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GLOBAL INTERSTITIAL CYSTITIS, BLADDER PAIN SOCIETY Newsletter

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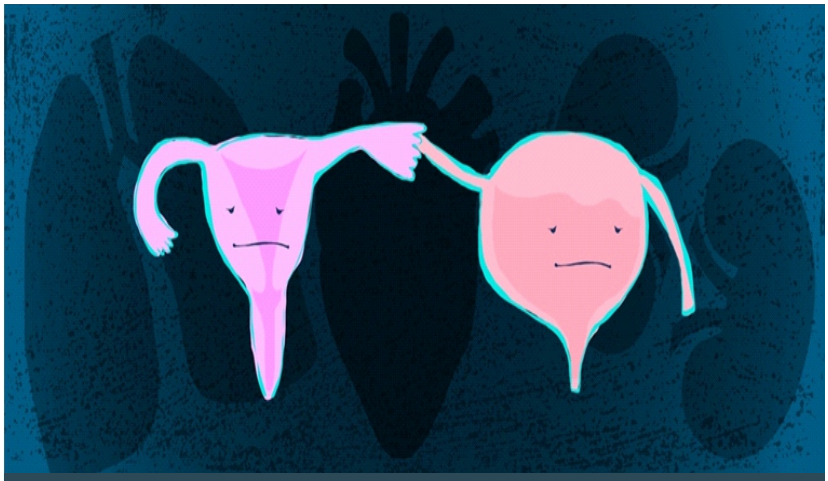
Chronic pelvic pain with Endometriosis!!



Focus on Bladder -The Evil Twin Syndrome

Introduction:

Chronic pelvic pain (CPP) in women is defined as persistent, noncyclic pain perceived to be in structures related to the pelvis and lasting more than six months[1]. It is a common complaint of women presenting for gynaecologic and primary care.[2] Many diagnoses that live under the umbrella of "chronic pelvic pain" have similar symptoms, confounding the differential diagnosis and need development of a treatment pathway. Hence evaluation of CPP requires obtaining a careful history including not only obstetrical and gynaecologic information but also screening for gastrointestinal, urologic, musculoskeletal, and neurological disorders.

As Gynecologist, we are miffed with pelvic pain specially the chronic ones. These Patients with chronic pain, have ongoing lingering pain that confuses us due its longevity and the overall debilitating effect it has on the women population. Among the different reasons of chronic Pelvic pain, endometriosis remains the most common condition, 1 in 7 women suffer in the reproductive or I should say post menarcheal age. It is the 3rd common reason for Hysterectomies. The Gold standard diagnoses still remains in the Histopathological confirmation through laparoscopic guided biopsy. The challenge to any treating Physician is when women continue to have pain post treatment, and these are the patients whom we need to evaluate for the complexity of Syndromes that can Co-exist in the same individual at a given time. Studies have shown that 50-84% of women with endometriosis may *also* have Interstitial Cystitis. So It's Time for us to rethink and change the way of treating these patients pain or supra pubic pain, bladder pressure, and urinary dysfunction such as urgency/frequency, nocturia and Dyspareunia .[7]

As Dr. Charles Butrick, **in an article published in 2007,** suggested that gynaecologists "Be alert to…interstitial cystitis in patients who present with chronic pelvic pain typical of endometriosis." The concurrent conditions of bladder pain syndrome (BPS) and endometriosis have been described as "evil twins' syndrome" in the realm of chronic pelvic pain.

Interstitial Cystitis(IC), Bladder pain syndromeis a condition

commonly associated with pelvic pain or supra pubic pain, bladder pressure, and urinary dysfunction such as urgency/frequency, nocturia and Dyspareunia .[7]

The Co-existence of endometriosis and IC, they mimic each other confusing the diagnosis :

- Both are Benign condition with multifactorial causes.
- There is no proven infection or other obvious pathology.
- Pelvic Pain is the common factor mostly from Inflammatory responses.
- Cause of pain or proportion is not entirely clear.
- Pain in both conditions become more pronounced before /around the onset of menstruation.[8,10]
- Approximately 15% of patients with IC first present with pain in the absence of urologic symptoms.[7] and nearly 25% of women with endometriosis are asymptomatic.
- Dyspareunia is not uncommon, and symptoms often flare after sexual intercourse.[9]
- There is no cure for both the conditions but the GOAL is to provide Pain relief.
- They both have Multimodal management approaches.

History and Physical Examination

1. A thorough history and physical examination are critical for an evaluation of any patient who presents with CPP with Endometriosis

2. It is important to ask about the onset of symptoms, the extent and location of the pain (in IC, pain usually worsens as the bladder fills and improves after voiding). Details on voiding symptoms, such as urgency, hesitancy, and/or frequency, should be determined as well.[10]History of menstrual pain or flares and Dyspareunia to be noted.

3. A physical examination should be performed to evaluate for tenderness and to determine whether the tenderness elicited reproduces the pain that the patient typically experiences.[1] In patients with IC, a pelvic examination will often reveal tenderness of the bladder base, even upon gentle palpation.[8] As with Endometriosis the physician may detect tender nodules and masses in the pelvic region, a tender retroverted uterus, or implants in uterosacral ligaments is diagnostic.

4. A urinalysis and urine culture should be performed to detect the presence of infection or haematuria. Patients with IC may also have a concurrent bladder infection that requires diagnosis and treatment.[8,11]

5. A 3-day voiding diary should be used to assess urinary frequency, nocturia, and fluid intake.[8] Voided volumes is also important.

6. The Pelvic Pain and Urgency/Frequency (PUF) patient symptom scale is a questionnaire that screens for urinary urgency/frequency,behaviours associated with IC, as well as pelvic pain and dyspareunia.[12]

7. The VAS (Visual Analog Scale) or NRS Numerical Rating Scale) for each type of typical pain related to endometriosis (dysmenorrhea, deep dyspareunia and non-menstrual chronic pelvic pain), combined with the CGI and a quality-of-life scale HRQol for Endometriosis

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Literature review:

1. The studies show that there is a high prevalence and association of IC and endometriosis.
2. A study by Chung *et al*. of 178 women with CPP found that 65% of CPP patients suffered from both active endometriosis and IC.[4]
3. In a prospective study carried out of 162 patients with CPP, Paulson and Delgado found that 66% of the sample was diagnosed with both endometriosis and IC.[5]
4. A recent systematic review estimated the prevalence of BPS/IC, and the coexistence of BPS/IC and endometriosis in women with CPP.
5. Nine studies including 1016 patients with CPP showed the mean prevalence of BPS was 61%, of endometriosis 70%, and coexisting BPS and endometriosis 48% (range 16–78%, CI 44–51%).
6. These data suggest the importance of considering the bladder as the source of pain even where endometriosis is confirmed, and in the case of unresolved endometriosis and persistent pelvic pain, patients must be evaluated to rule out the presence of BPS/IC.[6]

Conclusion:

- It is critical that gynaecologists consider IC as a diagnostic possibility, as well as pain in the absence of other symptoms—when a patient initially presents with symptoms of CPP. Endometriosis is frequently asymptomatic. (Butrick, 2019)
- Even if endometriosis is confirmed by biopsy in a patient with CPP, it should not be assumed to be the only cause of pain, because it is common for patients with CPP to have multiple pain generators. Hence these 2 disease entities "The Evil Twins" should always be kept in mind while managing women with endometriosis, though both conditions are not Curable but Treatable with a multi-Disciplinary approach. (FM, 2019). Avoiding delay in diagnosis can save these women of prolonged suffering.