Classification of Pelvic Pain Syndromes (Alex Digesu) ESSIC, EAU, AUA, IPPS, ICS and IUGA Systems'

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Chronic (also known as persistent) pain is associated with changes in the central nervous system (CNS) that may maintain the perception of pain in the absence of acute injury. These changes may also magnify perception so that nonpainful stimuli are perceived as painful (allodynia) and painful stimuli are perceived as more painful than expected (hyperalgesia). Core muscles (eg, pelvic muscles) may become hyperalgesic with multiple trigger points. Other organs may also become sensitive (eg, the uterus with dyspareunia and dysmenorrhoea or the bowel with irritable bowel symptoms). The changes within the CNS occur throughout the whole neuroaxis. As a consequence, abnormal efferent activity may be the cause of functional changes (eg, irritable bowel symptoms) and structural changes (eg, neurogenic oedema found in some bladder pain syndromes [BPSs]). The central changes may also be responsible for some of the psychological changes, which also modify pain mechanisms in their own right. Basic investigations must be undertaken to rule out ''well-defined'' pathologies. If the results are negative, a well-defined pathology is unlikely. Further investigations should be done only for specific indications (eg, for subdivision of a pain syndrome). The EAU guidelines avoid spurious diagnostic terms that are associated with inappropriate investigations, treatments, and patient expectations and, ultimately, with a worse prognostic outlook [4]. The classification represents the efforts of many groups, and further changes in this classification system are likely (Table 1).

Table 1 is not comprehensive and emphasises mainly the urologic pain syndromes.

Table 1 – European Association of Urology classification of chronic urogenital pain syndromes

Axis I Region	Axis II System	Axis III End organ as pain syndrome as identified from Hx, Ex and Ix		Axis IV Referral characteristics	Axis V Temporal characteristics	Axis VI character	Axis VII Associated symptoms	Axis III Psychological symptoms
Chronic pelvic pain: Pelvic pain syndrome	Urologic	Bladder pain syndrome Urethral pain syndrome Prostate pain syndrome Scrotal pain syndrome Penile pain syndrome endometriosis associated pain syndrome	(See Table 5 on ESSIC classification) Type A inflammatory Type B noninflamatory Testicular pain syndrome Epididymal pain syndrome Post-vasectomy pain syndrome	Suprapubic Inguinal Urethral Penile/clitoral Perineal Rectal Back Buttocks	ONSET Acute Chronic ONGOING Sporadic Cyclical Continuous TIME Filling Emptying Immediate post Late post PROVOKED	Aching Burning Stabbing Electric Other	URINARY Frequency Nocturia Hesitance Poor flow Pis en deux Urge Urgency Incontinence Other GYNAECOLOGICAL e.g., Menstrual SEXUAL e.g., Female dyspareunia impotence Gastrointestinal *** MUSCULAR Hyperalgesia CUTANEOUS Allodynia	ANXIETY About pain or putative cause of apin Other DEPRESSION Attributed to pain/impact of pain Attributed to other causes or unattributed SHAME, GUILT related to disclosed or undisclosed sexual experience/s PTSD SYMPTOMS Reexperiencing Avoidance Hyperarousal MONOSYMPTOMATIC DELUSIONS
	Gynaecologic	Vaginal pain syndrome Vulvar pain syndrome	Generalised vulvar pain syndrome Localised vulvar pain syndrome Vestibular pain syndrome Clitoral pain syndrome					
	Anorectal							
	Neurologic	e.g., Pudendal pain syndrome						
	Muscular							
Non-pelvic pain syndromes	e.g., Neurologic e.g., Urologic	e.g., Pudendal neuralgia						

Hx = History; Ex = Examination; Ix = Investigation; ESSIC = European Society for the Study of IC/PBS; PTSD = posttraumatic stree disorder.

Table 2 defines some terms used in chronic pelvic pain [1,2,5].

Table 2 – Definitions of chronic pelvic pain terms

Terminology	Description
Chronic pelvic pain	Nonmalignant pain perceived in structures related to the pelvis of both males and females. In the case of documented nociceptive pain that becomes chronic, pain must have been continuous or recurrent for at least 6 mo. If nonacute and central sensitisation pain mechanisms are well documented, the pain may be regarded as chronic, irrespective of the time period. In all cases, there are often associated negative cognitive, behavioural, sexual, and emotional consequences [1,2]. Chronic pelvic pain is subdivided into pelvic pain syndromes and non–pelvic pain syndromes.
Pelvic pain syndrome	Persistent or recurrent episodic pelvic pain associated with symptoms suggesting lower urinary tract, sexual, bowel, or gynaecological dysfunction. No proven infection or other obvious pathology [6].
Bladder pain syndrome	Suprapubic pain is related to bladder filling accompanied by other symptoms such as increased daytime and nighttime frequency. No proven urinary infection or other obvious pathology.
Prostate pain syndrome	Persistent or recurrent episodic prostate pain, associated with symptoms suggestive of urinary tract and/or sexual dysfunction. No proven infection or other obvious pathology [1,2]. Definition adapted from the NIH consensus definition and classification of prostatitis [5] and includes conditions described as "chronic pelvic pain syndrome."
Scrotal pain syndrome	Persistent or recurrent episodic scrotal pain associated with symptoms suggestive of urinary tract or sexual dysfunction. No proven epididymoorchitis or other obvious pathology [6].
Pelvic floor muscle pain syndrome	Persistent or recurrent episodic pelvic floor pain with associated trigger points either related to the micturition cycle or associated with symptoms suggestive of urinary tract, bowel, or sexual dysfunction. No proven infection or other obvious pathology [1,2].

NIH = US National Institutes of Health.

3.3. Classification of chronic pelvic pain syndromes The EAU classification of 2004 has been updated to provide a classification related to investigation and further management of the pain syndromes. This allows for a possible overlap of mechanisms between different conditions. It also encourages recognition of overlapping symptoms and treatment by a multidisciplinary approach (Table 1). A physician using the classification in Table 1 should start on the left side of the table and proceed to the right only if he or she can confidently confirm the pain to be perceived in the appropriate system and organ. In many cases, it may not be possible to go further than labelling a condition as a pelvic pain syndrome. For example, in many cases previously described as prostadynia, it may not be possible to state categorically that the pain stems from the prostate and not from other sites (eg, pelvic floor muscles). Such cases are therefore labelled pelvic pain syndrome. The European Society for the Study of IC/PBS (ESSIC) has recently defined the BPS/interstitial cystitis (IC) syndrome, supported by an international consensus editorial [7,8]. As with the EAU system, ESSIC excluded well-defined nonpelvic pain (confusable) conditions. ESSIC has further divided the BPS/IC syndrome according to the results of cystoscopy and biopsy (Table 5).

Table 5 – European Society for the Study of IC/PBS classification of bladder pain syndrome based on cystoscopy with hydrodistension and biopsies*

	Cystoscopy with hydrodistension			
Biopsy	Not done	Normal	Glomerulations (grade 2–3)	Hunner lesions, with/without glomerulations
Not done	XX	1X	2X	3X
Normal	XA	1A	2A	3A
Inconclusive	XB	1B	2B	3B
Positive†	XC	1C	2C	3C

* From van de Merwe et al [8].
† Histology showing inflammatory infiltrates and/or detrusor mastocytosis and/or granulation tissue and/or intrafascicular fibrosis.

The diagnosis and treatment of chronic pelvic pain (CPP) have moved away from targeting a specific organ to multifactorial and multidisciplinary individualized approach to treatment strategies.

Recognition that response to current treatment approach to CPP syndrome is variable; organizations such as the European Association of Urology, American Urologic Association, International Continence Society, International Association for the Study of Pain, and others have integrated the most current evidence and management strategies from multiple specialties (urology, gynecology, pain medicine, gastroenterology, colorectal surgery, neurology,

physiotherapy, and psychology). New classification systems allow for overlap of mechanisms between conditions and a multidisciplinary treatment approach.