The frustrations of chronic pelvic pain

To the Editors:

I would like to address a number of issues raised by Dr. Slocumb in his paper on chronic pelvic pain (Slocumb JC. Neurological factors in chronic pelvic pain: trigger points and the abdominal pelvic pain syndrome. AM J OBSTET GYNECOL 1984;149:536). The subject is most important because there is a large number of women whose extensive complaints cannot be diagnosed precisely and whose treatment remains unsatisfactory.

I agree with Dr. Slocumb that conditions such as functional ovarian cysts, pelvic adhesions and congestion, the "universal joint syndrome" are, as causes of chronic pelvic pain, often merely figments of our frustration. I believe that the complaints may be psychosomatic, but this hypothesis is difficult to prove.[1] Certainly our patients generally detest the suggestion that their suffering is due to anything other than physical disease. Apart from reassurance and support, mainstream gynecology has little to offer in the care of these patients.

If Dr. Slocumb's success can be duplicated, patients and gynecologists will be indebted to him. However, success cannot be evaluated from a mixture of telephone calls, letters, and office visits. A great many treatments of this refractory condition have not stood the test of time. There may be a very substantial placebo effect from the care and treatments provided by Dr. Slocumb. Above all, Dr. Slocumb used trigger-point injections as well as supportive therapy and medications for insomnia, depression, and/or anxiety in his management. Which of these helped the most? Outcome should be asesssed from carefully designed protocols and instruments, not from a mixture of treatments applied in undescribed proportions.

Questions should be asked about the pathologic conditions identified in the dorsal horns. A physical disease is postulated in an effort to explain the pain, but emotional factors are remarked upon, and thus psychosomatics are again invoked. Is there solid evidence of dorsal horn malfunction apart from subjective phenomena such as pain and hypersensitivity? Is it possible that higher centers produce whatever disease is identified in the dorsal horns? Has Dr. Slocumb given his patients another face-saving but scientifically suspect diagnosis?

A number of gynecologists have noted that chronic pelvic pain patients frequently present with multiple nongynecological symptoms such as headaches, lethargy, irritability, and depressive symptoms.[1-4] While these observations have been uncontrolled, more recent controlled studies have shown psychopathologic conditions in patients with chronic pelvic pain but no demonstrable disease.[5,6]

Much work remains to be done. Meanwhile, I hope that gynecologists will continue to perform laparoscopies instead of producing diagnoses unsupported by inspection of the internal genitalia. Dr. Slocumb's success with chronic pelvic pain patients appears to be impressive. If his methods can be duplicated, we should proceed to investigate the mechanisms involved.

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Reply to Strausz

To the Editors:

I would like to thank Dr. Strausz for his questions and comments concerning the paper on abdominal-pelvic pain. As pointed out by Dr. Strausz, current therapy for pelvic pain is unsatisfactory and the wide range of theories and the degree of operative intervention with little improvement is of concern. It was for these reasons that I felt it necessary to reassess my gynecologic skills and began incorporating neurological concepts in the evaluation of abdominal and pelvic pain.

The consistent finding of locally tender tissues in the abdominal wall, para cervix, dorsal sacrum, and levator muscles all reproducing the same chronic pain sensations strongly implicates abnormal neurological thresholds in both visceral somatic and peripheral sensory pain fibers of the T12 and S2-4 dermatomes. The association of onset with physical trauma such as that after an operation, rape, delivery, and intrauterine contraceptive device infections, etc., is commonly followed with persistence of the same pain sensations for years after resolution of the traumatic process.

The techniques of reproducing pain with (1) focal pressure (single finger, cotton tip, and/or needle tip), (2) examination of the abdominal wall by tensing the rectus muscles, and (3) blocking of tender tissues with a local anesthetic to document extended pain relief be-