Pelvic Pain

Summary from Rosen's By Justin Yuan

Epidemiology

- Pelvic pain common and presentation may be diffuse or lower abd pain, pelvic pain, or low back pain
- >1/3 of reproductive age women will have non-menstrual pelvic pain
- Ectopic account for 2% 1st trimester pregnancies, but among ED visits the incidence is as high as 18%
- Incidence of heterotopic pregnancy is 1 in 8000 and of special concern for women undergoing fertility treatment (1/100)

Pathophysiology

- Visceral pain afferents that supply pelvic organs also supply appendix, ureters, colon
- Pain 2/2 inflammation, distention, ischemia, or blood, pus, or other material in the pelvis
- Parietal pain due to afferent nerves in the parietal peritoneum adjacent to an affected organ are stimulated

Differential Diagnosis

- MCC fit into 3 categories:
- 1) Reproductive: Ovarian torsion/cyst, PID, TOA, Endometriosis, Endometritis, Uterine perforation, Fibroids, Dysmenorrhea,
    - Pregnancy 1st Tri: Ectopic, threatened abortion, nonviable pregnancy, ovarian hyperstimulation syndrome
    - Pregnancy 2/3rd Tri: Placenta previa/abruption, round ligament pain, labor/Braxton-Hicks, Uterine Rupture
- 2) Urinary: Pyelonephritis, Cystitis, Ureteral Stone
- 3) Intestinal: Appendicitis, diverticulitis, ischemic bowel, perf viscus, bowel obstruction, hernia, IBD, GE, IBS
- Other possible causes: septic pelvic thrombophlebitis, ovarian vein thrombosis, pelvic congestion syndrome, depression, herpes zoster
- ED prevalence of potentially catastrophic causes of pelvic pain: ectopic (common), ruptured ovarian cyst (uncommon), Torsion (uncommon), appy (common), PID (common), TOA (uncommon)

Signs and Symptoms

- Location of pain and radiation pattern helpful in focusing diff dx (i.e. lateral pelvic pain often in tube or ovary)
- Abnormal vaginal d/c in vaginitis, cervicitis, endometritis, PID, and retained FB
- CMT most commonly indicates reproductive tract inflammation but also of adjacent structures
- Fundal tenderness difficult to distinguish from cystitis but can suggest PID, endometritis, necrotic fibroids
- Unilateral adnexal mass/tenderness suggest ovarian cyst, ectopic, TOA, torsion
- Constellation of adnexal/uterine tenderness and CMT is classically PID

Work-up

- Complete H&P including LMP, menstrual patterns, sexual activity, obstetric history,
- Pelvic exam performed in almost all patients including pregnant patients <20weeks; >20weeks w/vag bleeding should undergo TA pelvic US for placental localization before pelvic, have FHR measured, and may need timely OB consult
- Pregnancy test in all childbearing age patients w abdominal pain
    - If positive- bedside or formal US to r/o ectopic (should visualize a yolk sac or embryo for confirmation of IUP)
- UA (absence of hematuria does not r/o ureteral stone but does lower likelihood and pyuria can be seen in extravesicular conditions such as appy)
    - Should be performed in all pregnant patients w/ pelvic pain
- Possible hemorrhage- H&H, type and crossmatch, pregnant patients with vaginal bleeding require blood typing

Empiric Management

- Critical most likely hemorrhaging and needs rapid resuscitation with fluid, blood products, FAST, and most likely surgical intervention
    - <20 weeks pregnant- presumed ectopic: rapid resuscitation, STAT gyn consult, FAST, and RhoGAM prn
- If in septic shock- volume resuscitation, abx, surg/gyn consult, imaging when stabilized

Disposition