Mental disorders in patients with chronic pelvic pain syndrome (CPPS)*

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ARTICLE INFO
Keywords:
Chronic pain
Chronic pelvic pain
Chronic pelvic pain syndrome
Chronic prostatitis
Mental disorders
Somatoform disorders

ABSTRACT
Objective: Chronic pelvic pain syndrome (CPPS) is a debilitating pain condition with prevalence rates between 2.0% and 26.6%. Studies indicate that CPPS is often associated with psychosocial factors, but little is known about the presence of full-blown mental disorders in female and male patients with CPPS. Therefore, the aim of this study was to investigate the frequencies of mental disorders in patients with CPPS.

Methods: Cross-sectional data were collected from patients visiting a specialized outpatient clinic. Frequencies of mental disorders were investigated using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) and compared to the general population. Furthermore, self-rating questionnaires were used to assess somatic symptom severity (PHQ-15), depression severity (PHQ-9) and anxiety severity (GAD-7).

Results: Data from 178 CPPS patients (60.1% female; age M = 49.1, SD = 18.0) were analyzed. Of the total sample, 95.2% (95% CI 90.8–97.9) suffered from at least one mental disorder. The most prevalent mental disorders were somatoform disorders (91.7%; 95% CI 86.4–95.4), followed by mood disorders (50.6%; 95% CI 42.8–58.4) and anxiety disorders (32.1%; 95% CI 25.2–39.8). The self-reported symptom burden was also significantly higher than in the general population. Compared to men, women met the diagnoses of somatoform disorder (p = 0.012) and anxiety disorders (p = 0.027) significantly more often and reported a significantly higher total somatic symptom severity (p = 0.001).

Conclusion: Our results provide evidence for a clinically relevant psychosocial symptom burden in patients with CPPS, indicating the need for the examination of psychopathologies and multi-professional treatment for this patient group.

1. Introduction

The International Association for the Study of Pain (IASP) and the European Association of Urology (EAU) define Chronic Pelvic Pain Syndrome (CPPS) as a subdivision of Chronic Pelvic Pain (CPP), “where there is no proven infection or other obvious local pathology that may account for the pain”. Furthermore, “it is often associated with negative cognitive, behavioral, sexual or emotional consequences as well as with symptoms suggestive of lower urinary tract, sexual, bowel or gynecological dysfunction” [1,2]. Chronicity is defined by persistent pain lasting longer than 6 months or recurrent episodes of pain [1,2]. This pain syndrome affects both men and women and shows a high variety in its particular location and symptomatology. CPPS can be subcategorized by its particular pain location and symptoms, e.g. bladder pain syndrome, myofascial pain syndromes, endometriosis associated pain syndrome, when there is a clear association to an organ, symptom or structure in the pelvis. While many studies focus on subgroups of CPPS according to a specific end-organ, research groups such as the MAPP Research Network stress the complexity of the multiple systems involved in this syndrome, leading to multiple effects and patients' perceptions of multiple pain areas [1–3]. Worldwide prevalence rates in the general population range between 2.1% and 26.6% in women and 2.0% and 9.7% in men [4–8]. The quality and the intensity of the symptoms can differ between patients and are related to psychological variables such as pain-catastrophizing, depressive symptoms and anxiety, which play an important role in the etiology and maintenance of CPPS.

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of CPPS [2,9]. Furthermore, pain intensity as well as associated psychological factors have an impairing effect on the health-related quality of life [2]. Therefore, the diagnostic guidelines of the European Association of Urology (EAU) as well as the Chronic Pelvic Pain Working Group of the International Continence Society (ICS) support an axial and interdisciplinary diagnostic algorithm to diagnose CPPS, focusing both on biological as well as psychosocial aspects in the diagnostic process [2,10]. The guidelines of the German Society of Psychosomatic Obstetrics and Gynecology (Deutsche Gesellschaft für psychosomatische Frauenheilkunde und Geburtshilfe, DGPPG) also stress the importance of a diagnostic process simultaneously considering the biological and psychosocial components involved [11]. Furthermore, phenotyping tools such as the System for the clinical phenotyping of chronic pelvic pain – UPOINT [12] recommend the clinical evaluation of psychosocial components in CPPS.

Nevertheless, knowledge about psychiatric co-morbidity is rare [9], although diagnoses constitute a crucial requirement for the initiation of an adequate therapeutic approach. A literature search yielded only three studies in which the prevalence rates of mental disorders in patients with chronic pelvic pain were investigated [13–15]. Only one of these studies employed the Structured Clinical Interview for Axis I Disorders (SCID-I) [16], which is established as a criterion standard for the diagnosis of mental disorders. In this study, a prevalence rate of 54.5% for at least one Axis-I-disorder was found, with affective disorders (40.9%) and anxiety disorders (31.8%) having the highest prevalence rates [13]. However, the study was conducted with a small sample of only 22 female patients. Using the National Institutes of Mental Health Diagnostic Interview Schedule (DIS), the second study found high comorbidity rates of phobias (32%) and depression (28%) as well as substance use disorders (32%) in a similarly small sample of 25 women with chronic pelvic pain [14]. In another study employing the DIS in a sample of 50 women, high frequencies of full or abridged somatization disorder (72%), drug abuse/dependence (40%) and alcohol abuse/dependence (34%) as well as major depression (24%) and dysthymia (26%) were found [15]. To our knowledge, no studies have investigated the frequencies of mental disorders in male patients.

The lack of studies identifying mental disorders in female and male patients with CPPS is even more alarming because CPPS is not only a syndrome with a high symptom burden and high prevalence rates but also substantial health economic consequences [4]. Furthermore, the comorbidity of mental disorders, especially depressive, anxiety, somatoform, substance-related and AXIS-II disorders, is common in patients with chronic pain conditions [17–22], and the multimorbidity of depressive, anxious and somatoform disorders has been shown to be associated with higher functional impairment and a stronger use of the health care system in comparison to a single diagnosis [23–25].

Therefore, the first aim of this study was to investigate the frequency of mental disorders in female and male patients with CPPS by using a structured criterion standard interview. Second, we aimed to compare these findings with the prevalence rates in the general population. Third, we aimed to investigate the association of the numbers of diagnoses and types of diagnoses with pain intensity. Fourth, we aimed to conduct an exploratory investigation of gender differences regarding the frequency of mental disorders and the severity of somatic and mental symptoms. Finally, we aimed to complement the results of the diagnostic interview with self-administered measures of mental and somatic symptom severity. To our knowledge, this is the first study to investigate mental disorders in a large sample of patients with CPPS of both sexes and using a systematic criterion standard assessment.

2. Methods

2.1. Patient sample

Employing a cross-sectional observational design, data were collected from female and male patients who visited an interdisciplinary specialized outpatient clinic for CPPS at the University Medical Center Hamburg, Germany between October 2012 and February 2016. These patients were usually referred by primary or secondary care physicians, mainly general practitioners, urologists and gynecologists. To diagnose CPPS, each patient completed a standardized diagnostic pathway examining somatic and psychosocial factors involved [26]. For all patients, this diagnostic process comprised a psychosomatic anamnesis as well as urological and physiotherapeutical examinations. Female patients were also examined by a gynecologist. If required, other specialists, e.g. neurologists, surgeons and specialists for internal medicine were called in. Every fortnight, all experts involved discussed findings, assign diagnoses and define therapeutic recommendations. Inclusion criteria for this study were a valid diagnosis of CPPS, at least 18 years of age, sufficient knowledge of the German language, and written informed consent. Exclusion criteria were severe medical conditions, suicidality and pain duration of < 6 months. Diagnosis of CPPS was based on the diagnostic guidelines of chronic pelvic pain syndrome defined by the EAU [1], the International Association for the Study of Pain (IASP) [1] and the National Institutes of Health (NIH) guidelines on chronic prostatitis/chronic pelvic pain [27]. The study was approved by the ethics committee of the Medical Association of Hamburg, Germany (PV4220). Written informed consent was provided by all patients. All data were pseudonymized before analysis.

2.2. Instruments

To determine the presence of mental disorders, the SCID-I for DSM-IV [16], which is established as a criterion standard for the diagnosis of mental disorders, was conducted. With the DSM-5, somatoform disorders underwent a comprehensive re-conceptualization [59]. However, until now, neither a German version of a structured clinical interview for DSM-5 nor representative studies about the prevalence rates of DSM-5 diagnoses in the German general population exist. Therefore, we decided to use DSM-IV criteria holding the advantage of having available data for comparison. The conducted SCID sections comprised somatoform disorders, mood disorders, anxiety disorders and substance use disorders. This diagnostic focus was chosen because symptoms associated with these disorders were found to occur frequently with CPPS [2,9,11]. The interviews were performed according to the SCID-I interview guidelines and were carried out by trained physicians and psychologists.

Furthermore, three modules from the German version of the Patient Health Questionnaire (PHQ-D) were used. The Patient Health Questionnaire depression scale (PHQ-9) constitutes the depression-specific module of the PHQ-D. Values ≥ 9 have been found to identify a clinically relevant depressive disorder with sufficient sensitivity and specificity [28]. The Generalized Anxiety Disorder Scale (GAD-7) constitutes the anxiety-specific module of the PHQ-D and can be used for the detection of generalized anxiety disorder as well as for the measurement of general anxiety severity [28]. A cut-off point ≥ 8 has been found to offer the best ratio between sensitivity and specificity in the detection of generalized anxiety disorder as well as other anxiety disorders [29]. The PHQ-15 is a module for the evaluation of somatic symptom severity [30]. Regarding the concordance with a clinically relevant somatoform disorder, a threshold of three or more severe symptoms represents the best ratio between sensitivity and specificity [31].

Sociodemographic data (age, gender, marital status, living situation and educational level) and pain-related characteristics, such as duration of pain in years, current pain intensity on a VAS scale from 0 to 100 and pain experience with the Short-form McGill Pain Questionnaire (SF-MPQ) [32], were assessed. CPPS-specific symptom severity was assessed using the German version of the National Institutes of Health Chronic Prostatitis Symptom Index (NIH-CPSI) [33].
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