DIFFERENTIAL DIAGNOSIS OF LOWER ABDOMINAL/ PELVIC PAIN INYOUNG WOMAN

60% attributed to GI problems

Gynaecological

Cyclical

Pre menstrual syndrome
Pelvic pressure, heaviness, back ache, 7- 10 days before menses

Mittelshmerz
Mid cycle pain secondary to rupture of the follicle and subsequent irritation of peritoneum. Can produce severe pain which generally resolves spontaneously

Dysmenorrhea

Primary – painful menstruation in absence of pelvic pathology.
Diagnosis of exclusion
Spasmodic, crampy lower abdominal pain radiating to the back or upper thighs. Lasts 24-48 h. Associated symptoms include headache, nausea and vomiting.

Secondary related to pelvic pathology.
Eg endometriosis, cervical stenosis, adenomyosis, leiomyomata (fibroids), endometrial polyps.

Endometriosis
Endometrial glands and stroma present outside uterine cavity
Initially pain cyclical, as adhesions develop pain often becomes acyclic.
Typically pelvic pain a few days before menses, extending variably into cycle.
May find mass, midline or adnexal tenderness. Bowel involvement can cause symptoms related to defecation.

Often physical examination is normal.

Adenomyosis
Benign condition characterized by in growth of endometrial glands into stroma.
Menorrhagia and dysmenorrhoea

Leiomyoma
Benign myometrial tumours.
Often cyclical pain.
Acute pain associated with torsion or degeneration (most often seen in pregnancy)

Pelvic Congestion Syndrome
7-10 days before menses
Chronic dull ache localised to pelvis, with sharp stabbing exacerbations.
Dilation, congestion and venous stasis of pelvic veins.
Deep palpation normally reproduces pain.
May see vulval varices and cervix may appear engorged with a bluish tinge.

Non- cyclical

Pregnany related
All pelvic pain need to have assessment for pregnancy.
Ectopic
Miscarriage.

Pelvic Inflammatory Disease (salpingitis, endometritis)
Usually bilateral and associated with severe abdominal pain and cervical motion tenderness.
Fever, leukocytosis, mucopurulent cervical discharge
Tubo- ovarian abscess is late complication
Presentation ranges from non specific pain to acute peritonitis
RUQ pain raises possibility of Fitz-Hugh-Curtis syndrome. (perihepatitis secondary to inflammatory peritoneal fluid in subphrenic and sub diaphragmatic spaces.)

Usually due to ascent of microorganism – N. Gonorrhoea, C. Trachomatis

Adnexal Pathology

Torsion of adnexae
3rd decade of life, 3-5% of emergency gynaecological surgery
90% associated with cystic tumours or simple cysts of ovary.
Often associated enlarging adnexal mass secondary to venous obstruction and oedema
Unilateral, increasingly severe pelvic pain. May be intermittent pain if intermittent torsion.

Para ovarian, paratubal cysts, hydrosalpinx.
All may present acutely due to rupture haemorrhage or torsion

Ovarian

Rupture of follicular cyst – Mittelshmerz
Rupture of corpus luteum cyst, day 20-26. Bleeding may be catastrophic

Intraovarian haemorrhage
Into cyst or tumour, sudden onset sharp unilateral pain. Localised or generalised peritonism.

Endometriomata
Deposits of endometriosis in the ovary. Causes chocolate cysts (altered blood).

Adhesions
Possibly account for 33% of chronic pelvic pain
Associated with PID, endometriosis, surgery, inflammatory bowel disease.
Pain often consistent in location and aggravated by sudden movement, intercourse or physical activity.

Deep thrust dyspareunia
No intrinsic abnormality. Treatment by decreasing depth of thrust

Incarcerated uterus
Acute pelvic pain early in pregnancy. Related to retroversion and adhesions.

GI
Appendictis
Diverticulitis
IBD
Bowel obstruction
Gastroenteritis

Urinary
Cystitis
Retention
Pyelonephritis
Urolithiasis

Musculoskeltal

Separation of pubic symphysis, usually secondary to pregnancy, rare.

Somatization disorder
Emotional problems manifest as physical pain.
Often multiple complaints with no cause found.

Other

Hernia
Porphyria
Pelvic vein thrombophlebitis