SITM: CHRONIC PELVIC PAIN (CPP)

SECTION 1: CAPABILITIES IN PRACTICE

CCP CiP 1: The doctor can assess the patient with chronic pelvic pain	
Key Skills	**Descriptors**
Takes history and performs an appropriate clinical examination	• Takes a detailed history with a focus on pain history (including pain flares), pain burden (e.g. physical, work, social activities, sexual function), pelvic pain comorbidities (e.g. fibromyalgia, migraine) and non-pain comorbidities (e.g. sleep, mood) as well as relevant assessments of bladder and bowel function (e.g. difficulty starting stream, repeat voiding, "constipation" with soft stool etc). • Understands the utility and limitations of validated tools to assess pain and other symptoms. • Focuses on good patient communication. • 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. • 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 when it may be preferable to defer this until a subsequent appointment.

Is able to appropriately investigate women with chronic pelvic pain	• Demonstrates a clear understanding of the differential diagnoses associated with chronic pelvic pain
	  ○ endometriosis/adenomyosis
	  ○ irritable bowel syndrome
	  ○ bladder pain syndrome
	  ○ myofascial dysfunction
	  ○ neuralgias (e.g. pudendal nerve)
	  ○ post-operative and post-natal pain (including adhesions, mesh)
	  ○ chronic/recurrent UTIs
	  ○ pain persisting after successful treatment of gynaecological/pelvic cancers
	• Recognises that there is a lack of evidence to support the diagnosis of pelvic congestion syndrome as a cause of chronic

	pelvic pain.
	• Demonstrates a clear understanding of the mechanisms that can generate and maintain chronic pelvic pain and can explain these in an understandable and sensitive manner
	  ○ Ongoing pathology and/or tissue damage
	  ○ Peripheral and central sensitisation
	  ○ Viscero-visceral and viscerosomatic referral
	  ○ Musculoskeletal dysfunction including deconditioning
	  ○ Psychological factors
	  ○ Trauma and other adverse childhood events (ACEs)
	• Is able to arrange appropriate investigations and understands their strengths and limitations.
	  ○ Urine dipstick/culture
	  ○ STI screen
	  ○ ultrasound (abdominal, transvaginal, endoanal, translabial)
	  ○ Pelvic MRI
	  ○ Laparoscopy
	  ○ Cystoscopy
	  ○ Sigmoidoscopy
	• 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 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 is not found (‘chronic pelvic pain syndrome’).
	• 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 chronic pelvic pain 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, 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 which promotes atrophy and can increase the vaginal pH and increase the risk of vaginitis and cervicitis. • Recognises that transgender men may have decreased access to or utilization 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 secondary to testosterone therapy may result in changes in postural carriage and contribute to pain.

Evidence to inform decision

• 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 • Attendance at gastroenterology clinics • Attendance at rheumatology clinics • Attendance at appropriate neurology clinics (e.g. headache, neuropathy) • Attendance at vulval dermatology clinics • Attend menopause clinic	• Local and Deanery Teaching • RCOG e-learning • Attendance at course • NOTSS • Team Observation (including Supervisor Observation) • Mini-CEX • CbD

Knowledge criteria

- Ability to take a history and perform an appropriate clinical examination
- Ability to diagnose women with chronic pelvic pain
- Ability to assess an acute flare of chronic pelvic pain
- Ability to take a history and perform an appropriate clinical examination in transgender men

CPP CiP 2: The doctor can counsel and instigate / describe treatments for chronic pelvic pain	
Key Skills	**Descriptors**
Understands the key principles to managing chronic pelvic pain	• Understands and can convey to the patient that pain management does not mean learning to live with the pain but is a process that includes restoration of function in line with reducing the burden of pain and that frequently this leads to a

	reduction in pain intensity. • Demonstrates understanding that management of chronic pelvic pain often requires several visits, long-term follow-up, and interaction with multiple clinicians (including primary care, specialist nurses, gynaecology, pain management, gastroenterology, urology, physiotherapy, and psychology) and that patients need to engage with this model. • Appreciates that becoming too focused on disease or investigations can delay therapy for pain and can be counterproductive. • Recognises that pain management should focus on all biopsychosocial factors known to affect pain severity and recovery, including sleep and mood. • Recognises that the relationship between trauma, abuse, and poor mental health and chronic pelvic pain is complex. • Understands psychoeducation about pain mechanisms is a key component of pain management and facilitates patient engagement. • Recognises that condition-specific interventions be combined with adjuvant therapies addressing anxiety, depression, sleep, fatigue and sexual dysfunction when needed. • Recognises that condition-specific interventions be combined with pelvic floor physiotherapy to address myofascial pain when musculoskeletal factors contribute to chronic pelvic pain. • Recognises (and can diagnose/manage) chronic pelvic pain after the menopause. • Recognises the importance of empowering the patient. • Understands that there is limited evidence for treatments for chronic pelvic pain specifically (and that most approaches only have evidence for chronic pain in general). • Recognises and manages pain flares e.g. use of 'rescue packages'.

Recognises and manages endometriosis	• Understands the indication for and counsels regarding use of hormonal treatment including
	  ○ Progestogens
	  ○ COCP
	  ○ Intrauterine systems
	  ○ GnRH +/- HRT (in particular, counsel about bone health and cardiovascular risk)
	• 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 endometriosis specialist including referral for MDT.

	• Understands that endometriosis can coexist with other pain generating and maintaining factors including peripheral and central sensitisation, visceral hypersensitivity and myofascial dysfunction. • Can sensitively explain the need to focus on other pain generating/maintaining factors whilst 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 support community. • Understands the value of hormonal therapies even if endometriosis not present.
Recognises and manages adenomyosis	• Understands the benefits/limitations of pelvic ultrasound and MRI in the diagnosis of adenomyosis. • Understands the indication for and counsels regarding use of hormonal treatment (see section above).
Recognises and manages irritable bowel syndrome	• Initiate appropriate treatment for constipation and diarrhoea. • Understands the role of viscero-visceral referral in generating IBS-like symptoms and 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 urinary tract infection 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 and 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, CT/MRI/USS KUB/urodynamics and when onward referral to specialist urogynaecology services is indicated. • 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 but can

	also occur secondary to pain and altered function/deconditioning and is able to explain this sensitively to the patient. • 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, psoriatic arthritis etc) and can refer appropriately to Rheumatology for investigation and management.

Recognises and manages chronic pelvic pain syndrome	• 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 regarding use of analgesic treatments including
	  ○ simple analgesia
	  ○ opioids
	  ○ co-analgesics (as below)
	• Considers side effects of medication and appropriate treatment.

Recognises and manages vulvovestibular pain syndromes	• Counsels on treatment options available including the multidisciplinary approach. • Counsels on the available drugs for pain management, 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 in association with both laparoscopy, laparotomy and mesh insertion. • Is aware that multiple mechanisms can contribute to chronic post-surgical pain including peripheral and central sensitisation, nerve entrapment and myofascial dysfunction. • Understands the risk factors for chronic post-surgical pain and can discuss these sensitively, highlighting where management of these factors before further surgical treatment may be helpful. • 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 arrange appropriate referrals to e.g. chronic pain clinic, mesh centre etc.
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 including SPD, lower back pain and carpal tunnel syndrome. • Understands the limits of pain management approaches in pregnancy and the benefits of a multidisciplinary approach. • Understands that managing pre-existing chronic pain during pregnancy can be complex and requires a multidisciplinary approach to mitigate any risk of delivery and risk to the fetus. • Is aware of strategies to prevent perineal trauma in the antenatal and intrapartum period and their limitations and the importance of information sharing with pregnant women about perineal trauma • Is aware that evidence to support interventions to alleviate postpartum pain is sparse. • Can appreciate that post-partum pain can interfere with maternal-newborn bonding and feeding and, by impeding mobility, can increase the risk of postpartum complications. • Understands the use of pharmacological methods of pain management with regards to breast feeding. • Understands that assisted vaginal delivery, episiotomy, and obstetric lacerations are associated with an increased likelihood of perineal/vaginal pain. • Appreciates that Postpartum pain can impact a woman's sexual function, micturition and defecation and is able to refer to appropriate services for management. • Understands that a hypo-oestrogenic state post-partum and during breast feeding can contribute to persistent vulval/vaginal symptoms and is able to use vaginal oestrogens appropriately. • Understands the limited role of perineal re-fashioning procedures for pain management.

Is able to recommend or prescribe appropriate analgesics including co-analgesics	• Understands the WHO analgesic ladder.
	• Can discuss the pros and cons of pharmacological management in the context of an MDT approach.
	• Understands that opioids should not be routinely started for CPP and that specialist support may be required to withdraw long-term opioids.
	• Understands the risks associated with opioids:
	  ○ Constipation
	  ○ Dependence
	  ○ Endocrinopathy

	○ Opioid induced hyperalgesia ○ Addiction/abuse • Understands that if opioid prescription is considered necessary this should only be under appropriate supervision due to the current thinking/evidence on opioid use/abuse. • 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 the gabapentinoids. • Can describe the side effect profile of each class of co-analagesics to facilitate patient choice. • Understands regimes for starting and stopping co-analgesics and appropriate intervals for reviewing efficacy and side effect profile. • Realises the benefit of treating other chronic pain conditions in reducing overall pain burden and can refer as appropriate to other specialties (e.g. rheumatology, gastroenterology, neurology) and work with primary care to ensure coordinated care.
Ability to describe role of physiotherapy in the multidisciplinary treatment of chronic pelvic pain (and understand when to refer)	• Recognises >70% women with pelvic pain have a musculoskeletal component to their pain. • Understands the role of ○ Postural exercises ○ Breathing release techniques ○ Pelvic floor manual therapy ○ Myofascial trigger point therapy ○ Dry needling ○ Connective tissue manipulation • Transcutaneous electrical nerve stimulator (TENS)
Ability to describe role of psychology in the multidisciplinary treatment of chronic pelvic pain (and understand when to refer)	• Understands the importance of addressing beliefs and help with reframing them e.g. education about pain mechanisms and dealing with the belief that “pain = damage”. • Understands the importance of increasing engagement in valued activities e.g. pacing activities rather than boom/bust pattern of activity. • Awareness of specific coping strategies ○ cognitive behavioural therapy / acceptance and commitment therapy ○ challenging unhelpful thoughts linked to difficulty ○ relaxation ○ mindfulness • adjusting to life with pain (use of pain imagery)

Understands the role of lifestyle factors in chronic pain 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 aware of resources to facilitate lifestyle improvements:
	  ○ Sleep e.g. sleepio
	  ○ Diet
	  ○ Stress
	  ○ Mindfulness e.g. apps such as Headspace, Calm
	  ○ Exercise e.g. online pilates, yoga
	  ○ Acupuncture
	• 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 with the aim of interrupting these nerve pathways. • 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 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 access to treatment for pain.

Evidence to inform decision	
• 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 psychological therapy sessions with relevant case mix and/or attendance at psychosexual study day or Balint groups • Attend menopause clinic • Local and Deanery Teaching • RCOG eLearning • Attendance at course • NOTSS • Team Observation (including Supervisor Observation) • Mini-CEX • CbD

• Attendance at women's health physiotherapy sessions with relevant case mix	

Knowledge criteria

- Understands the basic principles of the management of chronic pelvic pain
- Ability to manage an acute flare of chronic pelvic pain
- Recognises and manages endometriosis and adenomyosis
- Recognises and manages irritable bowel syndrome
- Recognises and manages bladder pain syndrome / interstitial cystitis
- Recognises and manages myofascial dysfunction
- Recognises and manages chronic pelvic pain syndrome
- Recognises and manages vulvovestibular pain syndromes
- Recognises and manages chronic post-surgical pain
- Recognises and manages antenatal and post-partum pain
- Ability to recommend or prescribe appropriate analgesics including co-analgesics
- Ability to recommend physiotherapy in CPP management
- Ability to recommend psychology in CPP management
- Understands the role of lifestyle factors in chronic pain and can counsel appropriately
- Basic knowledge of the role of procedural interventions in CPP management
- Understanding of ethics of pain management

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**
Demonstrates service development	• Liaises with management. • Has an understanding of financial considerations. • Participates in clinical governance experience. • Demonstrates involvement in quality improvement. • Is able to undertake data analysis and collection related to 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 both written and web-based information. • Designs or adapts patient information for local use and understands local process. • Participates in writing protocols, clinical pathways, service development and evidence-based guidelines. • Establishes and/or enhances local clinical pathways. • Supports alignment of the pelvic pain service to the national standards on CPP.

Evidence to inform decision

• Reflective practice • Meeting attendance and membership of one or more of the following - British pain Society, WCAPP, EFIC, IASP, IPPS • TO2 (including SO) • Mini-CEX • CbD	• RCOG eLearning • Leadership questionnaire • Quality improvement project • Develops, enhances local clinical pathways • Attendance and presentation at chronic pain MDTs • NOTSS

Knowledge criteria

- NHS service requirements and local procedures for service development / improvement.
- Clinical governance issues in pelvic pain services
- The importance of the pelvic pain multidisciplinary team 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 patient outcome with CPP

SECTION 2: PROCEDURES

Procedures	*Level by end of training*	*CIP*
Imaging e.g. ultrasound, CT, MRI	1	1
Cystoscopy	1	1
Imaging guided nerve blocks	1	1
Pudendal nerve block	1	2

SECTION 3: GMC GENERIC PROFESSIONAL CAPABILITIES

Mapping to GPCs
Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty Domain 3: Professional knowledge • Professional requirements • National legislative structure • The health service and healthcare system in the four countries Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship

SECTION 4: MAPPING OF ASSESSMENTS TO CCP CiPs

CCP CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor can assess a patient with chronic pelvic pain		X	X	X	X	X
2: The doctor can counsel and instigate / describe treatments for chronic pelvic pain		X	X	X	X	X
3: The doctor has the communication		X	X	X	X	X

CCP CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
and governance skills to set up, run and develop a multidisciplinary pelvic pain service						

SECTION 5: RESOURCES (OPTIONAL)

RCOG Pelvic Pain Green-top Guideline
NICE Endometriosis Guideline
NICE Neuropathic Pain Guideline
NICE Management of chronic primary pain guideline
RCOG OASIS Guideline
https://www.fpm.ac.uk/opioids-aware