Summary

Chronic pelvic pain is a common and debilitating problem that can impair the quality of life of the patient. It can affect males and females.

Nerve supply to various pelvic and perineal structures separates it into three parts male organs, female organs and rectoperitoneal area. In addition, small part of sigmoid colon is present inside the pelvis. So, many specialists may share in the management of chronic pelvic pain as gynecologists, urologists, gastroenterologists and oncologists.

Chronic pelvic pain may be due to non-malignant causes as adhesions, endometriosis, pelvic congestion chronic cystitis, Prostatitis urethral syndrome and irritable bowel syndrome.

Chronic pain may be related to the tumor involvement, cancer therapy as post-irradiation, post-chemotherapy and post-surgical and neoplastic syndromes indirectly associated with cancer bone invasion.

The sudden onset of pain in the pelvic or lumbar region be the first symptom of intrapelvic malignancy and is usually associated with vertebral body collapse.

Gynecologic malignant tumors account for approximately quarter of all malignant diseases in women and carcinoma of the cervix is the commonest cancer in women after carcinoma of the breast.

Many urologic cancer including renal, bladder and prostatic tumors have the potential to spread and invade bone and produce chronic pelvic pain.

An advance in diagnosis, therapy and understanding of pathophysiological mechanisms of pain and pain perception has improved the overall care of patients with chronic pelvic pain.

Cancer pain management is still inadequate and it is mandatory to search for the causes of such inadequacy. Some reasons are associated with the patient or the family e.g. belief that pain in cancer is inevitable and untreatable. Other reasons are due to the doctor or the nurse e.g. lack of knowledge about pain and ignoring the psychological aspect of pain. Third group of reasons are due to absence of national policies of cancer pain and lack of financial resources. To get an improved management of cancer pain, all these reasons must be solved.

The first most important step in pain management is proper assessment of pain, to help follow up and assess adequacy of treatment, several method of pain measurement are developed. Such approaches may be subjective or objective.

Cancer pain management at present is based on the analgesic ladder system proposed by WHO (1986). However, it is important to treat the cause of the pain and to assess the psychological status of cancer patients from the start. In a minority of patients, where drugs fail to relieve pain, invasive techniques may be employed.

Many patients with cancer will be administrated an opioid at a time of his disease course. However opioids are not with drawbacks that may limit there use or affect the clinical status of the patients. The problems special to opioid use and cancer pain management include:

1- Effect of opioids on the immune system.

2- Development of tolerance and dependence.

3- Opioids neurotoxicity.

The perineum is composed of diverse anatomic structures with extensive sympathetic and somatic innervation. The extensive and redundant innervation may be one of the reasons that explain the limited efficacy of various analgesic therapies. Historically, nerve blocks in this region are targeting somatic, rather than sympathetic components. The trans-sacrococcygeal approach technique for ganglion of impar block described by **Wemm and saberski (1995)** as an alternative means of managing intractable neoplastic perineal pain of sympathetic origin.

In the yet obscure world of pelvic pain, interventional techniques are helpful when probably designed in a comprehensive evaluation of the patient's psychological, physiologic, and sexual status.

In the setting of nononcologic pain, these procedures have diagnostic, prognostic, and therapeutic value.

The use of sympathetic blocks (either the hypogastric or the ganglion of impar) seems promising in the setting of chronic pelvic pain , including pain caused by non bacterial prostatitis and valvular or clitoral pain.

In the world of cancer pain, sympathetic blocks may also be used for diagnostic purposes and for predicting the efficacy of neurolytic techniques.

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The strategies for treatment of chronic pelvic pain can start with analgesic drugs, interventional therapy and psychological management.

All of the above procedures can help and improve the quality of life of the patient.