Chronic Pelvic Pain Case Study

Melissa, a 28-year-old veteran comes to your office complaining of lower abdominal pain for the past 6 months. She has tried acetaminophen and ibuprofen but they only help a little.

Vital signs: 5 feet 3 inches tall, 123 lbs., HR 78, RR 18, temp 98.6 F, BP 118/74

Q1: What additional history would you like to know about Melissa?

A. Full pain history
B. Sexual history
C. Psychosocial history
D. Medical/Surgical history

Discussion Points

A. Full pain history
   • Severity, timing, quality, location, associated signs and symptoms, modifying factors, how the pain is affecting Melissa’s life
   • Relation of her pain to her menstrual period and to sexual intercourse, urination, and defecation
B. Sexual history: pregnancies, number of sexual partners, number of sexually transmitted infections, and last menstrual period
C. Psychosocial history: any current or past emotional, physical, or sexual abuse
D. Medical history: any abdominal surgeries

Case Study, continued

Melissa states that the pain is in her left lower quadrant, feels crampy, and seems to be worse with her period and with intercourse, but also occurs at other times. She notes occasional constipation and bloating, and occasional urinary frequency, but no pain on urination or defecation.

She is a G2P2, has had no surgeries, and is currently in a monogamous relationship. She uses condoms for birth control. Melissa reports no military or other sexual trauma.
Q2: Which of the following exams would you perform to help diagnose Melissa’s problem?

A. Abdominal exam  
B. Pelvic exam  
C. Rectal exam  
D. All of the above

Q3: Which lab tests would you consider?

A. Pregnancy  
B. Gonorrhea  
C. Chlamydia  
D. Wet mount  
E. Pap smear  
F. UA  
G. All of the above

Discussion Points

The physical exam should include an abdominal and pelvic exam that tries to locate and possibly reproduce the pain. In this case, a rectal exam may also be useful (we don’t recommend a rectal exam for screening as part of a routine pelvic exam).

Testing for pregnancy, gonorrhea and chlamydia is warranted, and (if indicated) a wet mount. Check UA.

If Melissa is not current on her Pap smear, this should also be performed.

Case Study, continued

Melissa’s pelvic exam is painful throughout. No specific areas are more painful than others.

Her urinalysis, wet mount, GC/Chlamydia test, and Pap smear are all normal. Pregnancy test is negative.

Q4: Which is the least likely cause of her pain?

A. Endometriosis  
B. Adhesions  
C. Irritable bowel syndrome (IBS)  
D. Interstitial cystitis (IC)
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Discussion Points

The four most common causes of chronic pelvic pain are:
1. Endometriosis  
2. Adhesions  
3. Irritable bowel syndrome (IBS)  
4. Interstitial cystitis (IC)

Given that she has no history of prior surgeries or inflammatory disease, adhesions are the least likely cause of Melissa’s pain.

Other diagnoses include: chronic infection or pelvic inflammatory disease, adenomyosis, constipation, abdominal wall myofascial pain, and other conditions of the uterus, bladder, colon, and musculoskeletal system.

Q5: Dysmenorrhea, deep dyspareunia, pain with defecation, low back pain that worsens with menses, and infertility are characteristics of:

A. Endometriosis  
B. Adhesions  
C. Irritable bowel syndrome (IBS)  
D. Interstitial cystitis (IC)

Q5: Dysmenorrhea, deep dyspareunia, pain with defecation, low back pain that worsens with menses, and infertility are characteristics of:

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B. Adhesions  
C. Irritable bowel syndrome (IBS)  
D. Interstitial cystitis (IC)

Q6: Abdominal pain relieved by defecation, and associated with changes in frequency or consistency of stool, mucus, and bloating are characteristics of:

A. Endometriosis  
B. Adhesions  
C. Irritable bowel syndrome (IBS)  
D. Interstitial cystitis (IC)

Q6: Abdominal pain relieved by defecation, and associated with changes in frequency or consistency of stool, mucus, and bloating are characteristics of:

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B. Adhesions  
C. Irritable bowel syndrome (IBS)  
D. Interstitial cystitis (IC)
Q7: Urinary frequency, urgency, burning on urination, normal urinalysis, and dyspareunia are characteristics of:

A. Endometriosis
B. Adhesions
C. Irritable bowel syndrome (IBS)
D. Interstitial cystitis (IC)

Q7: Urinary frequency, urgency, burning on urination, normal urinalysis, and dyspareunia are characteristics of:

A. Endometriosis
B. Adhesions
C. Irritable bowel syndrome (IBS)
D. Interstitial cystitis (IC)

Case Study, continued

Melissa returns to discuss her lab results. She complains that her abdominal pain is getting worse, and she’s feeling bloated. She is having multiple daily bowel movements.

Q8: What diagnosis is now most likely?

A. Endometriosis
B. Adhesions
C. Irritable bowel syndrome
D. Interstitial cystitis

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Q9: There is no evidence to support using which of the following to treat IBS?

A. Tricyclic antidepressants
B. Probiotics
C. Narcotics
D. Peppermint oil
E. Antispasmodics

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Case Study, continued

After trying various treatments for IBS, Melissa’s bloating and multiple daily bowel movements have improved. She continues to have abdominal and low back pain.

She notes that the pain is worse with her periods and during intercourse.

Q10: You suspect that Melissa most likely also has endometriosis. You will need to confirm the diagnosis prior to initiating treatment.

A. True
B. False

Q11: How would you treat Melissa’s endometriosis at this time?

A. Narcotics
B. Oral contraceptives
C. Recommend endometrial ablation
D. Recommend hysterectomy
E. None of the above

Discussion Points

- Laparoscopy that visualizes endometrial tissue outside of the uterine cavity is the only way to definitely diagnose endometriosis. However, it is not necessary to make the diagnosis prior to treatment.
- Many sources recommend a transvaginal ultrasound in the work-up of chronic pelvic pain. It would not necessarily be able to visualize endometriosis, but it could look for adenomyosis and other causes of pain.
Q 11: How would you treat Melissa’s endometriosis at this time?

A. Narcotics
B. Oral contraceptives
C. Recommend endometrial ablation
D. Recommend hysterectomy
E. None of the above

Discussion Points

• An oral contraceptive is a first-line treatment for endometriosis
  — Oral contraceptives may work better if they are taken continuously
• NSAIDS are most helpful for treating dysmenorrhea if they are started several days prior to the onset of menses
• Treating any concurrent depression, anxiety, or PTSD is also important

Case Study, continued

Melissa returns 6 months later and states that her pelvic pain has improved some on the oral contraceptives, but is still there.

Q 12: What do you do now?

A. Perform a more thorough evaluation of IBS
B. Perform a more thorough evaluation of IC
C. Address any psychosocial issues
D. Refer to a gynecologist
E. All of the above

Discussion Points

• Women with chronic pelvic pain may have multiple diagnoses
  — More thorough evaluation of IBS and IC is appropriate
• Psychosocial issues may be contribute to pain
  — Women veterans have high rates of: 1) physical, emotional and sexual abuse, 2) depression, and 3) PTSD.
• Referral to a gynecologist is likely appropriate for evaluation and treatment of endometriosis which could include: —Gonadotropin-releasing hormone agonist (GnRH agonist) therapy —Laparoscopy
• A multidisciplinary approach that includes a generalist, obstetrician, pain specialist, psychiatrist, and social worker is often helpful for managing chronic pelvic pain