Acute Pelvic Pain

ACUTE ABDOMINAL OR PELVIC PAIN IN A WOMAN OF REPRODUCTIVE AGE IS AN ECTOPIC PREGNANCY UNTIL PROVEN OTHERWISE

- **Epidemiology:** the most common reason for urgent laparoscopy in the UK.
- **Causes**
  - **Common things are common…**
    - UTI
    - Kidney/bladder stones
    - Constipation
    - Irritable bowel syndrome
    - Appendicitis
    - Diverticulitis
    - Strangulated hernia
    - Bowel obstruction
  - **Uterine pathology**
    - **Pelvic inflammatory disease**
    - **Adenomyosis/endometriosis**
    - Salpingitis/tubal abscess
    - Severe dysmenorrhoea
    - Haematometra/haematocolpos
  - **Urological pathology**
    - Urinary retention (acute/chronic)
  - **Pregnancy complications**
    - **Ectopic pregnancy**
    - **Miscarriage**
    - **Premature labour**
    - **Placental abruption**
    - Uterine rupture
    - Fibroid degeneration
    - Ligament stretch/SPD
    - **Ovarian hyperstimulation syndrome**
  - **Ovarian pathology**
    - **Ovarian cyst torsion or rupture**
    - Fallopian tube/parafimbrial cyst torsion
    - Salpingo-ovarian abscess
    - Adhesions
    - Mittelschmerz (mid-cycle ovulation pain)
  - **Systemic pathology**
    - Hypercalcaemia
    - Acute porphyria
    - Psychogenic: somatisation of anxiety/depression; psychosexual disorder 2° to abuse
  - Could also be an **acute exacerbation of a chronic pelvic pain condition** *(see next section)*
- **History**
  - Pain: SOCRATES, any relationship to menstrual cycle, whether it has happened before
  - Gynae: LMP, contraception, recent UPSI, abnormal vaginal discharge or bleeding
  - Obs: parity, details of past pregnancies, ectopic RFs
  - Uro: urinary symptoms, history of infections/stones
  - GI: any change in bowel habit
- **Examination**
  - ABCDE and basic obs
  - Abdominal examination: assess for guarding/rebound tenderness, masses, hernia
  - Pelvic examination
    - Cusco speculum: bleeding/discharge; assess condition of cervix (open/closed)
    - Bimanual palpation: size, tenderness, mobility and consistency of uterus; any adnexal tenderness or masses; cervical excitation tenderness
  - PR if indicated
- **Investigations**
  - Urinalysis and MSU (including pregnancy test if bloods not taken)
  - Triple swabs during speculum examination if indicated
  - Bloods: FBC, G&S +/- crossmatch, CRP, ESR, serum beta-hCG, Ca^{2+} if indicated
  - Pelvic USS: to assess for cysts, masses and pregnancy complications → XR/CT/MRI if indicated
  - Diagnostic laparoscopy if indicated (e.g. suspected ectopic pregnancy, cyst torsion, appendicitis)
- **Basic management**
  - **Resuscitation** with fluids +/- whole blood if required
  - Appropriate **analgesia**
  - Prompt management of specific cause once known

Chronic Pelvic Pain

- **Chronic pelvic pain** is intermittent or constant pain in the lower abdomen or pelvis of at least 6 months' duration, which is not solely associated with menstruation, intercourse or pregnancy.
- **Epidemiology** women >> men; 3.8% prevalence in primary care; it may take years to find a cause
- **Causes**
  - **Uterine pathology**
    - **Adenomyosis/endometriosis**
    - **Uterine fibroids**
    - **Chronic pelvic inflammatory disease**
    - Pelvic venous congestion
  - **Ovarian pathology**
    - **Ovarian cysts or cancer**
    - Adhesions
  - **Neurological pathology**
    - Nerve entrapment (occurs in scarring after Pfannenstiel incision in 3.7%)
    - Neuropathic pain e.g. post-operative, diabetic neuropathy, post-herpetic neuralgia
  - **Musculoskeletal pathology**
    - Fibromyalgia
    - Trigger points
  - **Psychogenic**
    - Somatisation of anxiety/depression
    - Psychosexual disorder 2° to abuse
  - Be sure to rule out potential **acute causes** if the problem is getting worse *(see previous section)*
  - **Urological pathology**
    - Kidney/bladder stones
    - Chronic cystitis/urethritis
    - Interstitial cystitis/urethral syndrome
  - **GI pathology**
    - Constipation
    - Irritable bowel syndrome
    - Hernia
    - Colorectal cancer
- **History**
  - Pain: SOCRATES, emphasis on pattern, any relationship to menstrual cycle and movement
  - Gynae: LMP, menstrual history, contraception, previous infections, abnormal discharge/bleeding
  - Obs: parity, details of past pregnancies and deliveries, plans for future pregnancies
  - Uro: urinary symptoms, history of infections/stones
  - GI: any change in bowel habit, bloating, PR bleeding, appetite, weight loss
  - Neuro: altered sensation, paraesthesiae, allodynia, psychological state
  - Patient's perceptions of potential causes and associations
- **Examination**
  - General examination of patient's state of health
  - Abdominal examination: assess for tenderness, masses, hernias
  - Pelvic examination
    - Cusco speculum: bleeding/discharge; inspection of cervix
    - Bimanual palpation: size, position, tenderness, mobility and consistency of uterus; pelvic floor tension/trigger points; adnexal tenderness or masses; cervical excitation tenderness
  - PR if indicated
- **Investigations**
  - Pain diaries can be helpful
  - Urinalysis and MSU
  - Triple swabs during speculum examination if indicated
  - Bloods: FBC, CRP
  - Pelvic USS: to assess pelvic organs → XR/contrast studies/CT/MRI if indicated
  - Diagnostic laparoscopy if indicated (e.g. suspected endometriosis, PID, adhesions)
- **Basic management**
  - Prompt management of specific cause if found (or appropriate referral for treatment)
  - Appropriate **analgesia** using analgesic ladder and adjuncts
  - **Physiotherapy** can be helpful in up to 75% of cases
  - **Hormonal measures** (as for menorrhagia) are often effective e.g. OCP, Mirena IUS, GnRHas
  - **Hysterectomy** may be considered as a last resort