Sophie (pelvic pain)
(My CDHB pelvic pain questionnaire is at https://edu.cdhb.health.nz/Patients-Visitors/patient-information-pamphlets/Documents/Healthpathways/Pelvic-Pain-Questionnaire.pdf)

My formulation for Sophie is that she has a complex pain presentation of a predominantly nociplastic phenotype. This includes visceral hypersensitivity (IBS, bladder pain syndrome, vulvodynia) and myofascial pain (the stabbing/meat hook pain, "ovarian pain", the "bloating", unable to tolerate tampons, "lightning crotch", urinary hesitancy, dyspareunia).

Notably her pain is widespread in distribution, present daily, of a very long duration, has a number of other COPCs and her scores on the CSI and PCS are both high.

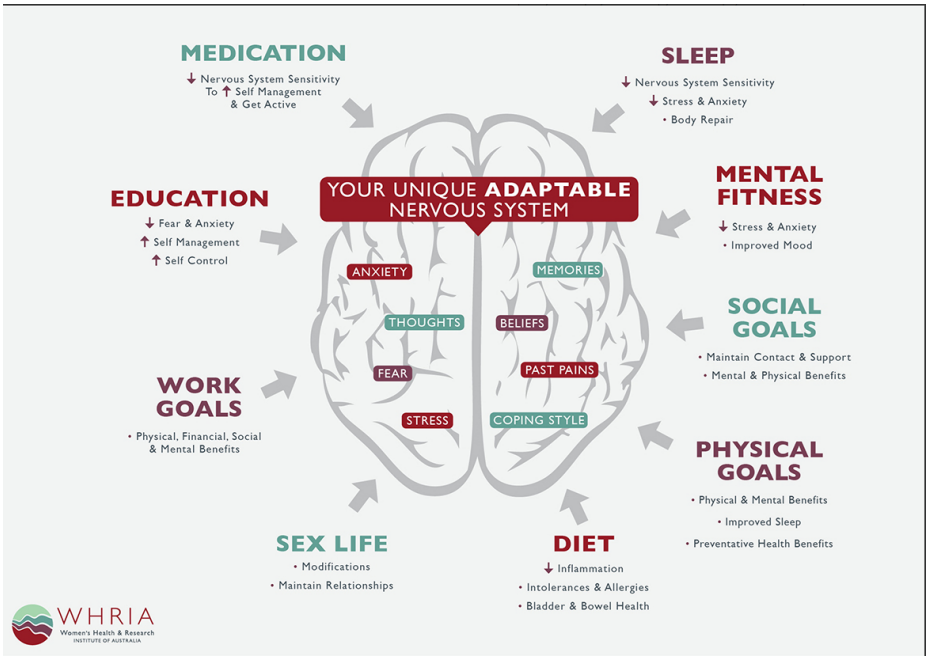
There are potentially some predisposing factors including potential past adversity (I would respect her wish not to disclose at present but perhaps this will be disclosed once a therapeutic rapport is established).

It would be worth exploring what precipitating event occurred 10m ago - which may or may not be something that can be incorporated into a flare up plan as a potential trigger.

RED: Sophie appears to have been well investigated but she should be encouraged to report any future development of red flags (e.g. PCB/weight loss etc)

YELLOW: PCS and CSI in high ranges. Experiencing a feeling of invalidation and misunderstandings/worries about her fertility and her anatomy/ovaries.

All of the above are both risk factors for complexity of rehabilitation BUT also positively, targets for treatment.



GREEN: Sophie needs to be supported to come to an understanding that her pain is valid and deserves care; however as her journey and current suffering are complex, her management needs to also be complex/multifaceted.

This needs to be grounded in an understanding about pain and her anatomy and in clear repeated validation that her suffering is very real and that we will work together to try and 'sort out the jigsaw'. Through this she can learn that her pain is not from her ovary and removal will not only not help her pain - it is likely to worsen her pain and bring other harms including on her fertility. She will also learn that she will not be ovulating while on Depo so the "ovulation" pains are not related to her ovaries and likely to be a nociplastic myofascial phenomenon.
I would explore her fertility intent and discuss that women are more fertile in the 20s than 30s and the pathways if she has fertility delay.

Medications:
I would encourage her to remain on menstrual/ovulation suppression until or unless she wishes to conceive that month. This might mean changing from Depo to an easily reversible method a year before she plans to conceive.
I would also recommend ceasing any medications which do not work, especially gabapentin which is ineffective in pelvic pain.

Vaginal Valium has been shown to not be effective and brings harms, and so I will provide her with information and not prescribe it - as I do not want her to be harmed.
I would give her information about amitriptyline and discuss the possibility of trying this to see if it improved her bladder and sleep.

There are no medications with good supportive evidence for vulvodynia. If there are atrophic changes on examination (from depo) then I might consider a 3m trial of Ovestin and then only continue if significantly helping. The only treatments with good supporting evidence are CBT and pelvic health PT. Simple skincare advice has not been studied well but is cheap and pretty much risk free.

PT:
There are many targets on her presentation for pelvic PT. There are some great resources for self-help measures for myofascial pain and high tone pelvic floor dysfunction however if possible some expert oversight would be great.

Sleep:
Always a great target and there are plenty of free resources available to recommend for non-medication sleep interventions.

Flare up plan and acute care plan:
As per session on TOPP day.