Chronischer Beckenschmerz aus der Sicht des Gastroenterologen

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Gastrointestinal pelvic pain and overlap…

1. **Starke Überlappung** von gastrointestinalen Beckenschmerzen und funktionellen Beschwerden sowie Beckenschmerzen anderer Ursache

2. **Koexistenz** spezifischer, gastrointestinaler Erkrankungen.

3. **Funktionelle Störungen** wie starkes Pressen können zu organischen Erkrankungen führen (rektaler Prolaps, solitäres Rectalulcus-Syndrom, or Nervus Pudendus-Schädigung)

Gastrointestinal pelvic pain and overlap…

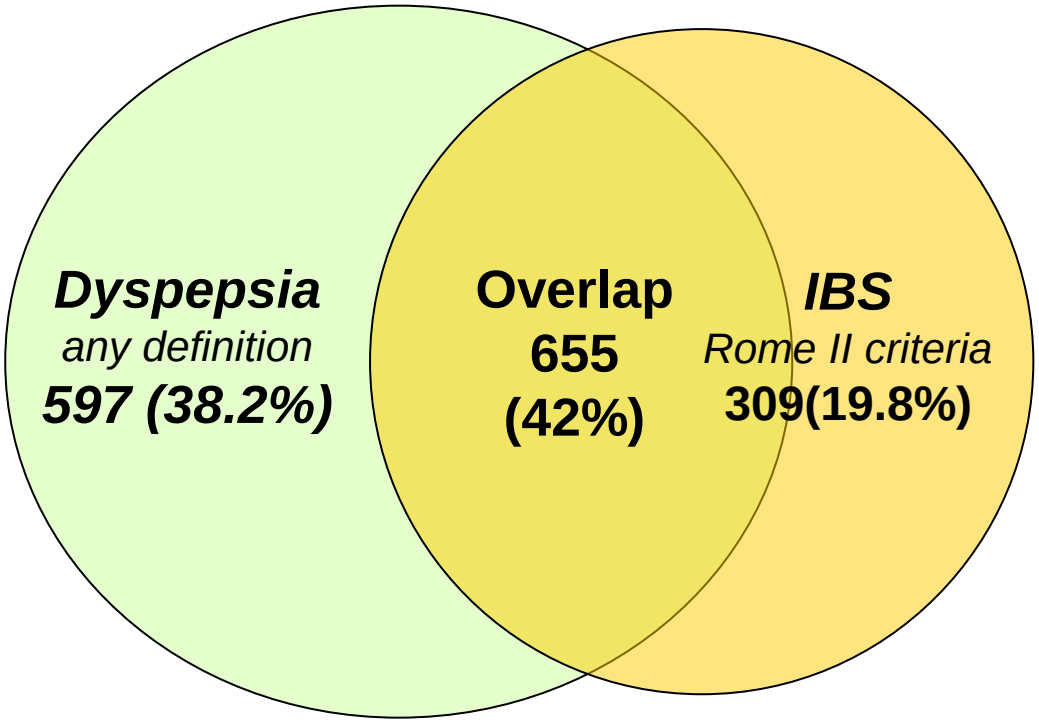
1. **Strukturelle Schäden** (e.g., postpartum Analsphinkterdefekt, or kleine Rectocelen) können mit dem gastrointestinalen Beckenschmerz-Syndrom eingergehen.

2. **Verschiedene Krankheiten** können bisher asymptomatische funktionelle Störungen aggravieren (Stuhlinkontinenz bei Patienten mit Diarrhoe)

3. **CAVE:** Funktionelle Krankheiten wie der anorektale Schmerz werden retrospektiv vs prospektiv über Tagebücher definiert.

Dyspepsia: 8-fold increase in prevalence of IBS

- The strength of the association suggests common pathogenesis
- Dyspeptic patients should be assessed routinely for IBS.

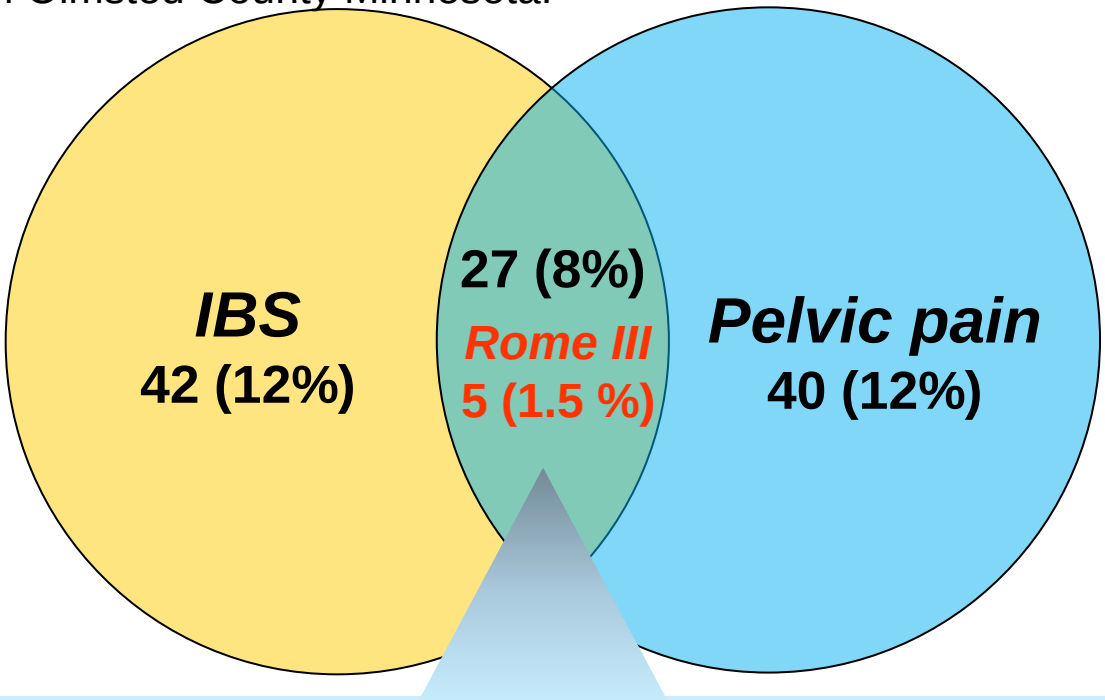


CLINICAL GASTROENTEROLOGY AND HEPATOLOGY 2010;8:401–409

Olmsted County, Minnesota: Prevalence of CPP was 20% among women

MAYO CLINIC

Number and proportion of women with IBS alone, pelvic pain alone, and both from Olmsted County Minnesota.

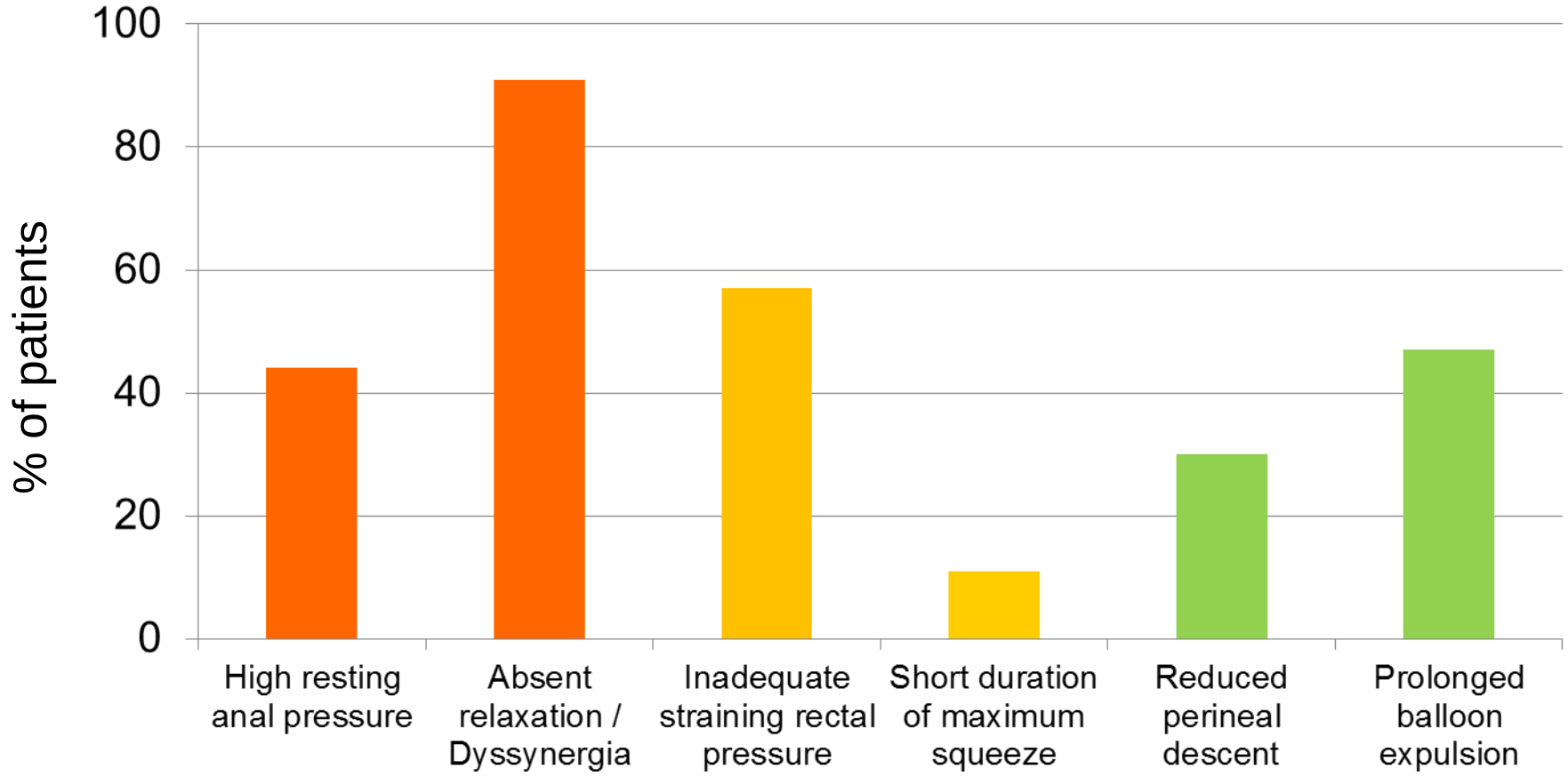


High somatization scores, depression, and dizziness were all individually associated with IBS-pelvic pain overlap versus both IBS alone and pelvic pain alone.

Choung et al J Clin Gastroenterol. 2010

Relationships between pelvic floor symptoms and function in IBS:

Prevalence of abnormal anorectal physiology

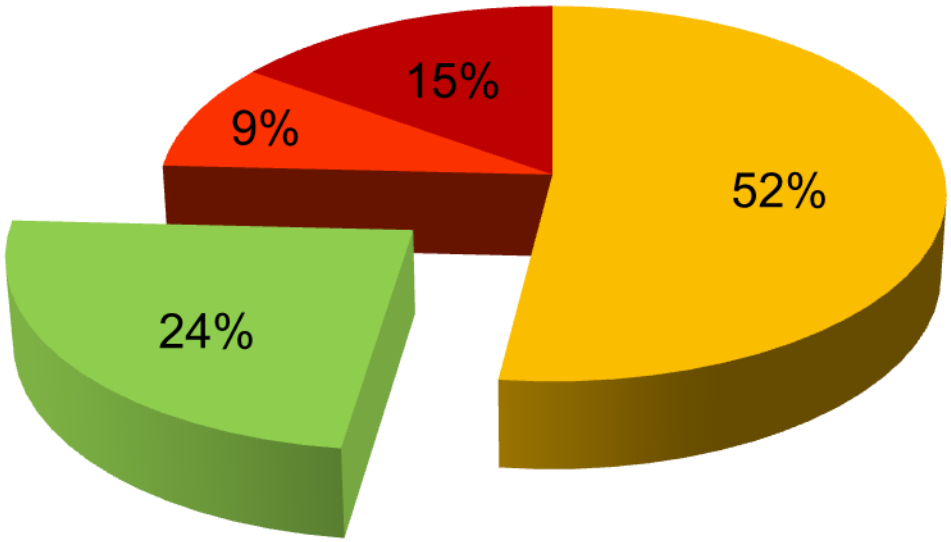


University of Sydney, Sydney, NSW, Australia

Neurogastroenterol Motil (2010) 22, 764–769

All chronic pelvic pain (n = 483; 24%)

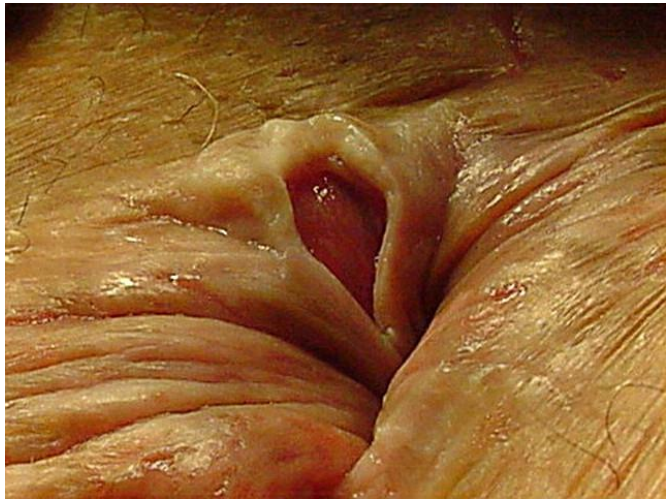
Oxfordshire Health Authority Register:
2016 Questionnaires

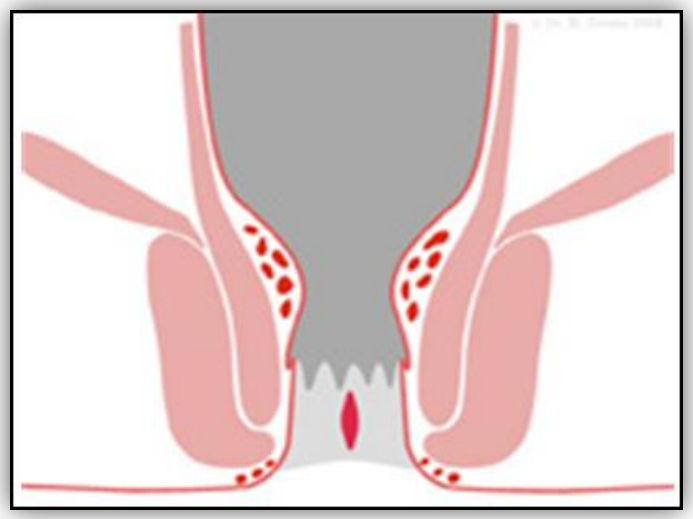


- Chronic pelvic pain CPP (n = 249)
- CPP and Irritable Bowel Syndrome IBS (n =114)
- CPP & Genitourinary (GU) Sy (n = 44)
- CPP & IBS & GU-Sy (n = 72)

Am J Obstet Gynecol 2001;184:1149-55

Overlap: chronic anal fissure





- Anal fissures with features of chronicity (> 6 weeks)
- Sentinel pile, hypertrophied papillae, and exposure of internal sphincter fibers.
- Location: 72% (89% men) posterior midline, 25% (8% men) anterior midline
- About 3% of patients have both anterior and posterior fissures

Chronic Anal Fissure: Advances and Insights in functional disease Pathophysiology and Treatment

Anorectal manometry:

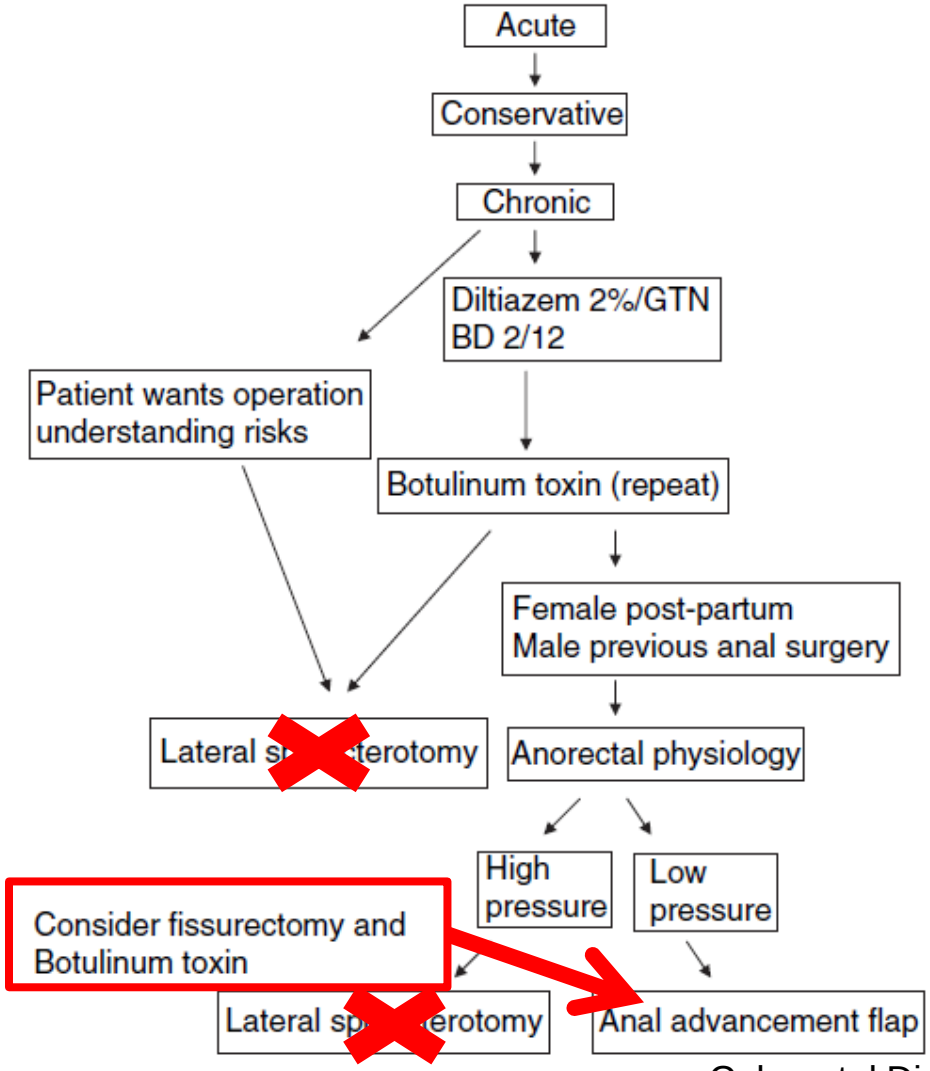
- Presence of **sustained resting hypertonia**, abnormally few episodes of spontaneous IAS relaxation
- **Anodermal perfusion**, at least in part, depends on arterioles that must cross the IAS.
- High anal pressures diminish perfusion pressure to the anoderm and lead to **ischemic ulceration**.

The mainstays of **surgical therapy** for fissure: anal dilatation, and internal sphincterotomy, both lead to decreased anal tone.

Each of these procedures dates to the 19th century, well before their mechanism of action could be documented.

Gastroenterology 2003

The Management of Anal Fissure: ACPGBI Position St.



Colorectal Disease 2008, 10 (Suppl.9 3), 1–7

Development of Abdominal Pain and IBS Following Gynecological Surgery: A Prospective, Controlled Study

Methods:

- 132 women without GI symptoms
- Elective gynecological surgery for nonpainful conditions were compared with:
- 123 nonsurgery controls without GI symptoms
- Socio-demographic, psychosocial, and surgery-related variables were potential predictor variables of pain at 3 and/or 12 months.

GASTROENTEROLOGY 2008;134:75–84

Development of Abdominal Pain and IBS Following Gynecological Surgery: A Prospective, Controlled Study

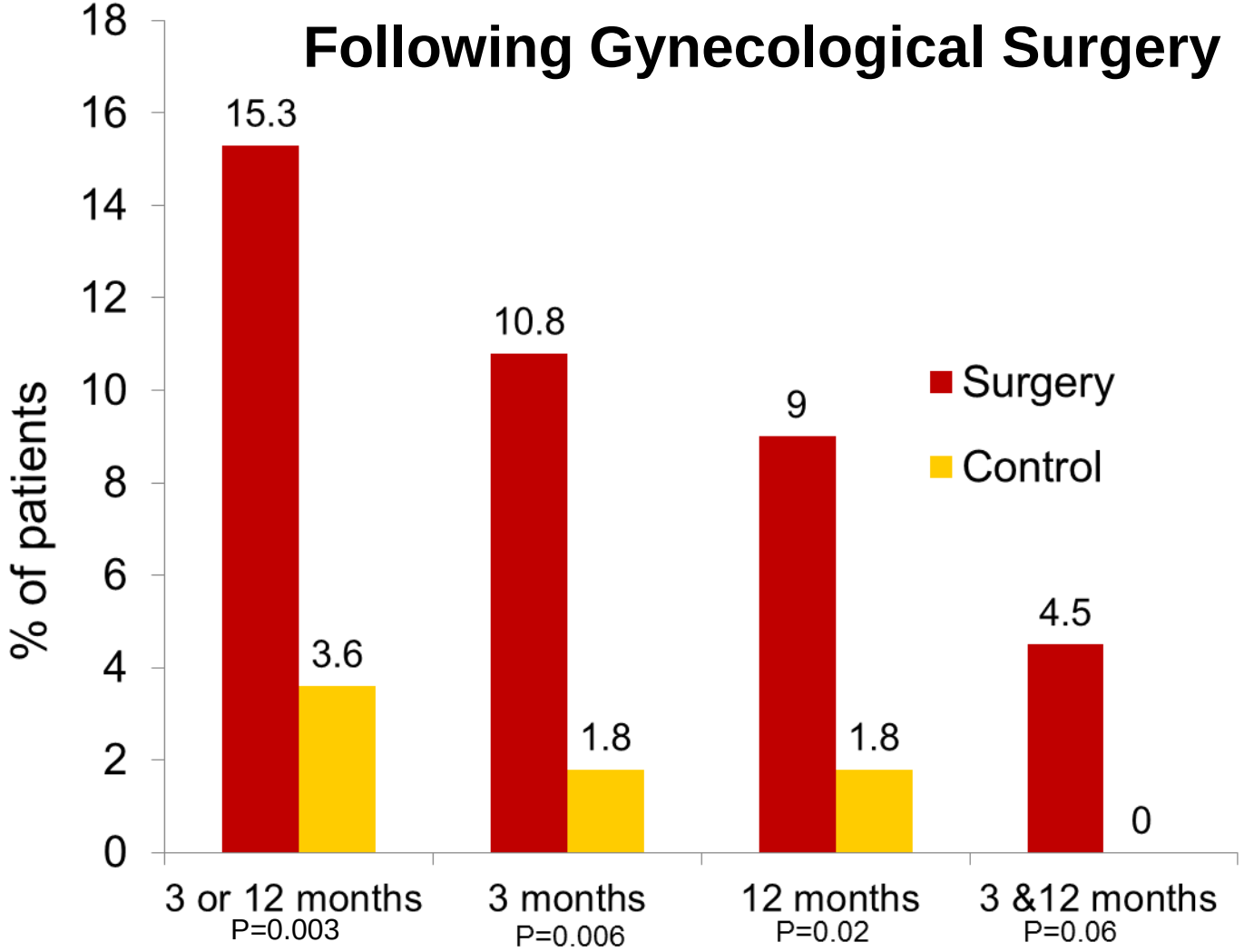
Results:

- No patients in either group met the Rome II criteria for IBS at 3 months;
- 3 patients in the surgical group (2.7%) met the Rome II criteria for IBS at 12 months vs 0 in the control group.

- **However, abdominal pain did develop in 17% of women in the surgical group**
- **Notably, only psychosocial variables predicted pain development.**

➢ **Does surgery facilitate the development of IBS ?**

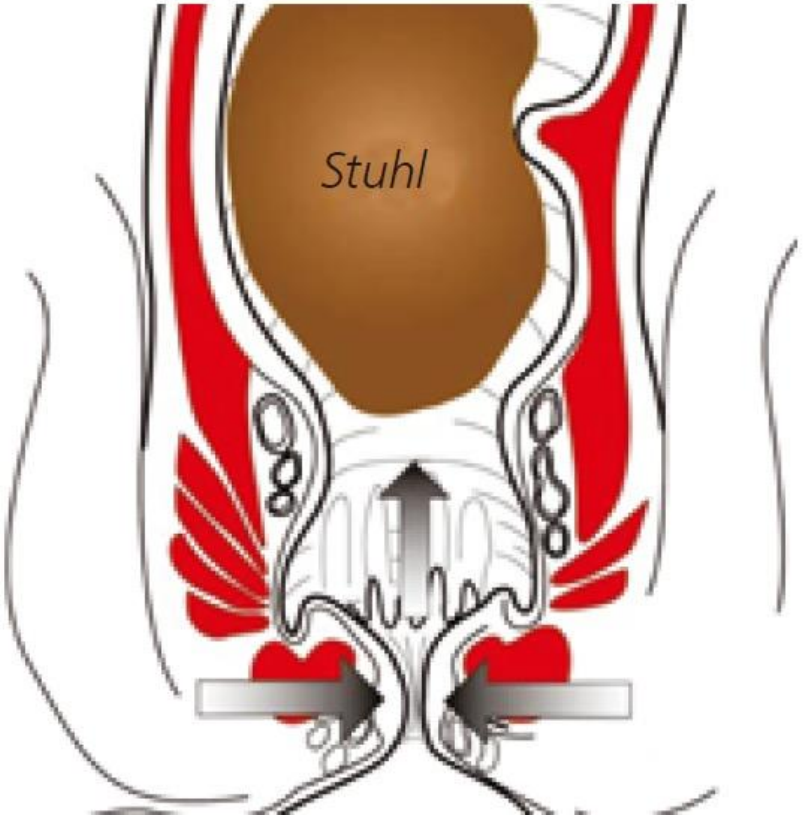
Abdominal Pain and IBS Following Gynecological Surgery

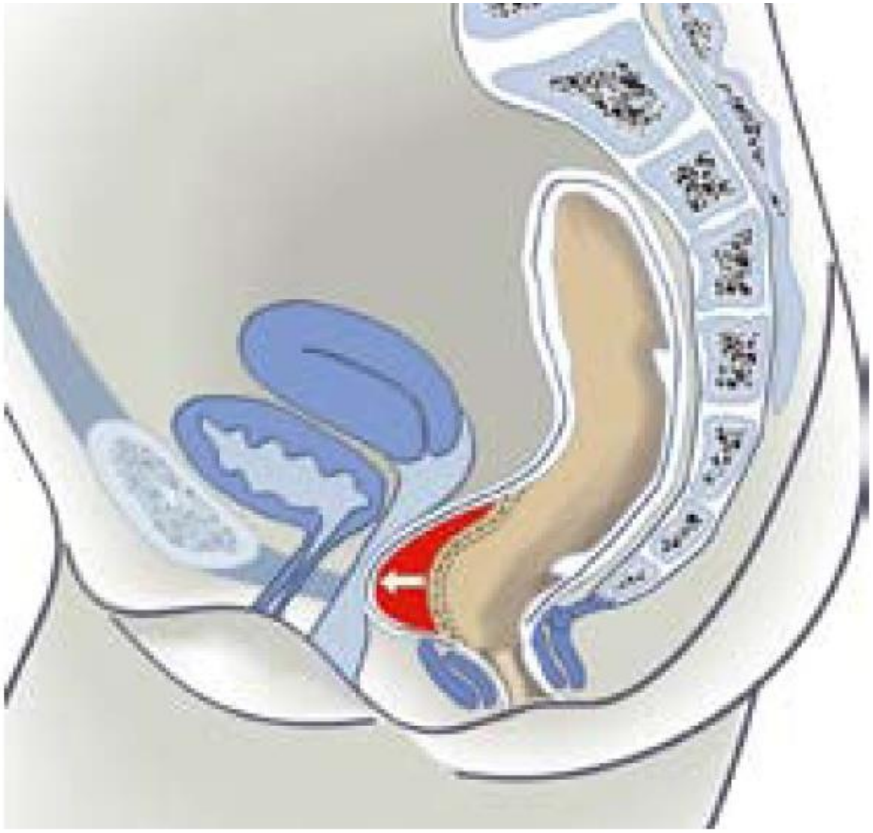


Incidence of abdominal pain (no pain at baseline)

Overlap in functional defecation disorders:

Functional constipation, dyssynergic defecation and anterior rectocele





Rome III Functional Gastrointestinal Disorders

A Functional esophageal disorders
B Functional gastroduodenal disorders
C Functional bowel disorders
D Functional abdominal pain syndrome
E Functional gallbladder & Sphincter of Oddi disorders
F Functional anorectal disorders
G Functional disorders: neonates and toddler
H Functional disorders: children and adolescents

Rome III Functional Gastrointestinal Disorders

C Functional bowel disorders

- **C1 Irritable bowel syndrome IBS**
- **C2 Functional bloating**
- **C3 Functional constipation**
- **C4 Functional diarrhea**
- **C5 Unspecified functional bowel dosorder**

Rome III Functional Gastrointestinal Disorders

F Functional anorectal disorders

- F1 Functional fecal incontinence
- **F2 Functional anorectal pain**
  - **F2a Chronic proctalgia / Chronic anal pain syndrome**
    - F2a1 Levator ani syndrome
    - F2a2 Unspecified functional anorectal pain
  - **F2b Proctalgia fugax/ intermittent chronic anal pain syndrome**
- F3 Functional defecation disorders
  - F3a Dyssynergic defecation
  - F3b Inadequate defecatory propulsion

Intermittent chronic anal pain syndrome (proctalgia fugax) consists of all the following diagnostic criteria:

1. Recurrent episodes of pain localised to the anus or lower rectum.
2. Episodes last from several seconds to minutes.
3. There is no anorectal pain between episodes.

**For research purposes, criteria must be fulfilled for 3 months; however, clinical diagnosis and evaluation may be made before 3 months.*

Diagnostic criteria for chronic anal pain syndrome (chronic proctalgia) according to Rome III crietria must include all of the following:

1. Chronic or recurrent rectal pain or aching.
2. Episodes last at least 20 min.
3. Exclusion of other causes of rectal pain such as:

   ischaemia, inflammatory bowel disease, cryptitis, intramuscular abscess and fissure, haemorrhoids, prostatitis, and coccygodynia

Levator ani syndrome: Above criteria and tenderness during posterior traction on the puborectalis.

**Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis.*

Biofeedback Is Superior to Electrogalvanic Stimulation and Massage for Treatment of Levator Ani Syndrome

Design:

- prospective, randomized controlled trial
- to compare the effectiveness of biofeedback (pelvic floor relaxation), electrogalvanic stimulation (EGS), or massage of levator muscles

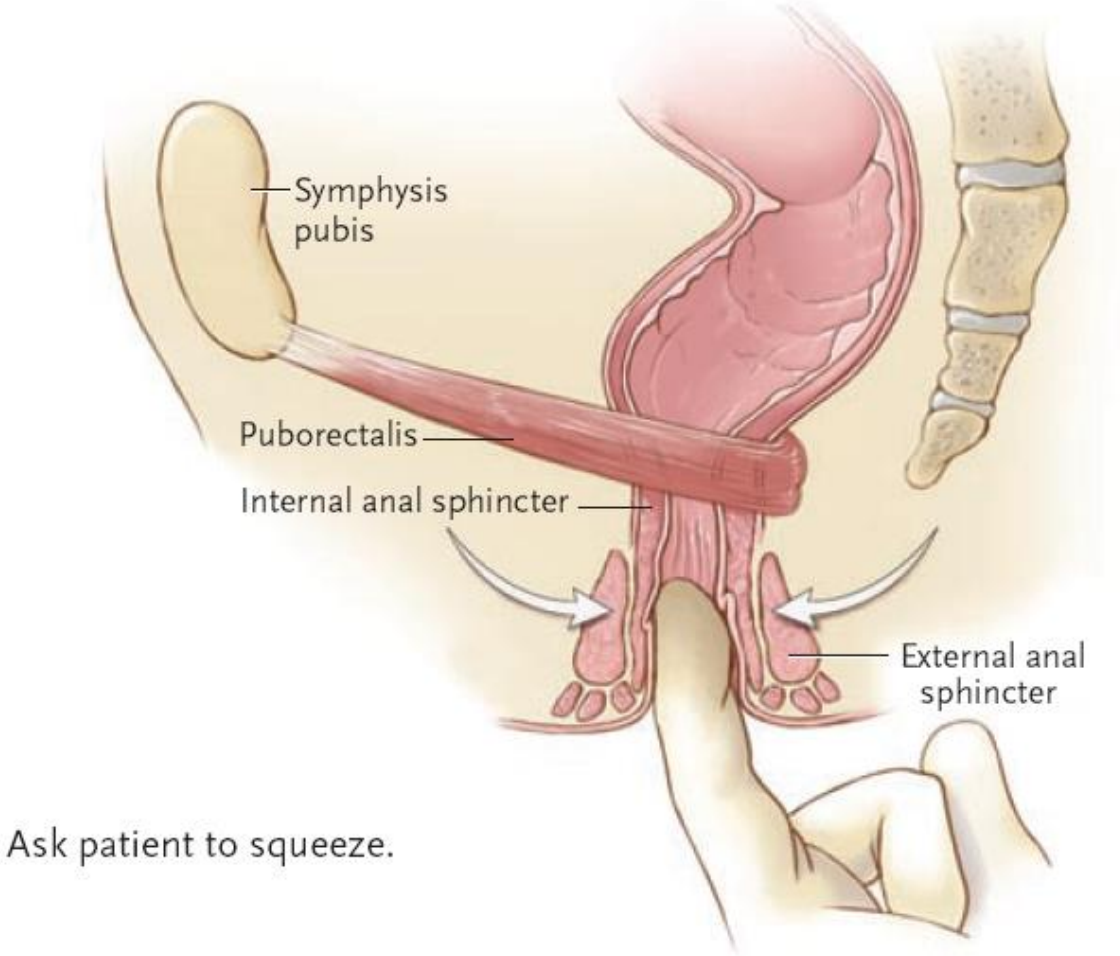
Methods:

- Rome II criteria plus weekly pain.
- Patients were categorized as “highly likely”/ “possible” for LAS according to tenderness with traction on the levator muscles
- All 157 patients received 9 sessions including psychologic counseling plus biofeedback, EGS, or massage.

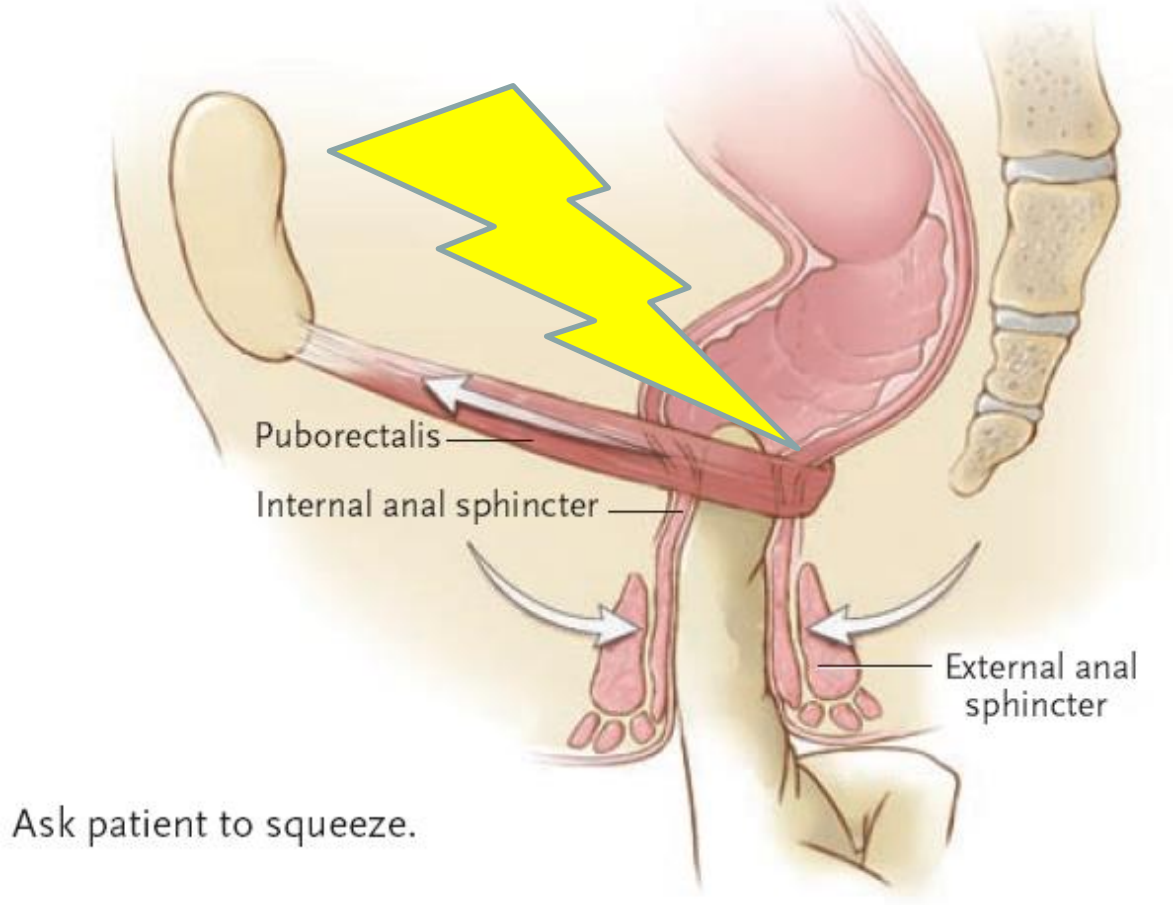
- **Outcomes were reassessed at 1, 3, 6, and 12 months.**

GASTROENTEROLOGY 2010;138:1321–1329

Digital rectal examination: Anal sphincter

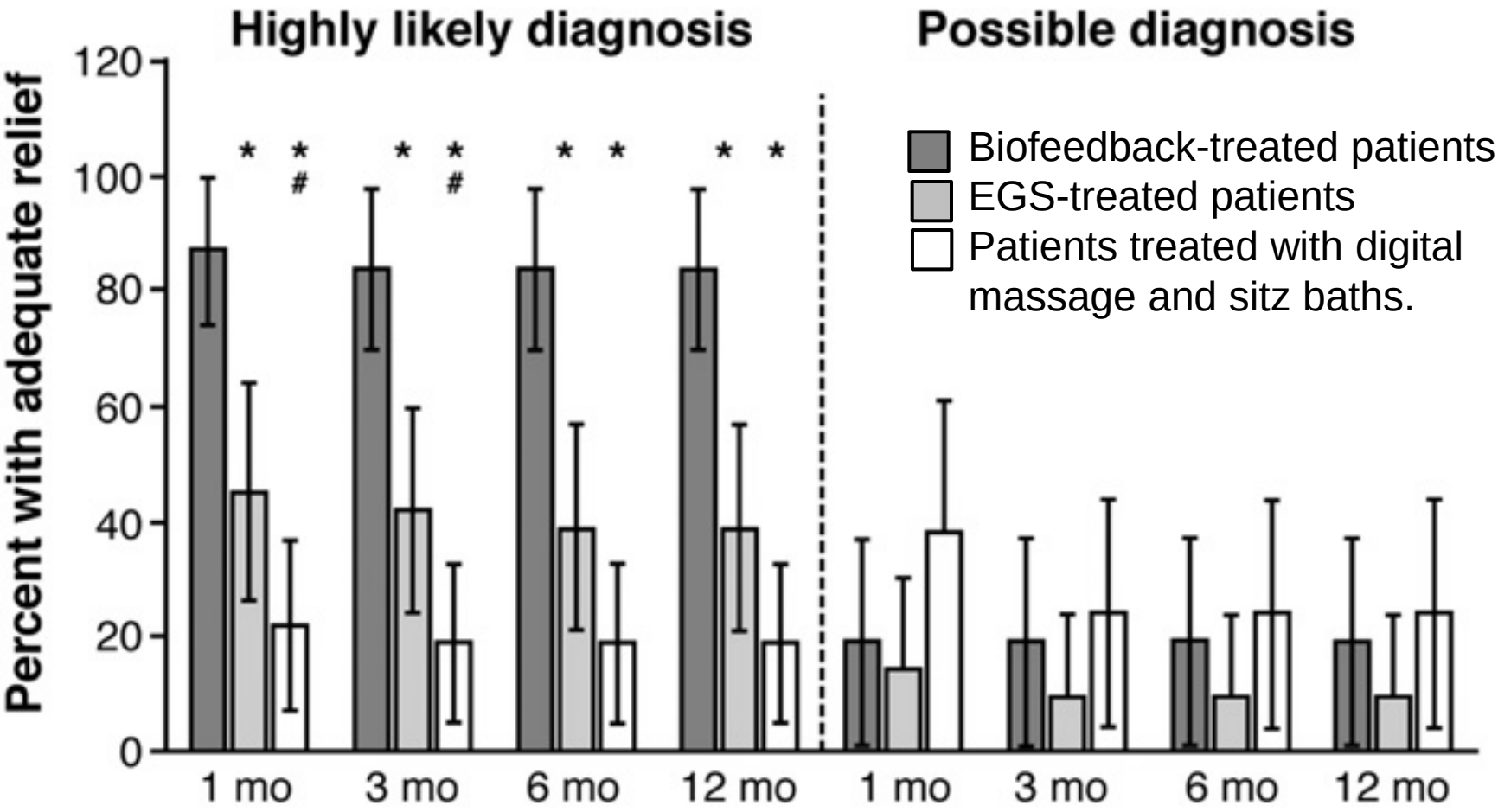


Tenderness of puborectal muscle on digital traction



N Engl J Med 2007

Biofeedback Is Superior to Electrogalvanic Stimulation and Massage for Treatment of Levator Ani Syndrome



GASTROENTEROLOGY 2010;138:1321–1329

Biofeedback Is Superior to Electrogalvanic Stimulation and Massage for Treatment of Levator Ani Syndrome

- Patients with only a “possible” diagnosis of LAS did not benefit from any treatment.
- Biofeedback and EGS improved LAS by increasing the ability to relax pelvic floor muscles and evacuate a water-filled balloon and by reducing the urge and pain thresholds.
- **Biofeedback is the most effective of these treatments, and EGS is somewhat effective.**
- **Only patients with tenderness on rectal examination benefit. The pathophysiology of LAS is similar to that of dyssynergic defecation.**

Algorithm for the diagnosis and management of chronic anal pain syndrome

History ≥ 6 months of anorectal pain lasting ≥20 min

↓ Yes

Diagnostic tests for other causes of anorectal pain (endoscopy)

→ Abnormal → Specific treatment (eg, anal fissure)

↓ Normal

Tenderness of puborectal muscle on digital traction

→ No → Unspecified functional anorectal pain: analgesics or antidepressants

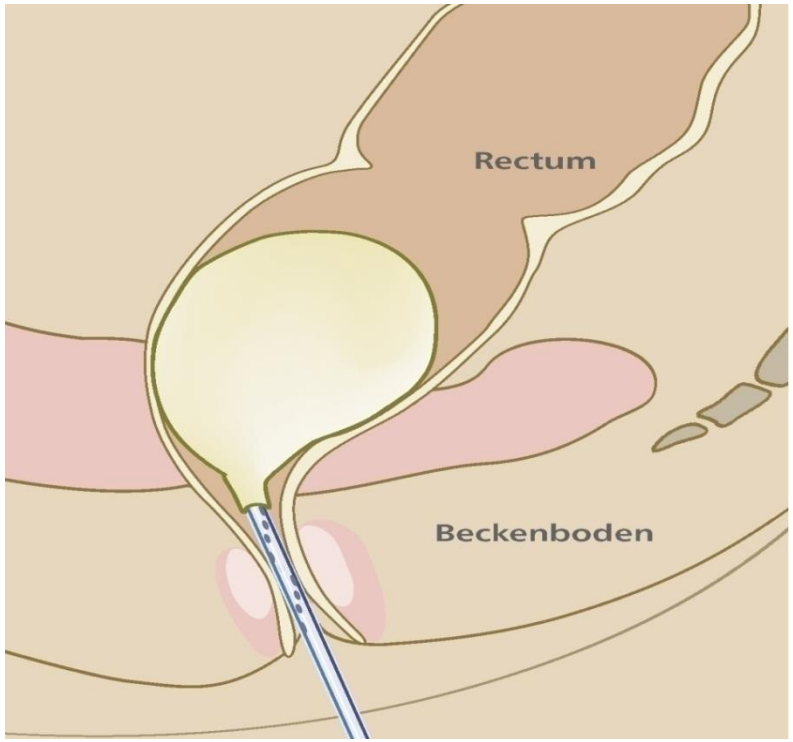
↓ Yes

Dyssynergia on testing shown by:
Anorectal manometry
Balloon expulsion test
MRI-Defecography

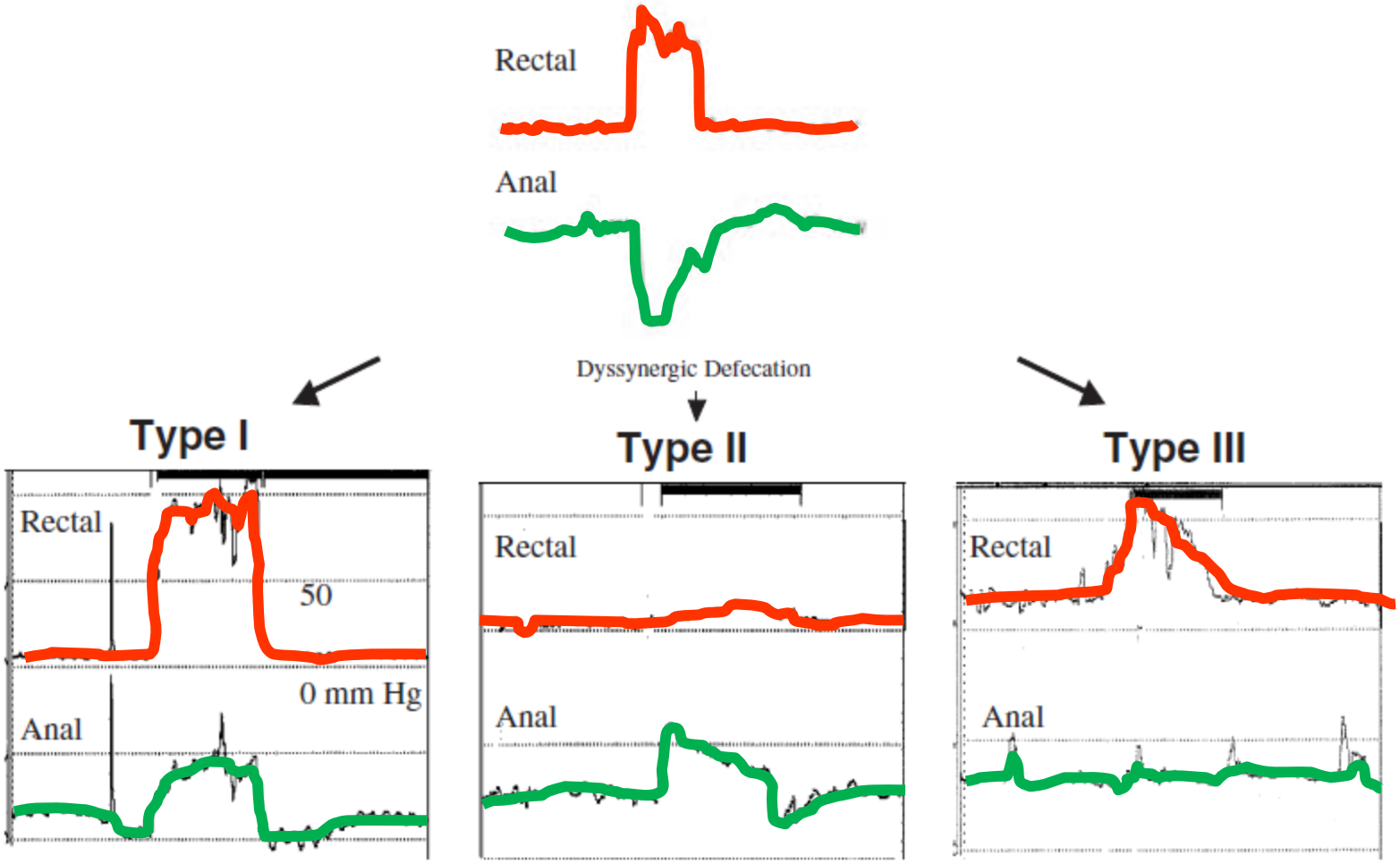
→ Either test abnormal → Chronic anal pain syndrome:
Treatment:
1st Biofeedback
2nd electrogalvanic stimulation

Whitehead WE Gastroenterology. 2010

Anorectal manometry

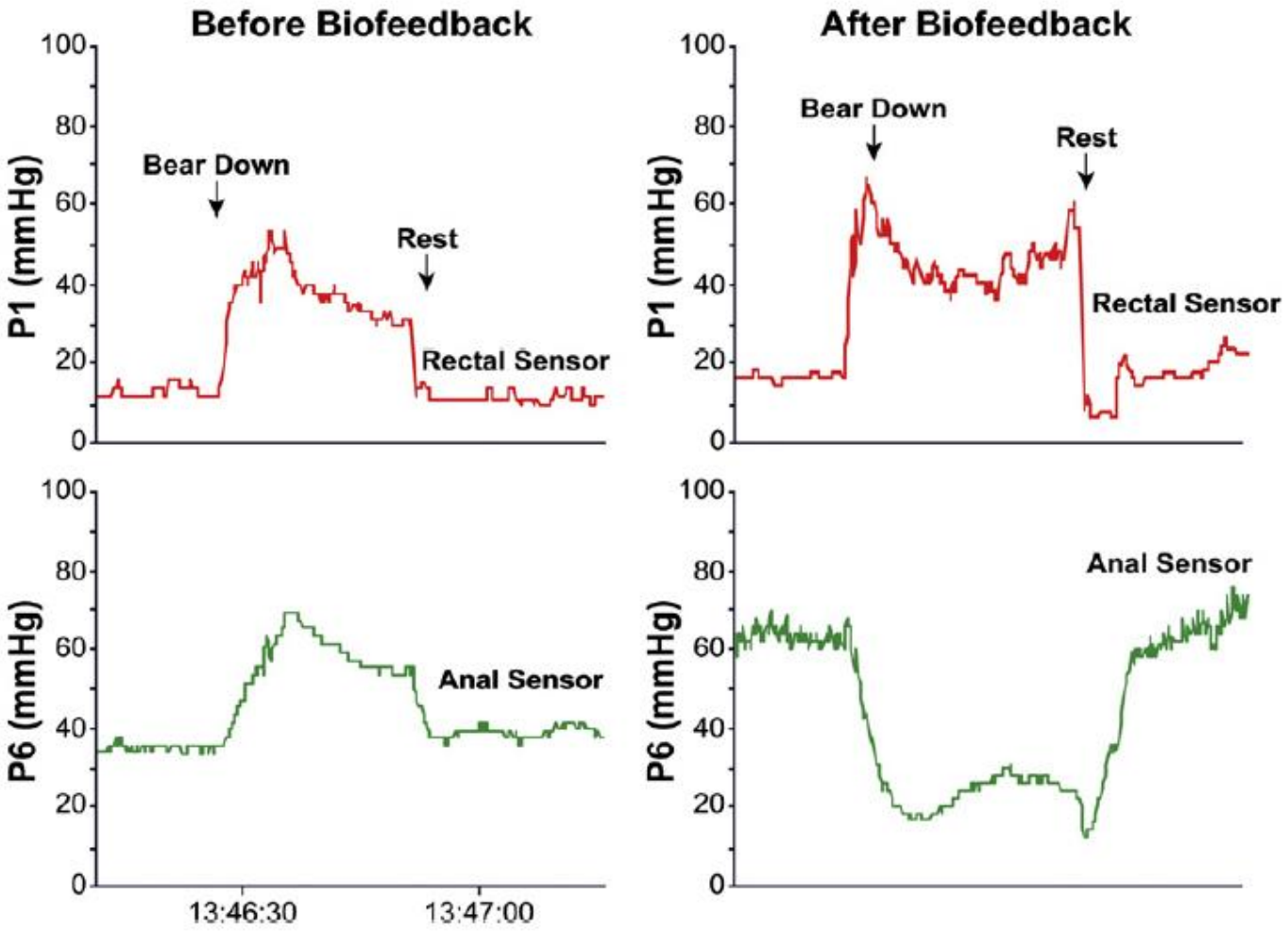


Dyssynergic defecation I: paradoxical contraction, II: impaired propulsion and III: impaired relaxation.



Neurogastroenterol Motil (2004) 16, 589–596

Biofeedback: Dyssynergic defecation



Best Practice & Research Clinical Gastroenterology 25 (2011) 159–166

Summary: Assesment and treatment algorithm for anorectal pain syndrome

Assessment	Treatment	
Endoscopy	Grade A recommended	Biofeedback treatment
Pelvic floor muscle testing		
Anorectal manometry	Grade B recommended	Botulinum toxine A in women with pelvic pain
		Electrogalvanic stimulation
		Percutaneous tibial nerve stimulation
Rectal balloon expulsion test	Other comments	Sacral neuromodulation should be considered
MRI-defecography		Inhaled salbutamol should be considered in intermittent anal pain syndrome

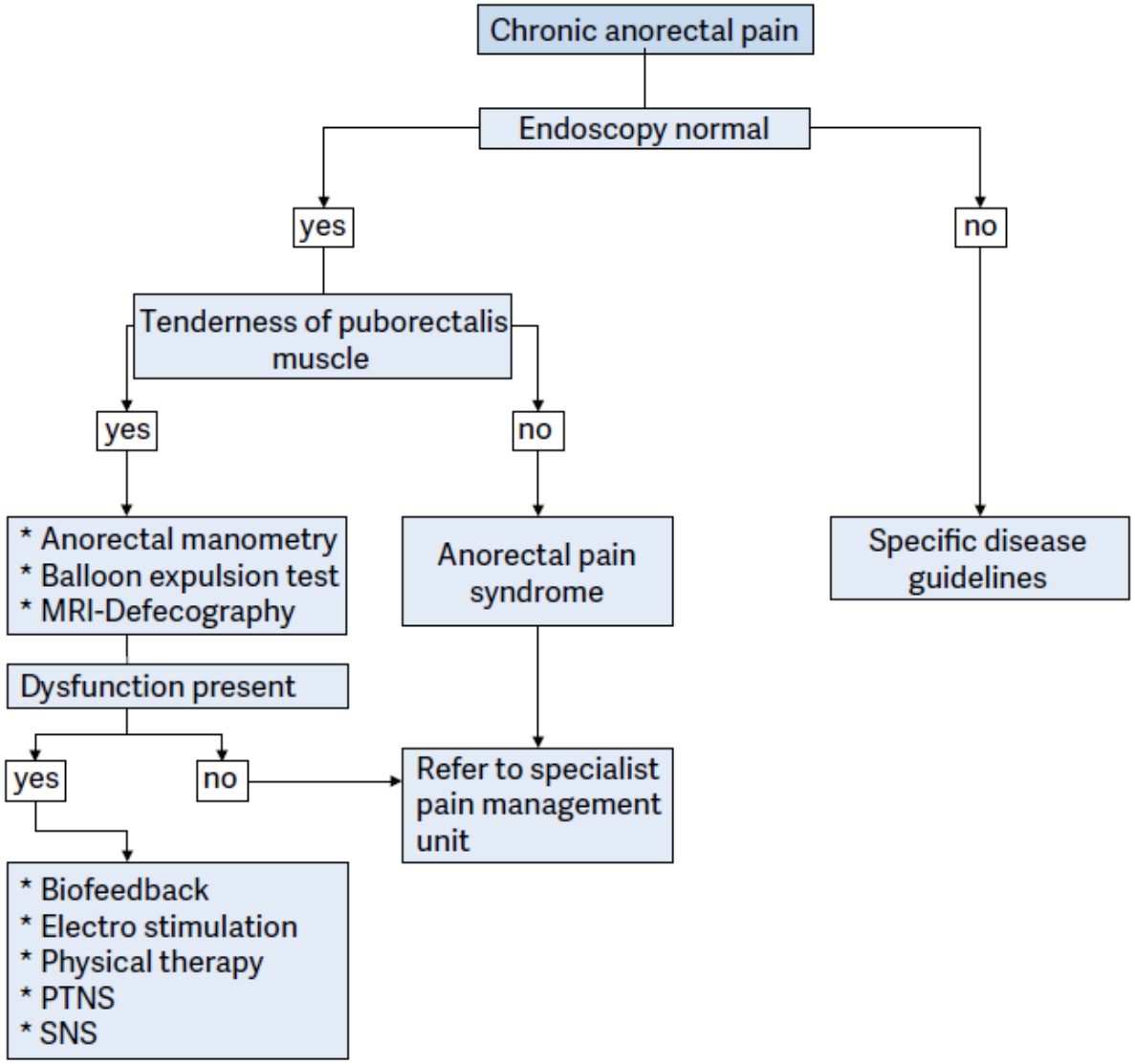
GUIDELINES ON CHRONIC PELVIC PAIN

(Partial text update April 2014)

D. Engeler (chairman), 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

Eur Urol 2004;46(6):681-9
Eur Urol 2010;57(1):35-48
Eur Urol 2013;64(3):431-9

Diagnosis algorithm for chronic anorectal pain



Guidelines on Chronic Pelvic Pain

D. Engeler (chairman), A.P. Baranowski, J. Borovicka, P. Dinis-Oliveira, S. Elneil, J. Hughes, E.J. Messelink, A. van Ophoven, Y. Reisman, A.C. de C. Williams

Recommendations for functional anorectal pain	GR
Functional testing is recommended in patients with anorectal pain.	A
Biofeedback treatment is recommended in patients with pelvic pain and dyssynergic defecation.	A
Botulinum toxin A and electrogalvanic stimulation can be considered in the chronic anal pain syndrome.	B
Percutaneous tibial nerve stimulation can be considered in the chronic anal pain syndrome.	B
Sacral neurostimulation should be considered in the chronic anal pain syndrome.	C
Inhaled salbutamol should be considered in the intermittent chronic anal pain syndrome.	C

"I had to quit drinking coffee. It keeps me awake during presentations."

Besten Dank für Ihre Aufmerksamkeit !