ongoing pelvic pain and is associated with tuberculosis or actinomycosis. *Pelvic congestion syndrome* is associated with pelvic varicosities with low blood flow, resulting in pelvic venous congestion. However, this is no clear evidence to indicate that this finding is associated with chronic pelvic pain.

TREATMENT

Chronic Pelvic Pain

DYSMENORRHEA

Local application of heat is of some benefit. Exercise, sexual activity, a vegetarian diet, use of vitamins D, B_1, B_6, and E and fish oil, acupuncture, and yoga have all been suggested to be of benefit, but studies are not adequate to provide recommendations. However, NSAIDs are very effective and provide >80% sustained response rates. Ibuprofen, naproxen, ketoprofen, mefanamic acid, and nimesulide are all superior to placebo. For best response, treatment should be initiated prior to the onset of menses and continued for at least 2–3 days. Combined oral contraceptives taken cyclically or continuously effectively reduce symptoms of dysmenorrhea.

ENDOMETRIOSIS

Combined hormonal contraceptives or continuous progestin (either orally or a levonorgestrel IUD) are used for the treatment of endometriosis. Evidence of an endometrioma on ultrasound imaging can be medically managed and does not require surgical removal unless symptomatic. Patients who do not respond to medical management and laparoscopic resection of endometriotic lesions can be offered GnRH agonist suppression with add-back therapy or aromatase inhibitors.

Chronic pain and dysmenorrhea associated with *fibroids* can be managed surgically depending on the number and location of fibroids and associated symptoms. Chronic pain and dysmenorrhea associated with adenomyosis can be managed with combined