Pelvic Pain

Pelvic pain is both a common presentation in primary care and one of the most common reasons for referral to a gynaecologist. Pelvic pain may be either acute or chronic.

Acute pelvic pain

Acute pelvic pain is much more common in women than in men. Most women experience mild pelvic pain at some time due to periods, ovulation or sexual intercourse. In its severest form, it is the most common reason for urgent laparoscopic examination in the UK.

Aetiology

Common causes include pelvic inflammatory disease (PID), urinary tract infection (UTI), miscarriage, ectopic pregnancy and torsion or rupture of ovarian cysts.

- Pregnancy-related: miscarriage, ectopic pregnancy, rupture of corpus luteum cyst; causes in later pregnancy include premature labour, placental abruption and uterine rupture.
- Gynaecological: ovulation (mid-cycle, may be severe pain), dysmenorrhoea, PID, rupture or torsion of ovarian cyst, degenerative changes in a fibroid; the possibility of a pelvic tumour or pelvic vein thrombosis must also be considered.
- Other causes include appendicitis, irritable bowel syndrome, UTI, adhesions, strangulated hernia, prostatitis in men.

Investigations

- Urinalysis, midstream specimen of urine (MSU).
- High vaginal swab (HVS) for bacteria and endocervical swab.[1]
- Pregnancy test.
- FBC.
- Urgent ultrasound (if miscarriage or ectopic pregnancy is suspected).
- Laparoscopy.

Management

- Management is based on identifying and treating the cause. Empirical use of antibiotics and analgesia without a clear diagnosis must be avoided.
- Referral is required if the diagnosis cannot be established (especially if there is a possibility of urgent treatment being required, eg ectopic pregnancy, appendicitis), the patient is haemodynamically unstable or if there is no response to treatment in primary care.

Chronic pelvic pain

Chronic pelvic pain is much more common in women than in men. It may occur in as many as 1 in 6 adult women.[2]

- Chronic pelvic pain is defined as non-malignant pain, perceived in structures related to the pelvis of either men or women, that has been continuous or recurrent for at least six months. It is a symptom, not a diagnosis.[3]
- Chronic pelvic pain presents in primary care at a rate of 38 per 1,000 women per year, comparable to that of asthma (37 per 1,000) and back pain (41 per 1,000).[4]
- No organic cause for the pain is found at laparoscopy in at least 33% of cases.[5]

Aetiology

- Endometriosis, adenomyosis: cardinal symptoms are dysmenorrhoea, dyspareunia and chronic pelvic pain but symptoms alone are a poor predictor of diagnosing endometriosis. The combination of clinical examination and transvaginal ultrasound accurately identifies ovarian endometriosis but not peritoneal disease.
- Pelvic venous congestion has been proposed as a cause of pelvic pain, but there is no consensus.
- Fibroids.
- PID. [6]
- Adhesions may be a cause of pain but can also be asymptomatic.
- Gastrointestinal, eg irritable bowel syndrome, diverticular disease.
- Urological, eg interstitial cystitis (also called bladder pain syndrome), chronic urethritis, urinary tract calculi.
- Musculoskeletal pain, eg low back pain, fibromyalgia.
- Postherpetic neuralgia.
- Psychological and social issues commonly occur in association with chronic pelvic pain and may be important in resolving symptoms. [4]

Other causes in men include epididymo-orchitis, prostatitis and testicular tumours. [3] [7]

Presentation

- Initial history should include questions about the pattern of the pain and its association with other problems. These may include psychological, bladder and bowel symptoms and the effect of movement and posture on the pain.
- Although many symptom complexes (eg irritable bowel syndrome) and pain perception itself may vary a little with the menstrual cycle (50% of women experience a worsening of their symptoms in association with their period), strikingly cyclical pain is usually gynaecological in nature, eg endometriosis.
- Suggested red flag symptoms and signs: [2]
    - Bleeding per rectum.
    - New bowel symptoms in patients over 50 years old (see 'Investigations', below).
    - New pain after the menopause.
    - Pelvic mass.
    - Suicidal ideation.
    - Excessive weight loss.
    - Irregular vaginal bleeding in patients over 40 years old.
    - Postcoital bleeding.

Investigations

- Samples to screen for infection (particularly chlamydia and gonorrhoea) should be taken if there is any suspicion of PID. Ideally, all sexually active women below the age of 25 years who are being examined should be offered opportunistic screening for chlamydia.
- FBC, CRP.
- Ca125 measurement is appropriate if symptoms suggesting ovarian cancer are experienced. A new diagnosis of IBS in a woman aged over 50 years is suspicious. [2]
- Urinalysis and send MSU.
- Transvaginal ultrasound scanning is an appropriate investigation to screen for and assess adnexal masses.
- Transvaginal scanning and magnetic resonance imaging (MRI) are useful tests to diagnose adenomyosis. The role of MRI in diagnosing small deposits of endometriosis is uncertain.
- Diagnostic laparoscopy has been regarded in the past as the gold standard in the diagnosis of chronic pelvic pain. It may be better seen as a second line of investigation if other therapeutic interventions fail. [2]
- Further urological investigations, eg cystourethroscopy, and/or bowel investigations, eg barium enema, may be required.

Management

Management is focused on identifying and treating the cause but the psychosocial causes and effects of chronic pelvic pain should also be considered. [2]

- The multifactorial nature of chronic pelvic pain should be discussed and explored with the patient from the start. The aim should be to develop a partnership between clinician and patient to plan a management programme.
- The woman should be given adequate time to tell her story. A symptom diary may be useful.
- Appropriate management of any specific underlying disorder.
- Many women with chronic pelvic pain can be managed in primary care. Referral should be considered when the pain has not been explained to the woman's satisfaction or when pain is inadequately controlled.
- If the history suggests a non-gynaecological component to the pain, referral to a gastroenterologist, urologist, genitourinary specialist, physiotherapist, psychologist or psychosexual counsellor should be considered.
- Women with IBS may be managed with antispasmodics, diet and simple analgesia (if other measures are unsuccessful).
- Women with cyclical pain should be offered a therapeutic trial using the combined oral contraceptive pill or a gonadotrophin-releasing hormone (GnRH) agonist for a period of three to six months before having a diagnostic laparoscopy.[2] The levonorgestrel-releasing intrauterine system (Mirena® coil) could be considered.
- Division of fine adhesions has not been proven to be beneficial.[2]
- Appropriate analgesia to control pain, even if no other therapeutic manoeuvres are yet to be initiated. If pain is not adequately controlled, there may be a need to refer the patient to a pain management team or a specialist pelvic pain clinic.

Further reading & references

- Management of prostatitis, British Association for Sexual Health and HIV (2008)
- MAPP Research Network, Multidisciplinary Approach to the Study of Chronic Pelvic Pain - collaborative research on urological chronic pelvic pain disorders
- Guidelines on chronic pelvic pain; European Association of Urology (2014)

1. Management of Pelvic Inflammatory Disease; British Association for Sexual Health and HIV (2011)
2. The initial management of chronic pelvic pain, Royal College of Obstetricians and Gynaecologists (May 2012)
3. Guidelines on Chronic Pelvic Pain, European Association of Urology (2012)
4. Latthe P, Mignini L, Gray R, et al; Factors predisposing women to chronic pelvic pain: systematic review. BMJ. 2006 Apr 1;332(7544):749-55. Epub 2006 Feb 16.
5. Daniels JP, Khan KS; Chronic pelvic pain in women. BMJ. 2010 Oct 5;341:c4834. doi: 10.1136/bmj.c4834.
6. Pelvic inflammatory disease, Prodigy (Aug 2009)
7. Prostatitis - acute; NICE CKS, February 2009

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