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THE INTERNATIONAL PELVIC PAIN SOCIETY

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The President's Perspective

Maurice K. Chung, MD, RPh, FACOG, ACGE

The two things often stated to be guaranteed in life are death and taxes. However, I strongly believe a third is change; it is the manner in which we recognize, embrace and utilize change that leads us to excel. As I look back on this past year and the obstacles that we have overcome, I want to thank the International Pelvic Pain Society board members for their support in weathering the changes that are needed to continue the stability and growth of this organization. As physicians pushing the horizons of the medical field, I am sure we have all faced challenges that, although initially frustrating, made us stronger and more experienced.

I faced such challenges when I began my practice 20 years ago in Lima, OH. In the very early 90s I began diagnosing women who came to me complaining of pelvic pain with endometriosis, and with the techniques I learned from Dr. CamrenNezhat, I treatedthese women by lasering the endometriosis through laparoscopy. However, my colleagues in the local medical community not only did not use Laser, they also did not believe that all these women had endometriosis and demanded that I stop lasering the endometriosis (the standard practice at the time) and excise the endometriosis to confirm its diagnosis by pathology. While the extra scrutiny was unfounded and wearisome, I became a more skilled laparoscopist and can now thank my colleagues that doubted me because excisional laparoscopy later became the better treatment option for endometriosis.

As I continued to perform laparoscopy and excise endometriosis for chronic pelvic pain, I realized that my patients would return to me after a period of time with the same pain I thought I was treating. After much time spent learning from researchers, other physicians and physical therapists, I concluded that many years of medical schooling and subsequent training were not enough to help me provide adequate treatments to help these women. I had to begin thinking "outside of the box" to treat these patients for the pain they were experiencing. First, I noted the overlap in overactive bladder and interstitial cystitis in patients with voiding dysfunction. Then, I found that patients with chronic pelvic pain had endometriosis and interstitial cystitis, a condition I termed the "evil twins." Thus, I see you see, you don't see the IC I see was implemented into my practice. Ten years ago, interstitial cystitis or painful bladder syndrome was not widely recognized and my local medical community often questioned my diagnosis and treatments. Today,

after much campaigning, it is a commonly accepted diagnosis and many women are finding relief for their symptoms. As fulfilling as it was to find a disease that could be treated, I knew that it was not the only explanation for chronic pelvic pain. Currently, my research has shown that pudendal neuralgia is one of the "evil triplets" that should also be considered when patients present with chronic pelvic pain.

I have had many mentors in my career, two of which were the founders of IPPS: James Carter and Paul Perry. In their impactful lives here on earth they made a difference by taking the "road less traveled" and thinking beyond their comfort zone. These pioneers were confronted daily for their non-medical textbook treatments. Yet, at the end of the day, the most important thing was that their patients were improving.

When following this less traveled pathway, I have incurred criticism and doubt from my colleagues. This did not deter me from altering my practice or from seeking out new treatments. I challenge all of us who encounter obstacles and difficult colleagues in all areas of the medical field to first listen to your patients and understand what they are really trying to tell us. Go back to the basics of medical treatment options and think of the human anatomy as a whole with all parts connected to one circuit. It is vitally important for us to open our eyes, ears and mind because "the eye doesn't see what the mind does not know; what the eye doesn't see and the mind doesn't know, doesn't exist." --- Lady Chatterley's Lover - D.H. Lawrence

Message from the 2011 Fall Program Co-Chairs

Georgine Lamvu, MD, MPH, FACOG
Frank Tu, MD, MPH

We were delighted to meet so many new friends as the 2011 IPPS Annual Meeting featured another strong turnout in Las Vegas. IPPS President Dr. Maurice Chung kicked off the meeting with some inspiring comments about his experience overcoming community disbelief in the validity of pelvic pain. Our two memorial speakers - MAPP site lead and gastroenterologist Dr. Emeran Meyer and world-renowned endometriosis surgeon Dr. Charles Koh - gave two inspiring talks bridging the central to peripheral spectrum of pelvic pain. Dr. Meyer spoke as the James E. Carter Memorial Lecturer and discussed his team's work at UCLA on cortical processing of pelvic sensation. Dr. Koh gave the G. Paul Perry Memorial Lecture talk on his vast experience in tackling severe endometriosis surgically.

The program committee is indebted again to the volunteer IPPS members who staffed a fantastic basics course. Two particular highlights of the all-day course were the multidisciplinary talks Dr. Zolnoun's team from North Carolina gave on vulvar and neuropathic pain, and the mindfulness demonstration by Drs Flynn and Fox from Brown University. Dr. As-Sanie's program also included a first ever experts panel where Drs. Chung and Howard and Amy Stein, MPT dissected a case of nerve entrapment "live."

The scientific meeting program heavily emphasized a holistic approach to pelvic pain and really put the spotlight on how the brain influences our interpretation of pelvic pain. We hope talks by Drs. Rapkin, Doggweiler, and Watier brought a lot of optimism

about the role of mind-body targeted therapies. It is refreshing to hear different perspectives at this multidisciplinary meeting, and Dr. Peterson's talk on environmental factors on endometriosis, Dr. Gehrig's practice-focused talk on painful bladder syndrome, and Dr. Findley's talk on fascia are becoming the type of eye-opening lectures IPPS features.

We had our first collaborative Surgical Film Festival Saturday over lunch, which engendered a substantial amount of discussion about surgical management of pelvic congestion syndrome and advanced endometriosis. Thanks to Eric Dastmalchian's team at SURFF for helping to put this together and we are hoping to expand this next year in Chicago!

The poster session had over 30 posters accepted and Brad Fenton, MD, PhD and Kristof Chwalisz, MD, PhD were selected by a panel of judges for the Best Poster Award.

The Physical Therapy Course was, as usual, very well attended. This year's course, Biomechanical Evaluation & Treatment Considerations for Patients with Pelvic Pain, was presented by Jerry Hesch, MHS, PT who provided an extremely informative and practical look at how to assess for joint dysfunction in pelvic girdle disorders.

We look forward to an even more exciting meeting in 2012 in Chicago. The chairs wish to thank Michael Hibner, MD, Sawsan As -Sanie, MD, Amy Stein, MPT, and Stephanie Prendergast, MPT, for their invaluable help in the planning of the entire fall meeting. In addition, we wish to recognize the local chair Dr. Howard Sharp for bringing a strong representation of Mountain/West Coast faculty to the meeting.

SAVE THE DATE!

IPPS 2012 Annual Fall Meeting
October 18 - 22, 2012
The Palmer House Hilton
Chicago, Illinois
http://pelvicpain.org/index.asp

2011 IPPS Annual Meeting - Poster Abstract Winners

Evaluating Multiple Clinical Measures in Chronic Pelvic Pain: Using Factor Analysis to Simplify Pain Assessment
Bradford Fenton, MD, PhD; Vivian VonGruenigen, MD
Summa Health System
Presented By: Bradford Fenton, MD, PhD

Objective: Patients with chronic pelvic pain (CPP) have impairment in a number of domains, however it is unknown if a concise set of factors can be developed as a minimum complete assessment. Factor analysis is a statistical technique designed to find common elements from within a larger set of variables. The Patient Reported Outcome Measures Information System (PROMIS) is an NIH sponsored multidimensional patient evaluation tool particularly applicable to pain. This study tests the hypothesis that factor analysis can be used to identify primary components

of the pain experience based on a multidimensional assessment. The same approach, along with a correlation matrix, is applied to multiple visual analog scales (VAS) in CPP patients. The objective is to determine the minimum number of useful domains to assess.
Methods: A total of 212 patients completed the PROMIS assessment upon initial evaluation at a tertiary CPP referral center; along with multiple site specific VAS for pain. Multiple factor solutions were evaluated. A correlation matrix was used as confirmatory analysis.
Results: Factor analysis of the PROMIS domains resulted in a Phi of 0.482 ($p<0.001$). Five and six factor analysis produced final factors that were either individual items or had very low eigenvalues (10% or less). A four factor solution produced the highest eigenvalue percents: Factor 1 (30%): Anxiety, Depression, Anger; Factor 2 (23%): Satisfaction−Roles, Satisfaction−Activities, Physical Function; Factor 3 (22%): Waking Impairment, Sleep Disturbance, Fatigue; Factor 4 (23%): Pain Impact, Pain Behavior, Physical Function. The Global Physical domain had the highest correlation with Physical Function (−0.68) and Pain Impact (−0.58) while the Global Mental domain had the highest correlations with Depression (−0.76) and Anxiety (0.69). Absolute factor loadings after varimax rotation confirmed the results of a correlation matrix for the VAS results: Global pain correlated with, pelvic, sexual, and menstrual VAS scores and formed a single factor (0.47, 0.39, 0.42; phi=3.4, $p<0.001$, in a 3 factor solution).
Conclusion: Patients with CPP demonstrate impairment in psychological function, social function, sleep disturbance, and pain impact/behavior. Assessment of at least these factors is a minimum requirement in CPP evaluation. The PROMIS global measures assess pain impact and psychological function. Global VAS scores are related to pelvic, menstrual, and sexual pain, but bladder and back pain should be evaluated individually.
Key words: pain measurement, quality of life
Summary: CPP patients should at least be assessed in the areas of psychological, social, and sleep dysfunction, and pain related impairment; a single global VAS score assesses pelvic, sexual, and menstrual pain.

A Novel Oral GNRH Antagonist, Elagolix, is Effective for Reducing Endometriosis-Associated Pelvic Pain: Results of A 24-week Randomized Study
Bruce Carr, MD; Kristoff Chwalisz, MD, PhD; Roland Jimenez, MD; Joshua Burke, PhD; Ping Jiang, PhD; Chris O'Brien, MD
Abbott; Neurocrine Biosciences; University of Texas Southwestern Medical Center
Presented By: Kristof Chwalisz, MD, PhD

Objective: To evaluate efficacy and safety of elagolix, a novel oral GnRH antagonist, for the treatment of endometriosis-associated pelvic pain.
Design: A Phase 2, randomized, double-blind, placebo-controlled, parallel group study of women with surgically confirmed endometriosis, and moderate or severe dysmenorrhea and nonmenstrual pelvic pain (NMPP) at baseline, who received elagolix 150 mg q.d. (n=66) or placebo (n=66) for 8 weeks followed by 16 week open-label treatment with elagolix 150 mg q.d.
Materials and Methods: Assessment of dysmenorrhea, NMPP, dyspareunia and endometriosis-related analgesic use was recorded daily. Changes from baseline in the monthly mean (1 month equaled 4 weeks) of daily pain scores (0−3 scale) and percent of days with analgesic use were summarized and analyzed by ANCOVA.
Results: For all assessments, the average reduction from baseline to week 8 was significantly greater with elagolix compared with placebo (dysmenorrhea −1.1 vs. −0.4, NMPP −0.5 vs. −0.2, dyspareunia −0.6 vs. −0.2, percent days with analgesic use −21.6% vs. −9.2%, $p<0.01$ for all). Additional improvements were observed for elagolix patients during the open-label treatment period; patients who were initially randomized to placebo had comparable improvements by week 24 (dysmenorrhea −1.4 and −1.3, NMPP −0.8 and −0.5, dyspareunia −0.8 and −0.6, percent days with analgesic use −29.2% and −20.6%; elagolix and placebo, respectively). Quality of life (QoL, EHP−5) and patient's global impression of change (PGIC) were significantly improved with elagolix treatment consistent with reductions in pain. Over the 24 week study period, the most

commonly occurring adverse events in patients receiving elagolix were nausea, headache, and hot flush, each of which occurred in 9.9% of patients.
Conclusions: Elagolix treatment was well-tolerated and resulted in consistent, sustained reduction in dysmenorrhea and NMPP and improvements in QoL and PGIC in women with moderate to severe endometriosis-associated pelvic pain.
Summary: In this 24-week study of women with moderate to severe endometriosis, elagolix 150 mg q.d. was well-tolerated, reduced endometriosis-related pelvic pain, and improved patients' QoL.
Support: Neurocrine Biosciences and Abbott Laboratories
Key words: Elagolix, GnRH antagonist, endometriosis

2011 Speaker PowerPoint Presentations

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