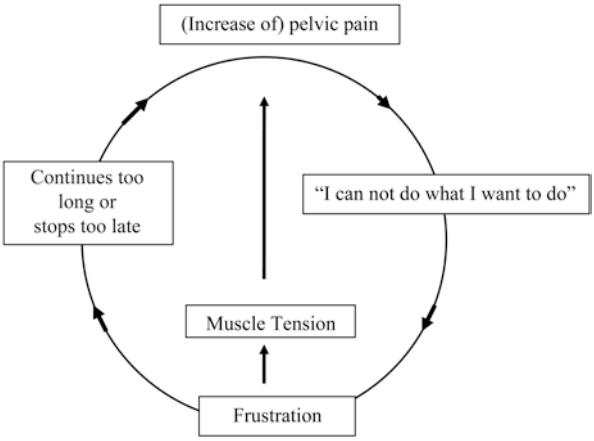

Fig. 11.1 "Nonaccepting thoughts about pain." An example of a vicious circle between cognitive, emotional, behavioral, physical, and social consequences and chronic pelvic pain

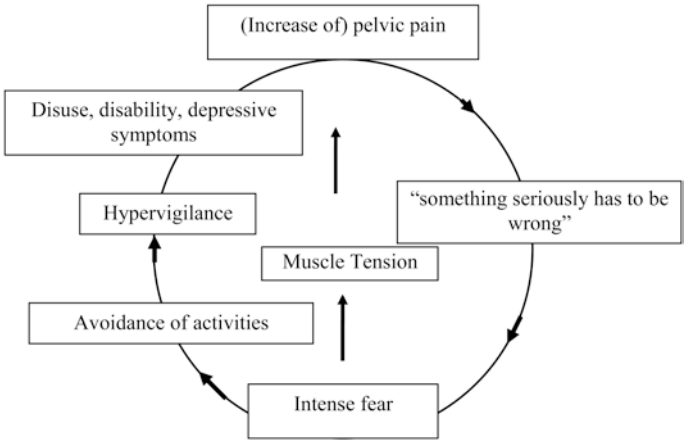

Fig. 11.2 Catastrophizing: "Anxious thoughts and avoidance behavior." An example of a vicious circle between cognitive, emotional, behavioral, physical, and social consequences and chronic pelvic pain (Used with permission of Informa Healthcare from [17])

11.6.4 Step 4: Reorientation

After a summary of the findings of the consultation so far, specific points are communicated to the patient:

1. An explanation of current views on chronic (pelvic) pain is given. "Being in pain" is an unpleasant sensory and emotional, thus *subjective experience*. An objective quantification of the severity of pain as experienced by the patient is impossible, but the consequences of CPP for everyday life illustrate the impact and burden of these complaints. Moreover, the patient is informed that only a minority of patients suffering from CPP will recover over time, taking a narrow definition of recovery as complete relief of pain.

2. Further examinations are considered to be of minor value because each imaging investigation or invasive technique evaluates only the shape or size of the internal organs. If an abnormality is diagnosed, it is judged coincidental rather than causal. That the cause of CPP cannot be explained properly is "bad news" and might lead to deterioration of the patient's condition because her expectations of a specific diagnosis and subsequent medical solution for her pain are not met.
3. By recapitulating the medical aspects and psychosocial consequences of the patient's complaint, the gynecologist expresses and demonstrates his or her genuine interest in and acknowledgment of the patient and her pain. Using one of the vicious circles as an example, the gynecologist can explain how the consequences of pain in everyday life can prolong and even worsen her pain.
4. At this stage, the patient is given the opportunity to reorientate her thinking about chronic pain. She is encouraged to change her view from the former dualistic biomedical way of thinking toward a multidimensional biopsychosocial perspective.

For some women, it is easy to make this reorientation, because they have experienced again and again that most investigations and medical treatment did not help to relieve her complaints. They recognize and understand that the impact of their pain is reflected in the consequences of pain in day-to-day life, which in its turn are linked to the experienced pain. Other women find it really difficult to hear that from a medical point of view "nothing more can be done." They need time to be able to make a reorientation. Only a minority, for instance, those women who are involved in labor law procedures, will not be able to follow another point of view on chronic pain.

11.6.4.1 What Are Essential Ingredients to Be Able to Support the Patient with Chronic Pelvic Pain to Change Her View on Pain from a Biomedical Toward a Biopsychosocial View on Pain?

Case History: Continued

Renata Emerald recognizes herself in the summary of her pelvic pain history, current pain experience, and the impact of her pain on everyday life. She is really disappointed to hear that further investigations and a surgical treatment will not be provided. It is really difficult for her to give up her quest for this supposed cure, immediately. It becomes clear that Renata needs time to reconsider her former beliefs and to accept a new perspective. After having read some parts of the self-help book *The Pain Survival Guide* [13], she recognizes how she is troubled by her pain, like others with chronic pain. She also realizes that she has to start to live with her pain. She makes a new appointment with her gynecologist although she is rather reserved about the new direction.

11.6.5 Step 5: Pain Management

If the patient is willing to identify with and accept the CB model as previously presented, the gynecologist is in a position to explain what can be achieved with pain management based on this model. Referral to a cognitive behavioral psychologist with special chronic pain expertise is recommended for further evaluation. This should also include the assessment of psychological comorbidity such as anxiety and depressive disorders.

In this way, it is possible to tailor pain management to the needs of a particular patient. This approach aims to alleviate the impact of pain on daily life. A combination of medical (pain medication), physical (functional restoration, i.e., graded activity and graded exposure to stimuli that may generate pain), and psychological modalities can be offered that can help to live with pain (such as goal setting, problem solving, relaxation training, development of effective coping strategies, changing maladaptive beliefs about pain). These ingredients aim to help the patient reclaim her own life despite chronic pain. At the start of this trajectory, it is difficult to predict to what extent the patient will recover from her pain. Medical consultation has to continue on a regular basis during treatment to provide support for the pain management program and to preempt any perception of feeling dismissed. If complaints should increase at a given point in time, a thorough medical examination remains mandatory, as some underlying conditions such as endometriosis can manifest new symptoms.

11.7 Specific Therapeutic Aspects

Treatment modalities for CPP that are studied so far vary and depend on a different point of view on chronic pelvic pain and supposed action of the intervention.

11.7.1 Surgical Treatment

Any surgical interventions, for instance, uterine nerve ablation and presacral neurectomy, are designed to disrupt the nerve plexus that may be involved with the perpetuation of the perception of pelvic pain [14]. In the same way, adhesiolysis can be performed to disrupt the nerve fibers found in adhesions. The role of pelvic venous congestion in the pathogenesis of pain remains unclear. So far, no benefits on pain for any specific surgical intervention have been demonstrated in surgical treatment outcome studies.

11.7.2 Nonsurgical Treatment

Other kinds of treatment also are offered to women with CPP, focusing on medical, psychological, and social factors associated with CPP [15]. The Cochrane Review

on this topic shows that there is evidence of moderate quality supporting progestogen as a treatment option for CPP with efficacy reported during treatment. However, this option may be only acceptable among women unconcerned about the progestogenic adverse effects (i.e., weight gain, bloatedness). Some evidence suggests possible benefit of goserelin when compared with progestogen, gabapentin compared with amitriptyline, reassuring counseling and ultrasound versus "wait and see," and writing therapy versus nondisclosure. All studies included in this Cochrane Review are randomized controlled trials (RCTs). Each study focuses on a different treatment that is related to a possible hypothesized working mechanism to explain chronic pelvic pain.

11.8 Conclusion

There is a paucity of studies on the effectiveness of surgical as well as nonsurgical treatment modalities for women suffering from CPP. Based on evidence in chronic pain patients, it seems valid to concentrate treatment on pain-maintaining factors [16]. A cognitive behavioral (CB) model that focuses on thoughts, feelings, and behavior that may increase and/or maintain (pain-related) distress and disability can be used for the assessment of chronic pain conditions and of CPP women as well [17]. Following this CB-based model, the so-called model of consequences as illustrated in Fig. 11.3, a tailored pain management program becomes apparent.

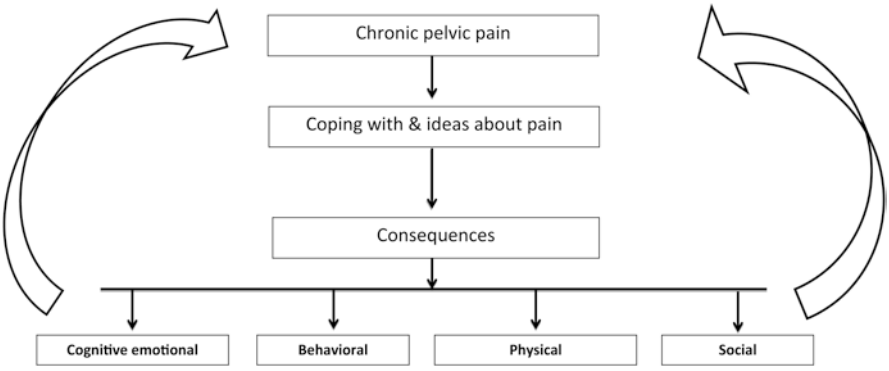

Fig. 11.3 Model of consequences (Used with permission of Informa Healthcare from [17])

Case History: Continued

After repeated consultations, Renata Emerald accepts the offer to be assessed by a psychologist. The results of self-report measures on pain, adjustment to pain, and pain appraisals and coping strategies endorse the burden of her chronic pelvic pain condition. They indicate high scores for depressive symptoms and impaired physical health. The ways she is coping with pain are ineffective, with a tendency to catastrophize pain.

Renata accepts a pain management program and she anticipates feeling better in the end. Her gynecologist instructs her to take pain medication periodically on fixed times instead of "on demand" if pain is unbearable.

The psychologist recommends a graded activity program to get a better physical condition, discusses items associated with over- and underactivity and her energy balance. She also gives her instructions for relaxation training and assists her to develop new more helpful and effective pain-coping strategies. Gradually, Renata realizes that it takes time to get a better life despite her chronic pelvic pain.

At a follow-up visit, 2 years thereafter, Renata still suffers from pelvic pain complaints, but the impact of pain on her life has decreased substantially. She has found a new balance between rest and activity. She no longer feels depressed and has started a new job on a part-time basis.

11.9 Critical Reflection and Conclusive Remarks

The use of a model based on cognitive behavioral principles for the assessment of CPP patients has great advantages for the gynecologist as well as the patient.

The model provides the gynecologist with an elegant and sufficiently inclusive method of understanding patients' symptoms and its impact on everyday life. Furthermore, the patient feels that her pain is taken seriously and is validated because not only the physical aspects are addressed but also her concerns, her thoughts, and her ways of coping with pain. In addition, by labeling the pain-related sequelae as consequences rather than as potential etiological agents, the gynecologist can avoid fruitless discussions about the causality of a number of somatic or psychological factors.

This CB-based assessment according to the model of consequences is one of the strategies to motivate the patient for pain management referral and can be applied by each gynecologist dealing with CPP patients. For patients suffering chronic pain, a CB-based management has been found to be an effective approach regarding improving pain and disability [18]. Further studies are warranted to demonstrate its

putative clinical benefits for women with CPP. Additionally, other specific questions are of interest and need further study, for instance, the health service issues arising from the need to devote more time than is allotted to a normal consultation when using this model. What should be the appropriate management pathway for patients who insist on further medical treatment to the exclusion of psychological intervention? How to cope with patients' stated or unstated inappropriate ideation about chronic pain based on the traditional biomedical view, for example, that extreme pain indicates pathology? And how can practitioners be best equipped to handle the emotional challenges arising from interactions with patients such as feeling frustrated, angry, or helpless?

Tips and Tricks
It is good to realize that:

- Gynecologists as well as other medical specialists are likely to be confronted with a small and selected group of women suffering from CPP.
- Given the prevalence and healthcare costs associated with CPP in women, RCTs of surgical, medical, psychological, and lifestyle interventions are urgently required.
- The step-by-step assessment, based on cognitive behavioral principles, provides information about the impact of chronic pelvic pain on the daily lives of women with CPP.
- CPP women for whom no somatic explanation for their pelvic pain is found, as well as CPP women whose complaints persist despite adequate treatment of the initial diagnosis, might benefit from a cognitive behavioral assessment.
- It takes time to support the patient to change her perspective on chronic pain.
- The use of a structured CB model facilitates referral for pain management, tailored to patients' needs.

Test Your Knowledge and Comprehension

1. What do you feel when the last patient of your office hours is a 35-year-old woman who complains about chronic pelvic pain and requires a hysterectomy? Give an illustration how you are coping with these feelings.
2. Give five items that are essential to be informed about regarding the pain experience of your patient.
3. Which five items have to be addressed to know more about the impact of chronic pelvic pain in the everyday life of your patient? Give an example of a question that addresses each item.
4. Give an example of how you would explain to your patient how a vicious circle has been started between (the severity of) pelvic pain and one of the consequences of pain that she has told you.
5. What can be considered as "bad news" during the interview with the patient suffering chronic pelvic pain?

6. Chronic pelvic pain is a subjective experience.
   (a) True
   b. False
7. To diagnose chronic pelvic pain in women, a CT scan is needed.
   (a) True
   (b) False
8. A history of sexual abuse is a risk factor to develop chronic pelvic pain after an acute episode of pelvic pain.
   (a) True
   (b) False
9. 40 % of all women in the general population experience chronic pelvic pain.
   (a) True
   (b) False
10. Full recovery from chronic pelvic pain is possible in 80 % of the cases.
    (a) True
    (b) False
11. Catastrophizing plays an important role in pain persistence in women with CPP.
    (a) True
    (b) False
12. Laparoscopy is an essential tool to be able to find an abnormality in women suffering CPP. In 20 % of the cases, no abnormality is found.
    (a) True
    (b) False

Answers

1. I am feeling desperate, a bit exhausted and tired, and in a hurry, and I don't want to go into details with her. When I have read the letter of referral sent by her GP, I first drink a cup of coffee and try to relax. I realize that also this woman must have the opportunity to visit a doctor who has genuine interest in her and her chronic pain.
2. When using the well-known seven dimensions of pain, one has to be informed about:
   (a) A detailed description of the pain experience; how would you describe your kind of pain?
   (b) When did the pain complaint start and what was the course?
   (c) How is the pain severity on this moment (VAS score)? Continuously, intermittent?
   (d) Describe the location of pain.
   (e) Does the pain radiate through your abdomen, along legs, etc.?
   (f) Associated complaints, other pain complaints.
   (g) Factors that influence the severity of pain.
3. The cognitive, emotional, behavioral, physical, and social consequences of pain have to be addressed during the interview. Examples of specific questions are summarized in Table 11.1.

4. (Extreme) tiredness is very often mentioned by patients with chronic pelvic pain as one of the consequences in daily life. Everyone has the experience that feeling tired influences the capacity to encounter pain and vice versa.
5. That the cause of CPP cannot be explained properly is "bad news." Moreover, that only a minority of patients suffering from CPP will recover over time, taking a narrow definition of recovery as complete relief of pain, makes it even worse.
6. True
7. False
8. True
9. False
10. False
11. True
12. False

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