

D3:Obs&Gynae & GUM

Urgent referrals

Acute PID (see Fig 8)
Acute epididymo-orchitis (see Fig 9)
Genital Herpes
Acute reactive arthritis
HIV related disease
Any patient with genital problems
who is distressed or in pain

Non-Urgent referrals

Urethral discharge
Dysuria in young men
Vaginal discharge
Genital warts
Pubic lice
Mild or recurrent genital
ulcers

Any patient can ring the GUM clinic between 9.00 and 16.30 for an appointment, from an outside line ring:-

Male 392 6724
Female 392 6725

3.1 Management of lower abdominal / pelvic pain in females of reproductive age.

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Introduction:

Abdominal pain is a common presenting symptom in A/E departments (5-10 % of all patients). The underlying pathology may include one or more of the body's systems (GIT, GU , vascular, etc.). The sequelae of a misdiagnosis or late treatment may range from the benign to the disastrous.

This advice will focus on acute presentation to A/E of females of reproductive age with lower abdominal / pelvic pain. This group includes females who are threatening to or actually miscarrying. They often wait in A/E for a significant period of time only to be discharged to complete the process at home. Both of these eventualities are distressing to both patient and family.

Background:

There is a wide range of differential diagnoses with LAP:

- Gynaecological and obstetric 61%
 - PID, mittelschmerz, ovarian torsion (2 recent missed diagnoses), endometriosis, ovarian cysts, chronic undifferentiated pelvic pain, malignancy.
 - Ectopic pregnancy, threatened or spontaneous miscarriage, placental abruption, preterm labour, or post partum complications.
- GIT 23%
 - Appendicitis, gastroenteritis, diverticulitis, IBS, IBD, malignancy, constipation.

- Urological 7%
 - UTI, pyelonephritis, ureterolithiasis.
- Miscellaneous 9%
 - Herniae, AAA, aortic dissection, herpes zoster, musculoskeletal, psychosomatic, neurological.

History is important as to time of onset:

- Acute – tubo ovarian rupture or torsion, AAA, Ureterolithiasis.
Gradual (hours to days) – appendicitis, shingles, miscarriage, GE
- Slow (days to weeks) – UTI, ectopic gestation, PID, diverticulitis, miscarriage, malignancy.
- Chronic – endometriosis, fibroid, IBS, IBD, psychosomatic.

Presentation:

- All females in the above group should be assessed on arrival with a urine pregnancy test as well as urinalysis.
- If patients are unstable then they should be transferred to the resuscitation room for immediate care.
- Once the result of a pregnancy test is known then referral can be made.
- If preg. –ve then refer to surgery, and if preg. +ve, then refer to gynae.
- IV access should be gained with Hb and crossmatch essential. (see algorithm)

Ectopic pregnancy:

- The classic triad of lower abdominal pain, vaginal bleeding, and amenorrhoea is present in only 50% of acute presentations.
- Therefore, there must always be a clinical suspicion of ectopic pregnancy in all females with a +ve pregnancy test who present with any or all of the above symptoms and do not have a proven intrauterine gestation. (see algorithm).

PID vs. Appendicitis:

- Minimal CDC criteria for the diagnosis of PID is lower abdominal pain, cervical motion tenderness, and bilateral adnexal tenderness.
- However common symptoms include: vaginal discharge and deep dyspareunia.
- Common pathogens include *Neisseria gonorrhoea*, *Chlamydia trachomatis*, *Gardnerella vaginalis*, *E. coli*, and anaerobes.
- There will always be a question of whether a female is suffering from appendicitis as opposed to PID.
- The history and some clinical differences will help to make the decision.
- Both usually have a raised white cell count but PID will average 15, appendicitis around 13. Appendicitis usually accompanies anorexia with pain localised to the RIF. Both may be pyrexial but PID tends to be higher (>38) vs. (~37.5).

Threatened or impending miscarriage:

- Patients who present with PV bleeding +/- LAP who have a known intrauterine gestation must be treated with care and sympathy.
- Their care in A/E should be quick and appropriate for the circumstances.
- They require an internal examination by either an A/E clinician of some seniority or through the gynae service if the gestation is <20 wks.
- If the cervical os is closed then the patient can be offered the choice of an admission or an OP scan.
- If the gestation is <12 wks then book through the EPU.
- If gestation 12 – 20 wks then refer gynae or OB if >20 wks.
- If patient discharged they require FBC and G&S (rhesus +/-).
- If referring then to include IV access.

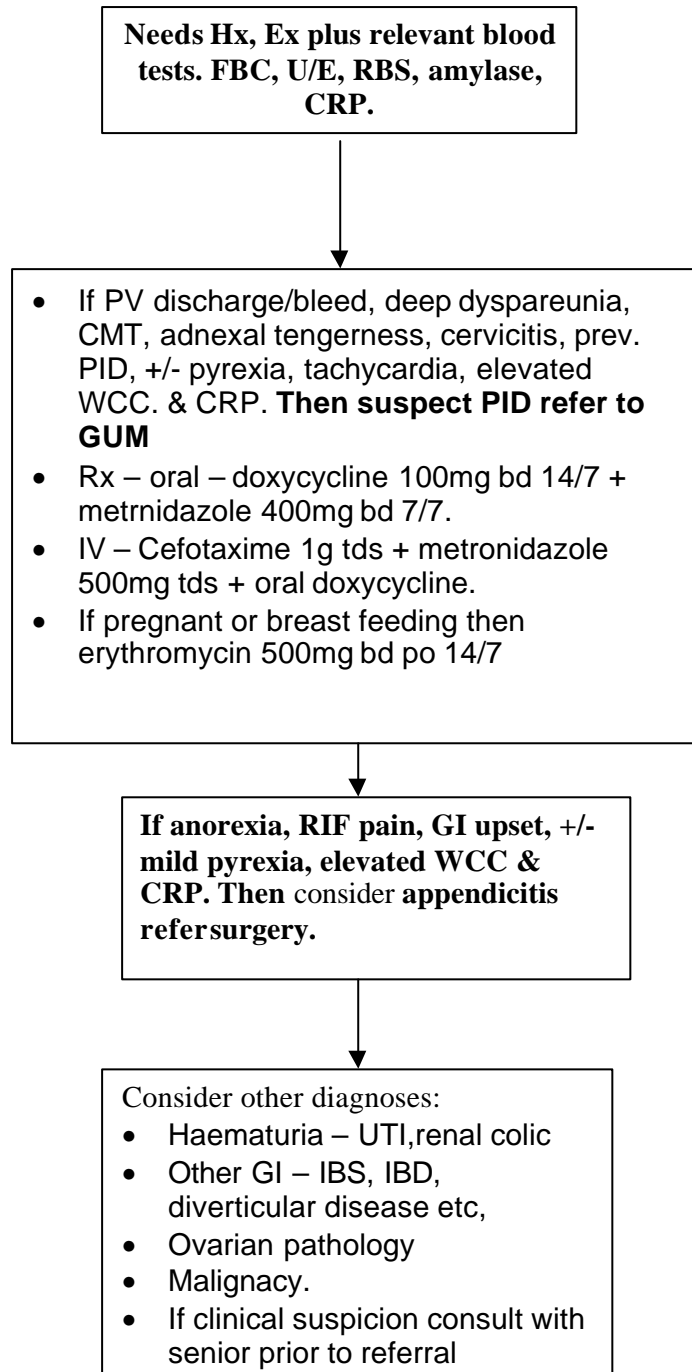
Conclusion:

- Lower abdominal pain is an extremely common presentation which covers several specialities.
- Clinical skills are essential in making the diagnosis. Mistakes in time and accuracy can lead to distress as well as catastrophic consequences in a young age group.
- Morbidity includes: infertility and future reproductive difficulties; unwarranted surgery; bowel perforation; haemorrhage; intra-abdominal abscess with recurrent sepsis; chronic pelvic pain; overwhelming sepsis; and even death.

Key messages:

- All females of reproductive age presenting with abdominal pain must have pregnancy status checked.
- Consider PID if not pregnant and treat appropriately.
- There must be a high suspicion of ectopic gestation unless already excluded.
- All patients with a threatened miscarriage should be offered admission and all actual miscarriages should be referred.
- All gestations <20 wks refer to gynae, >20 wks to OB. EPU will only scan <12 wks.

Lower Abdominal Pain in a non-pregnant female



3.2 Suspected Ectopic Pregnancy in stable patient

