EAU Guidelines on Chronic Pelvic Pain

Management

MANAGEMENT:

The philosophy for the management of chronic pelvic pain (CPP) is based on a bio-psychosocial model. This is a holistic approach with patients' active involvement. Single interventions rarely work in isolation and need to be considered within a broader personalised management strategy, including self-management.

Conservative management

Pain education: Information improves adherence to treatment and underpins self-management.
Physical therapy: The physiotherapist is part of the pain management team (including doctors, psychologists and nurses).
Physiotherapists can either specifically treat the pathology of the pelvic floor muscles, or more generally treat myofascial pain if it is part of the pelvic pain syndrome.
Psychological therapy: Psychological interventions may be directed at pain itself or at adjustment to pain in terms of function and mood and reduced health-care use, with or without pain reduction.
Dietary treatment: Scientific data are limited and dietary restriction alone does not produce significant symptomatic relief.

Management of primary prostate pain syndrome (PPPS)

Summary of evidence	LE
Phenotypically directed treatment may improve treatment success.	3
α-blockers have moderate treatment effect regarding total pain, voiding, and QoL scores in PPPS.	1a
Antimicrobial therapy has a moderate effect on total pain, voiding, and QoL scores in PPPS.	1a
Non-steriodal anti-inflammatory drugs have moderate overall treatment effects on PPPS.	1a
Phytotherapy has some beneficial effect on pain and overall favourable treatment response in PPPS.	1a
Pentosane polysulphate improves global assessment and QoL score in PPPS.	1b
There are insufficient data on the effectiveness of muscle relaxants in PPPS.	2b
Pregabalin is not effective for the treatment of PPPS.	1b
Botulinum toxin type A injection into the pelvic floor (or prostate) may have a modest effect in PPPS.	2b
Acupuncture is superior to sham acupuncture in improving symptoms and QoL.	1a
Posterior tibial nerve stimulation is probably effective for the treatment of PPPS.	1b
Extracorporeal shock wave therapy is probably effective over the short term.	1b
There are insufficient data supporting the use of other surgical treatments, such as transurethral incision of the bladder neck, transurethral resection of the prostate, or radical prostatectomy in patients with PPPS.	3
Cognitive behavioural therapy designed for PPPS may improve pain and QoL.	3

Recommendations	Strength rating
Offer multimodal and phenotypically directed treatment options for Primary Prostate Pain Syndrome (PPPS).	Weak
Use antimicrobial therapy (quinolones or tetracyclines) over a minimum of six weeks in treatment-naïve patients with a duration of PPPS less than one year.	Strong
Use α-blockers for patients with a duration of PPPS less than one year.	Strong
Offer high-dose oral pentosane polysulphate in PPPS.	Weak
Offer acupuncture in PPPS.	Strong
Offer non-steroidal anti-inflammatory drugs (NSAIDs) in PPPS, but long-term side-effects have to be considered.	Weak

Management of primary bladder pain syndrome (PBPS)

Summary of evidence	LE
There is insufficient data for the long-term use of corticosteroids.	3
Limited data exist on effectiveness of cimetidine in PBPS.	2b
Amitriptyline is effective for pain and related symptoms of PBPS.	1b
Oral pentosane polysulphate is effective for pain and related symptoms of PBPS.	1a
Oral pentosane polysulphate plus subcutaneous heparin is effective for pain and related symptoms of PBPS, especially in initially low responders to pentosane polysulphate alone.	1b
Intravesical lidocaine plus sodium bicarbonate is effective in the short term.	1b
Intravesical pentosane polysulphate is effective, based on limited data, and may enhance oral treatment.	1b
There are limited data on the effectiveness of intravesical heparin.	3
Intravesical chondroitin sulphate may be effective.	2b
There is insufficient data for the use of bladder distension as a therapeutic intervention.	3
Hydrodistension plus BTX-A is superior to hydrodistension alone.	1b
Intravesical BCG is not effective in PBPS.	1b
Transurethral resection (coagulation and laser) may be effective in PBPS type 3 C.	3
Sacral neuromodulation may be effective in PBPS.	3
Pudendal nerve stimulation is superior to sacral neuromodulation for treatment of PBPS.	1b
Avoidance of certain foods and drink may reduce symptoms.	3
Outcome of cystectomy for PBPS is variable.	3

Recommendations	Strength rating
Offer subtype and phenotype-oriented therapy for the treatment of Primary Bladder Pain Syndrome (PBPS).	Strong
Always consider offering multimodal behavioural, physical and psychological techniques alongside oral or invasive treatments of PBPS.	Strong
Offer dietary advice.	Weak
Administer amitriptyline for treatment of PBPS.	Strong
Offer oral pentosane polysulphate for the treatment of PBPS.	Strong
Offer oral pentosane polysulphate plus subcutaneous heparin in low responders to pentosane polysulphate alone.	Weak
Do not recommend oral corticosteroids for long-term treatment.	Strong
Offer intravesical hyaluronic acid or chondroitin sulphate before more invasive measures.	Weak
Offer intravesical lidocaine plus sodium bicarbonate prior to more invasive methods.	Weak
Offer intravesical heparin before more invasive measures alone or in combination treatment.	Weak
Do not use bladder distension alone as a treatment of PBPS.	Weak
Consider submucosal bladder wall and trigonal injection of botulinum toxin type A plus hydrodistension if intravesical instillation therapies have failed.	Strong
Offer neuromodulation before more invasive interventions.	Weak
Only undertake ablative and/or reconstructive surgery as the last resort and only by experienced and PBPS-knowledgeable surgeons, following a multi-disciplinary assessment including pain management.	Strong
Offer transurethral resection (or coagulation or laser) of bladder lesions, but in PBPS type 3 C only.	Strong

Management of scrotal pain syndrome

Summary of evidence	LE
Microsurgical denervation of the spermatic cord is an effective therapy for primary scrotal pain syndrome.	2b
Vasovasostomy is effective in post-vasectomy pain.	2b

Recommendations	Strength rating
Inform about the risk of post-vasectomy pain when counselling patients planned for vasectomy.	Strong
Do open instead of laparoscopic inguinal hernia repair, to reduce the risk of scrotal pain.	Strong
In patients with testicular pain improving after spermatic block, offer microsurgical denervation of the spermatic cord.	Weak

Management of primary anorectal pain syndrome

Summary of evidence	LE
Biofeedback is the preferred treatment for Chronic Primary Anal Pain Syndrome.	1a
Electro-galvanic stimulation is less effective than biofeedback.	1b
Available evidence fails to confirm effectiveness of BTX-A in management of Chronic Primary Anal Pain Syndrome.	3
Percutaneous tibial nerve stimulation is effective in anal pain.	3
Sacral neuromodulation is effective in anal pain.	3
Inhaled salbutamol is effective in intermittent Chronic Primary Anal Pain Syndrome.	3

Recommendations	Strength rating
Undertake biofeedback treatment in patients with chronic anal pain.	Strong
Offer percutaneous tibial nerve stimulation in Chronic Primary Anal Pain Syndrome.	Weak
Offer sacral neuromodulation in Chronic Primary Anal Pain Syndrome.	Weak
Offer inhaled salbutamol in intermittent Chronic Primary Anal Pain Syndrome.	Weak

Management of gynaecological aspects of chronic pelvic pain:

Recommendations	Strength rating
Involve a gynaecologist to provide therapeutic options such as hormonal therapy or surgery in well-defined disease states.	Strong
Provide a multi-disciplinary approach to pain management in persistent disease states.	Strong
All patients who have developed complications after mesh insertion should be referred to a multi-disciplinary service (incorporating pain medicine and surgery).	Strong

Management of sexological aspects in chronic pelvic pain:

Recommendations	Strength rating
Offer behavioural strategies to the patient and his/her partner to reduce sexual dysfunctions.	Weak
Offer pelvic floor muscle therapy as part of the treatment plan to improve quality of life and sexual function.	Weak

Management of pelvic floor dysfunction:

Recommendations	Strength rating
Apply myofascial treatment as first-line treatment.	Weak
Offer biofeedback as therapy adjuvant to muscle exercises, in patients with anal pain due to an overactive pelvic floor.	Strong