Royal College of Obstetricians & Gynaecologists

Curriculum 2024 Guide for Special Interest Training Module (SITM): Chronic Pelvic Pain (CPP)

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1. The Chronic Pelvic Pain SITM

This SITM is aimed at learners with an interest in management of chronic pelvic pain. Learners who undertake this SITM will learn how to facilitate appropriate investigation and management of women presenting with chronic pelvic pain. Throughout the SITM, learners will develop the skills and knowledge to make appropriate diagnosis and institute effective management, which will in turn improve the patient's quality of life. During training, learners will learn the importance of good history taking, thorough physical examination, understanding different differential diagnoses, instigating appropriate investigations and engaging the multidisciplinary team (MDT) to ensure evidence-based and standardised management.

After completing the SITM, learners will be prepared to set up, run and develop a multidisciplinary pelvic pain service.

As a learner progresses through the SITM, they will learn how to handle a variety of diagnostic and treatment situations. Learners will also participate in educational events to further develop their training.

Throughout training, learners will need to reflect on whether a project has gone well, learn from positive and negative experiences, and use this to improve their own skills.

Before signing off on this SITM, the Educational Supervisor will decide the level of supervision required for each Chronic Pelvic Pain (CPP) Capability in Practice (CiP), and whether this has been met. More detail is provided in Section 5 of the Special Interest Training Definitive Document.

2. Design of the SITM

The CPP 2024 SITM is made up of three CCP CiPs. If undertaking the module full time, it is expected to take 12–18 months. However, this timeframe is indicative as training is entirely competency based.

Learners must complete a minimum of two SITMs to obtain a certificate of completion of training (CCT). They can undertake any obstetrics or gynaecology SITM as their second SITM, depending on whether they are aspiring to a combined obstetrics and gynaecology or gynaecology-only special interest post.

Here is the GMC-approved CCP SITM:

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3. Capabilities in Practice (CiPs)

CCP CiP 1: The doctor can assess the patient with CPP.	
Key skills	**Descriptors**
Takes history and performs an appropriate clinical examination	• Takes a detailed history with a focus on pain history, pain burden, pelvic pain comorbidities, non-pain comorbidities and bladder and bowel function. • Has the ability to sensitively take a history to identify psychological or social triggers. • Can respond to and discuss sensitively any trauma history that may be revealed. • Understands the usefulness and limitations of validated tools to assess pain and other symptoms. • Trying to explain the difficulty of communicating with patients who have a chronic condition with no answers. • Carries out a general assessment, musculoskeletal and neurosensory assessment, external vulvovestibular and neurosensory assessment, and internal single-digit musculoskeletal assessment. • Understands when it is inappropriate to perform internal examination and to defer this until a subsequent appointment.
Is able to appropriately investigate women and people with CPP	• Demonstrates a clear understanding of the differential diagnoses associated with CPP. • Recognises that there is a lack of evidence to support the diagnosis of pelvic congestion syndrome (PCS) as a cause of CPP. • Demonstrates a clear understanding of the mechanisms that can generate and maintain CPP and can explain these in an understandable and sensitive manner. • Is able to arrange appropriate investigations and understands their strengths and limitations. • Understands when laparoscopy is appropriate, and is able to counsel the patient accordingly, including about possible findings and their significance. • Recognises the red flag symptoms that warrant repeat investigations. • Understands that repeated investigations in the

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	absence of red flag symptoms can perpetuate a "medical model". • Recognises that diagnoses can co-exist. • Recognises that, in many cases, structural pathology that could account for pain, may not be found through investigating chronic pelvic pain syndrome (CPPS). • Understands that when a clear pathology cannot be identified, the pain should still be considered as real. • Understands that, in cases in which examination and pelvic imaging does not reveal an organic cause for the pain, it is acceptable to start pain management and/or hormonal suppression, before laparoscopy.
Is able to diagnose and appropriately investigate CPP in transgender men	• Recognises that pelvic pain in transgender men can be a clinical challenge and has a broad differential diagnosis. • Considers that medical aetiologies include: atrophic vaginitis, cervicitis, adhesions and post-surgical sequelae. • Can appreciate that associated factors to consider include: depression, history of emotional trauma and post-traumatic stress disorder. • Understands that the use of testosterone has a dose dependent effect on vaginal tissue and induces a hypoestrogenic state. This promotes atrophy and can increase the vaginal pH and risk of vaginitis and cervicitis. • Recognises that transgender men may have decreased access to or utilisation of screening and treatment. • Appreciates that prior surgery may cause adhesions, bladder dysfunction, or nerve injury, which may contribute to pain. • Appreciates that a genotypic female skeleton and increased muscle mass, caused by testosterone therapy, may result in changes in postural carriage and contribute to pain.

Evidence to inform decision – examples of evidence (not mandatory requirements)	
• Reflective practice • Attendance at pelvic pain clinics • Attendance at chronic pain clinics +/- MDTs • Attendance at endometriosis clinics +/- MDTs • Attendance at urology and/or urogynaecology clinics • Attendance at a mesh centre/mesh centre MDT	• Local and deanery teaching • RCOG e-learning • Attendance at relevant courses • NOTSS

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• Attendance at gastroenterology clinics • Attendance at rheumatology clinics • Attendance at appropriate neurology clinics (e.g. headache, neuropathy) • Attendance at vulval dermatology clinics • Attendance at menopause clinic	• Team observation (including supervisor observation) • Mini-CEX • CbD

Mandatory requirements

No mandatory evidence

Knowledge criteria

- The concept of pain burden
- Causes of pelvic pain co-morbidities
- Causes of non-pain morbidities
- Differential diagnoses associated with chronic pelvic pain, including
    - Ongoing pathology and/or tissue damage
    - Peripheral and central sensitisation
    - Myofascial dysfunction
    - Visceral hypersensitivity
    - Viscero-visceral and viscerosomatic referral
    - Musculoskeletal dysfunction including deconditioning
    - Psychological factors
    - Trauma and other adverse childhood events (ACEs)

CPP CiP 2: The doctor can counsel and instigate/describe treatments for CPP.	
Key skills	**Descriptors**
Understands the key principles to managing CPP	• Understands and can convey to the patient the concepts of restoration of function and reduction in the burden of pain. • Demonstrates understanding that management of CPP often requires several visits, long-term follow-up, and the involvement of the multi-disciplinary team. • Management of chronic pelvic pain requires patient engagement with this multidisciplinary approach. • Appreciates that becoming too focused on disease or investigations can delay therapy for pain and be counterproductive. • Recognises that pain management should focus on all biopsychosocial factors known to affect the severity of and recovery from pain, including sleep and mood. • Recognises that the relationship between trauma, abuse, and mental health and CPP is complex.

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	• Understands psychoeducation about pain mechanisms is a key component of pain management and facilitates patients to engage with this. • Recognises that condition-specific interventions should be combined with adjuvant therapies addressing anxiety, depression, sleep, fatigue and sexual dysfunction when needed. • Recognises that condition-specific interventions need to be combined with pelvic floor physiotherapy to address myofascial pain when musculoskeletal factors contribute to CPP. • Recognises (and can diagnose and manage) CPP after the menopause. • Recognises the importance of empowering patients. • Understands that there is limited evidence for treatments for CPP specifically. • Recognises and manages pain flares e.g. using 'rescue packages'.
Recognises and manages endometriosis	• Understands the indication for, and gives advice about, using hormonal treatments for CPP. • Recognises the need for diagnostic laparoscopy and surgical treatment. • Is aware of the limited evidence for other treatments for endometriosis-associated pain. • Recognises the need for referral to an endometriosis specialist, including referral for MDT. • Understands that endometriosis can coexist with other pain generating and maintaining factors. • Can sensitively explain the need to focus on other pain generating/maintaining factors while acknowledging the role endometriosis plays as a predisposing or perpetuating factor in the chronic pain cycle. • Understands the value to patients of feeling part of a supportive community. • Understands the value of hormonal treatment to help with CPP, even if endometriosis is not present.
Recognises and manages adenomyosis	• Understands the benefits/limitations of pelvic ultrasound and magnetic resonance imaging (MRI) in the diagnosis of adenomyosis. • Understands the indication for, and gives advice about, using hormonal treatment for CPP (see the above section).

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Recognises and manages irritable bowel syndrome (IBS)	• Initiates appropriate treatment for constipation and diarrhoea. • Understands the role of viscero-visceral referral in generating IBS-like symptoms. Plus the value of treating bowel symptoms to reduce viscero-visceral and viscero-somatic referral.
Recognises and manages bladder pain syndrome/interstitial cystitis	• Recognises the limitations in the diagnostic tools used to exclude UTIs and is able to take a detailed history of recurrent infections and liaise with an appropriate specialist to treat/manage chronic infection. • Understands that voiding problems may be related to pelvic floor dysfunction and can distinguish between retention and sensory/pelvic floor dysfunction. • Understands the role of viscero-visceral referral in generating BPS-like symptoms. Plus the value of treating bladder symptoms to reduce viscero-visceral and viscero-somatic referral. • Is able to appreciate the indications and limitations of investigations of the urinary tract, such as cystoscopy, **computerised tomography** (CT) scan/MRI/ultrasound scan (USS) kidney ureters and bladder (KUB)/urodynamics and when onward referral to specialist urogynaecology services is needed. • Appreciates the evidence for the use of local oestrogens/HRT for bladder pain/bladder syndromes.
Recognises and manages myofascial dysfunction	• Understands that myofascial dysfunction may be localised (e.g. pelvic floor) or widespread (e.g. chronic widespread pain). • Recognises the components of the history that make myofascial dysfunction likely. • Understands that myofascial dysfunction may be primary. • Appreciates that Kegel-type pelvic floor exercises are likely to exacerbate pelvic floor dysfunction and can counsel appropriately. • Can adequately describe their findings on musculoskeletal examination and make a referral to specialist physiotherapy. • Is familiar with current diagnostic criteria for fibromyalgia and can refer appropriately to local services to confirm this diagnosis, if suspected. • Is familiar with the presentation of inflammatory arthropathies (e.g. rheumatoid arthritis and psoriatic

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	arthritis) and can refer appropriately to rheumatology for investigation and management.
Recognises and manages CPPS	• Understands the limited evidence supporting the use of medication in CPPS and the importance of counselling when suggesting these medications. • Understands the indication for, and counsels people about, using analgesic treatments. • Considers side effects of medication and appropriate treatment.
Recognises and manages pain from vulvovestibular syndromes	• Counsels patients about what treatment options are available, including a multidisciplinary approach. • Counsels patients on what drugs are available for managing pain, as well as the effectiveness, side effects and complications of treatment. • Manages vulvodynia subgroups, including poor responders to treatment.
Recognises and manages chronic post-surgical pain	• Understands that chronic post-surgical pain is relatively common. • Is aware that multiple mechanisms can contribute to chronic post-surgical pain. • Understands the risk factors for chronic post-surgical pain and can discuss these sensitively with patients. • Is aware of, and can communicate to patients, the expectations of further surgical management for post-operative pain and its limitations. • Can arrange initial management of chronic post-surgical pain and appropriate referrals. For example, to chronic pain clinic and mesh centre.
Recognises and manages chronic pain in obstetrics	• Is aware that pregnancy-induced biomechanical, hormonal, and vascular changes can give rise to a wide variety of musculoskeletal problems. • Understands the limits of pain management approaches in pregnancy and the benefits of a multidisciplinary approach. • Is aware of strategies to prevent perineal trauma in the antenatal and intrapartum period and their limitations. Plus the importance of information sharing with pregnant people about perineal trauma. • Understands the limited role of perineal refashioning procedures for pain management. • Is aware that evidence to support interventions to alleviate postpartum pain is sparse.

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	• Can appreciate the risks associated with postpartum pain. • Understands the use of pharmacological methods of pain management to support breastfeeding. • Appreciates that postpartum pain can have an impact on someone's sexual function, micturition and defecation and is able to refer to appropriate services to manage this. • Understands that a hypooestrogenic state, postpartum and during breastfeeding, can contribute to persistent vulval/vaginal symptoms.
Is able to recommend or prescribe appropriate analgesics, including co-analgesics	• Understands the World Health Organization (WHO) Analgesic Ladder. • Can discuss the pros and cons of pharmacological management in the context of an MDT approach. • Understands the risks of opioids and that they should not be routinely started for CPP. • Understands harm reduction strategies if opioids are deemed necessary. • Understands the limited evidence in CPP specifically for other analgesics/co-analgesics and is able to discuss their value in other chronic pain conditions. • Is aware of the dependence, addictive and abuse potential of gabapentinoids drugs. • Can describe the side effect profile of each class of co-analgesics to facilitate patient choice. • Understands regimes for starting and stopping co-analgesics and appropriate intervals for reviewing their efficacy and side effect profile. • Realises the benefit of treating other chronic pain conditions in reducing someone's overall pain burden and can refer, as appropriate, to other specialties and work with primary care to make sure there is coordinated care.
Ability to describe the role of physiotherapy in the multidisciplinary treatment of CPP (and understand when to refer)	• Recognises that more than 70% of women with pelvic pain have a musculoskeletal component to their pain. • Understands the role of interventions aimed at this component.
Ability to describe the role of psychology in the multidisciplinary treatment of CPP (and understand when to refer)	• Understands the importance of addressing beliefs and help with reframing them. • Understands the importance of increasing engagement in valued activities. • Awareness of specific therapies and coping strategies.

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	• Adjusting to life with pain (use of pain imagery).
Understands the role of lifestyle factors in CPP and can counsel appropriately	• Demonstrates awareness of the role of lifestyle factors in chronic pain. • Can discuss lifestyle factors sensitively without making the patient feel dismissed or blamed. • Is able to signpost to resources to facilitate lifestyle improvements. • Understands the value of patient support groups and can point to specific resources, as required.
Understands the role of procedural interventions e.g. nerve blocks	• Understands that interventional techniques involving nerve blocks target the specific nerves and pathways involved in pain transmission. • Aware that nerve blocks may be performed for diagnosis, pain relief or both (usually under imaging). • Awareness of the role of sympathetic nerve blocks, somatic nerve blocks, trigger point injections and neuromodulation with nerve root or spinal cord stimulators in CPP management. • Can discuss the limited evidence for the above interventions these in CPP specifically and the potential side effects of altered visceral functions, as appropriate.
Has an understanding of the ethics of pain management	• Pain as a public health problem. • The right to receive treatment for pain. • Gender bias in accessing treatment for pain.

Evidence to inform decision – examples of evidence (not mandatory requirements)	
• Reflective practice • Attendance at pelvic pain clinics • Attendance at chronic pain clinics +/- MDTs • Attendance at endometriosis clinics +/- MDTs • Attendance at urology and/or urogynaecology clinics • Attendance at gastroenterology clinics • Attendance at rheumatology clinics • Attendance at appropriate neurology clinics (e.g. headache, neuropathy) • Attendance at vulval dermatology clinics • Attendance at women's health physiotherapy sessions with relevant case mix	• Attendance at psychological therapy sessions with a relevant mix of patients and/or attendance at psychosexual study day or Balint groups • Attend menopause clinic • Local and deanery teaching • RCOG Learning • Attendance at professional courses • NOTSS • Team observation (including supervisor observation) • Mini-CEX • CbD

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Mandatory requirements	
No mandatory evidence	
Knowledge criteria	

- Understands the basic principles of managing CPP
- Can manage an acute flare of CPP
- Knows the clinical and diagnostic presentations of a range of contributors to pelvic pain, and how to manage them, including:
    - endometriosis and adenomyosis
    - irritable bowel syndrome
    - bladder pain syndrome/interstitial cystitis
    - myofascial dysfunction
    - CPPS
    - vulvovestibular pain syndromes
    - chronic post-surgical pain
    - antenatal and post-partum pain
    - analgesics ladders and the role of co-analgesics
- Understands the role of lifestyle factors in chronic pain
- Recognises the role of physiotherapy and psychology in CPP management
- Knows of coping strategies that can be recommended, including:
    - cognitive behavioural therapy / acceptance and commitment therapy
    - challenging unhelpful thoughts linked to difficulty
    - relaxation
    - mindfulness
- Basic knowledge of the role of procedural interventions in managing CPP
- Knows the full range of targeted treatment strategies for the musculoskeletal components of pain, including:
    - postural exercises
    - breathing release techniques
    - pelvic floor manual therapy
    - TENS
    - myofascial trigger point therapy
    - dry needling
    - connective tissue manipulation
- Understands the ethics of managing pain

CPP CiP 3: The doctor has the communication and governance skills to set up, run and develop a multidisciplinary pelvic pain service.	
Key skills	**Descriptors**

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Demonstrates service development	• Liaises with management. • Has an understanding of financial considerations. • Participates in clinical governance experience. • Demonstrates involvement in quality improvement. • Can collect and analyse data about outcomes.
Is able to be part of a multidisciplinary team	• Liaises effectively with colleagues in other disciplines aligned to CPP (including, primary care, specialist nurses, gynaecology, pain management, gastroenterology, urology/urogynaecology, physiotherapy and psychology). • Recognises the impact of caring for patients with chronic conditions and/or traumatic pasts on both themselves and the other members of the team. • Is able to signpost other members of the team to sources of psychological support and to engage with support and wellbeing opportunities themselves.
Develops clinical guidelines and patient information	• Is aware of available sources of written and web-based information. • Designs or adapts patient information for local use and understands local process. • Participates in writing protocols, clinical pathways, developing services and evidence-based guidelines. • Establishes and/or enhances local clinical pathways. • Supports the alignment of their pelvic pain service to the national standards on CPP.

Evidence to inform decision – examples of evidence (not mandatory requirements)	
• Reflective practice • Meeting attendance and membership of one or more of the following – British Pain Society, World Congress on Abdominal and Pelvic Pain (WCAPP), European Pain Federation (EFIC), International Association for the Study of Pain (IASP), International Pelvic Pain Society (IPPS) • TO2 (including SO) • Mini-CEX • CbD	• RCOG Learning • Leadership questionnaire • Quality improvement project • Develops and enhances local clinical pathways • Attendance and presentation at chronic pain MDTs • NOTSS

Mandatory requirements
No mandatory evidence

Knowledge criteria
• NHS service requirements and local procedures for service development/improvement

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- Clinical governance issues in pelvic pain services
- The importance of the pelvic pain MDT and the different skills across different disciplines and roles, including:
    - primary care
    - specialist nurses
    - gynaecology
    - pain management
    - gastroenterology
    - urology/urogynaecology
    - physiotherapy
    - psychology
- National guidance on CPP
- The role of guidelines audit (including the analysis of workload) and how this influences practice
- The principles underlying evidence-based guidelines and audit and how they relate to outcomes for patients with CPP

4. GMC Generic Professional Capabilities (GMCs)

The key skills in the CCP CiPs also map to a variety of generic professional capabilities (GPCs). When providing evidence of their progress in this SITM, learners should make sure that it also displays progress/capability in the GMC GPCs, such as dealing with complexity, teamwork and leadership, and knowledge of patient safety issues.

Mapping to the GPCs
Domain 1: Professional values and behaviours
Domain 2: Professional skills
Domain 3: Professional knowledge
Domain 4: Capabilities in health promotion and illness prevention
Domain 5: Capabilities in leadership and team-working
Domain 6: Capabilities in patient safety and quality improvement
Domain 7: Capabilities in safeguarding vulnerable groups
Domain 8: Capabilities in education and training
Domain 9: Capabilities in research and scholarship

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Learners can expect to be assessed on their wider skills as a medical professional, their skills in leadership and teamwork, and their level of clinical competence. Evidence showing progress in these areas will result in the learner progressing through the SITM.

To help learners and Educational Supervisors determine what acceptable progress looks like, there is a Statement of Expectations for each CCP CiP.

	Statement of Expectations for the CCP SITM
Meeting expectations for the CPP CiP1	Learners are meeting expectations and can independently obtain relevant history, conduct appropriate examination, instigate appropriate investigations, consider differential diagnoses, provide evidence-based explanation of aetiology, institute appropriate treatment and support women during the evaluation.
Meeting expectations for the CPP CiP2	Learners are meeting expectations and demonstrate a clear understanding of management of differential diagnoses of CPP, and the role and involvement of the relevant MDT.
Meeting expectations for the CPP CiP3	Learners are meeting expectations and are able to demonstrate and communicate a clinical governance skill set, to set up an effective CPP service with robust involvement of the MDT.

The CiP knowledge criteria show the processes/frameworks a learner should understand and the clinical knowledge they must have if they want to provide care for women presenting with chronic pelvic pain. This is more in-depth than the knowledge base expected for the MRCOG. The key skills and descriptors outline the expected learning outcomes for the SITM. However, learners will not experience the entire range of possible scenarios during their training for this SITM; therefore, after completing the module they should continue their learning and skill development through their independent practice and at MDT meetings.

5. Procedures associated with the CCP CiPs

The procedures required to complete this SITM are listed below. A learner can show progress in these procedures through OSATS, procedure logs, and other forms of evidence.

If a procedure is marked with *, the learner will require three summative competent OSATS to demonstrate the level of competency needed to complete the SITM.

Procedures	Level by end of training	CiP1	CiP2	CiP3
Cystoscopy	1	X		
Imaging guided nerve blocks	1	X		

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Pudendal nerve block	1		X	

The 'level by end of training' corresponds to the levels of entrustability defined in Section 5.4 of the Special Interest Training Definitive Document. Level 5 indicates that a learner should be able to perform the procedure independently.

OSATS are not assigned a level of entrustability, rather they are assessed as being *competent* or *working toward competence.* The entrustability levels here are given to guide the assessor in judging whether the learner has reached the required degree of independence at the end of training.

6. Evidence required

As learners progress through SITM training, they are expected to collect evidence that demonstrates development and acquisition of the key skills, procedures and knowledge. This evidence will be reviewed by the SITM Educational Supervisor when they are making their assessment for each CiP. Examples of types of evidence a learner may use to show progress in the SITM are given below. **Please note that this list shows possible, not mandatory, types of evidence** (see Section 5.6 in the Special Interest Training Definitive Document for more detail).

If workplace-based assessments are listed, then at least one must be presented as evidence. The emphasis should be firmly on the **quality** of evidence, not the quantity.

• Objective Structured Assessment of Technical Skills (OSATS) **(mandatory)**	• Local, Deanery and National Teaching
• Case-based discussions	• RCOG (and other) eLearning
• Mini-Clinical Evaluation Exercise (Mini-CEX)	• Attendance at relevant conferences and courses
• Discussion of correspondence (Mini-CEX)	• Procedural log
• Reflective practice	• Case log
• Team observation (TO2), including self-observation	• Case presentations
• NOTSS	• Quality improvement activity

The table below may be useful for learners to see whether a specific workplace-based assessment can be used as evidence of progress in a specific CCP CiP:

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CPP CiP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor can assess the patient with CPP.		X	X	X	X	X
2: The doctor can counsel and instigate/describe treatments for CPP.	X	X		X	X	X
3: The doctor has the communication and governance skills to set up, run and develop a multidisciplinary pelvic pain service.		X	X	X	X	X

7. Career guidance

Learners can only undertake two SITMs at any one time, and a minimum of two SITMs are required to obtain a CCT in obstetrics and gynaecology. Learners can undertake any obstetrics or gynaecology SITM with the CPP SITM. The choice of second SITM depends on whether a learner is aspiring to a combined obstetrics and gynaecology or gynaecology-only special interest career. However, this will also depend on the training opportunities available for their chosen SITMs.

For further career advice, learners should have a discussion with their SITM Director.

8. Further resources

The further resources listed below can be found on the RCOG Curriculum 2024 webpages:

- Essential Curriculum Guide

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- Special Interest Training Definitive Document (containing the 2024 curricula for SITMs and SIPMs)
- The British Pain Society (BPS)
- International Association for the Study of Pain (IASP)
- European Pain Federation (EFIC)
- International Pelvic Pain Society (IPPS)

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Find out more at

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