

Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
1. Ahangari A. Prevalence of chronic pelvic pain among women: an updated review. <i>Pain Physician</i> . 2014;17(2):E141-147.	Review/Other-Dx	7 studies	To update the review of the worldwide estimation of the chronic pelvic pain (CPP) prevalence considering the World Health Organization systematic review by Latthe et al in 2006 as point of departure.	From 140 studies, only 7 studies were about CPP prevalence. Their study design consisted of 3 cross sectional studies, one population based mailing questionnaire study, one survey study (computer assisted telephone interview), one data analysis by questionnaire, and one prospective community based study.	4
2. Latthe P, Latthe M, Say L, Gulmezoglu M, Khan KS. WHO systematic review of prevalence of chronic pelvic pain: a neglected reproductive health morbidity. <i>BMC Public Health</i> . 2006;6:177.	Review/Other-Dx	148 articles	To systematically review worldwide literature on the prevalence of different types of chronic pelvic pain (CPP) to assess the geographical distribution of data, and to explore sources of variation in its estimates.	There were 178 studies (459975 participants) in 148 articles. Of these, 106 studies were (124259 participants) on dysmenorrhoea, 54 (35973 participants) on dyspareunia and 18 (301756 participants) on noncyclical pain. There were only 19/95 (20%) less developed and 1/45 (2.2%) least developed countries with relevant data in contrast to 22/43 (51.2%) developed countries. Meta-regression analysis showed that rates of pain varied according to study quality features. There were 40 (22.5%) high quality studies with representative samples. Amongst them, the rate of dysmenorrhoea was 16.8 to 81%, that of dyspareunia was 8 to 21.8%, and that for noncyclical pain was 2.1 to 24%.	4
3. Gemmell LC, Webster KE, Kirtley S, Vincent K, Zondervan KT, Becker CM. The management of menopause in women with a history of endometriosis: a systematic review. <i>Hum Reprod Update</i> . 2017:1-20.	Review/Other-Dx	39 articles.	To systematically review the existing literature on management of menopausal symptoms in women with a history of endometriosis and to evaluate the published literature on the risks associated with hormone replacement therapy (HRT) in these women, and details regarding optimal formulations and timing (i.e. initiation and duration) of HRT.	We present a synthesis of the existing case reports of endometriosis recurrence or malignant transformation in women undergoing treatment for menopausal symptoms. We highlight common presenting symptoms, potential risk factors and outcomes amongst the studies. Sparse high-quality evidence was identified, with few observational studies and only two randomized controlled trials. Given this paucity of data, no definitive conclusions can be drawn concerning risk.	4

Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
4. Bagarinao E, Johnson KA, Martucci KT, et al. Preliminary structural MRI based brain classification of chronic pelvic pain: A MAPP network study. <i>Pain</i> . 2014;155(12):2502-2509.	Observational-Dx	33 patients; 33 healthy controls	To identify a multivariate structural brain classifier coinciding with chronic pelvic pain (CPP) using an support vector machine (SVM) algorithm, and to assess the accuracy of this brain classifier in discriminating CPP from healthy controls.	Our regional findings suggest that in individuals with CPP, greater gray matter density may be found in the identified distributed brain regions, which are consistent with some previous investigations in visceral pain syndromes.	1
5. Berman SM, Naliboff BD, Suyenobu B, et al. Reduced brainstem inhibition during anticipated pelvic visceral pain correlates with enhanced brain response to the visceral stimulus in women with irritable bowel syndrome. <i>J Neurosci</i> . 2008;28(2):349-359.	Experimental-Dx	14 IBS patients; 12 healthy controls	To characterize abnormalities in preparatory brain response before aversive pelvic visceral distention in irritable bowel syndrome (IBS) patients and their possible relationship to the consequences of distention.	During cued anticipation of distention, activity decreased in the insula, supragenual anterior cingulate cortex (sACC), amygdala, and dorsal brainstem (DBS) of controls. IBS patients showed less anticipatory inactivation. Group differences were significant in the right posterior insula and bilateral DBS. Self-rated measures of negative affect during scanning were higher in patients than controls ($p < 0.001$), and the anticipatory BOLD decreases in DBS were inversely correlated with these ratings. During subsequent distention, both groups showed activity increases in insula, dorsal ACC, and DBS and decreases in the infragenual ACC. The increases were more extensive in patients, producing significant group differences in dorsal ACC and DBS. The amplitude of the anticipatory decrease in the pontine portion of DBS was associated with greater activation during distention in right orbitofrontal cortex and bilateral sACC.	2

Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
6. Borg C, Georgiadis JR, Renken RJ, Spoelstra SK, Weijmar Schultz W, de Jong PJ. Brain processing of visual stimuli representing sexual penetration versus core and animal-reminder disgust in women with lifelong vaginismus. PLoS One. 2014;9(1):e84882.	Observational-Dx	62 patients	To recapitulate, the present functional magnetic resonance imaging (fMRI) paradigm was designed to test whether i) women with vaginismus have stronger activity in response to visual stimuli representing sexual penetration in areas known to express sex-disgust overlap; ii) disgust- and sexual penetration-related brain networks overlap most in women with vaginismus; iii) the overlap of the disgust- and the sexual penetration-related brain network is restricted to one specific class of disgust elicitors or if it is evident for disgust elicitors in general.	At the subjective level, both clinical groups rated penetration stimuli as more disgusting than asymptomatic women. However, the brain responses to penetration stimuli did not differ between groups. In addition, there was considerable conjoint brain activity in response to penetration and disgust pictures, which yield for both animal-reminder (e.g., mutilation) and core (e.g., rotten food) disgust domains. However, this overlap in brain activation was similar for all groups.	3
7. Gupta A, Rapkin AJ, Gill Z, et al. Disease-related differences in resting-state networks: a comparison between localized provoked vulvodynia, irritable bowel syndrome, and healthy control subjects. Pain. 2015;156(5):809-819.	Observational-Dx	78 patients	To determine whether the brain regions reported to be altered in previous neuroimaging studies in localized provoked vulvodynia (LPVD) also show altered intrinsic connectivity within three resting state networks compared to healthy controls (HCs) and a chronic visceral pain group.	Subjects with LPVD showed substantial alterations in the intrinsic connectivity of these networks compared with HCs and IBS. The intrinsic connectivity of many of the regions showing group differences during rest were moderately associated with clinical symptom reports in LPVD. Findings were robust to controlling for affect and medication usage. The current findings indicate that subjects with LPVD have alterations in the intrinsic connectivity of regions comprising the sensorimotor, salience, and default mode networks.	3
8. Shobeiri SA, Rostaminia G, White D, Quiroz LH, Nihira MA. Evaluation of vaginal cysts and masses by 3-dimensional endovaginal and endoanal sonography. J Ultrasound Med. 32(8):1499-507, 2013 Aug.	Review/Other-Dx	N/A	To describe the utility of 3-dimensional endovaginal and endoanal sonography in the assessment of vulvovaginal cysts and masses.	No results stated in abstract.	4
9. Cicchiello LA, Hamper UM, Scutt LM. Ultrasound evaluation of gynecologic causes of pelvic pain. Obstet Gynecol Clin North Am. 2011;38(1):85-114, viii.	Review/Other-Dx	N/A	To review the role of ultrasound (US) in the evaluation of gynecologic causes of acute and chronic pelvic pain.	No results stated in abstract.	4

Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
10. Ganeshan A, Upponi S, Hon LQ, Uthappa MC, Warakaulle DR, Uberoi R. Chronic pelvic pain due to pelvic congestion syndrome: the role of diagnostic and interventional radiology. <i>Cardiovasc Intervent Radiol.</i> 2007;30(6):1105-1111.	Review/Other-Dx	N/A	To briefly describe the clinical manifestations, and to review the role of diagnostic and interventional radiology in the management of this probably under-diagnosed condition.	No results stated in abstract.	4
11. Kuligowska E, Deeds L, 3rd, Lu K, 3rd. Pelvic pain: overlooked and underdiagnosed gynecologic conditions. <i>Radiographics.</i> 2005;25(1):3-20.	Review/Other-Dx	N/A	To describe the transvaginal ultrasonographic (US) and magnetic resonance (MR) imaging appearances of some gynecologic conditions that can cause chronic pelvic pain.	No results stated in abstract.	4
12. Somprasit C, Tanprasertkul C, Suwannarurk K, Pongrojapaw D, Chanthasenanont A, Bhamarapratana K. Transvaginal color Doppler study of uterine artery: is there a role in chronic pelvic pain? <i>J Obstet Gynaecol Res.</i> 2010;36(6):1174-1178.	Observational-Dx	25 patients	To determine the value of transvaginal color Doppler study of uterine artery and investigate the differences in blood flow of uterine artery among women with chronic pelvic pain (CPP).	The mean ages were 36.6 +/- 10.6 and 32.0 +/- 6.7 years in the study group and control group, respectively. The duration of pain ranges from 6-48 months (mean, 14.8). The mean PI and RI values of the uterine arteries in patients with CPP were significantly lower than in the control group; PI = 2.12 +/- 0.78, 2.76 +/- 0.84 and RI = 0.79 +/- 0.19, 0.89 +/- 0.05, respectively (P < 0.05).	3
13. Patel MD, Dubinsky TJ. Reimaging the female pelvis with ultrasound after CT: general principles. <i>Ultrasound Q.</i> 2007;23(3):177-187.	Review/Other-Dx	N/A	To discuss the general principles that clarify when ultrasound is and is not helpful in reimaging the female pelvis after computed tomographic (CT).	No results stated in abstract.	4

**Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE**

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
14. Yitta S, Mausner EV, Kim A, et al. Pelvic ultrasound immediately following MDCT in female patients with abdominal/pelvic pain: is it always necessary? <i>Emerg Radiol.</i> 2011;18(5):371-380.	Observational-Dx	70 patients	To determine the added value of reimaging the female pelvis with ultrasound (US) immediately following multidetector computed tomography (MDCT) in the emergent setting.	Ultrasound changed the diagnosis for the ovaries/adnexa 8.1% of the time (three reader average); the majority being cases of a suspected CT abnormality found to be normal on US. Ultrasound changed the diagnosis for the uterus 11.9% of the time (three reader average); the majority related to the endometrial canal. The 95% confidence intervals for the ovaries/adnexa and uterus were 5-12.5% and 8-17%, respectively. Ten cases of a normal CT were followed by a normal US with 100% agreement across all three readers. Experienced readers correctly diagnosed ruptured ovarian cysts and tubo-ovarian abscesses (TOA) based on CT alone with 100% agreement.	2
15. Juhan V. Chronic pelvic pain: An imaging approach. <i>Diagn Interv Imaging.</i> 2015;96(10):997-1007.	Review/Other-Dx	N/A	To describe endometriosis, adenomyosis, chronic pelvic infections, adhesions, pelvic congestion syndrome, and pudendal neuralgia, which are the major causes of chronic pelvic pain (CPP) and to highlight the role of imaging in the diagnostic approach.	No results stated in abstract.	4
16. Tabibian N, Swehli E, Boyd A, Umbreen A, Tabibian JH. Abdominal adhesions: A practical review of an often overlooked entity. <i>Ann Med Surg (Lond).</i> 2017;15:9-13.	Review/Other-Dx	N/A	To provide a clinically practical synopsis of the etiopathogenesis, symptoms, differential diagnosis, evaluation, and treatment of abdominal adhesive disease.	No results stated in abstract.	4
17. Silva PD, Suarez SA. A Case of Disabling Urinary Frequency and Pelvic Pain Due to Postoperative Uterine Adhesions. <i>WMJ.</i> 2016;115(1):43-45.	Review/Other-Dx	1 case	To confirm the possibility that clinically significant lower abdominal adhesions may be visualized by ultrasound, we report on a patient who had developed disabling urinary frequency and pelvic pain after a cesarean section.	No results stated in abstract.	4
18. Ignacio EA, Dua R, Sarin S, et al. Pelvic congestion syndrome: diagnosis and treatment. <i>Semin Intervent Radiol.</i> 2008;25(4):361-368.	Review/Other-Dx	N/A	To review the diagnosis and treatment strategy of pelvic congestion syndrome (PCS).	No results stated in abstract.	4

**Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE**

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
19. Karaosmanoglu D, Karcaaltincaba M, Karcaaltincaba D, Akata D, Ozmen M. MDCT of the ovarian vein: normal anatomy and pathology. AJR Am J Roentgenol. 2009;192(1):295-299.	Review/Other-Dx	N/A	To show the multidetector computed tomography (MDCT) findings of normal ovarian (gonadal) vein anatomy and associated disorders, including the "ovarian vascular pedicle" sign, phlebolith, reflux, pelvic congestion syndrome, thrombosis, stenosis, and occlusion.	No results stated in abstract.	4
20. Koc Z, Ulasan S, Oguzkurt L. Right ovarian vein drainage variant: is there a relationship with pelvic varices? Eur J Radiol. 2006;59(3):465-471.	Observational-Dx	324 subjects	To correlate right ovarian vein (ROV) variations that drain into the right renal vein (RRV) with the presence of pelvic varices.	Thirty-two (9.9%) of 324 women studied exhibited ROV variant that drained into the right renal vein, and the remaining subjects (90.1%) exhibited a normal pattern of ROV drainage that flowed directly into the inferior vena cava. Pelvic varices were identified in 59 (18%) of the subjects. Reflux was not observed in any patient without pelvic varices. Fifty-seven of 59 women exhibited ovarian vein reflux. In 56 of those 57 individuals, reflux occurred only in the left ovarian vein(LOV), and in 1 subject, reflux was noted predominantly in the ROV. No significant relationship between the presence of an ROV that drained into the right renal vein and pelvic varices was noted.	3

Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
21. Koc Z, Ulsan S, Oguzkurt L. Association of left renal vein variations and pelvic varices in abdominal MDCT. <i>Eur Radiol.</i> 2007;17(5):1267-1274.	Observational-Dx	324 women	To determine whether left renal vein (LRV) variation is associated with pelvic varices and left ovarian vein (LOV) reflux.	Pelvic varices were detected in 59 (18%) of the total of 324 women, in 7 (37%) of the 19 women with retroaortic renal vein (RLRVs), in 7 (29%) of the 24 women with circumaortic renal vein (CLRV), and in 45 (16%) of the 281 women with normal LRVs. The frequency of pelvic varices in the women with LRV variation was significantly higher than that in the group with normal LRV anatomy (33 vs. 16%; p=0.009). The frequency of pelvic varices in the women with RLRVs was also significantly higher than that in the group with normal LRV anatomy (p=0.02). LRV diameter ratio was correlated with presence of pelvic varices and presence of LOV reflux (p=0.0001 for both).	3
22. Wang R, Yan Y, Zhan S, et al. Diagnosis of ovarian vein syndrome (OVS) by computed tomography (CT) imaging: a retrospective study of 11 cases. <i>Medicine (Baltimore).</i> 93(7):e53, 2014 Aug.	Observational-Dx	11 patients	To explore the characteristics of computed tomography (CT) images of ovarian vein syndrome (OVS).	Ureteral obstruction at the position and ureteral dilation above it, where the ovarian vein crosses over the ureter, were found in all 11 patients. In addition, 4 patients presented with right upper ureteric calculi, 10 with right renal calculi (including 8 patients with multiple renal calculi that also had obvious uronephrosis), and 2 with a urinary calculus or cystolith. The diameter of the ovarian vein in them ranged from 5 mm to 13 mm. Varicose veins around the uterus were found in 2 patients, and the diameter of the left ovarian vein was larger than 7 mm in 1 patient. In conclusion, analysis of CT images is a vital method in diagnosing OVS.	3
23. Thomassin-Naggara I, Darai E, Bazot M. Gynecological pelvic infection: what is the role of imaging?. [Review]. <i>Diagn Interv Imaging.</i> 93(6):491-9, 2012 Jun.	Review/Other-Dx	N/A	To review the role of imaging in gynecological pelvic infection.	No results stated in abstract.	4

Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
24. Valentini AL, Gui B, Basilio R, Di Molfetta IV, Micco M, Bonomo L. Magnetic resonance imaging in women with pelvic pain from gynaecological causes: a pictorial review. [Review]. Radiol Med (Torino). 117(4):575-92, 2012 Jun.	Review/Other-Dx	N/A	To illustrate the causes of pelvic pain in girls and women that may be inadequately diagnosed by ultrasound (US) and more adequately assessed by magnetic resonance imaging (MRI).	No results stated in abstract.	4
25. American College of Radiology. Manual on Contrast Media. Available at: https://www.acr.org/Clinical-Resources/Contrast-Manual .	Review/Other-Dx	N/A	Guidance document on contrast media to assist radiologists in recognizing and managing risks associated with the use of contrast media.	N/A	4
26. Ascitto G, Mumme A, Marpe B, Koster O, Ascitto KC, Geier B. MR venography in the detection of pelvic venous congestion. Eur J Vasc Endovasc Surg. 2008;36(4):491-496.	Observational-Dx	23 patients	To investigate the feasibility of using magnetic resonance venography (MRV) to detect pelvic venous congestion (PVC).	MRV agreed with P in 96% (Cohen-K-value 0.646) and in 70% (K 0.555) of the cases respectively in the venous anatomy and congestion grade. Sensitivity and specificity of MRV were 88% and 67% for ovarian veins, 100% and 38% for hypogastric veins and 91% and 42% for the pelvic plexus.	2
27. Yang DM, Kim HC, Nam DH, Jahng GH, Huh CY, Lim JW. Time-resolved MR angiography for detecting and grading ovarian venous reflux: comparison with conventional venography. Br J Radiol. 2012;85(1014):e117-122.	Observational-Dx	19 patients	To compare the diagnostic accuracy of time-resolved magnetic resonance angiography (TR-MRA) with that of conventional venography for the detection and grading of ovarian venous reflux, which aid in the diagnosis of pelvic venous congestion.	There was no significant difference between TR-MRA and conventional venography for grading ovarian venous reflux ($p>0.05$). The sensitivity, specificity and diagnostic accuracy of TR-MRA were found to be 66.7%, 100% and 78.9%, and 75%, 100% and 84.2%, respectively, for the two observers. The weighted kappa-values indicated excellent agreement between the two observers for grading ovarian venous reflux on TR-MRA (kappa = 0.894).	3
28. Leiber LM, Thouveny F, Bouvier A, et al. MRI and venographic aspects of pelvic venous insufficiency. Diagn Interv Imaging. 2014;95(11):1091-1102.	Review/Other-Dx	N/A	To review the imaging and to compare the appearance of pelvic venous insufficiency in magnetic resonance imaging (MRI) with venography.	No results stated in abstract.	4

Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
29. Bharwani N, Tirlapur SA, Balogun M, et al. MRI reporting standard for chronic pelvic pain: consensus development. <i>Br J Radiol.</i> 2016;89(1057):20140615.	Observational-Dx	28 panel members	To identify radiological parameters that should be reported on gynaecological magnetic resonance imaging (MRI) in order to create a standardized assessment pro forma for reporting chronic pelvic pain (CPP), which may be used in clinical practice.	75% response rate for the first round and 79% for the second. Following the second round, agreement was reached on the structure of the pro forma and the way in which information was sought, with overall consistency of agreement between experts deemed as fair (intraclass correlation coefficient = 0.394). This was accepted as the final version by consensus.	3
30. Dick EA, Burnett C, Anstee A, Hamady M, Black D, Gedroyc WM. Time-resolved imaging of contrast kinetics three-dimensional (3D) magnetic resonance venography in patients with pelvic congestion syndrome. <i>Br J Radiol.</i> 2010;83(994):882-887.	Observational-Dx	13 women	To assess the role of magnetic resonance venography (MRV) with time-resolved imaging of contrast kinetics (TRICKS) in dynamically evaluating ovarian vein dilation, reflux and direction of flow in patients with suspected pelvic congestion syndrome (PCS).	The mean left ovarian diameter for all patients with reflux was 7.9 mm (range 2.2-12 mm). There was high inter-observer agreement for ovarian vein diameter for both sequences. TRICKS showed significantly greater conspicuity than T(2)/T2*W imaging (TRICKS: T(2)/T2* mean (SD) = 7.80 (3.20):5.50 (1.97), F (1,12) = 5.80, p < 0.05). TRICKS MRV demonstrated high inter-observer correlation for timing and grade of reflux (r (36) = 0.77,0.71,0.79, p < 0.01). TRICKS MRA/V was significantly degraded by breathing artefact in two patients.	3
31. van der Meijden WI, Boffa MJ, Ter Harmsel WA, et al. 2016 European guideline for the management of vulval conditions. <i>J Eur Acad Dermatol Venereol.</i> 2017.	Review/Other-Dx	N/A	To provide guidelines for several aspects, such as diagnosis and treatment, of the more common vulval conditions (relatively) often encountered at vulval clinics, i.e. vulval dermatitis (eczema), psoriasis, lichen simplex chronicus, lichen sclerosus, lichen planus, vulvodynia and vulval intraepithelial neoplasia (VIN).	No results stated in abstract.	4
32. Hwang JH, Oh MJ, Lee NW, Hur JY, Lee KW, Lee JK. Multiple vaginal mullerian cysts: a case report and review of literature. <i>Arch Gynecol Obstet.</i> 2009;280(1):137-139.	Review/Other-Dx	N/A	To review the case of abnormal menstruation in malarial infection.	No results stated in abstract.	4

Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
33. Surabhi VR, Menias CO, George V, Siegel CL, Prasad SR. Magnetic resonance imaging of female urethral and periurethral disorders. [Review]. Radiol Clin North Am. 51(6):941-53, 2013 Nov.	Review/Other-Dx	N/A	To review the normal anatomy of the female urethra, magnetic resonance (MR) imaging techniques, and the role of MR imaging in the evaluation of diverse urethral and periurethral diseases.	No results stated in abstract.	4
34. Tirlapur SA, Daniels JP, Khan KS. Chronic pelvic pain: how does noninvasive imaging compare with diagnostic laparoscopy? Curr Opin Obstet Gynecol. 2015;27(6):445-448.	Review/Other-Dx	N/A	To explore the value of noninvasive imaging, such as pelvic ultrasound and MRI in diagnosing coexisting pathologies with chronic pelvic pain (CPP).	A literature review from inception until January 2015 of the following databases: PubMed, MEDLINE, Cumulative Index to Nursing and Allied Health Literature, Excerpta Medica database, and System for Information on Grey Literature in Europe were performed to identify published studies assessing the usefulness of ultrasound, MRI, and laparoscopy in the diagnosis of CPP. Three studies (194 women) addressed their comparative performance in patients with endometriosis, showing the sensitivity of ultrasound ranged between 58 and 88.5%; MRI was 56–91.5% and in the one study using histology as its reference standard, the sensitivity of laparoscopy was 85.7%. Noninvasive imaging has the additional benefit of being well tolerated, safer, and cheaper than surgery.	4
35. Quinn M. Injuries to the levator ani in unexplained, chronic pelvic pain. J Obstet Gynaecol. 2007;27(8):828-831.	Observational-Dx	26 women	To evaluate the integrity of the levator ani, in a series of parous patients with chronic pelvic pain with no obvious cause at diagnostic laparoscopy.	Three patterns of injury/defect to the levator ani (LAd) were observed in 20/26 patients with unexplained pelvic pain: avulsion of the pubococcygeus from its origin at the pubis (LAd I, 3/20), avulsion of the pubococcygeus from its origin at the arcus tendineus levator ani (LAd II, 14/20), and, loss of shape and form of the pubococcygeus (LAd III, 6/20). Three patterns of injury to the levator ani have been described with Magnetic resonance (MR) imaging in parous women with unexplained chronic pelvic pain (CPP).	3

Postmenopausal Subacute or Chronic Pelvic Pain
EVIDENCE TABLE

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Study Quality
36. Savoye-Collet C, Koning E, Dacher JN. Radiologic evaluation of pelvic floor disorders. <i>Gastroenterol Clin North Am.</i> 2008;37(3):553-567, viii.	Review/Other-Dx	N/A	To review the standard imaging procedures including defecography, ultrasonography, and magnetic resonance imaging (MRI) and discusses its use in clinical practice by illustrating both normal and abnormal patterns.	No results stated in abstract.	4
37. Ackerman AL, Lee UJ, Jellison FC, et al. MRI suggests increased tonicity of the levator ani in women with interstitial cystitis/bladder pain syndrome. <i>Int Urogynecol J.</i> 2016;27(1):77-83.	Observational-Dx	30 women	To determine if pelvic floor hypertonicity manifests alterations on magnetic resonance imaging (MRI) in patients with interstitial cystitis/bladder pain syndrome (IC/BPS), we retrospectively compared pelvic measurements between patients and controls.	There were no significant differences in age, parity, or symptom duration between groups. Patients with IC/BPS exhibited shorter levator muscles (right: 5.0 +/- 0.7 vs. 5.6 +/- 0.8, left: 5.0 +/- 0.8 vs. 5.7 +/- 0.8 cm, P < 0.002) and a wider posterior puborectalis angle (35.0 +/- 8.6 vs. 26.7 +/- 7.9 degrees, P < 0.01) compared with controls. The H line was shorter in patients with IC/BPS (7.8 +/- 0.8 vs. 8.6 +/- 0.9 cm, P < 0.02), while M line did not differ. Total urethral length was similar, but vaginal cuff and bladder neck distances to the H line were longer in patients with IC/BPS (5.7 +/- 0.6 vs. 5.1 +/- 0.9 cm, P < 0.02; 1.9 +/- 0.4 vs. 1.4 +/- 0.2 cm, P < 0.001, respectively).	2
38. American College of Radiology. ACR Appropriateness Criteria® Radiation Dose Assessment Introduction. Available at: https://www.acr.org/-/media/ACR/Files/Appropriateness-Criteria/RadiationDoseAssessmentIntro.pdf .	Review/Other-Dx	N/A	Guidance document on exposure of patients to ionizing radiation.	No results stated in abstract.	4

Evidence Table Key

Study Quality Category Definitions

- *Category 1* The study is well-designed and accounts for common biases.
- *Category 2* The study is moderately well-designed and accounts for most common biases.
- *Category 3* There are important study design limitations.
- *Category 4* The study is not useful as primary evidence. The article may not be a clinical study or the study design is invalid, or conclusions are based on expert consensus. For example:
 - a. The study does not meet the criteria for or is not a hypothesis-based clinical study (e.g., a book chapter or case report or case series description);
 - b. The study may synthesize and draw conclusions about several studies such as a literature review article or book chapter but is not primary evidence;
 - c. The study is an expert opinion or consensus document.
- Meta-analysis
 - a. *Good quality* – the study design, methods, analysis, and results are valid and the conclusion is supported.
 - b. *Inadequate quality* – the study design, analysis, and results lack the methodological rigor to be considered a good meta-analysis study.

Abbreviations Key

Dx = Diagnostic

Tx = Treatment