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Chronic Pelvic Pain

Chronic pelvic pain is a common, burdensome, and costly condition that disproportionately affects women. Diagnosis and initial management of chronic pelvic pain in women are within the scope of practice of specialists in obstetrics and gynecology. The challenging complexity of chronic pelvic pain care can be addressed by increased visit time using appropriate coding modifiers, as well as identification of multidisciplinary team members within the practice or by facilitated referral. This Practice Bulletin addresses the diagnosis and management of chronic pelvic pain that is not completely explained by identifiable pathology of the gynecologic, urologic, or gastrointestinal organ systems. When evidence on chronic pelvic pain treatment is limited, recommendations are extrapolated from treatment of other chronic pain conditions to help guide management. The evaluation and management of potential gynecologic etiologies of pelvic pain (ie, endometriosis, adenomyosis, leiomyomas, adnexal pathology, vulvar disorders) are discussed in other publications of the American College of Obstetricians and Gynecologists (1–4).

Background

Definition

A lack of consensus on the definition of chronic pelvic pain has impeded efforts to understand its prevalence and the success of treatment alternatives (5). The American College of Obstetricians and Gynecologists and the ReVITALize data definitions initiative define *chronic pelvic pain* as "pain symptoms perceived to originate from pelvic organs/structures typically lasting more than 6 months. It is often associated with negative cognitive, behavioral, sexual and emotional consequences as well as with symptoms suggestive of lower urinary tract, sexual, bowel, pelvic floor, myofascial, or gynecological dysfunction" (6). Cyclical pelvic pain is considered a form of chronic pelvic pain if it has significant cognitive, behavioral, sexual, and emotional consequences (6). This Practice Bulletin does not address cyclic pain syndromes (eg, dysmenorrhea, Mittelschmerz) but does discuss dyspareunia as a component of chronic pelvic pain.

Chronic pelvic pain differs from acute pelvic pain in several important ways. Acute pain typically arises from an inflammatory, infectious, or anoxic event or traumatic injury that resolves over time with treatment and repair. When pain persists, a chronic stress phenotype may emerge and is characterized by a vicious cycle of physical and psychologic consequences. Prolonged activity restriction can lead to physical deconditioning. Continued fear, anxiety, and distress can lead to long-term deterioration in mood and social isolation. Although mood symptoms are ubiquitous in chronic pain syndromes, criteria for major depression are met in approximately 12–33% of women across samples of women living with or seeking care for chronic pelvic pain (7–9).

Epidemiology

A systematic review of high-quality studies by the World Health Organization in 2006 found the prevalence to range from approximately 2.1% to 24% for noncyclical pain, 8% to 21.1% for dyspareunia, and 16.8% to 81% for dysmenorrhea (10). An updated review published in 2014 used a more stringent definition (noncyclical pain lasting at least 6 months) and found prevalence estimates that ranged from 5.7% to 26.6% (11). Familiarity with contributors to

chronic pelvic pain unrelated to the female reproductive system is important, with the most common being irritable bowel syndrome, interstitial cystitis or painful bladder syndrome, pelvic floor muscle tenderness, and depression. The estimated prevalence of these conditions ranges from 20% to 60% in women with chronic pelvic pain (7, 12–14). In a systematic review that included nine studies of 1,016 women with chronic pelvic pain who were evaluated for other conditions, the mean prevalence of bladder pain syndrome was 61% (range 11–97%; CI, 58–64%); of endometriosis, 70% (range 28–93%; CI, 67–73%); and of coexisting bladder pain syndrome and endometriosis, 48% (range 16–78%; CI, 44–51%) (15).

Pathophysiology

Recent evidence supports the importance of central sensitization in perpetuating chronic pain syndromes. Central sensitization occurs when peripheral pain provokes an exaggerated response by the interneurons, which amplifies the pain perception. The resulting pathologic changes involve the central nervous system's response to noxious stimuli, the activation of specific brain regions, the hypothalamic–pituitary–adrenal axis, and the autonomic nervous system, all of which increase psychologic distress (16). Central sensitization explains why patients with chronic pelvic pain feel pain in response to innocuous stimuli (allodynia) and feel a heightened response to painful stimuli (hyperalgesia). The abnormal central processing of sensory information can explain why endometriosis pain can persist despite effective treatment (17).

Differential Diagnosis

The differential diagnosis for chronic pelvic pain is extensive. Organizing the possibilities into visceral and neuromusculoskeletal disorders and psychosocial contributors can facilitate evaluation and treatment while maintaining awareness of the likely multifactorial etiology (Box 1).

The multifactorial nature of chronic pelvic pain lends itself to an interdisciplinary model of care that seeks to identify and treat an individual's physical pain generators as well as comorbid conditions, such as depression and anxiety, which together create the symptomatology and contribute to the overall burden of disease (9). For example, a chronic pelvic pain patient's pain may not improve until her endometriosis is treated, reactive pelvic floor myalgia is addressed, central sensitization is controlled with neuromodulator treatment, and depression is in remission.

Visceral etiologies include disorders of the gynecologic, gastrointestinal, and urologic organ systems. Visceral pain results from stimulation of nociceptors of organs, which are particularly sensitive to distention,

Box 1. Common Conditions Associated With Chronic Pelvic Pain

Visceral

- Gynecologic
  - Adenomyosis
  - Adnexal mass
  - Chronic pelvic inflammatory disease/chronic endometritis
  - Endometriosis
  - Leiomyoma
  - Ovarian remnant syndrome
  - Pelvic adhesions
  - Vestibulitis
  - Vulvodynia
- Gastrointestinal
  - Celiac disease
  - Colorectal cancer and cancer therapy
  - Diverticular colitis
  - Inflammatory bowel disease
  - Irritable bowel syndrome
- Urologic
  - Bladder cancer and cancer therapy
  - Chronic or complicated urinary tract infection
  - Interstitial cystitis
  - Painful bladder syndrome
  - Urethral diverticulum

Neuromusculoskeletal

- Fibromyalgia
- Myofascial syndromes
  - Coccydynia
  - Musculus levator ani syndrome
- Postural syndrome
- Abdominal wall syndromes
  - Muscular injury
  - Trigger point
- Neurologic
  - Abdominal epilepsy
  - Abdominal migraine
  - Neuralgia
  - Neuropathic pain

Psychosocial

- Abuse
  - Physical, emotional, sexual
- Depressive disorders
  - Major depressive disorder
  - Persistent depressive disorder (dysthymia)
  - Substance-induced or medication-induced depressive disorder
- Anxiety disorders
  - Generalized anxiety disorder
  - Panic disorder
  - Social anxiety disorder
  - Substance-induced or medication-induced anxiety disorder

(continued)

Box 1. Common Conditions Associated With Chronic Pelvic Pain *(continued)*

- Somatic symptom disorders
  - Somatic symptom disorder with pain features
  - Somatic symptom disorder with somatic characteristics
- Substance use disorder
  - Substance abuse
  - Substance dependence

ischemia, and inflammation. The pain is typically diffuse and poorly defined without spatial discernment because of differing densities of visceral sensory innervation and scattering of input in the central nervous system. Autonomic symptoms, including diaphoresis, vital sign abnormalities, and gastrointestinal symptoms, often accompany visceral pain and can confuse the diagnosis. Patients are often focused on the viscera as the cause of pain, and so visceral etiologies should be addressed early and often, with reassurance that these diagnoses are not being overlooked.

Neuromusculoskeletal disorders are extremely common and often overlooked, which prolongs patient discomfort and delays appropriate treatment. No universal consensus exists on diagnostic criteria for neuromusculoskeletal pain, but the symptoms often can be a result of myofascial trigger points or neurovascular entrapment that is due to surgical injury or inflammation of tendons or ligaments. Pain is reproducible on examination with palpation of the affected muscle groups but does not typically trigger an autonomic response. The pathophysiology of neuromusculoskeletal pain is poorly understood but is likely related to repeated microtrauma, acute trauma, or postural misalignment, which results in hypertonicity and a myofascial pain syndrome (18).

Psychosocial factors play a role in all types of pain and can affect symptom severity and prognosis. Pelvic pain and dyspareunia are more prevalent in women with a history of abuse, mental illness, lack of support, social stressors, and relationship discord. These comorbidities do not alter the visceral or neuromusculoskeletal pain generators but may worsen the associated symptom burden and psychological effects. Treating psychosocial factors as separate but equally important pain contributors can increase the woman's awareness of her conscious and unconscious perception of pain and facilitate her recovery.

Pelvic congestion syndrome is a proposed etiology of chronic pelvic pain related to pelvic venous insufficiency. Although venous congestion appears to be associated with chronic pelvic pain, evidence is insufficient to conclude that there is a cause-and-effect relationship (19). In addition, there is no consensus on the definition of this condition, and diagnostic criteria are variable (19). Further research is needed to establish greater consistency in diagnosis and homogeneity in treatment studies.

Clinical Considerations and Recommendations

▶ ***What is the initial evaluation for a patient who presents with chronic pelvic pain?***

A detailed medical history and physical examination, with particular attention to the abdominal and pelvic neuromusculoskeletal examination, are recommended for the evaluation of chronic pelvic pain. Physical findings that increase the likelihood of neuromusculoskeletal contributors to chronic pelvic pain include pelvic floor muscle tenderness and abdominal wall tenderness that reproduce the patient's pain.

Perhaps the most critical portions of the evaluation of chronic pelvic pain are a detailed medical, surgical, and gynecologic history and a thorough physical examination (20, 21). Self-administered screening forms completed by patients in advance and increased visit times with appropriate coding modifiers can optimize the practice effect of chronic pelvic pain care. A systematic history begins with patient-reported information completed before the visit, a detailed chronology of symptoms, and a review of previous treatments. Eliciting pain aggravators and alleviators related to sexual activity and menstruation is a good starting point, but this information needs to be supplemented with an understanding of pain and other symptoms associated with physical activity and urinary and gastrointestinal function. The Pelvic Pain Assessment Form published by the International Pelvic Pain Society includes many of these assessments and is freely available for clinical use in four languages (22).

The medical history should include specific chronology, triggers, and treatments of pain as well as a review of all medical diagnoses, surgical procedures and findings, obstetric details, medications, and allergies. Psychosocial factors are also important and may influence treatment choices. The success or failure of previous treatment attempts also may be instructive.

Focusing the physical examination on the abdominal and pelvic neuromusculoskeletal system, with inclusion of a visceral examination, addresses most chronic pelvic pain etiologies. Attention to underlying myofascial structures in addition to the viscera is highly likely to yield an accurate diagnosis (20, 21). Evaluation should include palpation of the lower back, sacroiliac joints, pubic symphysis, as well as the abdomen and genitalia. Focal tenderness of the abdomen or the pelvic floor can

be found with a single digit examination or examination with a cotton tipped swab (23).

Several physical examination findings are indicative of neuromusculoskeletal chronic pelvic pain etiologies, with two findings that indicate potential benefit from physical therapy. The presence of pelvic floor muscle tenderness or a positive result on the forced flexion, abduction, and external rotation (FABER) test correctly classified neuromusculoskeletal pain in 85% of patients in a small U.S. study (24). A study in Denmark also showed a strong association between chronic pelvic pain of myofascial origin and the presence of pelvic floor muscle tenderness and hypertonicity (25). Both studies used trained examiners in research settings and likely overestimate associations found in clinical practice.

The abdominal examination finding most associated with chronic pelvic pain can be demonstrated by the Carnett test (26). A positive Carnett test result is defined by tenderness that worsens or does not improve during an abdominal wall muscle contraction. A negative Carnett test result indicates visceral pain that improves during the muscle contraction when the abdominal wall shields the viscera from the examiner's finger. A positive Carnett test result is independently associated with severity of chronic pelvic pain to a similar degree as pelvic floor muscle tenderness (27).

Laboratory and imaging tests for chronic pelvic pain are limited in their utility and should be tailored to the individual patient's symptoms and physical examination findings. For example, patients with risk factors for chronic sexually transmitted infection should be tested for gonorrheal, chlamydial, mycoplasmal, and trichomonal infections. Patients with uterine or adnexal tenderness or suspicion of a pelvic mass should have further evaluation for visceral gynecologic causes of chronic pelvic pain using transvaginal ultrasonography and possibly diagnostic laparoscopy (3, 28). Suspicion of chronic pelvic inflammatory disease can be evaluated further with endometrial biopsy and transvaginal ultrasonography.

▶ *What additional evaluation should be performed when nongynecologic etiologies are suspected?*

Evaluation for common nonreproductive conditions that contribute to chronic pelvic pain should include screening for interstitial cystitis or painful bladder syndrome, irritable bowel syndrome, diverticulitis, and comorbid mood disorders (depression, anxiety). Additional testing or referral may be required for patients who screen positive for any of these conditions to rule out other causes of urinary, gastrointestinal, or constitutional symptoms in patients with risk factors.

Symptom questionnaires can be completed before or during the visit to assist in screening for depression (29), interstitial cystitis (30), and irritable bowel syndrome (31). Patients with unexplained urinary symptoms (eg, frequency, urgency) and bladder pain may benefit from referral for additional evaluation. Patients with irritable bowel syndrome symptoms and risk factors may warrant additional evaluation to rule out inflammatory bowel disease or colon cancer through appropriate referrals to primary care or gastroenterology, or both. Patients with complex mood symptoms, suicidal thoughts, or other risk factors may benefit from evaluation by a mental health professional.

▶ *What are the roles of pelvic floor physical therapy, cognitive behavioral therapy, and sex therapy in the treatment of chronic pelvic pain?*

Chronic pelvic pain and associated dyspareunia often stem from a combination of myofascial and psychosocial causes, both of which should be addressed in the treatment plan. Referral for pelvic floor physical therapy, sex therapy, or cognitive behavioral therapy, alone or in combination, is recommended to manage the myofascial and psychosocial causes and consequences of chronic pelvic pain and associated dyspareunia.

A systematic review that included 202 randomized trials of treatments for chronic tension headache, fibromyalgia, and chronic musculoskeletal pain (low back, neck, knees, hips) found slight-to-moderate improvement in pain and functioning after exercise, multidisciplinary rehabilitation, acupuncture, cognitive behavioral therapy, and mind–body practices. Although these treatments were not associated with serious harms, few studies monitored patients for outcomes beyond the immediate treatment period (32).

Pelvic Floor Physical Therapy

Pelvic floor muscle tenderness is commonly associated with chronic pelvic pain. Physical therapists use a wide range of modalities and tools tailored to each patient's specific symptoms and clinical findings. These include external and internal tissue mobilization and myofascial release, manipulative therapies to mobilize visceral, urogenital, and joint structures; electrical stimulation; active pelvic floor retraining; biofeedback; bladder and bowel retraining; and pelvic floor muscle stretching (33–35). In one randomized trial, pelvic floor physical therapy and levator-directed trigger-point injections were equally effective in markedly decreasing vaginal pain and sex-related pain (36). Patients who do not improve with pelvic floor physical therapy may be

found to have treatable musculoskeletal disorders identified by a physician specializing in physical medicine and rehabilitation (37).

Cognitive Behavioral Therapy

Although pelvic pain may be due to an inciting event, the chronicity of pain predisposes patients to depression, anxiety, and social isolation. And, depression worsens the quality of life for women with chronic pelvic pain (38). Instead of attempting to determine which order is primary, or blaming one condition for causing the other, both need to be treated with equal urgency.

Cognitive behavioral therapy is a goal-oriented therapy and, when used in conjunction with medical and physical therapies, has the advantage of addressing the effects of depression and pain on relationships and other aspects of well-being. The evidence that supports the benefit of cognitive behavioral therapy and other counseling approaches for the treatment of chronic pelvic pain comes primarily from studies in which counseling is a component of multidisciplinary care (39, 40). Studies of patients with other chronic pain syndromes show small-to-moderate benefits of cognitive behavioral therapy when compared with no therapy (41). Patients learn to modulate their thoughts and manipulate their environment to lessen their pain perception and improve coping skills.

Emotional well-being should be assessed at every visit and professional counseling should be considered and offered to every patient with chronic pelvic pain. It is critical that the patient understands that referral does not mean that the pain is psychosomatic or any less real. Instead, counseling enables patients to obtain support in parallel with the other treatments being recommended to address the chronic pelvic pain generators.

Sex Therapy

Although there may be a myofascial component to genito–pelvic pain, this condition may require the additional expertise of individual counseling, couples therapy, or sex therapy to overcome the specific psychosocial barriers to recovery (4, 42). Sex therapy can be a useful adjunctive treatment to physical therapy to assist couples in the return to normal, pain-free intercourse; female orgasmic disorder and genito–pelvic pain have been shown to improve with sex therapy (43, 44).

▶ *What is the role of neuropathic medications in the treatment of chronic pelvic pain?*

Based upon their effectiveness for other neuropathic pain syndromes, serotonin–norepinephrine reuptake inhibitors (SNRIs) are recommended for patients with neuropathic chronic pelvic pain. These medications can be prescribed by obstetrician–gynecologists.

Antidepressant medications are most commonly prescribed, alone or with psychotherapy, for management of moderate to severe depression. Antidepressant medications also have been evaluated in nondepressed patients with chronic pain syndromes. Although no studies have established the benefit of antidepressant use for improvement in chronic pelvic pain specifically, a systematic review of 37 double-blind randomized trials found that SNRIs and tricyclic antidepressants were superior to placebo for improving depressive symptoms, pain, and quality of life in patients with neuropathic pain syndromes such as fibromyalgia and diabetic neuropathy, with a number-needed-to-treat of 24 patients for one to experience a clinical improvement. The analgesic effectiveness of SNRIs and tricyclic antidepressants was not evaluated separately in subgroup analyses (45).

Cochrane reviews of individual antidepressants show that duloxetine (an SNRI) is superior to placebo for the management of neuropathic pain from diabetic neuropathy and fibromyalgia (46), whereas trials of venlafaxine (a selective serotonin reuptake inhibitor with weak SNRI properties) for neuropathic pain showed strong placebo effects and high potential for selection bias (47). No published trials have established the efficacy of duloxetine or venlafaxine in the treatment of chronic pelvic pain in women.

Tricyclic antidepressants (eg, amitriptyline, nortriptyline, and desipramine) are commonly used to treat neuropathic pain. However, there is only weak evidence of efficacy (48–50). A 2009 double blind randomized controlled trial (RCT) found that gabapentin and nortriptyline worked better in combination than either drug worked in isolation for chronic neuropathic pain (51).

Based upon their effectiveness for other neuropathic pain syndromes, gabapentin and pregabalin are recommended for the treatment of neuropathic chronic pelvic pain. These medications can be prescribed by obstetrician–gynecologists. Neuropathic medications have a role in the medical management of chronic pelvic pain once underlying visceral etiologies have been addressed and a neuropathic component of the pain syndrome has been diagnosed (52). However, many studies are not specific to chronic pelvic pain and are small or retrospective in nature (53). Because neuropathic pain is often associated with tissue injury, it is critical to assess for and treat concurrent myofascial dysfunction. Treatment with neuropathic medications may improve the effectiveness of physical therapy and myofascial dysfunction by improving sensorineural tolerance of stimuli.

Calcium channel alpha 2-delta ligand medications (gabapentin or pregabalin) are common treatments for chronic pelvic pain. Although there is a lack of evidence

specific to women with chronic pelvic pain, a 2016 pilot RCT looked at the potential effectiveness of gabapentin in women with chronic pelvic pain and showed it to be a beneficial, well-tolerated, and cost-effective therapy (54). A Cochrane review of gabapentin for general neuropathic pain in adults showed overall improvement with the medication, particularly for those with postherpetic neuralgia or peripheral diabetic neuropathy. The benefit was modest, with approximately three or four out of 10 study participants experiencing at least a 50% reduction in pain with gabapentin, as compared with one or two out of 10 who received placebo (53).

A Cochrane review did not find sufficient evidence to recommend muscle relaxants for myofascial pain (55); however, only two studies were evaluated. Treatment should be individualized to the patient's pain and comorbidities as well as tolerance of adverse effects.

▶ *What is the role of opioid analgesics in the treatment of chronic pelvic pain?*

Opioids are not recommended for the treatment of chronic pelvic pain. Patients already on opioids should be slowly weaned. Although there is a role for opioids in the treatment of acute pain, nonpharmacologic and nonopioid treatments are preferred for chronic pelvic pain. Opioids neglect the underlying etiology; increase the risk of adverse medication effects, tolerance, or overdose; and may contribute to the opioid dependence epidemic (56).

The Centers for Disease Control and Prevention (CDC) guidelines for the use of opioids in the treatment of chronic pain recommend that other than active cancer or end-of-life palliative care, opioids should not be considered as first-line or routine therapy (57). The CDC guidelines emphasize use of concurrent nonopioid pain medications, measurement of pain and function, and avoiding the use of opioids and benzodiazepines together. Chronic opioid use is associated with serious adverse effects such as respiratory depression and lifelong opioid use disorder and more common effects such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids (57).

Patients already taking opioid medications should be slowly weaned and transitioned to a therapy to address the etiology and symptoms of chronic pelvic pain (57), which may necessitate referral to a pain or addiction specialist. During the process of weaning, review of treatment goals, review of state prescription drug monitoring program data, urine drug screens, and robust addiction counseling are encouraged to optimize the chance of successful cessation. Tapering the dose slowly (eg, 10% per month) may be better tolerated than faster tapering rates (57). When weaning is not possible because of patient intolerance of withdrawal symptoms or analgesic alternatives, opioids should be prescribed according to the CDC prescribing guidelines (57). For more information, see the American College of Obstetricians and Gynecologists' Opioid Resources webpage, available at https://www.acog.org/About-ACOG/ACOG-Departments/Tobacco–Alcohol–and-Substance-Abuse/Opioids.

▶ *When is it appropriate to involve pain specialists or to refer patients for multidisciplinary care for the treatment of chronic pelvic pain?*

Referral to pain medicine specialists may be part of the multidisciplinary care of women with chronic pelvic pain. The timing of consultation or referral to multidisciplinary care should be individualized based upon the complexity of the patient's condition, the primary clinician's expertise, and the availability of resources. A variety of specialists may focus their practice on specific elements of pain management, such as medication management or interventional procedures. However, a multimodal approach is needed for management of chronic pelvic pain. Specialists certified by the American Board of Pain Medicine are trained to develop comprehensive treatment plans for pain. Pain medicine specialists are also helpful in providing pharmacotherapy recommendations when multiple agents may be needed to address central and peripheral sources of pain. Because they are not trained to identify and treat primary sources of pelvic pain, pain medicine specialists should be part of a multidisciplinary care program that includes, at minimum, a gynecologist, a psychologist, and a physical therapist (9, 39).

▶ *What is the role of procedural treatments in the management of chronic pelvic pain?*

For myofascial etiologies of chronic pelvic pain, such as trigger points and nerve entrapment, procedural treatments can be useful in conjunction with other modalities.

Trigger Point Injections

Trigger point injections of saline, anesthetic, steroids, or opioids, in isolation or in combination with other treatment modalities, are recommended to improve pain and functional ability in patients with myofascial chronic pelvic pain. Trigger point injections can be performed by appropriately trained obstetrician–gynecologists. Trigger point injections are safe and can provide immediate relief of a hyperalgesic muscle cutaneous nerve entrapment or fascial trigger point (58) but may require repeated doses for full benefit (18, 59). Evidence that trigger point injections are beneficial regardless of the injectant used

raises the possibility that needle insertion itself may produce a strong placebo effect or be effective on its own (60). Trigger point injections are beneficial for pelvic floor muscle spasm refractory to pelvic floor physical therapy and medications (61) and may be more beneficial than ischemic compression physical therapy alone for the treatment of abdominal wall trigger points in patients with chronic pelvic pain (59). Patients should be counseled regarding expectations and anticipated concurrent therapies before starting injections.

Botulinum Toxin Injections

The evidence is inconclusive regarding the value of botulinum toxin injections for myofascial pain syndromes from all sources (62). Therefore, their use should be reserved for the treatment of myofascial pelvic pain refractory to physical therapy (63).

Other Procedures

There is limited evidence to support laparoscopic uterosacral nerve ablation and presacral neurectomy in the treatment of chronic pelvic pain. A large RCT found no improvement in pain scores or quality of life after laparoscopic uterosacral nerve ablation in chronic pelvic pain (64). Most studies that evaluated presacral neurectomy included patients that had dysmenorrhea, and there is insufficient evidence to support nerve interruption in the treatment of chronic pain (65).

▶ *What are the roles of complementary, alternative, and integrative medicine therapies in the treatment of chronic pelvic pain?*

Data from randomized trials are needed to evaluate whether complementary and integrative therapies studied for other chronic pain disorders are effective for chronic pelvic pain. However, based on evidence of benefit for the treatment of nongynecologic chronic pain, acupuncture and yoga can be considered for the management of chronic pelvic pain of musculoskeletal etiology.

Complementary and integrative therapies have been studied in patients with chronic musculoskeletal and neuropathic pain syndromes of the head, neck, back, and extremities as well as fibromyalgia. These therapies can be biologically based (natural compounds), mind–body (such as relaxation, yoga, and tai chi), manipulative (such as massage and osteopathic manipulation), and bioenergetic (acupuncture) (32, 66). A systematic review of 32 studies of chronic pain management included six randomized trials of acupuncture that showed strong evidence of benefit for reducing pain and opioid use in patients with chronic musculoskeletal pain. One of the trials showed short-term benefit of auricular acupuncture in pregnant women with low back and posterior pelvic pain. Studies of yoga, relaxation, tai chi, massage, and manipulation showed weaker evidence of benefit. None of the studies focused on women with chronic pelvic pain (66). Preliminary evidence from a single-arm trial that evaluated the success of a group-based therapeutic yoga program for women with chronic pelvic pain showed clinically important and statistically significant improvements in baseline pain, emotional well-being, and sexual function after 6 weeks of yoga practice (67).

Selective cannabinoids (ie, synthetic cannabinoids that contain only tetrahydrocannabinol [THC] and cannabis-based extracts that contain a combination of THC and cannabidiol [CBD]) for chronic neuropathic pain have been the focus of several recent systematic reviews (68, 69). A systematic review of 11 randomized trials that included 1,219 patients showed a statistically significant but clinically small benefit averaging less than 1 point on a 0–10-point pain scale (68). Another review included the findings from 24 randomized trials (1,334 patients) in a meta-analysis that showed inconsistent improvements in pain across trials, with most showing no effect (69). Participants in the trials had heterogeneous diagnoses including multiple sclerosis, diabetic neuropathy, brachial plexus injury, and chemotherapy-induced pain. None of the studies in either review focused on women with chronic pelvic pain (68, 69).

▶ *What is the role of laparoscopic adhesiolysis in the management of chronic pelvic pain?*

The routine use of laparoscopic adhesiolysis is not recommended for the management of chronic pelvic pain. Laparoscopic adhesiolysis is not helpful for the treatment of chronic pelvic pain after visceral gynecologic causes such as endometriosis, adenomyosis, and adnexal disorders have been excluded. However, intraoperative findings may support the role of adhesiolysis in specific circumstances such as bowel stricture and dense adhesions tethering the uterus.

Adhesions are common in patients who have undergone previous abdominal surgery and in patients with inflammatory conditions such as pelvic inflammatory disease and endometriosis. Pelvic adhesiolysis was once a common procedure in patients undergoing laparoscopy for chronic pelvic pain (70). Early uncontrolled studies showed large magnitude, short-lived improvements after lysis of adhesions, whereas later randomized trials show no benefit when compared with diagnostic laparoscopy (71), which challenges the value of laparoscopic adhesiolysis for chronic pelvic pain and the presumption that adhesions cause chronic pelvic pain.

A systematic review of two RCTs and 11 cohort studies on laparoscopic adhesiolysis found a lack of evidence of benefit, an increased risk of bowel injury, and a high rate of *negative laparoscopies* (defined in the review as no

diagnostic findings other than adhesions) (71). In a long-term follow-up study of one of the RCTs included in the systematic review, pain outcomes were poorer 12 years after laparoscopic adhesiolysis than after diagnostic laparoscopy alone (72). Among the study participants reporting outcomes at 12 years, 42% in the diagnostic laparoscopy group, and 19% in the adhesiolysis group reported complete relief of abdominal pain (relative risk, 1.3; $P=.033$) (72).

Summary of Recommendations

The following recommendation is based on good and consistent scientific evidence (Level A):

- The routine use of laparoscopic adhesiolysis is not recommended for the management of chronic pelvic pain.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Referral for pelvic floor physical therapy, sex therapy, or cognitive behavioral therapy, alone or in combination, is recommended to manage the myofascial and psychosocial causes and consequences of chronic pelvic pain and associated dyspareunia.
- Based upon their effectiveness for other neuropathic pain syndromes, serotonin–norepinephrine reuptake inhibitors are recommended for patients with neuropathic chronic pelvic pain.
- Based upon their effectiveness for other neuropathic pain syndromes, gabapentin and pregabalin are recommended for the treatment of neuropathic chronic pelvic pain.
- Opioids are not recommended for the treatment of chronic pelvic pain. Patients already on opioids should be slowly weaned.
- Trigger point injections of saline, anesthetic, steroids, or opioids, in isolation or in combination with other treatment modalities, are recommended to improve pain and functional ability in patients with myofascial chronic pelvic pain.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- A detailed medical history and physical examination, with particular attention to the abdominal and pelvic neuromusculoskeletal examination, are recommended for the evaluation of chronic pelvic pain.
- Evaluation for common nonreproductive conditions that contribute to chronic pelvic pain should include screening for interstitial cystitis or painful bladder syndrome, irritable bowel syndrome, diverticulitis, and comorbid mood disorders (depression, anxiety). Additional testing or referral may be required for patients who screen positive for any of these conditions to rule out other causes of urinary, gastrointestinal, or constitutional symptoms in patients with risk factors.
- Referral to pain medicine specialists may be part of the multidisciplinary care of women with chronic pelvic pain. The timing of consultation or referral to multidisciplinary care should be individualized based upon the complexity of the patient's condition, the primary clinician's expertise, and the availability of resources.
- Based on evidence of benefit for the treatment of nongynecologic chronic pain, acupuncture and yoga can be considered for the management of chronic pelvic pain of musculoskeletal etiology.

References

1. Management of endometriosis. Practice Bulletin No. 114. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;116:223–36. (Level III)
2. Alternatives to hysterectomy in the management of leiomyomas. ACOG Practice Bulletin No. 96. American College of Obstetricians and Gynecologists. Obstet Gynecol 2008;112:387–400. (Level III)
3. Evaluation and management of adnexal masses. Practice Bulletin No. 174. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128:e210–26. (Level III)
4. Persistent vulvar pain. Committee Opinion No. 673. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128:e78–84. (Level III)
5. Williams RE, Hartmann KE, Steege JF. Documenting the current definitions of chronic pelvic pain: implications for research. Obstet Gynecol. 2004;103:686–691. (Level III)
6. American College of Obstetricians and Gynecologists. reVitalize. Gynecology data definitions (version 1.0). Washington, DC: American College of Obstetricians and Gynecologists; 2018. Available at: https://www.acog.org/-/media/Departments/Patient-Safety-and-Quality-Improvement/reVITALize-Gynecology-Definitons-V2.pdf. Retrieved September 23, 2019. (Level III)
7. Learman LA, Gregorich SE, Schembri M, Jacoby A, Jackson RA, Kuppermann M. Symptom resolution after hysterectomy and alternative treatments for chronic pelvic pain: does depression make a difference? Am J Obstet Gynecol 2011;204:269.e1–9. (Level II-2)
8. Ayorinde AA, Bhattacharya S, Druce KL, Jones GT, Macfarlane GJ. Chronic pelvic pain in women of reproductive and post-reproductive age: a population-based study. Eur J Pain 2017;21:445–55. (Level II-3)
9. Allaire C, Williams C, Bodmer-Roy S, Zhu S, Arion K, Ambacher K, et al. Chronic pelvic pain in an interdisciplinary

setting: 1-year prospective cohort. Am J Obstet Gynecol 2018; 218:114.e1–12. (Level II-2)

10. Latthe P, Latthe M, Say L, Gülmezoglu M, Khan KS. WHO systematic review of prevalence of chronic pelvic pain: a neglected reproductive health morbidity. BMC Public Health 2006;6:177. (Systematic Review and Meta-Analysis)
11. Ahangari A. Prevalence of chronic pelvic pain among women: an updated review. Pain Physician 2014;17: E141–7. (Systematic Review)
12. Williams RE, Hartmann KE, Sandler RS, Miller WC, Savitz LA, Steege JF. Recognition and treatment of irritable bowel syndrome among women with chronic pelvic pain. Am J Obstet Gynecol. 2005;192:761–7. (Level II-3)
13. Cheng C, Rosamilia A, Healey M. Diagnosis of interstitial cystitis/bladder pain syndrome in women with chronic pelvic pain: a prospective observational study. Int Urogynecol J 2012;23:1361–6. (Level II-3)
14. Montenegro ML, Mateus-Vasconcelos EC, Rosa e Silva JC, Nogueira AA, Dos Reis FJ, Poli Neto OB. Importance of pelvic muscle tenderness evaluation in women with chronic pelvic pain. Pain Med 2010;11:224–8. (Level II-3)
15. Tirlapur SA, Kuhrt K, Chaliha C, Ball E, Meads C, Khan KS. The 'evil twin syndrome' in chronic pelvic pain: a systematic review of prevalence studies of bladder pain syndrome and endometriosis. Int J Surg 2013;11:233–7. (Systematic Review)
16. Brawn J, Morotti M, Zondervan KT, Becker CM, Vincent K. Central changes associated with chronic pelvic pain and endometriosis. Hum Reprod Update 2014;20:737–47. (Level III)
17. Aredo JV, Heyrana KJ, Karp BI, Shah JP, Stratton P. Relating chronic pelvic pain and endometriosis to signs of sensitization and myofascial pain and dysfunction. Semin Reprod Med 2017;35:88–97. (Level III)
18. Sharp HT. Myofascial pain syndrome of the abdominal wall for the busy clinician. Clin Obstet Gynecol 2003;46: 783–8. (Level III)
19. Champaneria R, Shah L, Moss J, Gupta JK, Birch J, Middleton LJ, et al. The relationship between pelvic vein incompetence and chronic pelvic pain in women: systematic reviews of diagnosis and treatment effectiveness. Health Technol Assess 2016;20:1–108. (Systematic Review and Meta-Analysis)
20. Gunter J. Chronic pelvic pain: an integrated approach to diagnosis and treatment. Obstet Gynecol Surv 2003;58: 615–23. (Level III)
21. Steege JF, Siedhoff MT. Chronic pelvic pain. Obstet Gynecol 2014;124:616–29. (Level III)
22. International Pelvic Pain Society. Documents and forms: history and physical. Available at: https://www.pelvicpain.org/IPPS/Professional/Documents-Forms/IPPS/Content/Professional/Documents_and_Forms.aspx. Retrieved September 23, 2019. (Level III)
23. Speer LM, Mushkbar S, Erbele T. Chronic pelvic pain in women. Am Fam Physician 2016;93:380–7. (Level III)
24. Neville CE, Fitzgerald CM, Mallinson T, Badillo S, Hynes C, Tu F. A preliminary report of musculoskeletal dysfunction in female chronic pelvic pain: a blinded study of examination findings. J Bodyw Mov Ther 2012;16:50–6. (Level II-3)
25. Loving S, Thomsen T, Jaszczak P, Nordling J. Pelvic floor muscle dysfunctions are prevalent in female chronic pelvic pain: a cross-sectional population-based study. Eur J Pain 2014;18:1259–70. (Level II-3)
26. Carnett JB. The simulation of gall-bladder disease by intercostal neuralgia of the abdominal wall. Ann Surg 1927;86: 747–57. (Level III)
27. Yosef A, Allaire C, Williams C, Ahmed AG, Al-Hussaini T, Abdellah MS, et al. Multifactorial contributors to the severity of chronic pelvic pain in women. Am J Obstet Gynecol 2016;215:760.e1–14. (Level II-3)
28. Juhan V. Chronic pelvic pain: an imaging approach. Diagn Interv Imaging 2015;96:997–1007. (Level III)
29. Hirschtritt ME, Kroenke K. Screening for depression. JAMA 2017;318:745–6. (Level III)
30. Humphrey L, Arbuckle R, Moldwin R, Nordling J, van de Merwe JP, Meunier J, et al. The bladder pain/interstitial cystitis symptom score: development, validation, and identification of a cut score. Eur Urol 2012;61:271–9. (Level II-3)
31. Engsbro AL, Begtrup LM, Kjeldsen J, Larsen PV, de Muckadell OS, Jarbol DE, et al. Patients suspected of irritable bowel syndrome—cross-sectional study exploring the sensitivity of Rome III criteria in primary care. Am J Gastroenterol 2013;108:972–80. (Level II-3)
32. Skelly AC, Chou R, Dettori JR, Turner JA, Friedly JL, Rundell SD, et al. Noninvasive nonpharmacological treatment for chronic pain: a systematic review. Comparative Effectiveness Review Number 209. AHRQ Publication No 18-EHC013-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2018. Available at: https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/nonpharma-chronic-pain-cer-209.pdf. Retrieved September 23, 2019. (Systematic Review and Meta-Analysis)
33. Anderson RU, Wise D, Sawyer T, Nathanson BH, Nevin Smith J. Equal improvement in men and women in the treatment of urologic chronic pelvic pain syndrome using a multi-modal protocol with an internal myofascial trigger point wand. Appl Psychophysiol Biofeedback 2016;41: 215–24. (Level II-1)
34. Polpeta NC, Giraldo PC, Teatin Juliato CR, Gomes Do Amaral R. L., Moreno Linhares I, Romero Leal Passos M. Clinical and therapeutic aspects of vulvodynia: the importance of physical therapy. Minerva Ginecol 2012; 64:437–45. (Level III)
35. Sharma N, Rekha K, Srinivasan JK. Efficacy of transcutaneous electrical nerve stimulation in the treatment of chronic pelvic pain. J Midlife Health 2017;8:36–9. (Level II-2)
36. Zoorob D, South M, Karram M, Sroga J, Maxwell R, Shah A, et al. A pilot randomized trial of levator injections versus physical therapy for treatment of pelvic floor myalgia and sexual pain. Int Urogynecol J 2015;26:845–52. (Level I)

37. Lillemon JN, Nardos R, Kaul MP, Johnson AN, Choate A, Clark AL. Complex female pelvic pain: a case series from a multidisciplinary clinic in urogynecology and physiatry. Female Pelvic Med Reconstr Surg 2019;25:e34–9. (Level III)

38. Romao AP, Gorayeb R, Romao GS, Poli-Neto OB, dos Reis FJ, Rosa-e-Silva JC, et al. High levels of anxiety and depression have a negative effect on quality of life of women with chronic pelvic pain. Int J Clin Pract 2009;63: 707–11. (Level II-3)

39. Twiddy H, Lane N, Chawla R, Johnson S, Bradshaw A, Aleem S, et al. The development and delivery of a female chronic pelvic pain management programme: a specialised interdisciplinary approach. Br J Pain 2015;9:233–40. (Level II-3)

40. Miller-Matero LR, Saulino C, Clark S, Bugenski M, Eshelman A, Eisenstein D. When treating the pain is not enough: a multidisciplinary approach for chronic pelvic pain. Arch Womens Ment Health 2016;19:349–54. (Level II-3)

41. Williams AC, Eccleston C, Morley S. Psychological therapies for the management of chronic pain (excluding headache) in adults. Cochrane Database of Systematic Reviews 2012, Issue 11. Art. No.: CD007407. DOI: 10. 1002/14651858.CD007407.pub3. (Systematic Review and Meta-Analysis)

42. Bergeron S, Likes WM, Steben M. Psychosexual aspects of vulvovaginal pain. Best Pract Res Clin Obstet Gynaecol 2014;28:991–9. (Level III)

43. Female sexual dysfunction. ACOG Practice Bulletin No. 213. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;134:e1–18. (Level III)

44. Pereira VM, Arias-Carrion O, Machado S, Nardi AE, Silva AC. Sex therapy for female sexual dysfunction. Int Arch Med 2013;6:37. (Level III)

45. Caruso R, Ostuzzi G, Turrini G, Ballette F, Recla E, Dall'Olio R, et al. Beyond pain: can antidepressants improve depressive symptoms and quality of life in patients with neuropathic pain? A systematic review and meta-analysis. Pain 2019;160:2186–98. (Systematic Review and Meta-Analysis)

46. Lunn MP, Hughes RA, Wiffen PJ. Duloxetine for treating painful neuropathy, chronic pain or fibromyalgia. Cochrane Database of Systematic Reviews 2014, Issue 1. Art. No.: CD007115. DOI: 10.1002/14651858.CD007115.pub3. (Systematic Review and Meta-Analysis)

47. Gallagher HC, Gallagher RM, Butler M, Buggy DJ, Henman MC. Venlafaxine for neuropathic pain in adults. Cochrane Database of Systematic Reviews 2015, Issue 8. Art. No.: CD011091. DOI: 10.1002/14651858.CD011091. pub2. (Systematic Review and Meta-Analysis)

48. Moore RA, Derry S, Aldington D, Cole P, Wiffen PJ. Amitriptyline for neuropathic pain in adults. Cochrane Database Syst Rev. 2015, Issue 7. Art. No.: CD008242. DOI: 10.1002/14651858.CD008242.pub3. (Systematic Review and Meta-Analysis)

49. Derry S, Wiffen PJ, Aldington D, Moore RA. Nortriptyline for neuropathic pain in adults. Cochrane Database of Systematic Reviews 2015, Issue 1. Art. No.: CD011209. DOI: 10.1002/14651858.CD011209.pub2. (Systematic Review)

50. Hearn L, Moore RA, Derry S, Wiffen PJ, Phillips T. Desipramine for neuropathic pain in adults. Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD011003. DOI: 10.1002/14651858.CD011003. (Systematic Review and Meta-Analysis)

51. Gilron I, Bailey JM, Tu D, Holden RR, Jackson AC, Houlden RL. Nortriptyline and gabapentin, alone and in combination for neuropathic pain: a double-blind, randomised controlled crossover trial. Lancet 2009;374:1252–61. (Level I)

52. Carey ET, As-Sanie S. New developments in the pharmacotherapy of neuropathic chronic pelvic pain. Future Sci OA 2016;2: FSO148. (Level III)

53. Wiffen PJ, Derry S, Bell RF, Rice AS, Tölle TR, Phillips T, et al. Gabapentin for chronic neuropathic pain in adults. Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD007938. DOI: 10.1002/14651858.CD007938. pub4. (Systematic Review and Meta-Analysis)

54. Lewis SC, Bhattacharya S, Wu O, Vincent K, Jack SA, Critchley HO, et al. Gabapentin for the management of chronic pelvic pain in women (GaPP1): a pilot randomised controlled trial. PLoS One 2016;11:e0153037. (Level I)

55. Leite FM, Atallah ÁN, El Dib R, Grossmann E, Januzzi E, Andriolo RB, et al. Cyclobenzaprine for the treatment of myofascial pain in adults. Cochrane Database of Systematic Reviews 2009, Issue 3. Art. No.: CD006830. DOI: 10. 1002/14651858.CD006830.pub3. (Systematic Review)

56. Valentine LN, Deimling TA. Opioids and alternatives in female chronic pelvic pain. Semin Reprod Med 2018;36: 164–72. (Level III)

57. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. JAMA 2016;315:1624–45. (Level III)

58. Oor JE, Unlu C, Hazebroek EJ. A systematic review of the treatment for abdominal cutaneous nerve entrapment syndrome. Am J Surg 2016;212:165–74. (Systematic Review)

59. Montenegro ML, Braz CA, Rosa-e-Silva JC, Candido-dos-Reis FJ, Nogueira AA, Poli-Neto OB. Anaesthetic injection versus ischemic compression for the pain relief of abdominal wall trigger points in women with chronic pelvic pain. BMC Anesthesiol 2015;15:175. (Level I)

60. Scott NA, Guo B, Barton PM, Gerwin RD. Trigger point injections for chronic non-malignant musculoskeletal pain: a systematic review. Pain Med 2009;10:54–69. (Systematic Review)

61. Fouad LS, Pettit PD, Threadcraft M, Wells A, Micallef A, Chen AH. Trigger point injections for pelvic floor myofascial spasm refractive to primary therapy. J Endometr Pelvic Pain Disord 2017;9:125–30. (Level II-3)

62. Soares A, Andriolo RB, Atallah ÁN, da Silva EM. Botulinum toxin for myofascial pain syndromes in adults. Cochrane Database of Systematic Reviews 2014, Issue 7. Art. No.: CD007533. DOI: 10.1002/14651858.CD007533. pub3. (Systematic Review)

63. Abbott J. Gynecological indications for the use of botulinum toxin in women with chronic pelvic pain. Toxicon 2009;54:647–53. (Level III)

64. Daniels J, Gray R, Hills RK, Latthe P, Buckley L, Gupta J, et al. Laparoscopic uterosacral nerve ablation for alleviating chronic pelvic pain: a randomized controlled trial. LUNA Trial Collaboration. JAMA 2009;302:955–61. (Level I)

65. Proctor M, Latthe P, Farquhar C, Khan K, Johnson N. Surgical interruption of pelvic nerve pathways for primary and secondary dysmenorrhoea. Cochrane Database of Systematic Reviews 2005, Issue 4. Art. No.: CD001896. DOI: 10.1002/14651858.CD001896.pub2. (Systematic Review and Meta-Analysis)

66. Lin YC, Wan L, Jamison RN. Using integrative medicine in pain management: an evaluation of current evidence. Anesth Analg 2017;125:2081–93. (Level III)

67. Huang AJ, Rowen TS, Abercrombie P, Subak LL, Schembri M, Plaut T, et al. Development and feasibility of a group-based therapeutic yoga program for women with chronic pelvic pain. Pain Med 2017;18:1864–72. (Level II-3)

68. Meng H, Johnston B, Englesakis M, Moulin DE, Bhatia A. Selective cannabinoids for chronic neuropathic pain: a systematic review and meta-analysis. Anesth Analg 2017;125:1638–52. (Systematic Review and Meta-Analysis)

69. Aviram J, Samuelly-Leichtag G. Efficacy of cannabis-based medicines for pain management: a systematic review and meta-analysis of randomized controlled trials. Pain Physician 2017;20:E755–96. (Systematic Review and Meta-Analysis)

70. Tu FF, Beaumont JL. Outpatient laparoscopy for abdominal and pelvic pain in the United States 1994 through 1996. Am J Obstet Gynecol 2006;194:699–703. (Level II-3)

71. van den Beukel BA, de Ree R, van Leuven S, Bakkum EA, Strik C, van Goor H, et al. Surgical treatment of adhesion-related chronic abdominal and pelvic pain after gynaecological and general surgery: a systematic review and meta-analysis. Hum Reprod Update 2017;23:276–88. (Systematic Review and Meta-Analysis)

72. Molegraaf MJ, Torensma B, Lange CP, Lange JF, Jeekel J, Swank DJ. Twelve-year outcomes of laparoscopic adhesiolysis in patients with chronic abdominal pain: a randomized clinical trial. Surgery 2017;161:415–21. (Level I)

The MEDLINE database, the Cochrane Library, and the American College of Obstetricians and Gynecologists' own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 2000—May 2019. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles. When reliable research was not available, expert opinions from obstetrician–gynecologists were used.

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I Evidence obtained from at least one properly designed randomized controlled trial.
II-1 Evidence obtained from well-designed controlled trials without randomization.
II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.
II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

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