

# **PELVIC**

**Acute pelvic pain**

**Chronic pelvic pain**

**Groin swellings**



# ACUTE PELVIC PAIN

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## The GP overview

This is nearly always seen in women rather than men. In its mildest form it is experienced universally at some time or other associated with periods, ovulation or sexual intercourse. In its severest form it is the commonest reason for urgent laparoscopic examination in the UK.

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## Differential diagnosis

### COMMON

- ❑ acute pelvic inflammatory disease (PID)
- ❑ urinary tract infection (UTI)
- ❑ miscarriage
- ❑ ectopic pregnancy
- ❑ ovarian cysts: torsion, rupture

### OCCASIONAL

- ❑ pelvic abscess (appendix, PID)
- ❑ endometriosis
- ❑ pelvic congestion (exacerbation of pelvic pain syndrome)
- ❑ prostatitis (men)
- ❑ functional (psychosexual origin)

### RARE

- ❑ misplaced IUCD (perforated uterus)
- ❑ referred (e.g. spinal tumour, bowel spasm)
- ❑ proctitis
- ❑ invasive carcinoma of ovaries or cervix
- ❑ fibroid degeneration
- ❑ strangulated femoral or inguinal hernia

## Ready reckoner

	<i>PID</i>	<i>UTI</i>	<i>Miscarriage</i>	<i>Ectopic</i>	<i>Ovarian cyst</i>
Abnormal vaginal bleeding	Possible	No	Yes	Possible	No
Purulent discharge PV	Yes	No	No	No	No
Fever	Yes	Yes	No	No	No
Palpable mass	No	No	Possible	No	Possible
Tender uterus PV	Yes	No	Possible	No	No

## Possible investigations

*LIKELY:* HVS, cervical swab, urinalysis, MSU.

*POSSIBLE:* FBC, pregnancy test, ultrasound, laparoscopy (all usually arranged by hospital admitting team).

*SMALL PRINT:* none.

- ❑ Urinalysis: look for nitrites and pus cells to make diagnosis of UTI.
- ❑ MSU will confirm UTI and guide antibiotic treatment.
- ❑ HVS for bacteria including gonococcus and endocervical swab for *Chlamydia* if purulent discharge present.
- ❑ Pregnancy test: positive in ectopic and miscarriage.
- ❑ FBC: raised WCC helps confirm PID and UTI if not being admitted. Also elevated in pelvic abscess.
- ❑ Urgent ultrasound helpful if miscarriage or ectopic pregnancy suspected.
- ❑ Cases referred to hospital are likely to undergo laparoscopy.

## TOP TIPS

- ❑ In miscarriage, pain follows bleeding. In ectopic pregnancy, the sequence is usually reversed.
- ❑ Remember that there may be no bleeding with an ectopic pregnancy – or that the vaginal loss may be a light, blackish discharge.
- ❑ PV bleeding will cause haematuria on urinalysis. Only diagnose UTI if the symptoms are suggestive and urinalysis also shows nitrites and pus cells.



- ❑ Severe unilateral pain and tenderness PV around 6 weeks after last menstrual period (LMP) suggests ectopic pregnancy, even with no bleeding. Admit urgently.
- ❑ The purpose of ultrasound in a possible ectopic pregnancy is to establish whether or not there is an intrauterine pregnancy rather than to 'visualise' the ectopic. If there is no intrauterine pregnancy, the patient should have a laparoscopy.
- ❑ If PID does not settle within 48 h of appropriate antibiotic treatment, consider abscess formation.
- ❑ Don't forget to check femoral and inguinal canals for a possible strangulated hernia.

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# CHRONIC PELVIC PAIN

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## The GP overview

Pelvic pain is defined as chronic if it has been present for three cycles or more. The difference between this and 'normal' period pain is one of intensity and duration. It is one of the commonest reasons for referral to a gynaecology clinic and for a woman to see her GP in the first place.

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## Differential diagnosis

### COMMON

- ❑ endometriosis
- ❑ chronic pelvic inflammatory disease
- ❑ pelvic congestion
- ❑ irritable bowel syndrome
- ❑ physiological (mittelschmerz, primary dysmenorrhoea)

### OCCASIONAL

- ❑ recurrent UTI
- ❑ mechanical low back pain
- ❑ uterovaginal prolapse
- ❑ benign tumours: ovarian cyst, fibroids
- ❑ chronic interstitial cystitis
- ❑ IUCD

### RARE

- ❑ malignant tumours (ovary, cervix, bowel)
- ❑ diverticulitis
- ❑ lower colonic cancer
- ❑ inflammatory bowel disease
- ❑ subacute bowel obstruction

## Ready reckoner

	<i>Endometriosis</i>	<i>PID</i>	<i>Pelvic congestion</i>	<i>IBS</i>	<i>Physiological</i>
Worse around period	Yes	Possible	Yes	Possible	Possible
Heavy periods	Yes	Yes	Yes	No	Possible
Altered bowel habit	No	No	No	Yes	No
Subfertility	Possible	Yes	No	No	No
Ovarian tenderness	Possible	Possible	Yes	No	No

## Possible investigations

*LIKELY:* MSU.

*POSSIBLE:* laparoscopy, ultrasound, HVS and cervical swab.

*SMALL PRINT:* FBC, bowel and back imaging.

- ❑ FBC: WCC may be raised during exacerbation of chronic PID.
- ❑ HVS and cervical swab for *Chlamydia* may help in determining the infective agent in PID.
- ❑ MSU detects UTI. Red cells alone may be present in interstitial cystitis.
- ❑ Ultrasound is helpful if there is a palpable mass.
- ❑ Laparoscopy is the investigation of choice for diagnosing PID, endometriosis and pelvic congestion.
- ❑ Further investigations, such as bowel and back imaging, might be undertaken by the specialist after referral.

## TOP TIPS

- ❑ A 'forgotten' coil can cause cyclical pelvic pain.
- ❑ If the pain links with periods, establish whether it is primary or secondary dysmenorrhoea – the latter is far more likely to have a pathological cause.
- ❑ In some cases the diagnosis will remain obscure. Avoid colluding with obviously erroneous diagnoses and try to adopt a constructive approach without over-investigating the patient.
- ❑ Don't overlook non-gynaecological causes.
- ❑ Bloating is a very common gynaecological symptom, but is characteristic of IBS. A trial of antispasmodics may aid diagnosis.



- ❑ Women over 35 at first presentation and those with a mass should be referred for a gynaecological opinion.
- ❑ Misdiagnosis of PID without reliable evidence will delay the real diagnosis and lead to repeated courses of unnecessary antibiotics.
- ❑ Ovarian cancer nearly always presents late. Always do a pelvic examination in women with chronic pelvic pain.
- ❑ Beware the diagnosis of endometriosis. Even if confirmed at laparoscopy, remember that many women with similar findings are asymptomatic. Discuss this openly with the patient – this will help prevent dysfunction if she does not improve with antiendometriotic treatment.

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# GROIN SWELLINGS

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## The GP overview

Most causes of lumps in the groin are non-urgent. Many patients do not realise this, however – the development of a groin swelling often heralds an urgent appointment, either because the patient fears sinister pathology, or because the patient knows the diagnosis but erroneously perceives it as an emergency. GPs generally welcome the problem as diagnosis and disposal are usually straightforward.

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## Differential diagnosis

### COMMON

- ❑ sebaceous cyst
- ❑ palpable lymph nodes (LNs) – ‘normal’ or secondary to an infection
- ❑ inguinal hernia
- ❑ femoral hernia
- ❑ saphena varix

### OCCASIONAL

- ❑ retractile testicle
- ❑ abscess (local)
- ❑ metastatic tumour (usually as skin-fixed lymphadenopathy)
- ❑ hydrocele of spermatic cord
- ❑ low appendix mass, pelvic/inguinal tumour
- ❑ lipoma

### RARE

- ❑ abscess (psoas)
- ❑ lymphoma
- ❑ femoral artery aneurysm
- ❑ neurofibroma
- ❑ undescended or ectopic testis

## Ready reckoner

	Sebaceous cyst	LNs	Inguinal hernia	Femoral hernia	Saphena varix
Reducible	No	No	Possible	Possible	Yes
Cough impulse	No	No	Yes	Possible	Yes
Palpable thrill on Valsalva manoeuvre	No	No	No	No	Yes
Fixed to skin	Yes	No	No	No	No
Originates above and medial to pubic tubercle	Possible	Possible	Yes	No	No

## Possible investigations

*LIKELY:* none.

*POSSIBLE:* FBC, ESR, GUM screen.

*SMALL PRINT:* pelvic ultrasound.

- ❑ FBC and ESR useful if diffuse lymphadenopathy found, especially if no evidence of local cause or other significantly enlarged nodes found. Hb may be reduced and ESR elevated in malignancy; WCC and ESR elevated in abscess, infection and blood dyscrasias.
- ❑ Urethral, vaginal or endocervical swabs indicated if any associated discharge and/or suspicion of STD.
- ❑ Pelvic ultrasound useful if pelvic mass suspected.

## TOP TIPS

- ❑ A large saphena varix can look very much like a small hernia. Try the Valsalva test (see ready reckoner) and look for evidence of varicose veins.
- ❑ If the cause is local lymphadenopathy, look for local infective causes and don't forget to consider STDs.
- ❑ Don't be surprised to find no abnormality – normal groin nodes in a slim person, and a normally retractile testis can cause great anxiety in patients and parents.
- ❑ If the history suggests a hernia, but nothing is obvious on examination, get the patient to raise the intra-abdominal pressure with a vigorous cough or by raising the legs straight up while lying on the couch – and remember to examine the patient standing up, too.



- ❑ Femoral herniae (commoner in women) are at high risk of strangulation, so always refer.
- ❑ Undescended testis in the adult carries a high risk of malignancy. If the testis is not descended by the age of one year, then operative intervention is indicated.
- ❑ If lymphadenopathy is the cause, look elsewhere for abnormal lymph nodes and investigate or refer if any are found. Hard, skin-fixed nodes suggest metastatic malignancy – refer urgently.
- ❑ An acutely painful and irreducible groin lump suggests a strangulated or incarcerated hernia. If in any doubt, refer for urgent surgical assessment.

**NOTES:**