Pelvic Pain

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| general surgery,o&g,onthepods

Summary Writer: Amanda White

Editor: James Edwards

Interviewee: Natasha Andreadis

James talks to Dr Natasha Andreadis about managing patients presenting with pelvic pain on the wards and in the Emergency Department.

Natasha is a Gynaecologist, Certified Reproductive Endocrinologist and Infertility specialist (CREI) who works in private practice Newtown, Sydney. This qualification is held by only a limited number of doctors in Australia and NZ. CREI sub-specialists are the most qualified of gynaecologists to manage infertility and hormonal issues. Beyond this, Natasha is an Integrative Fertility Specialist. She is currently completing further studies in Nutrition and Environmental Medicine and incorporates this focus in her daily practice, for is not only the developing embryo that is exquisitely sensitive to diet and environment but children and adults. She helps people restore and maintain good health and is actively involved in Sarah Wilson's I Quit Sugar Programme. As a Lecturer at Sydney University Medical School, she inspires future doctors to adopt the same integrative clinical approach.

Pelvic Pain

With Dr Natasha Andreadis, Gynaecologist, Reproductive Endocrinologist and Infertility Specialist

Introduction

Junior doctors encounter patients presenting with pelvic pain on a regular basis, particularly in the Emergency Department. It is essential to take a systematic and thorough approach to examining and investigating these patients, as there is a considerable – and sometimes confusing – overlap of medical specialties that are involved in treating the various pathologies causing pelvic pain.

Case 1 – Young female presents to the Emergency Department with right iliac fossa pain and nausea.

1. Initial approach?

- **Aim to spend the first few minutes getting to know the patient with a few questions around social history and general medical history. This will help you to quickly establish rapport with the patient, and will help you better understand the pain**

- Simultaneously ensure the nurse is attending to the patient (by measuring vital signs, ensuring patient is NBM, inserting IV cannula, making the patient comfortable)
- Then lastly, focus on the pain historyusing acronyms such as'SOCRATES' (site, onset, character, radiation, associations, timing, exacerbating/relieving factors, severity)
- It may be helpful to ask the patient for their opinion on what is causing the pain – don't underestimate the insight some patients will possess

2. Outline your assessment approach by the bedside

- **History**
    - Gynaecological history
        - First day of last known menstrual period
        - Establish which day in their cycle they are
        - Are they sexually active? Are they using contraception?
        - Abnormal vaginal bleeding?
        - Vaginal discharge?
    - Obstetric history
    - Medical history
    - Regular medications
    - Gently enquire about a history of sexual abuse
    - Previous ED presentations for similar complaints e.g. may point to a diagnosis of recurrent haemorrhagic cysts
- **Examination**
    - General inspection to gauge the severity of the pain
    - Abdominal examination
        - Inspection for distension, scarring
        - Palpation for guarding, rigidity
    - Speculum examination including swabs if PID is suspected
    - Bimanual examination
        - Tenderness at introitus?
        - Nodules of endometriosis?
        - Cervical excitation?
            - A quick note regarding examining for cervical excitation: upon insertion of fingers into vagina, find cervix (feels like tip of nose), place fingers into posterior fornix and wiggle gently. If there is no inflammation there, this manoeuvre should not cause discomfort. Sometimes just touching cervix gently or gently moving cervix can cause a significant amount of pain for the patient, so be careful.

    - Uterine tenderness?
    - Adnexal tenderness?
  - Explain to the patient what and why you are examining, for e.g. “I am doing this to try and find a cause for your pain”
  - Positioning is important. Ensure privacy in the emergency department by positioning the patient facing the wall. It is not advised to put the patient in stirrups, as this is likely to increase their discomfort/anxiety.

3. Differential diagnosis

- The doctor should have a differential diagnosis in mind before seeing the patient, as this will help frame their questions on history taking
- It should be divided into non-gynaecological (appendicitis, UTI etc.) or gynaecological(PID [may be associated with tubo-ovarian abscess], ectopic pregnancy, infection, torsion [with or without associated ovarian cyst], ruptured haemorrhagic corpus luteum etc.)
- Junior doctors are advised to verbalise their working list/hypotheses to the patient as it may help comfort the patient, and also helps to keep the doctor focused
- Haemorrhagic corpus luteum is a common cause for pain in a patient who is in the luteal phase of their menstrual cycle (after ovulation). The corpus luteum is formed after ovulation and is quite vascular, so can be prone to rupture.
- Note that PID is a clinical diagnosis. There is a lack of reliable tests to rule out PID, so clinicians should have a low threshold for prescribing antibiotics. It can result from either;
    - Sexually-transmitted infections (e.g. chlamydia or gonorrhea) or;
    - Non-sexually transmitted infections (e.g. spread of infectious organisms from IUD insertion, termination of pregnancy, appendicitis)

4. Investigations

- Urine for dipstick, microscopy/culture/sensitivities (MCS), chlamydia and gonorrhea PCR
- Blood tests include FBC/UEC/LFT/B-hCG if sexually active
- Peripheral blood cultures should be attained if the patient is febrile
- IfPID is suspected, perform a high vaginal swab for MCS and an endocervical swab for chlamydia PCR
- A low vaginal swab for MCS may also be indicated
- Imaging
    - Any woman who presents to the Emergency Department with pelvic pain should have a pelvic ultrasound, whether that is in the context of admission to hospital or in an outpatient setting

- Reliability of outpatient ultrasound results can differ according to the quality of the radiology service
- Imaging can be diagnostic in the case of ovarian cyst (e.g. dermoid cyst, endometrioma, haemorrhagic corpus luteum), free fluid in the Pouch of Douglas, hydrosalpinges, or ectopic pregnancy
- If ovarian torsion is suspected in the patient, be sure to include this in the ultrasound request form, so that analysis of the blood flow to the ovaries will be performed. Be aware however that normal blood flow will not rule out an ovarian torsion, as it may be an intermittent, recurring process. In that situation laparoscopy is the only way that the diagnosis can be made.

- Concerning features suggesting ovarian torsion include;
    - Niggling pain in the iliac fossa that usually comes and goes, but then presents acutely as severe and prolonged pain
    - Increasing pain over hours
    - Association with nausea and vomiting
    - High temperature

5. Case update: the B-hCGhas returned as negative, the white cell count is elevated at 11, and the urine dipstick is clear. What are the next steps?

- These results help to exclude a lot of the differential diagnoses, including ectopic pregnancy
- In this situation, antibiotic treatment is still advised
- Be sure to give adequate analgesia
- Consider admission to hospital. Often a patient like this would need to be admitted for further investigations (e.g. ultrasound scan, diagnostic laparoscopy etc.), observation and treatment of pain, and perhaps IV antibiotic treatment.
- Consider whether surgical/O&G teams need to be involved.
- Gynaecology team review is advised if the diagnosis is unclear (diagnostic laparoscopy may be indicated), or if the patient needs IV antibiotic treatment (necessitating admission to hospital).
- Oral versus IV antibiotic choice
    - An intravenous dose of ceftriaxone and metronidazole can be given to the patient in the emergency department, followed up with oral doxycycline on discharge
    - If the patient is unwell and febrile, perhaps with significant leukocytosis, a more prolonged course of intravenous antibiotics is indicated

- This patient needs clear discharge instructions in regards to medication, the need for an outpatient ultrasound scan andthe need for follow up in the gynaecology clinic. Consider whether treatment for chlamydia or gonorrhea is required for the patient's sexual partner/s, and in that instance consider whether contact tracing needs to be done. Ensure good follow up is arranged for the purpose of reviewing analgesia, and prevention/treatment of constipation. Give the patient clear

instructions on whom to call if they are concerned, and of course advise the patient to represent to the emergency department at any time if they wish.

Take home messages

- Always strive to treat every patient as a human being
- Be sure to take the patient's pain seriously, and make that known to the patient. Feeling misunderstood, or that the doctor is not taking them seriously, can be a further cause of distress
- Try to achieve a balance of holistic and integrative approaches. This is possible even in the emergency department, and will make the patient feel well cared for.

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