

Are ‘psychiatric’ findings in patients with Chronic Pelvic Pain primary or secondary?

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Abstract: The often accepted view that CPP is not curable, may be psychological, is the background to the patient histories which form the main body of this paper. These are taken from a book for patients “Unlocking the Female Pelvic Floor” by Peter Petros, Joan McCredie and Patricia Skilling. As such, the descriptions are simplified, but clear. The theme of the book is “A conspiracy of Silence”

Key words: Chronic pelvic pain; Psychiatric; TFS ligament repair; Posterior fornix syndrome.

INTRODUCTION

The 2005 Cochrane Review summarizes Chronic Pelvic Pain as follows “*Chronic pelvic pain (CPP) is common in women in the reproductive and older age groups and causes disability and distress. Often investigation by laparoscopy reveals no obvious cause for the pain. As the pathophysiology of chronic pelvic pain is not well understood its treatment is often unsatisfactory and limited to symptom relief. Currently the main approaches to treatment include counselling or psychotherapy, attempts to provide reassurance by using laparoscopy to exclude serious pathology, progestogen therapy such as medroxyprogesterone acetate, and surgery to interrupt nerve pathways*”¹.

The association between pain, depression and psychological disturbance is well described^{2,3}.

Traditionally hysterectomy has been recommended as a cure for chronic pelvic pain by a significant body of specialist opinion⁴. The present trend to psychiatric evaluation and treatment appears to have arisen as a consequence of previous studies which showed a high correlation between CPP and psychiatric disturbances^{5,6}.

No mention is made by Cochrane¹ of Integral Theory related concepts for pain⁷, that CPP frequently co-occurs with urgency, nocturia, abnormal emptying and anorectal dysfunctions as part of the ‘Posterior Fornix Syndrome’. This was first reported in 1993⁷. Nor is there any mention of the substantial cure rates achieved with posterior sling surgery for pain, bladder and bowel dysfunctions⁸⁻¹⁵.

This often accepted view that CPP is psychological and not curable, is the background to the patient histories which follow. These are taken from a book for patients “Unlocking the Female Pelvic Floor” by Peter Petros, Joan McCredie and Patricia Skilling. As such, the descriptions are simplified, but clear. The theme of the book is “A conspiracy of Silence”¹⁶.

Excerpts from the patient book “Unlocking the Female Pelvic Floor” by Peter Petros, Joan McCredie and Patricia Skilling.

The Back Ligaments (uterosacral).

The back ligaments when damaged can cause prolapse of the uterus, which descends down the vagina as a firm “lump”. If the tissue damage is in the middle or lower part of the vagina, the patient may complain of a soft “lump” called a rectocele. However, not all prolapses have symptoms. The main symptoms of back ligament looseness are

urgency, getting up at night to pass urine more than twice ‘nocturia’, low dragging pain in the lower abdomen, pain on deep penetration with intercourse, “vulvodynia, (hypersensitivity or “burning” at the entrance of vagina), inability to empty the bladder properly, constipation and sometimes faecal incontinence. However, quite major symptoms can occur with only minimal prolapse of the uterus.

Characteristics of pelvic pain caused by back ligament (uterosacral) looseness

- Almost invariably occurs with other symptoms, specifically urgency, nocturia, abnormal emptying.
- Low abdominal ‘dragging’ pain, usually one side, often right-sided.
- Low sacral pain (pain near the tailbone)- present in 50% of cases.
- Pain on deep penetration with intercourse.
- Low abdominal ache the next day after intercourse.
- Pain worsens during the day and is relieved by lying down.
- Pain is reproduced on pressing the cervix or the back wall of the vagina if a patient has had a hysterectomy.
- Tiredness- worsening during the day.
- Irritability- worsening during the day

CASE REPORTS

Nocturia, urgency, abnormal emptying and pelvic pain caused by looseness in the back ligaments

Mrs LM was 53 years old. She stated, “*get up 4-5 times a night. I find this very tiring as I have to work next day. I have a dragging pain on the right side which can be quite distracting by the end of the day. I am always going to the toilet at work. My urine dribbles away after I stand up and I often wet the toilet seat. I have problems with bladder infections. My first GP did a whole lot of xrays, a CT scan, blood tests for the pain. I went to a gynaecologist who put a tube into my tummy and found nothing. She said that she couldn’t find anything wrong and she sent me to a psychiatrist, because she thought the pain was in my head. She said there was nothing wrong psychologically. I saw many GPs and several specialists about the bladder. They gave me tablets to stop the bladder from working so frequently but these made my emptying worse and they gave me a dry mouth as well, so I had to stop taking them. They said they couldn’t do anything else for me. One even said it might all be in my head. Mostly they said I had to learn to put up*

with these symptoms, because they were incurable. I came here because I felt a lump coming out." Mrs LM had symptoms typical of looseness in the back ligaments. When we examined her, we noted that her uterus was protruding outside the vagina. We inserted a TFS "minisling" (Tissue Fixation System, Adelaide, South Australia) to repair her back ligaments (cardinal/uterosacral). This repaired the prolapse and tightened the vaginal membrane. It was minimal surgery performed entirely from the vagina. Mrs LM required only an overnight stay in hospital and she returned to work in 7 days. When reviewed at 9 months, she was getting up only once per night to empty her bladder. She said that her low abdominal pain was still present but was 90% better and it rarely bothered her now. Her bladder emptying also was not entirely cured but had improved significantly and she had not had any bladder infections since the operation.

Pain during intercourse and bowel problems caused by back ligament looseness

Mrs RM was a hard-working 47 year old mother of 2 who worked in a Nursing Home. She stated:

"I always have urgency to empty my bowel but I am also frequently constipated. I get up 3-4 times a night to pass urine. I have problems emptying my bladder. My worst problem is that I can't have sex any more. Almost every time I have intercourse, my bowels open. It is so horrible. My husband is very understanding but I am sure he is as distressed as I am. I always have pain on deep penetration. Often I have a dragging pain low down on my right side which seems to get worse by the end of the day".

She had 2 teenage sons and helped her husband in his business in her spare time. At one stage she had sought medical advice, was told she could not be helped and that maybe a psychiatrist could help her learn how to deal with the pain. After confiding her problem to a close friend who had been to the clinic, she was persuaded to make an appointment. Many patients came to the clinic in this way.

Her symptoms of nocturia and abnormal emptying indicated damage in the back ligaments. When we examined her, there was very minimal prolapse. As Mrs RM's problems were complex, we recommended that we repair only the back ligaments and then we would re-assess her. We advised her that she could expect a cure rate of 80% for some of her symptoms. As for the urge to empty her bowel and constipation, these could be due to many other causes, so we were reluctant to predict a cure for these symptoms.

We inserted a TFS "minisling" to repair the back ligaments. Mrs RM was discharged the next day with very little pain and she went back to work the following week. She attended with her husband for the post-operative visit. She was smiling and confident. She could not contain her excitement and said to the secretary, "I'm cured. It's all gone". In the privacy of the consulting room, she reported cure of all her bowel symptoms and a major improvement in her other symptoms. Her husband said, "you don't know what a burden has been lifted from our lives". Mrs RM remained cured at last review 4 years later. Mrs RM is a good example of the passive "Conspiracy of Silence", a reticence to discuss this condition, even between man and wife. Without input from her friend, Mrs RM is unlikely to have sought assistance. Even with patients who do come to see us, faecal soiling is rarely volunteered in a face to face situation, another "Conspiracy of Silence", this time, even with her doctor. This is why it is important for patients to take the questionnaire (a series of printed questions) home and to answer the questions in their own time. It is so much easier to write it down, than to say it as it becomes almost anonymous.

Severe Pelvic Pain Caused by Back ligament looseness

Mrs D was a 34 year old science teacher from London, UK. She attended with severe pain in the right side of her abdomen. Some years previously, she had attended a London hospital where the Professor had created an international reputation using psychological tests to prove that such pain was psychological in origin. Mrs D had read widely on the subject of pain. Her facial expression indicated a person who was guarded. Her face lit up after she answered positively to the following questions because she suddenly became aware that we knew what her problem was.

- Do you have pain on deep penetration with intercourse?
- Do you get up more than twice per night to pass urine?
- Do you have problems emptying your bladder?
- Do you have urgency?"

Positive answers to at least some symptoms other than pain are required before we can predict that the pain is caused by damage to the back ligaments. There are, after all, many other causes of chronic pelvic pain in the 30 plus age group, for example, endometriosis, infection in the Fallopian tubes, problems with large intestine, to name just a few. This is what she said one week after her pain was cured by a small operation which tightened her back ligaments. "I was almost suicidal after interminable attacks of pain on my right side. It has now been a week since the operation and I feel like a rabbit that has been released from a trap. My mind keeps scanning up and down my body searching for the pain which for so long has been my centre and my focus."

Postscript. Mrs D. wrote to the Professor in England and told him her story. She sent him some published scientific articles which described cure of urgency, frequency, nocturia, and pelvic pain.

He could not understand the relationship between all these symptoms, or that her pelvic pain could be cured in such a simple way. He wrote back and said "but these articles are about bladder problems".

He just did not understand the ramifications of the "Integral System" which our clinic was applying. It is difficult even for the most learned person to associate lower abdominal pain with apparently unrelated symptoms such as urge and frequency which are thought to arise from the bladder.

Vulvodynia – Pain and Burning at the Entrance to the Vagina ("Vulvodynia") Caused by Back Ligament Looseness

- There are many causes of "vulvodynia", including skin conditions. The type we are describing is associated with low abdominal pain, urgency, nocturia and abnormal bladder emptying.

Mrs P was 49 years old. She had chronic pelvic pain and she requested referral to the clinic because she had heard that we were achieving good results in patients with pelvic pain. Her General Practitioner, an empathetic and caring man, rang the doctor before she arrived and asked that we "handle her very carefully" as she was severely disturbed psychologically, that this was the reason for her pain and there was nothing anyone could do for her. The first impression we had of this lady did indeed fit the description of her GP. Her face was contorted, she spoke rapidly and with obvious anxiety. She had visited many specialists over the years for her pain. She had undergone several diagnostic laparoscopies (a type of telescope inserted into the abdomen to view the uterus and ovaries), even a hysterectomy and had attended a pain clinic. None of these treatments had helped her pain. The consensus

from other specialists as reported to the GP was that her problem was psychological. Her replies to the questionnaire gave the first hint that this woman may have a physical cause for her problem, damage to her back ligaments. She woke 6 times per night to empty her bladder (nocturia), wore pads continually as she wet 6 times per day (urge incontinence) and had difficulties emptying her bladder. She also had faecal incontinence. We asked her if she had told her GP about her bladder and bowel problems. She said she had only consulted him about the burning pain around her vagina and anus. She said that her vagina was so tender that she couldn't have sexual intercourse and sometimes had problems sitting. Examination revealed a moderate prolapse of the back part of her vagina (apex). The entrance to the vagina was hypersensitive- she recoiled when gently tested with a cotton bud, the classical test for "vulvodynia" (pain at the entrance of the vagina). We did not claim that we could cure this lady's pain, as there are many other causes for pelvic pain. Nevertheless, it was explained that her vaginal prolapse needed to be fixed and that there was a strong possibility that some of her symptoms would also improve with a sling inserted into the back part of her vagina, a fairly minor day-care procedure. The first thing we noticed at the 6 week post-operative visit was the absence of tension in her face. She was smiling and calm. Her pain was gone, as was her urgency and faecal incontinence. Her nocturia had reduced to 2 per night and her bladder emptying was "60% improved".

Pelvic Pain Commencing Soon After the First Period Caused by Back Ligament Looseness.

Miss PN was 23 years old. She complained of severe pelvic pain which began some months after her first period at the age of 15. The pain was worse at period time. She had already undergone two laparoscopies where nothing was found. The doctor thought her problem was psychological and she had been referred to a psychiatrist. She came to the clinic with her mother, who was certain that her daughter was not only psychologically normal but there was some physical reason for the pain. On assessment, it was clear to us that Miss PN had looseness in her back ligaments dating from birth, a looseness exacerbated by hormones from her periods. The ligaments were just not strong enough. She had symptoms of urge and nocturia. These symptoms were all worse at period time. We explained that at period time, the brain secretes a hormone which relaxes the collagen fibres in the cervix sufficiently for the menstrual blood to exit the uterus. This relaxation also loosens the ligaments which are attached to the uterus, causing her symptoms of pain and urge to worsen. Miss PN did not respond to the pelvic floor exercises which were prescribed prior to surgery but had a very good result when the back ligaments were surgically tightened with a minor day-care operation. No tapes were used and this did not affect her ability to have children in any way.

Hysterectomy for Lower Backache and Pelvic Pain Caused by Back Ligament Looseness

Mrs JMK developed chronic lower back pain and pain with intercourse after a difficult forceps delivery of her second child 50 years ago when she was 27 years old. The pain as described earlier was constant and debilitating. At age 35, a specialist gynaecologist advised hysterectomy. This caused a major emotional shock, as she wished to have more children. She was persuaded to proceed with the operation. The operation did not go so well initially. She needed a blood transfusion during the surgery. Because of continuing

anaemia, she remained weak for another 6 months. Although the physical pain had improved, Mrs JMK was mentally traumatized by the hysterectomy for some time afterwards. By the time she was 65 years old, the chronic pelvic pain and lower backache had returned, along with urgency, nocturia and prolapse of the vagina and bladder. We attributed all this to age-related loss of collagen and weakening of the back ligaments, a long-term problem in many patients who have had hysterectomy. Ligament reconstruction cured the prolapse and greatly improved the symptoms.

DISCUSSION

In the patient book, we discussed the issues raised by these cases as 'comments'.

Comment on hysterectomy. Removal of the uterus is a major operation. It is not always complication-free and may have long-term physical and psychological consequences for some women. Fortunately, minor treatments for uterine haemorrhage, for example, intrauterine devices which slowly leach progesterone-type hormones, are now available.

Comment on pain with intercourse. The back ligaments form an important support for the pain nerves contained inside them. Earlier we discussed how a loose ligament will not support nerve fibres. As the penis thrusts into the back part of the vagina, it will cause pain if it stretches the unsupported nerve fibres.

Comment on psychiatric treatment of pain. Like the case of Mrs D, this lady's problem raises many issues about the attitudes of doctors, patients, even modern medicine itself. Many doctors, including this lady's General Practitioner, were not aware that this type of pelvic pain is associated with loose ligaments. Because of the scientific nature of medicine, if an obvious cause cannot be found, the doctor seeks another cause, usually "psychological".

The concept of psychological disturbance as the root cause of a medical condition can be traced back to Sigmund Freud himself. However, any type of chronic pain is sufficient to unsettle even the most rational person and such patients do become psychologically disturbed, often severely, as we saw in several of the histories. According to our experience, it is the pain which causes the psychological disturbance, not the other way round. Whether it be Freud's influence, or exhaustion of all known physical causes, attributing these difficult problems to a psychological cause is an important contributor to the "Conspiracy of Silence". No woman wishes to be labelled a "nut case". As soon as a psychological causation has been hinted at, she becomes silent. She remains so for all subsequent medical consultations, another contributor to the "Conspiracy of Silence". Our experience is that modern women are far too busy to complain about symptoms they do not have.

Comment on whether it be Freud's influence, or exhaustion of all known physical causes... There is another possibility, a new discovery which can address these so-called "incurable" problems of incontinence and pelvic pain. That is why we wrote this book, to inform women that a cure for these conditions already exists and to use this knowledge, especially the patient histories, to empower them when they choose to seek treatment for such problems.

Comment on the characteristics of 'Vulvodynia'. Vulvodynia which has no apparent local cause (such as a skin condition) is often expressed by a burning pain over the entrance of the vagina and anus with extreme sensitivity on touching, often associated with dragging lower abdominal pain and sometimes, painful bladder conditions.

Comment on causes of vulvodynia. We do not claim that all vulvodynia patients have this cause. However, if other symptoms of back ligament looseness such as nocturia, abnormal bladder emptying, and urgency are grouped with the vulvodynia, there is a strong possibility that this pain can be improved in many patients with a posterior sling for repair of the back ligaments.

Tampon test. A simple test to see if the back ligaments are causing the problem. We have found that a large tampon inserted into the back part of the vagina as a test can often instantaneously relieve the sensitivity and pain in the vulva. Generally such women also have other back ligament symptoms.

Conflicts. None

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INVITED COMMENT

Persuasive medical tools to mitigate against patients psychologization

The field of cognitive sciences is affirming the approach of "embodied cognition" which proposes that our mental states are shaped by the characteristics and the state of our physical body. This perspective, besides inflicting a further blow to Cartesian dualism, contributes to consolidating the view of the chain of causality going from the body to the mind at the expense of the chain of events going from the mind to the body. This conception is in line with the implicit warning in Petros and colleagues' work: it is likely to fall into the trap of fundamentalist psychology if we neglect that a sick and suffering body (especially a chronically sick one), is more likely to produce a debilitated, confused and sick mind, rather than vice versa. Why then, as in Mrs D's report, are there some professors that persist in seeking psychological explanations of pain before excluding any possible physiological variables? And what could be an antidote to this (causal) "perversion"?

Our hypothesis is that the most fascinating and insidious psychologization is of the Freudian type, because with its sexual and anal conceptualization of psychopathology, it easily convinces women suffering from pelvic floor disorders. The concepts of dirtiness, feces, incontinence and vaginal penetration pain, find an easy and misleading resonance with psychoanalytic language and representations. If this resonance is then combined with the sense of impotence and despair caused by doctors who claim to have excluded all the possible physiological causes of pain, and the feelings of guilt and embarrassment that the women associate with these problems, then the temptation to "psychologize" becomes irresistible. Any antidote to this view must exploit the same mechanisms that make the Freudian conceptualization so fascinating. It is therefore necessary to create and disseminate (capitalizing on social media), evidence-based metaphors, for example, the uterus represented as a "lump" (that clings to the vagina) and other short and engaging clinical narratives that can attract through resonance women who otherwise would risk falling victim to the "conspiracy of silence."

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