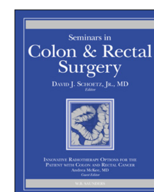
Seminars in Colon and Rectal Surgery 27 (2016) 59–63

Contents lists available at ScienceDirect

Seminars in Colon and Rectal Surgery

journal homepage: www.elsevier.com/locate/yscrs



# Management of pelvic pain

Pouya Javadian, MD[a], S. Abbas Shobeiri, MD, FACOG, FACS[b,*]

[a] Division of Female Pelvic Medicine and Reconstructive Surgery, Department of Obstetrics and Gynecology, The University of Oklahoma Health Sciences Center, Oklahoma City, OK
[b] Virginia Commonwealth University, Inova Fairfax Campus, Falls Church, VA

ABSTRACT

Pelvic pain is a common complaint of women which is frequently poorly managed. Diagnosis of pelvic pain in women can be challenging because many symptoms and signs are insensitive and nonspecific. The complex innervation of the pelvis and the anatomical proximity of pelvic viscera mean this symptom frequently overlaps traditional medical specialties, leading to diagnostic delay and frequently inadequate treatment. As the first priority, urgent life-threatening conditions (e.g., ectopic pregnancy, appendicitis, ruptured ovarian cyst) and fertility-threatening conditions (e.g., pelvic inflammatory disease, ovarian torsion) must be considered. Careful history taking and examination can in itself be therapeutic and will likely identify a number of causal and perpetuating factors which should be managed within the context of a multidisciplinary clinic. This review will provide a comprehensive summary of pelvic pain management in women for the generalist in order to facilitate appropriate investigation and management.

© 2016 Published by Elsevier Inc.

## Introduction

A variety of gynecologic, gastrointestinal, urologic, musculoskeletal, and body-wide disorders can cause pelvic pain. Pelvic pain may be either acute or chronic and may be due to a wide spectrum of causes. Chronic pelvic pain (PP) is defined as intermittent or constant pain in the lower abdomen or pelvis for at least 6 months in duration, with subsequent impact on ability to attend to daily living activities.[1] Acute pelvic pain, defined as noncyclic pain lasting for less than 3 months, is a common presenting symptom of premenopausal women in an emergency department or physician's office. In contrast to chronic pain, acute pain is useful in signaling tissue damage and prevents further damage from occurring. Sometimes, however, the sensation of pain outlasts the expected time of tissue healing, which leads to a more chronic condition, which is often debilitating and difficult to treat.[2] The socioeconomic cost of PP is considerable, the total expenditure involved in the treatment has been estimated to be more than $2.8 billion in direct and greater than $555 million in indirect costs.[3] Because of PP's multifactorial nature, it is critical to identify and address all contributing aspects rather than assigning causality to a single pathology.

This manuscript will provide a comprehensive summary of pelvic pain management in women and facilitates appropriate investigation and management.

* Correspondence to: Inova Fairfax Hospital Women's Center, 3300 Gallows Rd, Suite W6306, Falls Church, VA 22042.
*E-mail address:* abbas.shobeiri@inova.org (S.A. Shobeiri).

http://dx.doi.org/10.1053/j.scrs.2015.12.004
1043-1489/© 2016 Published by Elsevier Inc.

## Management strategies

### *Patient with acute pelvic pain*

Pelvic pain causes can be further categorized into obstetric and non-obstetric; accordingly, pregnancy test is the first step in the evaluation of a woman at reproductive age. Novice physicians may focus on an organ-specific approach to explain or identify the pain source. However, pelvic pain's multifactorial nature bridges specialties and make it difficult to establish a diagnosis with focus on one specific organ. Even though we artificially divide the pelvic into anterior, posterior, or lateral, in reality pelvic floor functions as cohesive interconnected entity. Broad range of gynecologic and non-gynecologic causes related to pelvic pain are summarized in the Table.

The clinician's first priority is to identify life-threatening conditions requiring emergent management. Women presenting in shock or with peritoneal signs may require immediate surgical intervention. For patient in acute pain, location, onset and duration, and character and prior history of pain are important points to be addressed initially. Based on pain nature, patients should be encouraged to talk about their symptoms and ideas regarding causation because they often have an existing theory about the pain's source.

For patient with acute pain, the first priority is to rule out emergent life-threatening conditions including appendicitis, ectopic pregnancy, and ruptured tubo-ovarian abscess or diverticulitis. Detailed pain history serves to narrow differential diagnoses. Physical examination would further guide to early

**Table**
Differential diagnosis of pelvic pain.

| Causes of pelvic pain | | | | | | |
|---|---|---|---|---|---|---|
| Gynaecological | Gastrointestinal | Urological | Neurological | Musculoskeletal | Pregnant women | Other |
| Endometriosis | Irritable bowel syndrome | Interstitial cystitis | Pudendal neuralgia | Fybromyalgia | Corpus luteum hematoma | Dissecting aortic aneurysm |
| Adenomyosis | Inflammatory bowel disease | Urethral syndrome | Trigger points | Osteoporosis | Endometritis | Malingering |
| Pelvic inflammatory disease | Coeliac disease | Painful blader syndrome | Nerve entrapment | Tumors | Ovarian vein thrombosis | Porphyria |
| Pelvic congestion syndrome | Constipation | Ureterolithiasis | Lead poisoning | Scoliosis/Kyphosis | Uterine impaction | Sickle cell crisis |
| Adhesions | Appendicitis | Pyelonephritis | Somatization disorder | Triger points | | Narcotic seeking |
| Residual ovary syndrome | Diverticulitis | | | Piriformis syndrome | | |
| Ectopic pregnancy | Inguinal hernia | | | Hernia | | |
| Mittelschmerz | Mesenteric venous thrombosis | | | | | |
| Ovarian torsion | | | | | | |
| Tubo-ovarian abscess | | | | | | |

diagnosis. Pregnancy test and urinalysis should be done before any imaging study. In patients with acute pain, it should be considered that early diagnosis is vital to halt permanent sequelae of damaged organs. If the origin of pain is confusing (e.g., RLQ), imaging studies may be of significant help. Young women should always be checked for sexually transmitted infections (STI). PID should be considered in young women who are sexually active and in other women at risk of STIs when they experience pelvic or lower abdominal pain and no other cause is apparent. Common causative organisms include *Chlamydia trachomatis*, *Neisseria gonorrhoea*, *Gardnerella vaginalis* and anaerobic infection. This is essentially important as in approximately 70% of patients with infertility due to obstructed fallopian tubes, chlamydia antibodies is detected, presumably from a missed diagnosis of PID. Pelvic sonography has a fundamental role in evaluation of acute pelvic pain. Acute pelvic pain in a woman can be secondary to a variety of disorders, which may be difficult to differentiate on clinical grounds. The history and physical examination narrow the differential diagnosis and allow the physician to choose the proper imaging test, because many of the diagnoses considered in acute pelvic pain require confirmatory testing. Transvaginal sonography (TVS) and endovaginal sonography (EVS) with higher resolution of anatomic details are always the first option. In case the uterine and adnexal structures are not in the field of view by transvaginal probe, a trans-abdominal sonography (TAS) is recommended. Color or power Doppler imaging are of interest when vascularity of the pelvic structures is needed to be visualized. Abdominal/pelvic computed tomography (CT) and/or magnetic resonance imaging can be used for further evaluation in cases of diagnostic uncertainty. Laparoscopy is sometimes indicated in the evaluation of acute pelvic pain, especially when the diagnosis is not clear and diagnoses may be potentially life-threatening or organ-threatening disorders including: appendicitis, pelvic inflammatory disease, diverticulitis, and ovarian torsion. Evaluation approach is summarized in the Figure

### *Patient with chronic pelvic pain*

The diagnosis should be made based on the associated pathologies and management strategies should be started by targeting the underlying pathological cause. In patients with chronic PP, identification of predisposing risk factors, chronic pain mechanisms, associated visceral and musculoskeletal dysfunctions are important. A six-point strategy for phenotyping patients with urological pelvic pain has been suggested,[4] which include the evaluation of the following systems: urinary, psychosocial, organ specific, infection, neurological/systemic, and musculoskeletal tenderness.

In our practice, we use the onion strategy. Most of the offending etiologies may be found with a thorough history taking and physical examination. We peel the patient's pain away by treating

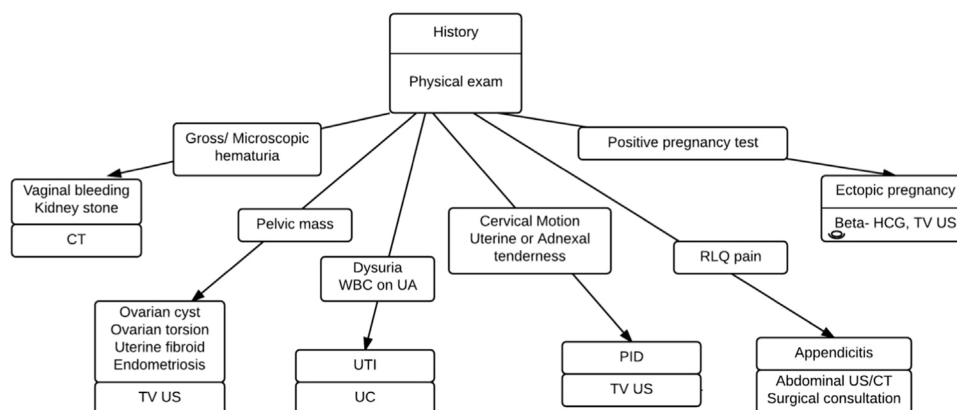



**Fig.** Approaches for the evaluation of acute pelvic pain in women. HCG: human chorionic gonadotropin, TV: trans-vaginal, US: ultrasound, CT: computed tomography, RLQ: right lower quadrant, PID: pelvic inflammatory disease, UTI: urinary tract infection, UA: urine analysis, UC: urine culture, WBC: white blood cell.

Download English Version:

https://daneshyari.com/en/article/3319224

Download Persian Version:

https://daneshyari.com/article/3319224

Daneshyari.com