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ABSTRACT BOOK

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1 OP - CHRONIC PELVIC PAIN

Educative video concerning the clinical exam for women suffering of chronic pelvic pain.

Faller Emilie ⁽¹⁾

Universitary hospital of Strasbourg, gynaecological unit, Strasbourg, France ⁽¹⁾

Etiologies of chronic pelvic pain in women can be gynaecological but also by nerve entrapment, osteomuskular problems, lombar problems... Examination by the gynecologist must be organized to attest in a minimum of time what can be the most likely diagnosis. In 15 steps we explain in an educative video the clinical exam.

2 OP - CHRONIC PELVIC PAIN

Pudendal neurolysis by laparoscopy

Pelissie mathilde ⁽¹⁾ - **Faller Emilie** ⁽¹⁾ - **Lecointre Lise** ⁽¹⁾ - **Boisrame Thomas** ⁽¹⁾ - **Akladios cherif** ⁽¹⁾

Hôpitaux universitaires de Strasbourg, gynaecologic surgery, Strasbourg, France ⁽¹⁾

INTRODUCTION

The pudendal nerve can be compressed and responsible for pain in the gluteal and perineal regions. After confirmation of the diagnosis, surgical decompression may be considered. The usual access procedures are the transgluteal and transischioirectal ways.

AIM OF THE STUDY

To demonstrate the safety and feasibility of the laparoscopic approach to perform pudendal neurolysis in a case of pudendal nerve entrapment syndrome.

DESIGN

Stepwise demonstration of the technique with narrated video tutorial that highlights the laparoscopic steps to perform pudendal neurolysis, with a focus on the main anatomic landmarks.

INTERVENTIONS

This video shows a total laparoscopic approach for a right pudendal neurolysis. It is a step-by-step didactic video. This technique of decompression of the right pudendal nerve by laparoscopy by means of dissection of the ischioirectal fossa along the right internal obturator muscle, after visualization of the obturator vessels and identification of the pudendal nerve, allowed the section of the right sacrospinous ligament and complete removal with repositioning of the nerve in its path. The nerve was followed until it passed freely through Alcock's canal. The procedure went well and without complications, with clinical improvement on waking up.

CONCLUSIONS

Pudendal nerve neurolysis by laparoscopic technique is a reproducible and safe method for treating pudendal neuralgia, allowing good visualization and dissection of the entire pelvis toward the ischioirectal fossa.

KEYWORDS

Nerve decompression; Pudendal entrapment syndrome; Pudendal neuralgia.

3 OP - PELVIC PAIN AND POSTURE DYSFUNCTION, COCCYODYNIA

Interest of the collaboration between the rehabilitation physician and the algologist on the effectiveness of the management of the chronic lombo pelvi perineal syndrome.

Pierre Arcagni⁽¹⁾ - Christian Baude⁽¹⁾ - Mario Barmaki⁽¹⁾ - Manon Duraffourg⁽²⁾ - Pierre Volckmann⁽³⁾ - Marine Freydier⁽¹⁾

Département Douleur et Soins de Support, Médipôle Lyon Villeurbanne, Lyon, France⁽¹⁾ - Centre d'Etude et de Traitement de la Douleur, Hôpital neurologique, Lyon, France⁽²⁾ - Département médecine physique et rééducation, Centre Orthopédique Paul Santy, Lyon, France⁽³⁾

INTRODUCTION AND AIM OF THE STUDY

Due to the anatomical proximity of the lumbar and pelvic perineal regions, several painful causes can coexist in the same patient, making it difficult to interpret clinical case (1).

The main objective of our multicenter retrospective observational study is to evaluate the effectiveness of a dual algological and rehabilitation treatment on the improvement of pain (primary endpoint) and quality of life of patients (secondary endpoints: improvement of sleep, mood, functional recovery).

MATERIALS AND METHODS

Patients consulting for chronic pelvic-perineal pain associated with low back pain and/or radicular pain were analyzed. The initial assessment was made by the algologist, then by the rehabilitation physician, adapted to the patient's spinal profile. Symptoms are reassessed after 4 months of rehabilitation (questioning, HAD scale, walking distance, sitting time).

RESULTS

Among the patients studied, 76% described pain in the territory of the pudendal nerve. Half have concomitant lumbosciatalgia, 17% are exclusively low back pain. 80% of patients report a marked improvement in their pain (on average more than 70%) after spinal rehabilitation. An improvement in sleep and mood, an increase in walking distance, sitting time and the resumption of sport are described. Discopathy of the last two lumbar levels is found in 90% of patients describing pain in the territory of the pudendal nerve.

INTERPRETATION OF RESULTS

Our results show that the multi-professional and multi-disciplinary approach to patients allows better management of pain maintenance mechanisms in order to progress more quickly towards improvement, both in terms of pain and functional recovery (2). It also appears that when painful lumbar and pelvic/perineal symptoms coexist, it is licit to start with adapted and supervised spinal rehabilitation.

CONCLUSIONS

Spinal involvement is essential to take into account when a patient consults for chronic pelvic-perineal pain. A specific study of the spine (3) should be integrated during the consultation, as well as close collaboration with a rehabilitation physician.

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4 OP - ENDOMETRIOSIC PAIN

Abscessualization of rectovaginal endometrioma: a case report.

Tomaso Melocchi ⁽¹⁾ - **Alice Cola** ⁽²⁾ - **Matteo Frigerio** ⁽²⁾ - **Marta Barba** ⁽¹⁾ - **Giuseppe Marino** ⁽¹⁾ - **Silvia Volontè** ⁽¹⁾ - **Desirée De Vicari** ⁽¹⁾

San Gerardo Hospital, ASST Monza, Monza, Italy, Milano-Bicocca University, Monza, Italy, Monza, Italy ⁽¹⁾ - ***San Gerardo Hospital, ASST Monza, Monza, Italy, San Gerardo Hospital, ASST Monza, Monza, Italy, Monza, Italy*** ⁽²⁾

INTRODUCTION AND AIM OF THE STUDY

Rectovaginal endometriosis comprises infiltrating lesions of the rectovaginal septum with variable involvement of the vagina, rectum and uterosacral ligaments [1]. We report the case of abscessualization of rectovaginal endometrioma.

MATERIALS AND METHODS

A 24-years-old woman was referred to our Unit due to recurrent rectal-perineal pain, smelly discharges and dyspareunia. Gynaecological evaluation found a tumefaction involving the posterior vaginal wall. We performed ultrasound and demonstrated endometrioma abscessualization (Figures 1-2). During laparoscopic surgery, we found the rectovaginal pouch involved in adhesions referable to endometriosis, and once we drained the mass, some “chocolate brown liquid” spilled out.

RESULTS

Patient had total relief from her symptoms. Histological analysis confirmed the diagnosis of endometriosis.

INTERPRETATION OF RESULTS

Rectovaginal septum endometriosis is rare and difficult to diagnose. Ultrasound can be helpful, with a sensitivity and specificity of 72% and 98% [2]. Anyway, surgical confirmation is always required for the diagnosis of endometriosis. Surgery is effective and reduces recurrence [3].

CONCLUSIONS

This case reports a rare case of rectovaginal septum endometrioma abscessualization, which can be the cause of rectal-perineal pain.

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Figure 1: Transperineal ultrasound – midsagittal view: a mixed echogeneity lesion involving the recto-vaginal septum of 39x26 mm is demonstrated

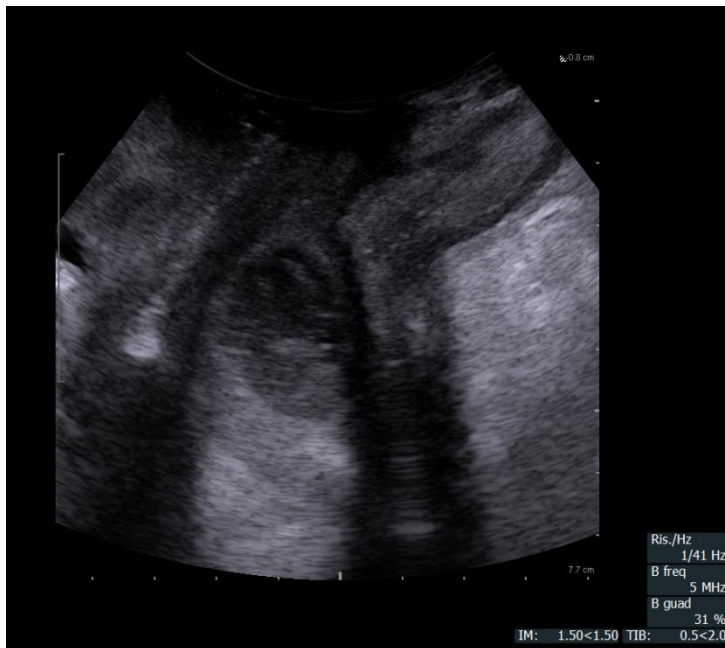
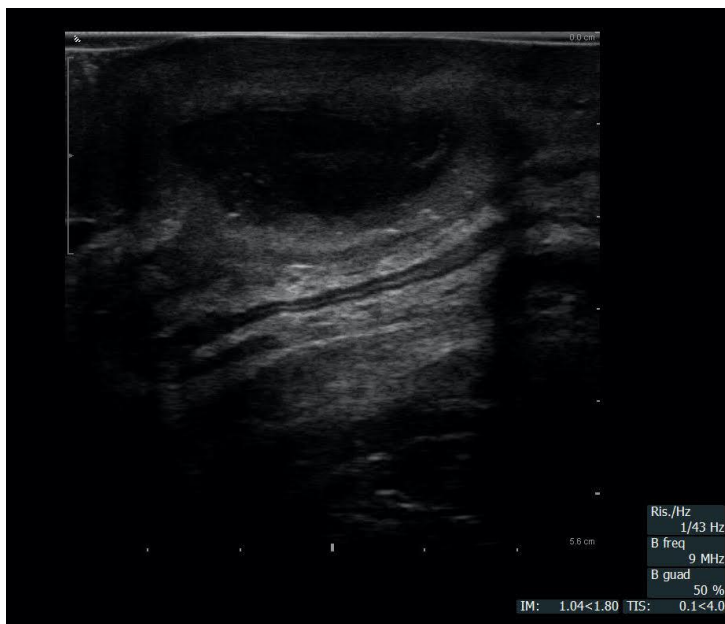


Figure 2: Transvaginal ultrasound – linear probe midsagittal view: the relationship between the endometrioma and the ano-rectal canal is demonstrated



5 OP - GENITAL PAIN AND DYSFUNCTION

Vulvodynia risk factors: a single centre experience

Sara Bosio ⁽¹⁾- **Simona Ruisi** ⁽¹⁾ - **Chiara Marra** ⁽²⁾ - **Stefano Manodoro** ⁽³⁾ -

Università degli studi di Milano, Milano, Italy ⁽¹⁾ - ***CasaMedica, Bergamo, Italy*** ⁽²⁾ - ***ASST Santi Paolo Carlo, Università degli studi di Milano, Milano, Italy*** ⁽³⁾

INTRODUCTION AND AIM OF THE STUDY

Vulvodynia (VVD) is a debilitating chronic pain condition, with onset during early-to mid-reproductive years. This study aimed to investigate the epidemiological characteristics and clinical factors related to VVD.

MATERIALS AND METHODS

Clinical files of a cohort of patients referring to our centre in the year 2020 were retrospectively analysed. Patients were questioned about spontaneous pelvic pain, dyspareunia, lower urinary tract (LUTS) and neuropathic symptoms. The gynaecological physical examination included a cotton swab test to investigate the evoked pelvic pain. Analysed clinical factors are the presence of **endometriosis**, any imbalance in the **hormonal** status, pubo-rectal **hypercontractility**, any **postural** issues, any **bowel dysfunction** and **psychosocial** factors.

RESULTS

Forty-eight patients were screened. The median age was 34 years. Analysed factors were distributed as follow in the study population: endometriosis in 13 (23%) patients, hormonal imbalance in 29 (39,6%), pubo-rectal hypercontractility in 39 (81,2%), postural alterations in 14 (29,2%), bowel dysfunctions in 24 (50%), a psychosocial issue in 16 (33.3%). Pubo-rectal hypercontractility resulted significantly related to those patients who are bothered by evoked pelvic pain (p 0,045). Most of patients with endometriosis did not report symptoms concerning neuropathic pelvic pain (p 0,0001).

INTERPRETATION OF RESULTS

In our sample population, pubo-rectal hypercontractility is the strongest factor related to evoked pain. This may be due to the very high prevalence of this condition in patients with VVD (81,2%). On the contrary, endometriosis does not match with neuropathic pain; this can be explained by the complexity of endometriosis symptoms. In these patients' pain-related-symptoms may follow different pathways than neuropathy.

CONCLUSIONS

Pubo-rectal hypercontractility is the leading factor of VVD and one of the heaviest causes of evoked pain. Nevertheless, further studies are required to assess VVD related factors.

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6 OP - GENITAL PAIN AND DYSFUNCTION

Pharmacological and non-pharmacological treatments of vulvodynia

Simona Ruisi ⁽¹⁾ - **Sara Bosio** ⁽¹⁾ - **Stefano Manodoro** ⁽²⁾ - **Chiara Marra** ⁽³⁾

Università degli studi di Milano, Milano, Italy ⁽¹⁾ - *ASST Santi Paolo Carlo, Università degli studi di Milano, Milano, Italy* ⁽²⁾ - *CasaMedica, CasaMedica, Bergamo, Italy* ⁽³⁾

INTRODUCTION AND AIM OF THE STUDY

Vulvodynia (VVD) is the combination of several pathological processes; therefore, a standard management is missing, and a patient-tailored approach is mandatory. This study aimed to identify whether the most effective treatment for VVD can be identified in a small cohort of patients referring to a multidisciplinary single centre specialized in chronic pelvic pain.

MATERIALS AND METHODS

Clinical files of a cohort of patients affected by VVD referring to our centre in the year 2020 were retrospectively analysed. Patients were questioned about spontaneous pelvic pain, dyspareunia, lower urinary tract (LUTS) and neuropathic symptoms. During the gynaecological physical examination, a cotton swab test was performed to investigate the evoked pelvic pain. Our multidisciplinary approach included at least one treatment among hormonal agents, antidepressants, gabapentinoids, cannabinoids, psychological therapy, and pelvic floor training. Patients joined group A if a significant relief of pelvic pain (spontaneous and/or evoked) was reported at 12-month follow up. Group B served as control with no improvement.

RESULTS

Forty women were screened. 29 (72.5%) patients had spontaneous pain, 25 (62.5%) evoked pain, 32 (80%) dyspareunia, 19 (47.5%) urinary symptoms, 8 (20%) neuropathic symptoms. In group A patients (n=13) hormonal agents were used in 5 patients (38.4%), antidepressants in 10 (77%), gabapentinoids in 3 (23%), cannabinoids in 2 (15.4%) and pelvic floor training was attended by 12 (92.3%). In almost all patients more than one treatment was adopted. No single treatment reached significant effectiveness over the others.

INTERPRETATION OF RESULTS

The aetiology of the VVD is uncertain and multifactorial, being patients wide heterogeneous. Our sample population upheld that a multi-modal approach is essential since no treatment demonstrated to be of utmost effectiveness in the healing process.

CONCLUSIONS

VVD requires a multidisciplinary team. Multiple treatments and a patient-tailored approach are the milestone of therapy.

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7 OP - MYO-FASCIAL PAIN

Prevalence of myofascial pain among women with endometriosis and chronic pelvic pain. Our experience

Guillermo Fernández Lizana ⁽¹⁾ - **Ana Belén Bolívar de Miguel** ⁽¹⁾ - **Álvaro Díaz Álvarez** ⁽¹⁾ - **Carmen Álvarez Conejo** ⁽¹⁾ - **Leticia Muñoz Hernando** ⁽¹⁾ - **Candela Canales Castro** ⁽¹⁾ - **Laura López Marín** ⁽¹⁾ - **Marta Ciáurriz Gortari** ⁽¹⁾ - **Estela Lorenzo Hernando** ⁽¹⁾

Hospital Universitario 12 de Octubre, Obstetrics & Gynaecology, Madrid, Spain ⁽¹⁾

INTRODUCTION

Endometriosis is a chronic estrogen-dependent gynecological disease common in women of reproductive age. One of the most relevant clinical presentation for patients is Chronic Pelvic Pain (CPP), since it can have a significant impact on physical, occupational, sexual and social well-being. CPP is often refractory to hormonal and surgical management. This work aims to examine CPP related to endometriosis from a perspective focused on pain as a disorder itself, independent of the initial pathology. Specifically, the focus of this study lies on the prevalence of myofascial pain and central sensitization as crucial components in the perpetuation of pain.

OBJECTIVES

To study the prevalence of myofascial pain in patients with endometriosis and CPP and to analyze whether the multidisciplinary approach taken at the CPP unit leads to reduce patient's pain.

MATERIALS AND METHODS

A retrospective, descriptive and observational study was carried out. The study population was based on 65 patients undergoing follow-up between 2015-2022 in the CPP consultation of a tertiary hospital. In the descriptive study, categorical variables were described by means of their absolute and relative frequencies. Quantitative variables were described by mean, standard deviation and range. In the comparative analysis at one and two years of follow-up, for categorical variables Chi-Square test was performed and for quantitative variables, a Student's t-test for independent samples.

CONCLUSIONS

Myofascial syndrome is a prevalent component of CPP associated with endometriosis. It's an underdiagnosed disorder; years of delay have been showed until it is specifically addressed. Classical treatment is insufficient when patients present clinical data of CPP and central sensitization. The multidisciplinary approach to CPP, which takes into account the visceral, myofascial, neuropathic and central dimensions, has statistically significant results in the reduction of the global VAS and the number of days with pain per month of patients.

8 OP - POST- DELIVERY PAIN

Effect of Mindfulness Meditation on the management of pain in childbirth in the care of pregnant women in perinatal physiotherapy.

Arianna Marcolini ⁽¹⁾ - **Corinne Oosterlinck** ⁽¹⁾ - **Costantino Balestra** ⁽¹⁾ - **Aurélie Barnavo!** ⁽¹⁾ - **Nadine Hollaert** ⁽¹⁾

Haute Ecole Bruxelles Brabant (HE2B) - ISEK, CHU Saint-Pierre, Bruxelles, Belgium ⁽¹⁾, *Department of Physiology, Vrije Universiteit Brussel (V.U.B.), Department of Motor Sciences - Université Libre De Bruxelles (U.L.B.), Research & Education DAN Europe; Belgian Soc. Diving and Hyperbaric Medicine, European Underwater & Baromedical Society, Department of Perineal and Pelvic Rehabilitation, Perineal Clinic, Centre Hospitalier Universitaire Saint-Pierre (C.H.U. Saint-Pierre), Brussels*

INTRODUCTION AND AIM OF THE STUDY

To determine the impact of a Mindfulness-Based Intervention program on the perception of pain, anxiety, depression, stress and fear of the pregnant woman during the prenatal period and during childbirth.

MATERIALS AND METHODS

16 women, aged $35,31 \pm 4,54$ years, were recruited then randomly divided into two groups: GM (intervention group: 8 sessions of Mindfulness Meditation in preparation for childbirth), GC (experimental group: no specific preparation for childbirth). Various parameters were measured during the second and third trimester of pregnancy, as well as during and after childbirth: pain intensity (EN), type of pain (QDSA), pain threshold (pressure algometer), anxiety and depression (HADS), pain catastrophizing (PCS), fear of childbirth (EPA), degree of mindfulness (FFMQ), satisfaction with childbirth (WOMBLSQ4).

RESULTS

Within the GM, there is a significant increase in the threshold of pain sensitivity between E1 and E2 ($p = 0.0142$) and between E1 and E4 ($p = 0.0141$), a significant decrease in the experience of anxiety and depression ($p = 0.0153$) and a significant increase in the degree of mindfulness ($p = 0.0200$) between E1 and E2. By comparing the two groups, we observe in the GM a significant decrease in the intensity of pain ($p = 0.0228$) and a significant increase in the pain threshold ($p = 0.0207$) in E4, a significant decrease in anxiety and depression ($p = 0.0448$) as well as in fear of childbirth ($p = 0.0296$) in E2.

INTERPRETATION OF RESULTS

An 8-week antenatal Mindfulness program appears to significantly increase the threshold of pain sensitivity and significantly decrease the intensity of perceived pain, anxiety and depression as well as fear of childbirth of the pregnant woman.

CONCLUSIONS

Further studies are needed to clarify the link between the decrease in psychological distress of pregnant women and the improvement of parameters related to their pain perception.

REFERENCES

Shi & MacBeth, 2017; Taheri et al., 2018

9 OP - CHRONIC PELVIC PAIN

Efficacy of capacitive resistive monopolar radiofrequency in the physiotherapeutic treatment of chronic pelvic pain syndrome: A randomized controlled trial

Andrea Carralero Martinez⁽¹⁾ - Ines Ramirez Garcia⁽¹⁾ - Stephanie Kauffmann⁽¹⁾ - Laia Blanco Ratto⁽¹⁾

***RAPbarcelona Clinical Center, Barcelona, Spain*⁽¹⁾**

INTRODUCTION AND AIM OF THE STUDY

Chronic pelvic pain syndrome (CPPS) has a high prevalence and in 61% of cases the etiology is unknown¹. Myofascial induction techniques (MIT) used as a first-line physiotherapy treatment that help to relax the tissues through specific gentle movements². The other treatment used in a novel way is capacitive resistive monopolar radiofrequency (CRMRF), which consists of a non-invasive strategy that promotes tissue regeneration through the action of radiofrequency electrical currents³. Despite its proven efficacy in other musculoskeletal pathologies, there is no necessary scientific evidence regarding its role in the management of CPPS.

The aim of the study was evaluating the efficacy of the combined CRMRF treatment at 448 kHz together with MIT compared to a sham treatment with the same techniques, for pain reduction and quality of life improvements in patients with CPPS.

MATERIALS AND METHODS

A triple-blind, randomized controlled trial including patients with CPPS randomly allocated (1:1) to a CRMRF-activated group (intervention) or a CRMRF-deactivated one (control). Both groups received physiotherapeutic techniques weekly for 10 consecutive weeks. Data from a visual analogical scale (VAS) and the SF-12 questionnaire were collected at trial commencement and repeated at the 5th and 10th sessions. For the analysis, the χ^2 and Student's t-test were used. Superiority was analyzed by estimating the mean change (95% confidence interval). The statistical significance level was set at $p < 0.05$.

RESULTS

81 patients (67.9% women) with a mean age of 43.6 years (SD 12.9) were included. The CRMRF constituted the VAS particles more than 2 points in the intervention group ($p < 0.05$), and the SF-12 improved by 5 points, without statistical significance. No adverse effects were observed, and adherence was 86.4%.

CONCLUSIONS

The study demonstrated the efficacy of RFMCR together with TIM in reducing pain intensity and improving quality of life in patients with CPPS.

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10 OP - CHRONIC PELVIC PAIN

Effectiveness Of Neuromodulator Centered Therapy for Vulvodynia

Laura López-Marín ⁽¹⁾ - **Álvaro Díez** ⁽¹⁾ - **Ana Bolívar** ⁽¹⁾ - **Gonzalo Pulido** ⁽¹⁾ - **Carmen Álvarez** ⁽¹⁾ - **Leticia Muñoz** ⁽¹⁾
Hernando ⁽¹⁾ - **Guillermo Fernandez Lizana** ⁽¹⁾ - **Marta Ciauriz** ⁽¹⁾ - **Estela Lorenzo** ⁽¹⁾

Hospital universitario 12 de Octubre, Obstetrics and Gynecology, Madrid, Spain ⁽¹⁾

INTRODUCTION AND AIM OF THE STUDY

Vulvodynia is defined as vulvar pain for more than 3 months without a clearly identifiable cause. The main aim of this study is to analyze the usefulness of multimodal approach in a specialized Chronic Pelvic Pain (CPP) Unit, centered on neuromodulator drugs use, for this condition.

MATERIALS AND METHODS

Observational retrospective study of women with vulvodynia treated in the CPP Unit between January 2019 and December 2021. The intensity of basal pain and dyspareunia was measured by the Visual Analogue Scale (VAS).

RESULTS

55 patients were subject of study. Mean age at diagnosis was 38.9 years old. Most common type of vulvodynia was localized, provoked and intermittent. Before first evaluation, 78.2% had received nonspecific treatments for pain. At CPP Unit, prescription of neuromodulator drugs was significantly increased ($p < 0.0001$). Amitriptyline was most frequently used (47.3%), followed by anticonvulsants (21.8%). Myofascial pain was found in 60% of these women, requiring specific management. Initially, mean baseline pain scored 4.4 at VAS and dyspareunia scored 7.4 points. Both significantly decreased after 6 months of treatment, respectively to 2.9 ($p = 0.001$) and 5.4 points ($p = 0.002$), and this effect was maintained at 12- and 24-months follow-up.

INTERPRETATION OF RESULTS

Neuromodulator treatment based in amitriptyline and anticonvulsants was effective for vulvodynia, both in acutely improving the pain and avoiding exacerbation and relapse. Physical therapy and lidocaine muscle injections may also play a role when myofascial pain is present.

CONCLUSIONS

- Neuromodulator centered therapy seem to be an effective treatment for vulvodynia patients in the short and long term.
- Specific treatments should be added when myofascial pain is found.

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11 OP - MYO-FASCIAL PAIN

Effect of radiofrequency in women with chronic pelvic pain of myofascial origin versus myofascial therapy and no treatment: a randomized clinical trial

Study design and initial findings

Carla Box ⁽¹⁾ - **Andrea Carralero** ⁽¹⁾ - **Lara Quintas** ⁽¹⁾ - **Cristina Ros** ⁽¹⁾ - **Francisco Carmona** ⁽¹⁾

Hospital Clinic Barcelona, ICGON, Barcelona, Spain ⁽¹⁾

INTRODUCTION AND AIM OF THE STUDY

Patients that suffer from chronic pelvic pain syndrome (CPPS) often present myofascial pain syndrome (MPPS) which has a high prevalence (14-23%) that can increase up to 60-85% in patients that have a CPPS. This pain lasts for over 6 months and is located most commonly in the levator ani and obturator internus muscles as well as in the connective tissue, resulting in trigger points.

Radiofrequency (RF) is a type of endogenous thermotherapy that uses electrical currents at 448 kHz that generate an increase in the temperature of the tissue and help it heal. There is not much evidence of the effect in these patients; however, this technique is one of the most commonly used to treat said problem as well as myofascial release therapy (MRT).

The **aim** of this study is to evaluate the role that RF plays in reducing the level of pain in patients that suffer MPPS versus myofascial release therapy and versus no treatment.

MATERIALS AND METHODS

A randomised clinical trial is being conducted in women (n=80) presenting MPPS (> 4 on the visual analogue scale (VAS)). We identify 4 groups; 2 receive 8 RF sessions (double-blinded, RF intervention group and RF control group which receives *sham* treatment), another group receives 8 MRT sessions and the last group receives no treatment.

The main outcome is the difference in the level of pain using the VAS in the first session versus the last session. Other psychological and functional outcomes have also been evaluated.

RESULTS

Our study has already included 70 women, 32 in the RF groups and 10 in the MRT group. 16 have completed the intervention.

CONCLUSIONS

Although the sample number is currently low, RF seems to have a positive impact on patients who have MPPS. However, it still is early to evaluate its effects.

We expect to have statistically significant results by next year.

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12 OP - ENDOMETRIOSIC PAIN

Evaluation of radiofrequency as a new adjuvant treatment in physiotherapy management of endometriosis related pelvic pain: a pilot randomized study

Margot Roy ⁽¹⁾ - **Christine Levêque** ⁽²⁾ - **Valérie Morel** ⁽²⁾ - **Anne-Florence Planté** ⁽²⁾
Efom Boris Dolto, *Université de Paris, Paris, Francia* ⁽¹⁾ - **Centre l'Avancée, Bastide d'Axium, Aix-en-Provence, Francia** ⁽²⁾

INTRODUCTION AND AIM OF THE STUDY

After the demonstration of its efficiency in other pathologies by reducing the pain's intensity and inflammation[1], radiofrequency is a conservative management strategy which principle is the emission of electromagnetic wave at a very-high frequency, provoking a heat emission into deep tissues of the body[2]. This painless thermic stimulation may allow to improve the cellular metabolism in order to boost the tissue's regeneration and healing process, while expanding pain threshold[2]. Manual therapy's approach of endometriosis includes tissular adhesions, myofascial syndrome and pelvic sensitivity[3]. Preliminary data extraction from the center l'Avancée seems promising to use radiofrequency in reducing pelvi-perineal pain perceived by women suffering from endometriosis, which motivated us to set up a pilot randomized study. This study aims to determine the interest of using radiofrequency in physiotherapy's painful endometriosis management.

MATERIALS AND METHODS

We will recruit at least 30 adults not yet menopausal with an endometriosis diagnosis and a physiotherapy's prescription from the expert center l'Avancée, in Aix-en-Provence. Patients will be randomized into two groups, one performing the radiofrequency protocol 2 months, then reallocated to manual therapy protocol another 2 months. This cross over will hence be a 4-month duration, each intervention will last 2 months at a rate of one weekly session.

The first outcome is quality of life measured by the Endometriosis Health Profile-5, a validated questionnaire for women who suffer from endometriosis. Secondary outcomes are sexuality (evaluated by the Female Sexual Function Index) and treatment appreciation. To date, since there is no validated satisfaction of treatment questionnaire for endometriosis, validated satisfaction questionnaires for other pathologies managed by physiotherapy will be used.

RESULTS

We expect some results around January 2023, 2 months after the beginning of the study.

INTERPRETATION OF RESULTS

Ongoing evaluation on Excel to calculate Chi² and p value.

CONCLUSIONS

This study could offer a non-painful adjuvant treatment for physiotherapists in the management of painful endometriosis.

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13 OP - CHRONIC PELVIC PAIN

Scoring by App finally a real tool for measurement and research?

Blondelle Pascal ⁽¹⁾

Unité de Rééducation et d'évaluation Pelvi-Périnéale, Nouvelle Clinique Bel Air, Bordeaux, France ⁽¹⁾

INTRODUCTION

The scoring reported by the patient is an instrument for analyzing and quantifying items such as pelvic-perineal pain...it justifies, with a report, the choice of treatment, the multidisciplinary opinion, the before-after comparative evaluation, clinical research, opposability to recommendations and authorities...

MATERIALS AND METHODS

The use of these scores is hampered by the complexity of implementation from a paper grid:

Scan, send by email to the patient,

Print, scan, send to the practitioner,

Scan then enter the file, ending up not being read again and abandoned.

The creation of a dedicated multidisciplinary App seemed relevant to us to create a link between the patient, health professionals and clinical research.

RESULTS

When making first appointment, a link is sent to the patient, who will benefit from secure direct access to the App to complete their medical, quality of life, clinical, evaluation or integration questionnaires in studies such as TRENSE and the return to the practitioner.

CONCLUSIONS

The practitioner may repeat this sending on fixed dates for follow-up and compliance. He will share the results and evolution of the scoring with his correspondents and will include it in the "RCPs".

The process becomes simple for the patient responsible for his care.

For practitioners, it is both a tool for evaluating care, exchange between colleagues and clinical research allowing an evaluation over time of the evolution of patients and treatment techniques for perineum pains.

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14 OP - PELVIC SENSITIZATION

Dysautonomia - Practical tool for patients

Meunier Maud ⁽¹⁾

Convergences PP, La Bastide Axiom, Aix en Provence, Francia ⁽¹⁾

INTRODUCTION AND AIM OF THE STUDY

Midwives are fortunate to be actors of prevention, screening and rehabilitation management, excluding allopathic and surgical management of painful syndromes.

This advantage gives us valuable time savings, allowing us to deepen certain consulting stream.

With regard to the phenomenon of dysautonomia, the emphasis can be placed on the explanation of the phenomenon, and the preponderant role that the patient has to play in her own management.

MATERIALS AND METHODS

Thus the objective of this presentation is to propose a practical tool for the patient.

This tool has a dual purpose.

The first will be to make accessible to the patient the physiopathological mechanisms of this complex phenomenon that is dysautonomia.

The second will be to allow him, visually and synthetically, to maintain the motivation necessary for his autonomy of support.

Indeed, the tool allows to easily visualize all the changes to be made in the daily life of women with neuro-vegetative boom, and why each axis has its importance.

Patients are the first actors in their “wellness” and it is important that they remember this regularly.

CONCLUSIONS

Finally, once the presentation of the tool is made, a clarification will be made on the importance of physical work that the rehabilitator, whether medical or paramedical, including the midwife, is required to practice with patients.

15 OP - GENITAL PAIN AND DYSFUNCTION

Photobiomodulation for primary dysmenorrhea - A systematic review

Isabelle Le Ray ⁽¹⁾ - **Sara Abboud** ⁽²⁾

ISM, Gynaecology, Boulogne-Billancourt, France ⁽¹⁾ - ***GHI Le Raincy Montfermeil, Obstetrics and Gynaecology, Le Raincy, France*** ⁽²⁾

INTRODUCTION AND AIM OF THE STUDY

Primary dysmenorrhea (PD) is of significant burden among childbearing age women worldwide. Current treatments are not always effective and may present adverse effects. Photobiomodulation (PBM) has been demonstrated as an effective treatment for pain in several settings. We conducted a systematic literature review to investigate the effects of photobiomodulation (PBM) on primary dysmenorrhea.

MATERIALS AND METHODS

We identified randomized controlled trials including women with PD and evaluating PBM vs placebo or standard treatment. The primary outcome measure was pain relief measured by a visual analogue scale (VAS). The quality of the studies was assessed using the Mixed Method Appraisal Tool (MMAT).

RESULTS

Three studies were included. The overall quality was limited. All investigated PBM as red light applied on acupuncture points CV4 and CV6. A total of 231 patients were included. Two studies comparing PBM and placebo found PBM was superior. The third study compared PBM to oral contraceptive pill (OCP). The post-treatment VAS was lower among the OCP group.

CONCLUSIONS

PBM may have some efficacy on PD pain compared to placebo. The level of evidence is very low, and OCP seem more effective. Further research investigating different PBM modalities is warranted.

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NON DISCUSSED POSTERS

16 P - GENITAL PAIN AND DYSFUNCTION

The place of physiotherapy in pelvic-perineal care for women with dyspareunia: a systematic review of the literature

Place de la prise en charge masso-kinésithérapique en pelvi-périnéologie chez des femmes atteintes de dyspareunies : une revue de la littérature systématique

Emma de Oliveira⁽¹⁾ - *Anne-Florence Planté*⁽²⁾

Cabinet libéral, , Montpellier, La France⁽¹⁾ - *Cabinet libéral et Centre gynécologique l'Avancée, Aix-en-Provence, La France*⁽²⁾

RÉSUMÉ

INTRODUCTION

Les dyspareunies chez la femme constituent encore aujourd'hui un sujet tabou et peu abordé. Ces douleurs sexuelles entraînent de multiples répercussions négatives sur la qualité de vie de la femme, sur sa sexualité et celle de son partenaire, aboutissant à un évitement des rapports sexuels, voire même à une inactivité sexuelle. De plus, de nombreuses femmes se retrouvent en errance thérapeutique et ignorent que leurs dyspareunies pourraient être prises en charge par un masseur-kinésithérapeute spécialisé en pelvi-périnéologie. L'objectif de cette revue est d'évaluer l'efficacité des prises en charge masso-kinésithérapiques chez les femmes atteintes de dyspareunies, sur la douleur, la fonction sexuelle, le plancher pelvien et la qualité de vie.

MÉTHODE

Une revue systématique de la littérature a été réalisée en suivant les lignes directrices PRISMA. Les bases de données PubMed, PEDro et Science Direct ont été consultées d'octobre à janvier 2022, afin de rechercher les études publiées entre 1995 et 2022. La méthode PICOS a été employée pour définir les critères d'éligibilité.

RÉSULTATS

La recherche a identifié 733 articles, treize d'entre eux ont rempli les critères d'éligibilité, dont six essais contrôlés randomisés. Les échantillons allaient de 20 à 212 patientes recevant entre 5 et 12 séances de masso-kinésithérapie (30 minutes à 1h30), pour les essais contrôlés randomisés. De multiples modalités d'intervention masso-kinésithérapique ont été décrites par sous-type de populations atteintes de dyspareunies : éducation thérapeutique, exercices des muscles du plancher pelvien, thérapie manuelle, biofeedback, électrostimulation, dispositifs vaginaux, exercices à domicile. Les études sont unanimes et montrent pour la plupart une amélioration significative de la douleur, de la fonction sexuelle, de la qualité du plancher pelvien et de la qualité de vie.

DISCUSSION ET CONCLUSIONS

Il semble apparaître que la prise en charge multimodale masso-kinésithérapique soit la plus recommandée en première intention thérapeutique pour les femmes atteintes de dyspareunies, quelle qu'en soit l'étiologie. De plus, la prise en charge pluridisciplinaire (selon l'étiologie de la dyspareunie) et la participation du conjoint semblent renforcer ces améliorations et contribuer à la reprise des rapports sexuels avec une meilleure qualité de vie. Néanmoins, des études de plus grandes cohortes seraient souhaitables afin de déterminer si ces améliorations se maintiennent à long terme, plusieurs années à distance de l'intervention masso-kinésithérapique, et notamment chez les survivantes d'un cancer.

MOTS-CLÉS

Dyspareunie, masso-kinésithérapie, douleur, fonction sexuelle, plancher pelvien, qualité de vie.

RÉFÉRENCES

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The place of physiotherapy in pelvic-perineal care for women with dyspareunia: a systematic review of the literature.

Abstract

INTRODUCTION

Dyspareunia in women is still a taboo subject that is rarely discussed. These sexual pains have multiple negative repercussions on the woman's quality of life, on her sexuality and her partner's sexuality, leading to an avoidance of sexual intercourse, or even sexual inactivity. Moreover, many women find themselves in therapeutic wandering and are unaware that their dyspareunia could be managed by a

physiotherapist specialising in Pelvi-Perineology. The aim of this systematic review is to assess the effectiveness of physiotherapy care for women with dyspareunia, on pain, sexual function, pelvic floor muscle and quality of life.

METHODS

A systematic review was performed according to PRISMA guidelines. The PubMed, PEDro, and Science Direct databases were consulted from October to January 2022 for studies published between 1995 and 2022. The PICOS method was used to define the eligibility criteria.

RESULTS

The search identified 733 articles, 13 of which met the eligibility criteria, including six randomized controlled trials. Sample sizes ranged from 20 to 212 patients attending 5 to 12 treatment sessions (30 minutes to 1.5 hours length) enrolled in RCTs. Multiple modalities of physiotherapy intervention have been implemented for each subtype of population with dyspareunia: therapeutic education, pelvic floor muscle training, manual therapy, biofeedback, vaginal accommodators, home exercises and electrical stimulation. The studies unanimously show significant improvement in pain, sexual function, pelvic floor muscle relaxation and quality of life.

DISCUSSION AND CONCLUSIONS

Multimodal physiotherapy is the most recommended first-line treatment for women with dyspareunia. Furthermore, multidisciplinary management and partner involvement appear to reinforce improvements and contribute increasing libido and sexual activity also with a better quality of life.

Larger cohorts would be advisable to determine whether these improvements are maintained in the long term and especially in cancer survivors.

KEYWORDS

Dyspareunia, pelvic floor physiotherapy, pain, sexual function, pelvic floor, quality of life

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17 P - CHRONIC PELVIC PAIN

Testimony of two patients with chronic pelvic pain

Diana Torrecillas Martínez ⁽¹⁾ - **Alba Requena Gómez** ⁽¹⁾

ADOPEC, ESPAÑA, Madrid, Spain ⁽¹⁾

(Diana) Buenos días me llamo Diana Torrecillas, es un placer poder saludarlos.

Soy una paciente de **Dolor Pélvico Crónico** y Ayudante de Presidencia de la Asociación de pacientes **ADOPEC**: formada por pacientes de **Dolor Pélvico Crónico** procedentes de todo el territorio nacional cuyo **objetivo principal** es dar VISIBILIDAD y CONOCIMIENTO a la sociedad en general sobre esta patología invisible. Además de ayudar y asesorar a todas aquellas personas que padecen de Dolor Pélvico Crónico. Servimos de **enlace** entre los pacientes y los profesionales de la salud, nunca sustituimos al médico.

MI HISTORIA

“Mi historia comienza en la adolescencia con dolores menstruales y dolores pélvicos inexplicables. Tras una Laparotomía de urgencia en 2005, tuve múltiples consultas a urgencias por dolor abdominal, al orinar y defecar, en 2010 empecé a tener contracciones vagino-anales, imposibilidad de poder permanecer de pie y sentada mucho tiempo, todo sin un diagnóstico claro. Finalmente, en 2018 me ingresaron de nuevo de urgencia y tras muchas pruebas dieron con los diagnósticos que les menciono:

- Endometriosis Profunda
- Dolor pélvico crónico complejo de larga evolución en fase de Sensibilización central con afectación del Sistema Nervioso Central de forma permanente y crónica.
- Sde. Adherencial severo con algias pélvicas incapacitantes.
- Sde. Miofascial severo.
- Hiperalgesia persistente en región pélvica-perineal y miembro inferior derecho.
- Neuropatía crónica bilateral severa de ambos nervios pudendos.
- Neuralgia crónica nervio obturador derecho
- Estreñimiento crónico severo por disfunción puborrectal
- Sde. de Intususcepción rectal grado II
- Rectocele estadio II

- Síncopes de repetición
- Fibromialgia
- Sde. fatiga Crónica

Este Dolor Pélvico Crónico me incapacita no sólo por el importante DOLOR FÍSICO, me ocasiona un deterioro significativo en mi calidad de vida e impotencia funcional significativa ya que, debo permanecer tumbada en la cama/sofá la mayor parte del tiempo.

Mi día a día es un infierno, siendo sincera, no sé **cómo voy a amanecer cada mañana**, si seré capaz de poder levantarme, de poder afrontar las tareas cotidianas como preparar a mi hija para llevarla al colegio o hacer las tareas de casa. El dolor es tan **intenso e INCAPACITANTE** que hace que, a veces, no pueda ni levantarme de la cama y deba pedir ayuda a algún familiar o vecina. Me frustra que mi hija, desde bien pequeñita, me vea así (ahora tiene 7 años). Ella sufre al ver a “su mamá” en cama y darse cuenta que, su madre, no puede hacer las mismas cosas que las mamás de sus amigas, esas mamás que están sanas. Mi familia sufre conmigo mi enfermedad.

Me he sometido a diversas intervenciones, terapias e incluso Neuromodulación Sacra que supuso una ligera mejoría, pero, a pesar de todo ello, el Dolor NO ha desaparecido y me limita mi día a día haciéndome incapaz de poder desempeñar un trabajo.

El camino recorrido, en los últimos 15 años, no ha sido nada fácil sufriendo dolores que se iban agravando con los años, sin que los médicos supiesen diagnosticar lo que me pasaba, ni el “por qué” de mis síntomas hasta 2018 y 2019 cuando obtuve mis diagnósticos. Mi vida como paciente de DPC no ha sido fácil, me ha privado de muchas cosas: el trabajo, vida social y familiar, hobbies y sobre todo como madre; soy una mamá que lucha cada día con dolor crónico. Durante el camino hubo veces en las que quise tirar la toalla y no seguir luchando, ni por mi niña, ni mi familia, ni por mí misma.

Al principio de este recorrido, la desinformación hace que te invada la angustia, el miedo, la ansiedad y la depresión y te preguntas: ¿qué me pasa? , ¿por qué a mí ?, ¿esto tiene cura?

Por desgracia, la mayoría de pacientes acabamos buscando información en Internet, por ello, es importante que para los pacientes no sea Internet y Míster Google la 1º opción de búsqueda de información, tenemos que intentar tanto los médicos como las Asociaciones que esa 1º búsqueda sea a

través de una información veraz, contrastada y creíble tanto por parte del facultativo como por parte de la Asociación y eso sólo se puede hacer juntos .

Por lo que, el Rol del paciente es muy importante, es entonces cuando mi visión de paciente cambió y empecé a formarme con cursos y talleres, pues, un **paciente Activo-Empoderado** y Experto, bien formado e informado fomenta la participación activa en su proceso de salud, en la toma de decisiones que afectan a la gestión de su enfermedad y en su autocuidado además de crear mejor adherencia al tratamiento.

No todos los profesionales de la medicina te toman en serio al principio, ni empatizan con el sufrimiento de los pacientes, familiares y cuidadores. Por eso, creo que deberían ponerse más en “**la piel del paciente**”, necesitamos que se tenga en cuenta nuestra salud emocional, personal y social (incluido el impacto en el trabajo, la calidad de vida la persona y el impacto económico del dolor) en definitiva, que se valore la afectación del dolor en todos los aspectos de nuestras vidas.

Por eso, la relación médico-paciente debe de ser PROACTIVA siendo el papel del paciente más activo, con una buena comunicación entre ambos, ya que, una participación más efectiva trabajando en equipo (paciente-médico) hará que un paciente bien informado tome mejores decisiones respecto a su salud.

Otro aspecto importante para los pacientes es poder conocer y compartir nuestras experiencias con otras personas en una situación similar, para fomentar aprendizajes y dar mayor visibilidad al DPC(web, RRSS ...), es ahí , donde las **Asociaciones de pacientes** juegan un **papel importante** a la hora de servir como apoyo y un punto de referencia de información. Para ello, es primordial que **motivemos el trabajo conjunto** entre profesionales de la salud y las Asociaciones.

Para finalizar, sólo pido que se creen más Unidades Multidisciplinares y se estudie este tipo de enfermedad pues, hoy por hoy, no existe ningún estudio o investigación que nos de esperanza para una mejor calidad de vida.

(ALBA) Encantada, soy Alba Requena, antigua paciente de dolor pélvico crónico y actual miembro de la junta directiva de ADOPEC. Me gustaría empezar explicando un poco mi historia...

Mis síntomas empezaron en 2019, teniendo yo 21 años. De un día para otro, sin ninguna causa aparente, empecé a tener síntomas de dolor pélvico crónico que me llevaron a urgencias un par de veces y que no arrojaron ninguna luz del por qué. Dos meses después empeoré y empecé a tener síntomas de vulvodinia. Mi dolor era tan abrumador que tuve que dejar los estudios porque no podía concentrarme, no podía estar tanto rato aguantando el dolor en clase y no podía desplazarme todos los días en transporte público por miedo a no poder bajar en mi parada por un brote de dolor. No podía estudiar y mucho menos trabajar, me obligó a tener que quedarme en casa de mis padres sin poder tener ningún proyecto de futuro porque no podía hacer nada, ni siquiera tener vida social.

Incluso llegué a tener terrores nocturnos en los sueños, en los que me imaginaba que me arrojaban ácido en mis genitales, hasta ese punto era mi ardor. Era una joven de 21 años, con mucho futuro por delante, que de un día para otro llegó un dolor inexplicable y me quedé 2 meses encerrada en mi habitación, sin salir al mundo exterior.

Cada semana iba una o dos veces al servicio de ginecología de mi ciudad, del que recibía comentarios ridiculizando mis síntomas o menospreciándolos, llegando finalmente a decirme que no volviera más, que no sabían lo que tenía y que no podían hacer nada más por mí. Una joven de 21 años sin poder salir de su habitación a la que le dijeron que no había solución y que parecía que a nadie le importase que mi vida se hubiera acabado.

En ese momento, no tenía de diagnóstico, ya habían pasado 8 meses y nada mejoraba. Tuve que ir de urgencias al hospital Vall d'Hebron de Barcelona, llorando y suplicando, junto con mi padre, que me atendieran en ese hospital (por protocolo mi hospital asignado era el de mi ciudad, pero expliqué que me habían pedido que no fuera más) Después de mucho insistir, conseguí meses después un diagnóstico, pero tuve que esperar un año y medio a que me atendieran en rehabilitación de suelo pélvico, y otro año más a que me visitara una uróloga de otro hospital que me diagnosticó como una neuralgia del nervio pudendo y me hizo un bloqueo. Todo este proceso duró 2 años, dos años en los que dediqué todo mi tiempo íntegramente a solucionar este problema, ya que por el dolor me impedía hacer nada más, y aun y así, se tardó tanto tiempo en el abordaje de la patología. Aunque de primeras no lo parezca tengo

suerte, puesto que muchos pacientes tardan muchísimos más años en lograr un abordaje del dolor pélvico crónico.

A día de hoy, después de casi 4 años, me considero una persona casi 100% recuperada, con alguna recaída, pero que puede hacer vida normal, pude retomar estudios y pude empezar a trabajar en el servicio de rehabilitación del hospital de mi ciudad. Decidí colaborar con ADOPEC y hacer todo lo que estuviera en mi mano para que estas patologías tengan reconocimiento y un abordaje temprano, orientando y empoderando a otros pacientes.

Después de contar quiénes somos ADOPEC y nuestras historias como pacientes de DPC, que **sólo son dos de muchas experiencias** de los muchos pacientes que hay que sufren y están diagnosticados de esta patología, sin hablar de los que aún no están diagnosticados.

Desde ADOPEC seguimos abogando por:

- Una **Formación-Información Específica** sobre Dolor Pélvico Crónico al personal sanitario de Atención Primaria, profesionales de la salud o al público en general.
- La **creación de Unidades Multidisciplinares de Dolor Pélvico Crónico en los centros sanitarios**. Este tipo de trabajo mejora muchísimo la calidad asistencial y proporciona mejores tratamientos.
- **Apoyar e Incrementar campañas de sensibilización y concienciación** contando con el ámbito público, privado y asociativo y desde el mundo educativo en los Institutos, Centros Sanitarios y Centros de Atención Primaria.
- **Incrementar la ayuda en la investigación, prevención y tratamiento** del Dolor Pélvico Crónico y así, reducir la media de años que suelen tardar en recibir el diagnóstico, así como, conseguir métodos de diagnóstico menos invasivos y un diagnóstico precoz .
- **Difundir la información** en nuestra Web y RRSS e **instar al Ministerio de Sanidad a visibilizar y difundir** el conocimiento de las patologías del DPC en los medios de comunicación (TV, radio, prensa, Redes Sociales, etc.) y la sociedad en general.

De manera que en ADOPEC, intentamos día a día que los pacientes estén bien informados y sean más autónomos, siendo capaces de tomar sus propias decisiones a la hora de elegir un tratamiento. **Es muy**

importante lo que el paciente piensa y cree sobre su enfermedad y que va a esperar del tratamiento a recibir.

Por ello, animamos a que los Profesionales se unan a las Asociaciones de pacientes porque la **#UniónHaceLaFuerza.**

Gracias por su tiempo y ha sido un placer.

18 P - MYO-FASCIAL PAIN

Effect of radiofrequency in women with chronic pelvic pain of myofascial origin versus myofascial therapy and no treatment: a randomized clinical trial

Study design and initial findings

Carla Box ⁽¹⁾ - **Andrea Carralero** ⁽¹⁾ - **Lara Quintas** ⁽¹⁾ - **Cristina Ros** ⁽¹⁾ - **Francisco Carmona** ⁽¹⁾

Hospital Clinic Barcelona, ICGON, Barcelona, Spain ⁽¹⁾

INTRODUCTION AND AIM OF THE STUDY

Patients that suffer from chronic pelvic pain syndrome (CPPS) often present myofascial pain syndrome (MPPS) which has a high prevalence (14-23%) that can increase up to 60-85% in patients that have a CPPS. This pain lasts for over 6 months and is located most commonly in the levator ani and obturator internus muscles as well as in the connective tissue, resulting in trigger points.

Radiofrequency (RF) is a type of endogenous thermotherapy that uses electrical currents at 448 kHz that generate an increase in the temperature of the tissue and help it heal. There is not much evidence of the effect in these patients; however, this technique is one of the most commonly used to treat said problem as well as myofascial release therapy (MRT).

The **aim** of this study is to evaluate the role that RF plays in reducing the level of pain in patients that suffer MPPS versus myofascial release therapy and versus no treatment.

MATERIALS AND METHODS

A randomised clinical trial is being conducted in women (n=80) presenting MPPS (> 4 on the visual analogue scale (VAS)). We identify 4 groups; 2 receive 8 RF sessions (double-blinded, RF intervention group and RF control group which receives *sham* treatment), another group receives 8 MRT sessions and the last group receives no treatment.

The main outcome is the difference in the level of pain using the VAS in the first session versus the last session. Other psychological and functional outcomes have also been evaluated.

RESULTS

Our study has already included 70 women, 32 in the RF groups and 10 in the MRT group. 16 have completed the intervention.

CONCLUSIONS

Although the sample number is currently low, RF seems to have a positive impact on patients who have MPPS. However, it still is early to evaluate its effects.

We expect to have statistically significant results by next year.

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19 P - POST- OP PELVIC PAIN

A puncture of corticosteroid and levo-bupivacaine intravaginally: an alternative for women with postoperative pelvic pain

Nieves Climent⁽¹⁾ - **Carlos Juarez**⁽¹⁾ - **Sara Ruiz**⁽¹⁾ - **Victoria Martinez**⁽¹⁾

Hospital Universitario Fundacion Alcorcon, Obstetricia y Ginecologia, Alcorcon MADRID, Spagna⁽¹⁾

INTRODUCTION

Pelvic pain is a common symptom in women after prolapse surgery or vaginal delivery. The pudendal nerve entrapment (PNE) could be a possible cause of pelvic pain and it is a syndrome with a complex diagnosis and treatment. The patients with PNE describe pain, sexual dysfunction, urinary and proctological symptoms. Pudendal nerve damage can be caused after its compression during vaginal delivery or entrapment after vaginal prolapse surgery, mostly when meshes or anchors are applied. The pudendal nerve, which runs along the Alcock's canal, is formed by the union of roots S2-S3-S4. There are 3 critical points of eventual damage: between sacrotuberous and sacrospinous ligaments; the falciform; and at the Alcock's canal. The clinical symptoms are described as unilateral or bilateral pelvic pain, which worsens when seated and improves by lying down. Sometimes these are also associated with urinary or sexual symptoms or feelings of a rectal body. A vaginal exploration shows the "Tinel sign", which means pain by compressing the ischial spine. But the correct diagnosis is difficult and is usually reached when other syndromes are excluded and without anatomical defects in the CT, MRI, or ultrasound studies.

METHODS

We present an observational prospective study of 9 women with PNE by Nantes criteria and the follow-up 1-6 months after one single dose of vaginal infiltration of corticosteroid and levo-bupivacaine. The results were evaluated by the Visual Analog Scale (VAS) before puncture and one month and six months after the infiltration. All of the patients referred to clinical improvement. The technique starts in a lithotomy position, and by vaginal palpation of the ischial spine, we infiltrate 1ml Triamcinolone + 9ml levo-bupivacaine into the submucosa. No complications such as vaginal bleeding or vasovagal syncope were registered.

CONCLUSIONS

We conclude that a single dose of corticosteroid and levo-bupivacaine is an effective treatment for patients with pelvic pain according to PNE after vaginal surgery or vaginal delivery.

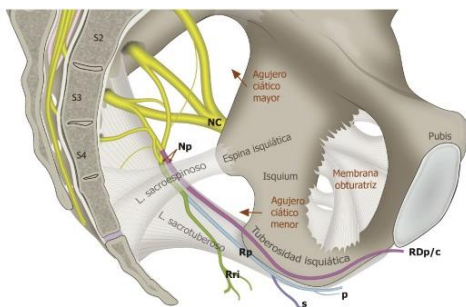


Figure 1. Pelvis innervation



Figure 2. Materials for infiltration

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