

IL DOLORE PELVICO CRONICO. NON SOLO RACHIDE

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1. **Aredo JV, Heyrana KJ, Karp BI, Shah JP, Stratton P.** Relating Chronic Pain and Endometriosis to Signs of Sensitization and Myofascial Pain and Dysfunction. *Semin Reprod Med.* 2017 Jan;35(1):88-97

Abstract

Chronic pelvic pain is a frustrating symptom for patients with endometriosis and is frequently refractory to hormonal and surgical management. While these therapies target ectopic endometrial lesions, they do not directly address pain due to central sensitization of the nervous system and myofascial dysfunction, which can continue to generate pain from myofascial trigger points even after traditional treatments are optimized. This article provides a background for understanding how endometriosis facilitates remodeling of neural networks, contributing to sensitization and generation of myofascial trigger points. A framework for evaluating such sensitization and myofascial trigger points in a clinical setting is presented. Treatments that specifically address myofascial pain secondary to spontaneously painful myofascial trigger points and their putative mechanisms of action are also reviewed, including physical therapy, dry needling, anesthetic injections, and botulinum toxin injections.

2. **Baranowski AP, Lee J, Price C, Hughes J.** Pelvic pain: a pathway for care developed for both men and women by the British Pain Society. *Br J Anaesth.* 2014 Mar;112(3):452-9.

Abstract

This paper aims to explain the key points and highlight some of the controversies in the development of the British Pain Society's pelvic pain patient pathway map. Many clinicians lack experience and confidence with this group of patients, and this issue is highlighted. Additionally, the difficulties of classification and definitions in this area are discussed in detail. These are historical causes of disagreement among specialists which can lead to confused clinical care. This group of patients have multiple issues that cross many professional boundaries; they are best managed by the co-ordinated involvement of multiple teams. Patients suffer from significant distress and disability that often needs specialist assessment and intervention (interdisciplinary). This suggests that an integrated approach is required across the historic boundaries of primary and secondary care. A variety of interventions, including opioids and neuromodulation are recommended in the pathway and the controversies surrounding these inclusions are aired in detail.

3. **Doggweiler R, Whitmore KE, Meijlink JM, Drake MJ, Frawley H, Nordling J, Hanno P, Fraser MO, Homma Y, Garrido G, Gomes MJ, Elneil S, van de Merwe JP, Lin ATL, Tomoe H.** A standard terminology in chronic pelvic pain syndromes: A report from the chronic pelvic pain working group of the international continence society. *Neurourol Urodyn.* 2017 Apr;36(4):984-1008.

Abstract

Terms used in the field of chronic pelvic pain (CPP) are poorly defined and often confusing. An International Continence Society (ICS) Standard for Terminology in chronic pelvic pain syndromes (CPPS) has been developed with the aim of improving diagnosis and treatment of patients affected by chronic pelvic pain syndromes. The standard aims to facilitate research, enhance therapy development and support healthcare delivery, for healthcare providers, and patients. This document looks at the whole person and all the domains (organ systems) in a systematic way.

A dedicated working group (WG) was instituted by the ICS Standardisation Steering Committee according to published procedures. The WG extracted information from existing relevant guidelines, consensus documents, and scientific publications. Medline and other databases were searched in relation to each chronic pelvic pain domain from 1980 to 2014. Existing ICS Standards for terminology were utilized where appropriate to ensure transparency, accessibility, flexibility, and evolution. Consensus was based on majority agreement.

The multidisciplinary CPPS Standard reports updated consensus terminology in nine domains; lower urinary tract, female genital, male genital, gastrointestinal, musculoskeletal, neurological aspects, psychological aspects, sexual aspects, and comorbidities. Each is described in terms of symptoms, signs and further evaluation. The document presents preferred terms and definitions for symptoms, signs, and evaluation (diagnostic work-up) of female and male patients with chronic pelvic pain syndromes, serving as a platform for ongoing development in this field.

4. **D. Engeler, A.P. Baranowski, J. Borovicka, A. Cottrell, P. Dinis-Oliveira, S. Elneil, J. Hughes, E.J. Messelink, A. van Ophoven, Y. Reisman, A.C. de C. Williams.** Guidelines on Chronic Pelvic Pain. *European Association of Urology* 2014.

Abstract

Chronic pelvic pain (CPP) is a prevalent condition which can present a major challenge to health care providers due to its complex aetiology and poor response to therapy. Chronic pelvic pain is a multifactorial condition and therefore, quite often, poorly managed. Management requires knowledge of all pelvic organ systems and their association with other systems and conditions, including musculoskeletal, neurologic, urologic, gynaecologic and psychological aspects, promoting a multidisciplinary approach. The European Association of Urology (EAU) Guidelines Working Group for Chronic Pelvic Pain prepared this guidelines document to assist urologists and medical professionals from associated specialties, such as gynaecologists, psychologists, gastroenterologists and sexologists, in assessing the evidence-based management of CPP and to incorporate evidence-based recommendations into their every-day clinical practice.

5. **Malykhina AP.** Neural mechanism of pelvic organ cross-sensitization. *Neuroscience*. 2007 Nov 9;149(3):660-72. Epub 2007 Sep 8.

Abstract

Clinical observations of viscerovisceral referred pain in patients with gastrointestinal and genitourinary disorders suggest an overlap of neurohumoral mechanisms underlying both bowel and urinary bladder dysfunctions. Close proximity of visceral organs within the abdominal cavity complicates identification of the exact source of chronic pelvic pain, where it originates, and how it relocates with time. Cross-sensitization among pelvic structures may contribute to chronic pelvic pain of unknown etiology and involves convergent neural pathways of noxious stimulus transmission

from two or more organs. Convergence of sensory information from discrete pelvic structures occurs at different levels of nervous system hierarchy including dorsal root ganglia, the spinal cord and the brain. The cell bodies of sensory neurons projecting to the colon, urinary bladder and male/female reproductive organs express a wide range of membrane receptors and synthesize many neurotransmitters and regulatory peptides. These substances are released from nerve terminals following enhanced neuronal excitability and may lead to the occurrence of neurogenic inflammation in the pelvis. Multiple factors including inflammation, nerve injury, ischemia, peripheral hyperalgesia, metabolic disorders and other pathological conditions dramatically alter the function of directly affected pelvic structures as well as organs located next to a damaged domain. Defining precise mechanisms of viscerovisceral cross-sensitization would have implications for the development of effective pharmacological therapies for the treatment of functional disorders with chronic pelvic pain such as irritable bowel syndrome and painful bladder syndrome. The complexity of overlapping neural pathways and possible mechanisms underlying pelvic organ crosstalk are analyzed in this review at both systemic and cellular levels.

Dolore e percezione del corpo: tra illusione e realtà.

Dott.ssa Jennifer Lewis.

1. **Bruehl S.** Complex regional pain syndrome. *BMJ-British Medical Journal* 2015 JUL 29;351:h2730.

Abstract

Complex regional pain syndrome is a chronic pain condition characterized by autonomic and inflammatory features. It occurs acutely in about 7% of patients who have limb fractures, limb surgery, or other injuries. Many cases resolve within the first year, with a smaller subset progressing to the chronic form. This transition is often paralleled by a change from “warm complex regional pain syndrome,” with inflammatory characteristics dominant, to “cold complex regional pain syndrome” in which autonomic features dominate. Multiple peripheral and central mechanisms seem to be involved, the relative contributions of which may differ between individuals and over time. Possible contributors include peripheral and central sensitization, autonomic changes and sympatho-afferent coupling, inflammatory and immune alterations, brain changes, and genetic and psychological factors. The syndrome is diagnosed purely on the basis of clinical signs and symptoms. Effective management of the chronic form of the syndrome is often challenging. Few high quality randomized controlled trials are available to support the efficacy of the most commonly used interventions. Reviews of available randomized trials suggest that physical and occupational therapy (including graded motor imagery and mirror therapy), bisphosphonates, calcitonin, subanesthetic intravenous ketamine, free radical scavengers, oral corticosteroids, and spinal cord stimulation may be effective treatments. Multidisciplinary clinical care, which centers around functionally focused therapies is recommended. Other interventions are used to facilitate engagement in functional therapies and to improve quality of life.

2. **Bean DJ, Johnson MH, Heiss-Dunlop W, Kydd RR.** Extent of recovery in the first 12 months of complex regional pain syndrome type-1: A prospective study. *European Journal of Pain* 2016;20(6):884-894.

Abstract

The literature concerning the outcomes of complex regional pain syndrome (CRPS) is contradictory, with some studies suggesting high rates of symptom resolution, whilst others demonstrate that CRPS symptoms can persist and lead to significant disability. The aim of the present study was to carefully document the extent of recovery from each of the signs and symptoms of CRPS.

A sample of 59 patients with recently onset (<12 weeks) CRPS-1 were followed prospectively for 1 year, during which time they received treatment-as-usual. At baseline, 6 and 12 months, the following were measured: CRPS severity scores (symptoms and signs of CRPS), pain, disability, work status and psychological functioning.

Analyses showed that rates of almost all signs and symptoms of CRPS reduced significantly over 1 year. Reductions in symptom severity were clinically relevant and were greatest in the first 6 months and plateaued thereafter. However, at 1 year, nearly 2/3 of patients continued to meet the IASP-Orlando criteria for CRPS and 1/4 met the Budapest research criteria for CRPS. Only 5.4% of patients were symptom-free at 12 months. Overall the results were less optimistic than several previously conducted prospective studies and suggest that few cases of CRPS resolve completely within 12 months of onset. Improvements were generally greater in the first 6 months, and suggest that it may be worth exploring early interventions to prevent long-term disability in CRPS.

3. **Lewis JS, McCabe CS.** Body perception disturbance in CRPS. *Practical Pain Management* 2010;10:60-66.

Abstract non disponibile

4. **Lewis JS, Kersten P, McCabe CS, McPherson KM, Blake DR.** Body perception disturbance: A contribution to pain in complex regional pain syndrome (CRPS). *Pain* 2007;133(1):111-119.

Abstract

In spite of pain in the CRPS limb, clinical observations show patients pay little attention to, and fail to care for, their affected limb as if it were not part of their body. Literature describes this phenomenon in terms of neurological neglect-like symptoms. This qualitative study sought to explore the nature of the phenomenon with a view to providing insights into central mechanisms and the relationship with pain. Twenty-seven participants who met the IASP CRPS classification were interviewed using qualitative methods to explore feelings and perceptions about their affected body parts. These semi-structured interviews were analysed utilising principles of grounded theory. Participants revealed bizarre perceptions about a part of their body and expressed a desperate desire to amputate this part despite the prospect of further pain and functional loss. A mismatch was experienced between the sensation of the limb and how it looked. Anatomical parts of the CRPS limb were erased in mental representations of the affected area. Pain generated a raised consciousness of the

limb yet there was a lack of awareness as to its position. These feelings were about the CRPS limb only as the remaining unaffected body was felt to be normal. Findings suggest that there is a complex interaction between pain, disturbances in body perception and central remapping. Clinically, findings support the use of treatments that target cortical areas, which may reduce body perception disturbance and pain. We propose that body perception disturbance is a more appropriate term than 'neglect-like' symptoms to describe this phenomenon.