

Pelvic Pain:

An Approach to Making It Your Favorite Chief Complaint

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Why Review Pelvic Pain?

- Common Problem
- Challenging Problem
- Frustrating Problem



Goal:

Create a framework to expedite the evaluation of the complaint; to improve the accuracy of the diagnosis; to provide the appropriate treatment, follow-up, or referral



Outline

- History
- Physical
- Testing
- Assessment
- Differential Diagnosis
- Management



History

SONRIFLAD

- Setting
- Onset
- Nature
- Radiation
- Intensity
- Features
- Location
- Associations
- Duration



Setting

- What was happening when the pain FIRST started?
- Trauma, activity, intercourse, medicines, stressors



Onset

- How quickly does the pain develop?
- Seconds, minutes, hours



Nature

- What is the quality or flavor of the pain?
- Stabbing, burning, stretching, tearing, cramping (menstrual, intestinal, bladder, musculo-skeletal), aching, pressure, gnawing, boring, etc.



Radiation

- Does the pain spread or shoot anywhere?
- To the low back, into the legs, into the vagina or labia, to one side or the other, into the rectum, toward the chest



Intensity

- Where is the pain on a scale of 1-10?
- Be sure to give the patient a reference for her pain (what 10 really means).
- Does her appearance of discomfort correspond with her response?



Features

- Other aspects of the pain
- Does it wax and wane?
- What makes it better or worse - activity, time of menstrual cycle medicines, position changes, urination/defecation, time of day, intercourse, stress?
- Ever had this pain before?



Location

- Where is the pain located?
- Midline, right, left, suprapubic, intravaginal, anterior iliac crest, sacro-iliac joint, inguinal area - use cm's distant from anatomic landmarks
- Strive to get as precise a location as possible ("Point to the location with one finger.")



Associations

- What are other concurrent problems?
- Headaches, low back pain, upper respiratory infection, psycho-social dysfunction, stressors, concurrent or long standing medical problems
- Some of these may be elicited in other parts of the history (Past Med, Gyn, etc.)



Duration

- How long has the pain been present?
- Brief, prolonged; days, months, years; last for days at a time, then resolves.



Other Medical History

- Gynecologic
- Obstetric
- Medical
- Surgical
- Family
- Psycho-social



Gynecologic History

- LMP (relation of pain to cycle)
- STD's and treatment
- Pap smear results
- Contraception, number/new partners, sexual preference
- H/O rape, sexual assault/abuse
- Menopausal symptoms



Obstetric History

- Gravity, Parity
- Complications
- Surgical interventions - cesarean section, episiotomy and repair, forceps
- Miscarriages, ectopics, treatments



Past Medical History

- Concurrent illnesses
- Medicines - OCP's, fertility treatments
- Allergies
- Use to develop suspicions for some diagnoses, or R/O others



Past Surgical History

- Especially abdominal events, and indications
- Review of findings, outcomes, relation to pain



Family History

- Few heritable causes of pelvic pain
- Review may give insight to current problems and their significance to the patient (ovarian CA, sister had hysterectomy for pain at age 22)



Psychosocial History

- Alcohol, tobacco, drugs
- Home life, relationships, marriage, social support, access to care, stability of lifestyle
- Employment
- Secondary gain - employer, insurance, lawsuit
- Meaning of the pain in the patient's life



Do I Need to Gather ALL This Information?!?

- Tailor detail to symptoms
- Many patients lack verbal dexterity, so they need examples for elaboration
- Patients may need prompting to make a connection, or permission to have a diagnosis, or to overcome denial
- Creates atmosphere of interest, empathy, understanding, collaboration



Non-Verbal Cues

- Quality of the responses - vague, inconsistent, evasive, frustrating answers suggest that the real problems aren't being addressed
- Body language - eye contact, affect, distraction, mobility, posture - use to corroborate verbal information, identify topics to revisit (abuse, drugs, sex, etc.)



Physical Exam

- Usually used to confirm dx from history
- Again, use to non-verbal cues to develop overall picture - appearance, affect, mobility in office and on table, distraction, consistency of findings



Physical Exam (cont.)

- Vital Signs (fever, pain manifestation)
- Abdomen - focus of pain, peritoneal signs, masses, localization, referred pain, reproducibility, consistency, surgical scars, hernias
- Pelvic/RV - same as for abdomen; appearance of tissue, masses, reproduction of symptoms, new pain



Physical Exam (cont.)

- Orthopedic
- Neurologic
- Mental Status
- As indicated



Helpful Tests

- For most patients - HCG, GC/Chlamydia, UA, C&S (Pap if due)
- More selectively - CBC, wet prep ultrasound, x-rays, stool guaiac, drug screen, other STD's, flexible sigmoidoscopy, psychiatric evaluation
- Will choose based on differential diagnosis



Diagnosis

- Obvious or very likely etiology - go right to treatment (UTI, dysmenorrhea, PID)
- Several likely diagnoses - FU after confirming test results
- Baffling, obscure, inconsistent, testing no help - go to consultation
- BUT - what are my choices?



Pelvic Pain: Differential Diagnosis

- Gynecologic
- Gastrointestinal
- Urologic
- Orthopedic
- Psycho-social
- Other



Gynecologic

- Ovary
- Fallopian Tube
- Uterus
- Cervix
- Vagina
- Vulva
- Pregnant
- Diffuse
- Post-operative



Ovary

- Cyst/Rupture
- Torsion
- Ovulation
- Ovarian Hyperstimulation Syndrome
- Cancer



Fallopian Tube

- PID
- Ectopic
- Hydrosalpinx
- ?Post-Tubal Syndrome?



Uterus

- Fibroids
- Adenomyosis
- Endometritis/PID
- Prolapse
- Polyp
- IUD
- Dysmenorrhea



Cervix

- Menses/Stenosis
- Infection



Vagina

- Infection
- Trauma (recent, remote, childbirth)
- Scar Tissue (trauma, episiotomy)
- Vaginismus
- Hypoestrogenism
- Foreign Body
- Cyst (Bartholin's, Gartner's Duct)



Vulva

- Infection
- Trauma
- Dystrophy



Pregnancy

- ECTOPIC, ECTOPIC, ECTOPIC
- Miscarriage



Diffuse

- Endometriosis
- Adhesions
- Infection



Post-operative

- Endometriosis
- Pelvic adhesive disease
- Foreign body (IUD, surgical tools)
- Get patient's surgeon involved



Urologic

- Urinary tract infection
- Detrusor instability
- Interstitial cystitis
- Nephrolithiasis
- Suburethral diverticulitis
- Urethral syndrome



Gastrointestinal

- Appendicitis
- Constipation
- Irritable bowel syndrome
- Cholelithiasis
- Diverticular disease
- Enterocolitis
- Ulcer
- Malignancy
- Hernia
- Pancreatitis
- Inflammatory bowel disease
- Small bowel obstruction



Orthopedic

- Arthritis
- Disc problems
- Hernia
- Low back pain
- Muscle spasm
- Nerve entrapment
- Fractures
- Strain/sprain/ overuse
- Radiculopathy
- Trauma



Psycho-social

- Abuse (child, spouse, sexual)
- Psychiatric disorders (depression)
- Stress
- Substance abuse
- Sleep disturbance
- Secondary gain
- Somatiform disorder



Other

- Heavy metal poisoning
- Hyperparathyroidism
- Porphyria
- Sickle cell disease
- Sympathetic dystrophy
- Tabes dorsalis



Guiding Your Treatment

- If clear diagnosis with finite treatment period, do it.
- If not, clarify the patient's desires:
 - does she want a cure/definitive treatment
 - does she want to exclude a serious problem (cancer, infertility)
 - does she want reassurance that it's minor, normal, or just one of those things



When to Refer

- Deterioration
- Failed treatments
- Uncomfortable with management
- Decreased effectiveness of collaboration
 - personality clashes (disorders)
 - deception, distrust
 - non-compliance

