Definitions of Pelvic Pain: a Modern View of a Neurologist

Izvozchikov SB*

candidate of medical science, neurologist, manual therapeutist, head office pelvic pain, City polyclinic №8, Medical center
"Unimed-S", Moscow, Russia

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Pelvic pain (PP) as a separate interdisciplinary medical problem began to stand out relatively recently. Numerous observations demonstrate the involvement of various structures of the pelvis (organs, muscles, ligaments, joints, etc.) and the psychosocial factor in the formation, maintenance, and timing of PP, regardless of the cause that caused it. This reason cannot always be clearly verified [1,2]. A violation of biomechanics in any link of the locomotor chain automatically causes a postural imbalance with a change in the motor stereotype, provoking the development of pain in the parts of the body, limbs, head, and internal organs remote from the pelvis.

In this context, it is appropriate to recall the statement of the Russian neurologist A.V. Bolotov (2005) that the number of causes of PP is comparable with the number of causes of headaches. Taking into account also pathogenetic multifactority, torpidity to treatment of their chronic forms, it is possible to equalize both problems by relevance [3].

Available information sources do not provide a full topographically characterized definition of PP. Two definitions are most often used. In gynecology: "Feeling of discomfort in the lower abdomen: below the navel, higher and medial than the inguinal ligaments, behind the bosom and in the lumbosacral region" [4]; in urology: "...pain in pelvic structures experienced by a man or a woman" [5]. Pain localized "below the navel" to the womb, "higher and medial than the inguinal ligament" [4] should not be called pelvic - this is abdominal pain. And the localization of pain in the "lumbosacral region" [4] is also difficult to call a pelvic. It can be seen that these terms do not adequately reflect the possible concentration of pain in patients. The author proposed a new definition of PP, which is much more representative of the algic topography: "pain (discomfort) localized within the oblique region to the genitalia ventral to the sacrum and buttocks dorsally and to the lumbosacral junction cranial, from the sacrococcygeal joint to the crotch of the caudal, from the crest of the ilium to the proximal hip lateral" [6,7]. In connection with the frequent causes of PP caused by diseases of the hip, here are the painful manifestations of the pathology of the large trochanter of the hip, connected with the joint by a common bag.

In view of the definition of pelvic pain presented above, its topographical classification can also be proposed [7]:

- Pain in the pubic region (pubalgia)
- Pain in the depth of the small pelvis (pelvalgia)
- Pain in the sacrum (sacralgia)
- Pain in the gluteal region (glutalgia)
- Pain in the groin (ingvinodinia)
- Pain in the anococcygeal region (coccigodinia)
- Pain in the perineum (perineal pain)
- Pain in the genitals (genitalgia)
- Pain in the proximal parts of the external surface of the thigh (trochanteral pain)

Continuing the topic of terminology, we should mention the "chronic pelvic pain syndrome". This definition, in our opinion, is best represented in the EAU Guidelines of Chronic Pelvic Pain: "Chronic pelvic pain is chronic or persistent pain perceived in structures related to the pelvis of either men or women. It is often associated with negative cognitive, behavioural, sexual and emotional consequences as well as with..."
symptoms suggestive of lower urinary tract, sexual, bowel, pelvic floor or gynaecological dysfunction. Perceived indicates that the patient and clinician, to the best of their ability from the history, examination and investigations (where appropriate) has localised the pain as being perceived in the specified anatomical pelvic area[5]. At the same time, the classification of chronic pelvic pain syndromes that exists to date requires some improvement.

While conducting pelvic pain studies, in some cases, we detected a pathogenetic commonality with tension headache, in which the leading role is played by the reaction to psychosocial stress in the form of anxiety and depression with the leading role of the latter [8]. Prolonged postural tension of pericranial, ocular and cervical muscles (muscular stress) creates an additional afferent painful flow that participates in symptom formation. It is the generality of the pathogenesis of some pelvic and headaches that gave us grounds to suggest the term "pelvic pain of tension"(PPT) [1,2], and later "chronic pelvic pain of tension"(CPPT) [3,9]. The revised criteria for CPPT [7] are presented below:

- Presence of permanent or recurring pelvic pain lasting for 3 months or more.
- Lack of proven connection of pain at the present time with persistent or anamnestic pathology of pelvic organs and structures.
- High (leading) role in the pathogenesis of the disease of psychosocial factors and distress.
- Exclusion of irradiating from another area in the pelvis of the character of pain.

The nosological analysis of 576 outpatients with pelvic pains directed to the neurologist by physicians of different specialties showed 9 cases (1.6%) corresponding to the criteria of CPPT [7].

CPPT, following the analogy with tension headache, it is advisable to classify on CPPT, combined, or not combined with clinically significant (!)muscle tension of the pelvic floor and perineum. Moreover, this stress is often directly related to psychoemotional factors, which can be explained phylogenetically. As is known, all emotions are expressed by a complex of various motor reactions. In higher animals, these are mimic reactions. In most animals, the activity of the tail carries a greater signal significance than the pathology of pericranial musculature.

Perhaps, it is necessary to divide PPT into chronic and episodic, as in cases with tension headache - we continue our research work in this direction.

We proposed to isolate CPPT into a separate nosology.

References