

History, Physical Key in Chronic Pelvic Pain Dx

BY NANCY WALSH
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LAKE BUENA VISTA, FLA. — The cornerstones of an evaluation for chronic pelvic pain are a complete and thorough history and a physical examination directed toward detecting the location of the pain and replicating it through systematic palpation.

Having the patient fill out a questionnaire before an initial consultation is essential for eliciting the necessary historical details in this complex, multifactorial condition, said Dr. Fred M. Howard, professor of obstetrics and gynecology, University of Rochester (N.Y.) Medical Center. A comprehensive questionnaire developed by the International Pelvic Pain Society (www.pelvicpain.org) can be very helpful and time saving, he said.

During the initial consultation, listen to the patient and take the time to establish trust. "Dismiss nothing as ridiculous, impossible, or unimportant," Dr. Howard said.

The history should be a multidimensional assessment of pain, encompassing gastrointestinal, gynecologic, urinary, and musculoskeletal causes, and should address the patient's symptoms, lifestyle, and psychological state. How the patient understands and interprets her pain is also important, he said at the annual meeting of the International Pelvic Pain Society.

Prominent among potential gastrointestinal causes is irritable bowel syndrome (IBS), which today is defined by

the Rome criteria as a pain syndrome. IBS can be identified with questions about whether, during the previous 3 months, the patient had at least 3 days of abdominal pain or discomfort that was relieved by a bowel movement or if there was a change in stool frequency, form, or appearance.

Possible sources of pain in the reproductive tract are endometriosis and pelvic congestion syndrome. Endometriosis is a likely cause if the pain worsens with or before menses, it is associated with deep penetration during intercourse, or there are problems with conceiving.

Pelvic congestion syndrome can be associated with dull, aching low back pain and premenstrual exacerbations, as well as with deep dyspareunia with postcoital ache that can last up to 24 hours. Other common causes include abdominal wall myofascial pain in a patient reporting activity that could acutely or repetitively overload the pelvic or abdominal muscles, such as gymnastics, or a history of trauma or injury.

Findings suggesting pelvic floor pain syndrome include pain that is aching or throbbing or described as "heaviness," that presents acutely in the rectum or vagina or increases with sitting or standing in one position at length.

In doing the work-up, laboratory and imaging studies don't add much to the evaluation. "Only tests that are need-

ed to rule out life-threatening diseases or that will definitively confirm your clinical diagnoses should be ordered."

The physical exam should focus on "pain mapping" to detect the locations of pain and tenderness, and replicate the pain with palpation in a "four S" sequence: standing, sitting, supine, and in stirrups, he said. "If the patient is anxious, try palpating gently with your stethoscope. Patients don't expect that to hurt."

While the patient is standing, evaluate her for groin and abdominal hernias, injuries to the pubic symphysis, fibromyalgia, and short leg syndrome. Also palpate any possible abdominal trigger points, pushing only hard enough to reach the rectus or external oblique muscles, which should reproduce all or part of her pain.

When she is sitting, look for asymmetric posture, which can be a manifestation of pain in the buttocks or perineum. In the supine position, inspect and palpate for lordosis or pelvic tilt, as well as for distension or masses.

Dr. Howard leaves the pelvic examination for last. "It helps to do it last when she may be less anxious."

Always consider the possibility of depression, a major psychological comorbidity with chronic pain, and particularly ask about suicidality. And be mindful of other unrelated problems, he warned. ■



'Dismiss nothing as ridiculous, impossible, or unimportant,' and ask about depression and suicidality.

DR. HOWARD

CDC: Assisted Reproduction May Elevate Birth Defects Risk

BY SHARON WORCESTER
Southeast Bureau

Assisted reproductive technology is associated with an increased risk of certain types of birth defects, according to a report from the Centers for Disease Control and Prevention.

The findings, based on data from the ongoing National Birth Defects Prevention Study—a population-based case-control study of birth defects—indicate that infants conceived using ART are twice as likely to be born with certain types of heart defects and with cleft lip (with or without cleft palate), and are more than four times as likely to have certain gastrointestinal defects, compared with those conceived naturally.

The investigators noted, however, that the underlying biologic mechanism by which ART might affect development remains unclear and that without further study, practical application of the results is limited.

The report, published in *Human Reproduction* (doi:10.1093/humrep/den387), says the overall risk of birth defects associated with ART is low, but important for consideration by prospective parents considering assisted conception. For example, cleft lip with or without cleft palate affects about 1 in 950 births in the United States; among those conceived using ART, cleft lip with or without cleft palate affects about 1 in 425 births, lead author Jennita Reefhuis, Ph.D., an epidemiologist at the CDC's National Center on Birth Defects and Developmental Disabilities, and her colleagues reported.

Those considering ART should be informed of the risks involved, they urged.

The investigators compared outcomes in 281 babies conceived using in vitro fertil-

ization (IVF) or intracytoplasmic sperm injection and 14,095 conceived without ART delivered between October 1997 and December 2003.

After controlling for maternal race and ethnicity, age, smoking, and parity, they found that among singleton births, the use of ART was associated with septal heart defects (adjusted odds ratio, 2.1), cleft lip with or without cleft palate (adjusted OR, 2.4), esophageal atresia (adjusted OR, 4.5), and anorectal atresia (adjusted OR, 3.7). Among multiple births, none of the more than 30 defects studied was significantly associated with ART.

The authors acknowledged that underlying infertility, small numbers, and chance may have played a role in the increased risk of birth defects found in the study.

Indeed, "this study suffers from the same significant deficiencies as many others looking at IVF outcomes," Dr. Elizabeth Ginsburg, president of the Society for Assisted Reproductive Technology (SART), said in an interview. That is, rather than comparing two similar populations, this study compares babies of infertile women undergoing ART with those of fertile women. As a result, no conclusions can be made about why the incidence of birth defects is higher in those undergoing ART, she explained.

"I don't think the study changes what we have been telling our patients for some time, which is that there may be a higher risk of birth defects or other adverse outcomes in babies born from IVF. Whether these findings are due to the fact that there is something different about couples with infertility who require IVF to conceive or something related to the treatment itself, we don't know," she said, adding that patients have the right to be informed, regardless. ■

Simvastatin Trumps Metformin For Menses Regularity in PCOS

BY SHARON WORCESTER
Southeast Bureau

SAN FRANCISCO — Simvastatin improved menstrual regularity in women with polycystic ovary syndrome—and it did so more effectively than either metformin or a combination of both drugs in a randomized study that compared the three treatments.

Furthermore, simvastatin was more effective than the metformin or combination treatment for reducing cardiovascular risk factors, including lipid profile and systemic inflammation, and was at least as effective for improving clinical and biochemical measures of hyperandrogenism, according to data presented at the annual meeting of the American Society for Reproductive Medicine.

Dr. Leszek Pawelczyk of the University of Medical Sciences in Poznan, Poland and his colleagues randomized 60 women with PCOS to receive simvastatin (20 mg/day), metformin (850 mg twice daily), or a combination of the two. Dr. Pawelczyk reported 6-month study data at the meeting.

The prospective study included only nonobese women who were not using oral contraceptives or other hormonal therapies.

The three treatment groups were comparable at baseline with regard to demographic and clinical characteristics; they averaged 2.5 menses every 6 months. The 18 women in the simvastatin group had an 89% increase in the number of menses after 6 months of treatment, compared with a 32% in-

crease in the 19 women in the metformin group, and a 68% increase in the 23 women in the combination group. The differences between the groups were statistically significant.

All groups experienced a significant decrease in body mass index, hirsutism, acne scores, and total and free testosterone levels, but the differences in these measures were not statistically improved in the combination therapy group, compared with the simvastatin and metformin groups. For example, testosterone decreased 27% in the simvastatin group, 19% in the metformin group, and 15% in the combination group. Body mass index decreased 2.2% in the simvastatin group, 4.3% in the metformin group, and 5.8% in the combination group.

Similarly, there was no additive effect of combination therapy on total cholesterol, LDL cholesterol, and C-reactive protein in the combination group.

Improvements in these measures were seen only in the presence of simvastatin, and the improvement was not greater in the combination group.

Given the increasing evidence that statins benefit women with PCOS, they "may be a very good option in these patients," Dr. Pawelczyk said in response to an audience member's question about whether he would recommend treatment in PCOS patients now, or wait for further study.

He noted, however, that this treatment is not an option in patients who are planning to become pregnant because statins have been associated with birth defects. ■