BMJ 2015;351:h5637 doi: 10.1136/bmj.h5637 (Published 12 November 2015)

PRACTICE

10 MINUTE CONSULTATION

Pelvic pain

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This is part of a series of occasional articles on common problems in primary care. *The BMJ* welcomes contributions from GPs.

A 28 year old woman presents with six months of pelvic pain associated with painful periods and painful sex.

What you should cover

History

With any woman with pelvic pain, ask the following questions, taking care to screen for red flag symptoms (see box):

- Can she describe exactly where she feels the pain? How long are her periods, are the cycles regular, how heavy is the bleeding?
- Does she have painful periods or pain with sex? If so, are these new symptoms? Primary dysmenorrhoea (since menarche) is less likely to be due to pathology[1] and therefore often doesn't need a referral.
- Is she worried about sexually transmitted infection? Does she have any vaginal discharge that is abnormal for her which might suggest infection?
- Explore her family history of cancer. It is also often useful to know how other family members cope with pain and periods.
- Is she getting any post-coital or intermenstrual bleeding suggestive of cervical pathology (see red flag box)?
- Does she have any history of genital trauma from sexual abuse, rape, female genital mutilation, or labour? If so, does she need psychosexual counselling or surgery for female genital mutilation reversal or episiotomy scar revision? Consider carefully how to ask these sensitive questions.[2]
- When does the pain come on in relation to her periods, defaecation, and sexual activity? A pain diary can be a useful tool to clarify cyclical pain, and "period tracker apps" can be used to monitor symptoms. The cardinal symptoms of dysmenorrhoea, rectal pain on defecation, dyspareunia, and chronic pelvic pain are characteristic of endometriosis or adenomyosis.[3]
- Are there any other associated symptoms suggesting a possible alternative diagnosis? However, it must be borne in mind that endometriosis can cause any of these symptoms

  - Bowel symptoms, such as bloating and wind, indicating irritable bowel syndrome or inflammatory bowel disease

  - Urinary symptoms, such as frequency or dysuria, suggesting interstitial cystitis

  - Musculoskeletal symptoms such as pain on walking or lifting.
- Does she have any symptoms suggesting a psychological cause that needs to be considered? Is she depressed or anxious?
- What contraception is she using? A recent intrauterine device insertion may be the cause of her symptoms, whereas an intrauterine system can be used as a management option.[3 4]
- Does she have a history of infertility, surgery, or pelvic inflammatory disease that might suggest pelvic scarring or adhesions? A history of infertility also raises the possibility of endometriosis.
- What is the impact of her symptoms on her quality of life? Is she able to have sex? Does she need time off work or school? Severe symptoms are suggestive of endometriosis.

Examination

- Examine the abdomen, looking for a mass (red flag)[5] or scars from previous surgery.
- Examine the vulva for skin disorders. Perform a speculum examination looking for cervical abnormalities such as contact bleeding with presence of a growth or ulcer. Take an opportunistic smear if due.
- Take endocervical and nucleic acid amplification test (NAAT) swabs to exclude sexually transmitted infection. Infection might be associated with tenderness.

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What you need to know

- Refer immediately to gynaecology all patients with a pelvic mass, abnormal cervix, or persistent bleeding
- Consider endometriosis and therefore referral in patients presenting with chronic dyspareunia and rectal pain who fail to respond to medical treatment

Red flags suggestive of serious pathology

Consider urgent gynaecology or gastrointestinal referral if there is evidence of:

- Persistent post-coital or intermenstrual bleeding[5]
- Pelvic mass[5]
- Abnormal appearance to cervix[5]
- Rectal bleeding or altered bowel habit
- Sudden weight loss

- Consider the size, shape, position, and mobility of the uterus and adnexae. A bulky uterus may indicate fibroids or adenomyosis. An adnexal mass could be an ovarian cyst or hydrosalpinx. Malignancy is unlikely but not impossible in a 28 year old woman. Tenderness or lack of mobility of the pelvic organs may suggest endometriosis, as would nodularity in the posterior fornix.[6] Adhesions from pelvic inflammatory disease or previous surgery could produce the same signs.
- The sacroiliac joints or the symphysis pubis may be tender, suggestive of a musculoskeletal cause.

What you should do

- Provided that serious pathology or debilitating symptoms have been excluded, most patients can be managed in primary care with the use of simple analgesia such as paracetamol and non-steroidal anti-inflammatory drugs.
- Cyclical symptoms may respond to suppressing ovulation (provided the patient does not wish to conceive) with the combined pill or some progestogen only pill (desogestrel 75 μg) or parenteral progesterone only contraceptives (implant or depo).[3]
- A transvaginal ultrasound scan may reassure the patient and doctor if clinical findings are normal. It is mandatory if the uterus is enlarged or if any pelvic masses are found on examination.[4] Sensitivity and specificity are high for the detection of fibroids and ovarian cysts. A normal scan does not exclude adhesions and endometriosis.
- Some patients benefit from localised heat, dietary alterations, vitamin supplementation, TENS (transcutaneous electrical nerve stimulation), and self help groups, though evidence is not extensive.
- The intrauterine system is a useful option and is indicated as treatment for endometriosis, particularly where the predominant symptom is dysmenorrhoea.[4]
- If symptoms are severe and suggestive of endometriosis or not settling with medical management, then referral for laparoscopy is advised. Evidence suggests that 30-50% of laparoscopies find no pathology and much of the pathology identified is not necessarily the cause of pain.[3]

Competing interests: We have read and understood BMJ policy on declaration of interests and declare the following: RB is a member of the NICE Guideline Development Group on Endometriosis.

Provenance and peer review: Not commissioned; externally peer reviewed.

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Accepted: 15 Sep 2015

Cite this as: *BMJ* 2015;351:h5637