

Navigating the COVID-19 waters with chronic pelvic pain

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1 | CHRONIC PAIN PATIENTS WERE UNDERSERVED BEFORE THE PANDEMIC

Chronic pelvic pain (CPP) is a common condition defined as pain arising from abdominopelvic structures, typically lasting between 3–6 months and associated with negative cognitive, behavioral, sexual, and emotional consequences, as well as symptoms suggestive of lower urinary tract, sexual, bowel, pelvic floor, myofascial, or gynecological dysfunction.¹ CPP patients often present with multiple conditions that co-occur such as endometriosis, bladder pain syndrome, irritable bowel syndrome, vulvodynia, low back pain, tension headache, and migraine headache to name a few, falling into the spectrum of a concept recently termed “overlapping chronic pain conditions”.² The prevalence of CPP has been compared to the global prevalence of asthma and low back pain; it is estimated to range between 5.7% and 26.6%.³ Like other chronic pain conditions, CPP is influenced by and associated with many psychological and social factors, such as depression, anxiety, post-traumatic stress disorder, substance abuse, catastrophization, hypervigilance, and helplessness.^{4,5} With all these factors evolving around the CPP experience, it is no surprise that patients may have feelings and attitudes leading to social isolation, including: avoiding intimacy; self-isolating from partners; friends, and family; perceptions that others lack understanding about the disease, and a sense of resignation.⁶ It has been well described that patients with specific CPP conditions face obstacles in receiving proper care, as seen in patients with endometriosis who experience a delay of 3.8 years on average between symptom onset and seeking medical care, and a delay in diagnosis ranging from 5–8 years.^{7,8} This can be attributed to several factors, both at patient and healthcare provider level, such as normalization of symptoms, misdiagnosis and reluctance to refer, or inappropriate referrals.⁷ Additionally, the lack of availability of specialized teams with different resources to provide an integral

multimodal, multi- or interdisciplinary approach to CPP patients may lead to delays in diagnosis and treatment.

2 | THE TURBID WATERS OF COVID-19 FOR CPP PATIENTS

The COVID-19 pandemic has forced us to experience significant changes to current healthcare practices. In response to the pandemic, several governmental and institutional policies have been implemented in order to protect patients and staff from acquiring the virus and to allow resources to be readily available to face this problem. Face-to-face visits, office and operative elective procedures have been postponed.^{9,10} This has led to acute needs being prioritized over chronic needs, leaving patients suffering from chronic pain conditions (including CPP patients) with questions about the efficiency and quality of care they will receive. A recent online survey of 2221 people with chronic pain or chronic illness, conducted by Pain News Network, the International Pain Foundation, and the Chronic Pain Association of Canada, explored the perceptions of patients and impact of isolation and social distancing due to the COVID-19 pandemic. With the majority of respondents living in the United States or Canada, almost 70% worried about going to the hospital or a doctor’s office, 60% feared losing access to medication, and almost 50% worried about not being able to see their doctors. Other concerns included contracting the virus, mental health, running out of food or essential supplies, and financial problems.¹¹ CPP patients who have established care with a team of specialists including gynecologists, primary care, physical therapists, and behavioral therapists (to name just a few) are facing these challenges as well. These patients have had to interrupt physical therapy and behavioral health sessions, office procedures (such as trigger point injections, bladder instillations, nerve blocks), and surgical interventions (operative laparoscopies and hysterectomies),

delaying not only therapeutic but also diagnostic interventions. This has affected their access to proper care, leading to increased anxiety, helplessness, and ultimately pain. Patients seeking care for the first time are also facing difficulties in establishing proper care due to these restrictions, leading to further delays in diagnosis and treatment.

3 | HOW TO APPROACH CPP PATIENTS

In order to overcome the limitations arising from these restrictions in providing “regular” care, many considerations have emerged, of which the following can be applied to the CPP population. First, chronic pain patients in general, including CPP patients, might be more susceptible to COVID-19 due to the effect on the immune system from chronic pain itself, opioids, the use of steroids in some specific interventional pain therapies, and the association of chronic pain conditions with multiple comorbidities.¹² These concepts could lead practitioners to act conservatively when treating patients, either with fewer face-to-face appointments or by discontinuing specific office and surgical interventions for the time being. It is important to consider not interrupting the aforementioned services and to carefully evaluate each patient and either use telehealth or arrange for face-to-face appointments only when appropriate (i.e. if the patient has acute pain, for a physical exam, or if the visit/procedure will most likely impact the patient). Practitioners must also follow strict safety measures and local/governmental protocols.¹³ Interrupting these services can lead to more pain and anxiety/stress, leading to immunosuppressive states. We must highlight the fact that long-term use of opioids is not recommended to treat CPP patients, and alternative medications such as NSAIDs, muscle relaxants, gabapentinoids, tricyclic antidepressants, and SNRIs should be considered.¹⁴ Second, many CPP patients present with dysmenorrhea as a primary complaint, and combined hormonal contraceptives (CHC) are frequently used to achieve menstrual suppression. It has been suggested that there is an increased risk of venous thromboembolism (VTE) in patients with severe COVID-19 disease,¹⁵ and this has led to concerns regarding the use of CHC in patients with COVID-19. Currently there are not enough data to indicate that women being treated with CHC who have asymptomatic COVID-19 or mild COVID-19 disease are at a higher risk of VTE; therefore, the decisions regarding the use of these medications should be individualized.¹⁶ Patients with severe COVID-19 disease who are taking CHC will usually have treatment discontinued because they would likely be admitted for hospital care. Overall, it might be worth considering the use of long-acting reversible contraceptives (LARC) or progestin-based medications for hormonal suppression in COVID-19-positive patients.¹⁷ Third, due to the complexity and multifactorial components of CPP, a multidisciplinary approach should be offered to the patient,^{18–20} thus applying trauma-informed care,^{21,22} and a shared decision model using a biopsychosocial approach.^{5,23} If this approach was limited before COVID-19, CPP patients currently face significant obstacles, as do other chronic pain patients. The use of telemedicine and telehealth has been widely adopted, allowing patients to communicate with healthcare providers

across different specialties. Technology could improve access to care and outreach, and also allow implementation of therapies including behavioral therapy, mindfulness, and physical therapy, thus favoring compliance.^{10,12,13} Having an initial conversation with a CPP patient over the phone or virtually could help further develop the patient–healthcare provider relationship without the anxiety, stress, and fears surrounding the need to perform a physical examination. This would enable the healthcare provider to educate the patient about their condition and foster a better understanding of the pathophysiology and treatment modalities. Research looking at the impact of this recent change in approach and the impact on patient behavior, attitudes, response to treatment, and compliance might be of value to support this approach. Fourth, with regard to treatments offered to CPP patients, we should continue to offer a multimodal, multidisciplinary, or interdisciplinary approach. Medications and surgical interventions should be offered as needed; however, complementary and alternative medicine should be considered. As described by Leonardi et al.,²⁴ these therapies include problem-focused (i.e. diet, education, sleep hygiene, exercise) and emotion-focused (i.e. relaxation, mindfulness, acceptance and commitment therapy, adopting a positive attitude) strategies.

4 | LOOKING BEYOND THE PANDEMIC

This pandemic has changed our daily activities and the way we interact as a society, as well as how we approach patients. As healthcare providers treating CPP patients, a vulnerable population, we need to adapt with them and offer—now more than ever—all the tools available to complement their treatment. We hope to see more research conducted on this topic so that we can continue to improve and provide the care they deserve.

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