The objective of our study was to analyze the demographic and clinical characteristics of patients referred to a multidisciplinary chronic pelvic pain clinic and to evaluate the response to different types of minimally invasive techniques to treat pain. Additionally, we aimed to register any compl

#469 MANAGEMENT OF CHRONIC PELVIC PAIN IN A MULTIDISCIPLINARY INTERVENTIONAL CLINIC

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Hypothesis / aims of study

The objective of our study was to analyze the demographic and clinical characteristics of patients referred to a multidisciplinary chronic pelvic pain clinic and to evaluate the response to different types of minimally invasive techniques to treat pain.

Study design, materials and methods

Retrospective descriptive study.
Patients who camed to consultation between January 2023 and 2024 at a multidisciplinary chronic pelvic pain clinic, that required treatment with minimally invasive techniques, were recruited.
The following variables were registered:

Demographic characteristics
Time until referral to the multidisciplinary chronic pelvic pain clinic
Follow-up at the unit
Possible pain triggers
Complementary examinations
Injection technique
Injected muscle
Affected laterality
Total number of injections during follow-up
Diagnostic infiltration
Injected drug
Total infiltration points
Percentage of pain reduction after injection
Complications

Descriptive statistical analysis was performed.

Results and interpretation

35 patients (33 women, mean age 49.41 years, range 29-80 years) were included. Mean body mass index was 23 kg/m2 (SD 2,75 kg/m2).
Mean evolution time to be refered at the multidisplinary chronic pelvic pain clinic was 51,9 months (range 4 to 252 months).
Mean follow up at the unit was 24,5 months (range 5 to 96 months).
The principal diagnoses were: myofascial pelvic pain syndrome (48.5%), painful scar and myofascial pelvic pain (22.8%), and neuropathic and myofascial pelvic pain (14.2%).
Possible pain triggers included: gynecological surgery 33.3%, obstetric history 27%, and unknown etiology 25.7% of patients.
Additionally, 14.3% of patients presented urinary incontinence, and 11.4% both urinary and fecal incontinence (table 1).

Complementary examinations
60% gynecological US 37.1% pelvic MRI 8.6% endoanal US
Injection technique
62.8% myofascial infiltration with needle guided electrostimulation 34.3% scar and myofascial infiltration 97% sedation
Injected muscle
85.7% puborectalis muscle 62.8% obturator internus muscle 54.2% iliococcygeus muscle 28.7% bulbospongiosus muscle 20% superficial transverse perineal muscle 8.57% internal anal sphincter 5.7% ischiocavernosus muscle
Affected laterality
85.7% of patients received bilateral injections
Total number of injections during follow-up
2.4(SD 1.49)
Diagnostic infiltration
54.3%
Injected drug
48.6% botulinum toxin and local anesthetic 20% botulinum toxin, local anesthetic and hyaluronidase to treat scars
Total infiltration points
4.3 (SD 1.58)
Percentage of pain reduction
65% (SD 27.7%)
Complications
1 patient presented self-limited fecal incontinence

Table 1

Most of the patients in the multidisciplinary chronic pelvic pain clinic are women with a very long history of pain. The most important diagnosis is myofascial pelvic pain syndrome, followed by painful scar added to myofascial pelvic pain. Obstetrics and gynecological surgery are the most frequent past medical history and possible pain triggers, but in a relevant percentage of patients, the etiology is unknown. The majority of patients received myofascial injections under sedation. The most frequent muscles injected were puborectalis, internal obturator, and iliococcygeus. The majority of patients presented bilateral pain. The most prevalent injections were Botulinum toxin and a combination of local anesthetic. A mean of 4 injections points were needed per patient. Patients reported a significant reduction of pain after the treatment, and the complication rate is low.

Conclusion

Patients often experience delays in accessing specialized multidisciplinary chronic pelvic pain clinics. They present a diverse array of symptoms and diagnoses. Injection with botulinum toxin and local anesthetic reduced pain in our patients. We recommend, based on our experience and results, performing injections under sedation. The complication rate we had is minimal, and when they appeared were reversible.

References

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