Pelvic Pain: Diagnosis and Management

Mr N Pisal
Consultant Gynaecologist
Advanced Laparoscopic Surgeon

www.london-gynaecology.com
History

- LMP
- Dysmenorrhoa / Dyspareunia
- Cyclical pain related to menstrual cycle
- Radiation to lower back / thigh

- Acute / chronic
Examination

- Abdominal / Speculum / Bimanual
- Pregnancy test
- STI screen
- Ultrasound scan
Acute pelvic pain: Gynae causes

- Young women: (always do a pregnancy test)
  - Ectopic pregnancy
  - Ovarian cyst accident
  - Infection

- Older women
  - New onset of pelvic pain in women over 45 is a significant symptom of ovarian cancer
Ectopic Pregnancy

- With early scans, acute presentation of ruptured ectopic has become uncommon
- Diagnosis: BHCG >1000 with empty uterus
- Timing of rupture: around 9 weeks
- Risk factors: Previous ectopic, endometriosis, adhesions, PID (Chlamydia), infertility, tubal surgery
PID

- Bilateral pain
- Associated with vaginal discharge, fever, cervical excitation, adnexal masses/tenderness, raised WBC/CRP
- Remove IUCD if present, triple swabs, consider USS if TO masses suspected
- Antibiotics:
  - Oral: Ofloxacin 400 mg BD plus oral Metronidazole 400 mg BD x 14
  - IM: ceftriaxone 500mg single dose, followed by oral doxycycline 100 mg BD plus metronidazole 400 mg BD x 14 days
Ovarian cysts

• Pain because of bleeding / torsion / rupture
• Three types: Functional / Benign / Malignant
• USS characteristics important:
  • Size / complexity / irregularity / bilateral / doppler / free fluid
• In women <45, simple 6cm cyst: Repeat USS 6wks
• If suspicious features / older women / persistent simple cyst: CA125 + Refer
Mittelschmerz

- Mid-cycle pain
- Unilateral
- NSAIDs
- OCPs
Endometriosis

- Ectopic endometrium

- Common sites: POD, Uterosacral ligaments, ovaries, pelvis, bowel
- Classical symptoms: Dysmenorrhoea + Dyspareunia

- Examination: Uterosacral nodularity in post fornix, adnexal tenderness, occasional RV fixed tender uterus
- USS: Useful if ovarian endometrioma present

- Laparoscopy: Diagnostic + Surgical treatment
- Medical Treatment: Pseudopregnancy (Tricycle OCP) OR Pseudomenopause (GnRH analogues) regimens
Chronic Pelvic pain

- Affects one in six women
- Frequently more than one component to chronic pelvic pain.
- Assessment should aim to identify all contributory factors rather than a single cause.
Cyclical pain

- Cyclical pelvic pain may be due to variety of hormonally driven conditions
  - Endometriosis: Cardinal symptoms of dysmenorrhoea, dyspareunia and pelvic pain
  - Adenomyosis
  - Pelvic venous congestion
  - IBS: Pain perception may vary with cycle
Chronic Pelvic pain

• Women with Chronic Pelvic Pain often have:
  • Irritable Bowel Syndrome 50%
  • Interstitial Cystitis 38-84%
  • Musculoskeletal pain 75%
Irritable bowel syndrome

- Symptom-based diagnostic criteria (98% positive predictive value)
  - At least 12 weeks of continuous or recurrent abdominal pain associated with at least two of the following:
    - Pain relieved with defecation
    - Associated with a change in frequency of stool
    - Associated with change in appearance or form of stool
Adhesions

- Adhesions may be a cause of pain, particularly on organ distension or stretching.
- Cause: Endometriosis, surgery, infection.
- Dense vascular adhesions are more likely to cause pain.
- Division often relieves pain.
- Trapped ovary syndrome: Known cause of pain after hysterectomy.
Psycho-social issues

- Depression
- Sleep disorder
- Sexual or physical abuse
- Social issues
Approach

• Many women are looking for an explanation for their pain.
• Initial history should include:
  • Pattern of the pain
  • Association with other problems (bladder, bowel, psychosocial)
  • Effect of posture on the pain
  • If appropriate ask re sexual abuse / domestic violence
  • Pain diary for 2-3 cycles
Investigations

- Sexual health screen
  - Transvaginal Ultrasound Scan
- Adnexal masses and endometriomas
  - Adenomyosis
- Diagnostic Laparoscopy
  - Only test to diagnose endometriosis and adhesions
Flowchart for the suggested management of chronic pelvic pain

- Allow the patient to tell her story
- Directed questions
- Vaginal examination
- Identify any specific aims/fears

- Recent change of partner
- Symptoms suggestive of pelvic inflammatory disease
- Concerns about sexually transmitted infection (STI)

Abnormal findings on vaginal examination

Yes

- Consider diagnostic laparoscopy or ultrasound scan

No

- Markedly cyclical pain with dysmenorrhoea
- Pain varies with movement
- Symptoms suggestive of irritable bowel syndrome
- Urogenital symptoms or other bowel symptoms
- Marked psychological component

Wanting to conceive?

- Yes
  - Refer to fertility treatment if necessary
- No
  - Trial of combined oral contraceptive or GnRH-A ± analgesia

? nerve entrapment

? musculoskeletal

Referral to physiotherapy or osteopathy

High-fibre diet ± mebeverine ± exclusion diet

Referral to urology or gastroenterology ± analgesia

Start analgesia

Refer to specialist if appropriate
Management Options

- Treatment of cause
- If idiopathic: Reassurance + Simple analgesia
- Most women with chronic pelvic pain will benefit from OCP
  - Dysmenorrhea
  - Ovarian Cysts
  - Endometriosis
Thank you!

Mr N Pisal
pisal@dr.com
07917721466
London-gynaecology.com