***Chronic Pelvic Pain (CPP) Definition:** While a universally accepted definition is still evolving, CPP is commonly defined as pain perceived in the pelvis, typically lasting six months or longer, associated with significant impairment of quality of life. Organizations such as the International Association for the Study of Pain (IASP), the American College of Obstetricians and Gynecologists (ACOG), the Royal College of Obstetricians and Gynecologists (RCOG), and the Society of Obstetricians and Gynecologists of Canada (SOGC) all offer slightly different definitions, reflecting the complexities of this condition.

^Trauma-informed care is an approach to health care that recognizes the prevalence of trauma and its impact on individuals' physical and mental health. It aims to create a safe and supportive environment for patients and staff, establish trust, and give a sense of control to avoid re-traumatizing individuals.

**** Therapeutic options:** The list of therapies included in this document is not all-inclusive. Although new therapies are rapidly emerging, this guide focuses on evidence-based interventions or those supported by expert opinion. Therapies are updated with each version of this document.

 # R U MOVING SOMe: This is the acronym promoted by FIGO and IPPS to assist in identifying and classifying conditions associated with CPP. R-reproductive, U-urologic, M-musculoskeletal, O-other (not listed in the classification system), V-vulvovaginal, I-idiopathic (no cause identified), N-neurologic, G-gastrointestinal, S-sensitization/nociplastic, O-overlapping pain syndromes, Me-mental health.

Abbreviations: IC/BPS-Interstitial Cystitis/Bladder Pain Syndrome, CT- Computed Tomography scan, IBD-Inflammatory Bowel Disorders, MRI-Magnetic Resonance Imaging

Acknowledgments: This document was created with support from the Orlando VA Healthcare System, Veterans Health Administration Office of Women's Health-Reproductive Health, and the International Pelvic Pain Society. The following collaborators were involved in developing this guide: Dr. Georgine Lamvu, Dr. Jorge Carrillo, Dr. Jessica Feranec, Dr. Chensi Ouyang, Dr. Alicia Christy, Dr. Elizabeth Patton, Dr. Mario Castellanos, and Dr. Amanda Johnson

How to cite this document: Lamvu G, Carrillo J, Feranec J, Ouyang C, Castellanos M, Christy A, Patton E, Johnson A. Chronic Pelvic Pain Evaluation and Management Guide. Available open access online at www.pelvicpaineducation.com, 2025. Last date accessed [insert date].

Version: Number 2.0, last edited 2.15, 2025.

PART 1: EVALUATION OF CHRONIC PELVIC PAIN*

1 COMPLETE A BIOPSYCHOSOCIAL HISTORY AND PHYSICAL EXAMINATION

HISTORY
Pain history, pain burden, pain co-morbidities, contributing factors, consequences of pain, general history (medical, surgical, gynecologic), sexual history, medications, and prior pain treatments.

EXAMINATION
The general mood, affect, and mobility; external musculoskeletal and neurosensory evaluation; external visual and neurosensory genital evaluation; internal single-digit examination, speculum. Specifically, identify myofascial tender points and whether pain radiates along dermatomes. Rule out masses, bleeding, infections, areas of acute inflammation, or tissue damage.

TRAUMA INFORMED CARE^

2 RED FLAG SYMPTOMS AND EXAMINATION FINDINGS?

Fevers, vomiting, rectal bleeding, hematuria, unexplained weight loss, foul vaginal discharge, abnormal vaginal bleeding not related to menstruation, acute onset pain, pelvic mass, new onset pain after age 50.

Begin evaluation for chronic / persistent pelvic pain

NO

YES

STOP: Not chronic pelvic pain: Begin evaluation for systemic or visceral disease, including malignancy.

STOP

3 CATEGORIZE SYMTPOMS BY ORGAN SYSTEMS AND CONSIDER CONDITIONS ASSOCIATED WITH CHRONIC PELVIC PAIN

Reproductive
Symptoms: cyclical or non-cyclical pelvic pain, dyspareunia, irregular menstrual bleeding, uterine tenderness.
Conditions: e.g., dysmenorrhea, endometriosis, adenomyosis, vulvodynia.

Urinary
Symptoms: dysuria, urgency, frequency, incomplete emptying
Conditions: e.g., Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS), incontinence.

Musculoskeletal
Symptoms: pelvic pain with activity, dyspareunia, urgency or frequency, constipation, myofascial tenderness.
Conditions: e.g., myofascial pelvic pain or dysfunction, SI Joint pain, pelvic girdle, tender points.

Other
Not otherwise specified by the R U MOVING SOMe[#] classification system.

Vascular
Symptoms: pain with prolonged standing, pain worse at the end of the day, cyclical or non-cyclical pain.
Conditions: pelvic vascular insufficiency.

Idiopathic
No cause identified despite complete evaluation.

Neurologic
Symptoms: burning pain, numbness, radiates along dermatomes, hyperalgesia, allodynia.
Conditions: e.g., neuropathies, pudendal neuralgia.

Gastroenterologic
Symptoms: abdomino-pelvic pain before or after defecation ± changes in bowel movements frequency or appearance of stool.
Conditions: e.g., IBS, IBD, constipation, diarrhea. Adhesions, chronic appendicitis.

4 ASSESS FOR SIGNS AND SYMPTOMS OF CENTRAL SENSITIZATION

Sensitization
nociplastic pain

Overlapping pain conditions

MEntal health

Nociplastic pain is defined by IASP as pain that arises from altered nociception despite no clear evidence of actual or threatened tissue damage causing the activation of peripheral nociceptors or evidence for disease or lesion of the somatosensory system causing the pain. Some features of nociplastic pain include having multiple pain sites or pain syndromes , hyperalgesia, allodynia, sleep and mood disturbance, debilitating cognitive distortions, e.g., catastrophic thinking, rumination.

5 DIAGNOSTIC TESTING

In chronic pelvic pain diagnostic testing is often negative. Testing should be kept to a minimum and targeted based on symptoms. Urinalysis, vaginal swabs, pregnancy test, and pap if needed. Pelvic ultrasound is the most accessible and preferred imaging modality, although MRI or CT scan may be needed in some cases. Cystoscopy, colonoscopy, endometrial biopsy are only indicated for evaluation of systemic or visceral diseases, if red flag symptoms are present or cannot be ruled out.

PART 2: MANAGEMENT

6 VALIDATION AND EDUCATION

Acknowledge the pain experience and its impact on quality of life. Discuss pain neuroanatomy, reconceptualize fear of pain, and if needed discuss the impact of central sensitization and overlapping pain syndromes. Assess learning style (print, digital, video) then recommend self-education through educational resources like www.pelvicpaineducation.com. Establish treatment expectations for multi-modal therapy, incremental improvement, and multiple visits.

7 SHARED DECISION MAKING AND GOAL SETTING

Use the **SHARE** model of shared-decision making (S- seek patient participation, H-help explore therapy options, A-assess values, preferences and situation, E-evaluate the patient's decision). After selecting therapy, set **SMART** goals (S-specific, M-measurable, A-achievable, R-relevant to the patient, and T-time bound). Select the best combination of therapies based on patient needs. Journals and diaries can be used to emphasize adherence and determine progress.

TRAUMA INFORMED CARE^

8 MUTI-MODAL THERAPY SELECTION**

Select the best combination of therapies based on patient SHARE discussion and SMART goals. Journals and diaries can be used to emphasize adherence and determine progress. May combine therapies, however, self-care, and physical, and psychological rehabilitation are key components of pain management. Start with one or more therapies that target pain, behavioral changes, and whole health, and combine those therapies with one or more disorder-specific therapies.

SELF-CARE
Diet
Exercise
Sleep
Stress management
Meditation, mindfulness
Support systems

PHYSICAL REHABILITATION
Physical therapy (PT), pelvic PT
Occupational therapy
Massage
Chiropractic therapy

PSYCHOLOGICAL
Cognitive, behavioral, and mental health therapy
Sleep therapy
Coping mechanisms
Interpersonal relationships
Environmental stressors
Sexual therapy

PHARMACOTHERAPY
Analgesics
Muscle relaxants
Antidepressants (preferably SNRIs)
Anticonvulsants
Hormonal suppression of menstruation if pain is cyclical.

INTERVENTIONAL
Neuromodulation
Trigger point injections
Anesthetic blocks
Bladder instillations
Photobiomodulation
Acupuncture
Surgery

EXAMPLES OF DISORDER-SPECIFIC THERAPIES

IBS-constipation: fiber, water, stool softeners, laxatives, pro-biotics, Linaclotide, Lubiprostone, Tegaserod. **IBS-diarrhea**: fiber, loperamide, probiotics, antispasmodics (dicyclomine, peppermint oil), TCA antidepressants, Rifaximin, Eluxadoline, Alosetron.
IC/BPS: avoid dietary irritants, pelvic PT, amitriptyline, cimetidine, hydroxyzine, pentosan polysulfate sodium (be aware of side effects), bladder instillations, hydrodistension, botulinum toxin A, neuromodulation.
Chronic Low Back Pain: NSAIDS, physical therapy, tramadol, duloxetine, muscle relaxants, radiofrequency ablation, neuromodulation.
Myalgias: NSAIDS, muscle relaxants, physical therapy, trigger point injections (saline, lidocaine, or botulinum toxin), acupuncture.
Neuralgias: anticonvulsants, anesthetic blocks, pelvic PT, neuromodulation, radio-frequency ablation, surgical decompression.
Fibromyalgia: PT, exercise, milnacipran, duloxetine, pregabalin.
Endometriosis: continuous suppression with OCPs, progestins (pills, IUD), GnRH analogs (antagonists or agonists), aromatase inhibitors, ±laparoscopic excision, hysterectomy.
Pelvic Vascular Insufficiency/Congestion: continuous hormonal suppression, venous occlusion, hysterectomy.
Vulvodynia: Pelvic PT, cognitive behavioral/ sexual therapy, vulvar care, topical estrogen in post-menopause, vestibulectomy.

9 FOLLOW-UP AND COMMUNICATION WITH COLLABORATING HEALTHCARE PROFESSIONALS

Therapies should be implemented for a **minimum of 4 weeks**. Effectiveness, quality of life, adherence, and goal progress should be assessed every **4-8 weeks** after initial treatment. If improved, continue therapy. If not improved, seek consultation from a pain specialist and interdisciplinary team members and **re-assess every 4-8 weeks until improved**. Communication with collaborating specialists should occur each time the therapy t plan is changed.