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A STUDY OF PELVIC PAIN IN WOMEN IN THE RURAL POPULATION

Dr Ravindra Y M — Assistant Professor, Department of Community Medicine, Shridevi Institute of Medical Sciences and Research Hospital.

Dr Raju Hanumant Patil* — Assistant Professor, Prakash Institute of Medical Sciences and Research Centre, Urun-Islampur, Maharashtra. *Corresponding Author

ABSTRACT

Background: Pelvic pain is not an uncommon complaint in women, and its diagnosis and management can be taxing at times. Acute pelvic pain is an emergency and requires prompt and selective investigations to deal with the condition. Treatment is either medical or surgical. Chronic pelvic pain can be very debilitating. In some rare cases even after extensive investigations, the diagnosis may not be arrived at and the treatment remains empirical. While chronic pelvic pain mainly affects women in the reproductive age group, acute pain can occur at all ages.

KEYWORDS : Pelvic Pain, Women, Acute, Chronic, Investigations, Management.

Introduction:

The causes of pelvic pain are diverse. They may be gynaecological and nongynaecological such as gastrointestinal tract, renal tract, skeletomuscular and peritoneal[1-6]. Gynaecological causes are often organic but can be functional. The well-reamnized organic lesions are: Pelvic endometriosis, chocolate cyst of the ovary (30-35%), Ovaries-ovarian adhesions. polycystic ovarian disease, residual ovarian syndrome, ovarian tumours (benign and malignant), Tubal-chronic PlD, tubal adhesions, postoperative adhesions. parametritis due to infection or malignancy (24%) Pelvic tuberculosis and adhesions, Uterine-fibroids, adenomyosis, pyometra in menopausal women, lixed retroverted uterus. Functional causes include Congestive dysmenorrhoea, Mittelschmerz and postcoital pain CI'PS. pelvic varicose or dilated veins (30%). Nongynaccological causes are: Intestinal tuberculosis. Diverticulitis, colitis, appendicitis, irritable bowel syndrome which account for 20% cases Carcinoma rectum like in intestinal obstruction Renal-ureteric colic, bladder stone, urinary tract infection, cystitis, chronic retention of urine. Skeletomuscular--joint pains (referred pain). Hernias, Sickle cell disease, porphyria Neurological-herpes zoster, nerve entrapment. nerve compression, referred pain Scar-scar pain. scar endometriosis. Nerve entrapment in Pfannenstiel incision can cause chronic pain which sometimes last as long as two years. In rare cases no Cause of CPP are found. In quite a few cases, no cause of CPP can be detected (3 5%). Even laparoscopic findings appear normal, and extensive investigations undertaken do not reveal a definite cause. It is also observed that even when a lesion is detected, it may not be the cause of the pelvic pain, i.e. loose peritoneal adhesions, mainly postoperative adhesions do not cause chronic pain. and adhesiolysis does not cure the symptom. A Sincere effort has been made to find the most common causes of pelvic pain, their incidence and other factors effecting.

Aims and Objectives:

To study the pelvic pain in women

Materials and Methods:

This study was done in 120 women who attended the clinics in the Department of OBG in Shridevi Institute of Medical Sciences and Research Hospital.

Higtory and Clinical Examination of the patient was thoroughly taken.

Age. Parity and menstrual history were recorded. The mode of onset pain, its location, severity, duration and radiation to other areas were inquired into. The relation to menstrual history is important. History of fever, vomiting, diarrhoea as well as urinary symptoms are also relevant while making a clinical diagnosis. Clinical examination and relevant investigations were done.

The most common symptoms and signs were noted. The investigations that were carried were noted. The management was noted and the patient were asked to come back at specific intervals for follow up and the findings were noted.

All the statistical analysis were done using the SPSS (2015) California.

Results:

Table 1: Intra group 2 age distribution (35-45 years = 37, 25 to 35 years = 30 and 35 to 45 years = 14)

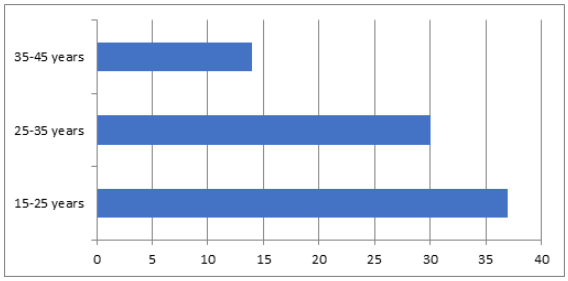

Table 3: Pain Chart (total number of patients n= 120)

Pain	Group 1	Group 2	Group 3
Dull	--	19	26
Sharp	3	32	01
Throbbing	1	30	08
Acute	4	70	31
Chronic	--	11	04
Referred Pain	--	09	17
Tenderness	2	38	12

Table 4: Test for Significance

Acuteness in Group 2	X-Value	Significance (p=<0.05)
70	0.623	Significant

Table 5: Most common diagnosis in each group (n=120)

Group	Inflammatory (Organs of Reproduction)	Benign (Organs of Reproduction)	Malignant (Organs of Reproduction)	Other GI and Renal Pathologies
Group - 1	01			03
Group - 2	08	59	06	08
Group - 3	20	02	11	02

PCOD was the most common diagnosis in the females in Group 2 and Malignancy was more seen as the age of the patients advanced.

Table 5: Test for significance

PCOD	X-Value	Significance (p=<0.05)
59	0.561	Significant

Discussion:

In this study Group 1 included 4 paients, Group 2 included 81 patients and group 3 included 35 patients.

Majority of the patients belonged to the age group of 15 years to 45 years.

Majority of the patients belonged to the 15-25 years age group.

When compared with that of the other studies, Prevalence rates for dyspareunia, dysmenorrhoea, and abdominal pain found in UK community-based studies were 8%, 45%, to 97%, and 23% to 29%, respectively, but definitions used varied greatly[7].

Women with chronic pelvic pain and variable degrees of endometriosis demonstrate altered pain sensitivity relative to pain-free healthy women in a control group and whether such differences are related to the presence or severity of endometriosis or comorbid pain syndromes[8].

In four years, there were 34 346 cases of surgery or inpatient admission for chronic pelvic pain amounting to $100.5 million with an average cost of $25 million per year. Pelvic and perineal pain accounted for 61.5% (n = 21 127) of the cases, while dysmenorrhea accounted for 31.8% (n = 10 936), and dyspareunia accounted for 6.6% (n = 2283). The vast majority of the cases (92.9%, n = 31 923) were associated with surgical interventions, with the most common surgeries being hysterectomy (47.1%, n = 16 189), followed by laparoscopy (25.8%, n = 8850), adnexal surgery (6.8%, n = 2349), and other procedures (11.6%, n = 3968)[9].

History taking almost in majority of the cases pin-points the diagnosis. Pelvic pain is common in reproductive years. The onset, type, duration and location of pain will provide guidance to the probable cause of the pain. Radiation of pain and its relation to menstruation is important. Obstetric and sexual history are significant. History of intrauterine contraceptive device suggests pelvic infection. Associated urinary and bowel symptoms should be inquired into. Some women with chronic pelvic pain also complain of dysmenorrhoea and dyspareunia. Past history of tuberculosis and psychiatric problem will help. History of cancer in the family will suggest probable cancer phobia in the woman. General examination will reveal lymphadenopathy (tuberculosis), anaemia and swelling of feet. Abdominal mass, ascites and tenderness suggest organic lesion. Vaginal discharge is seen in PB. Bimanual pelvic examination is necessary to rule out organic pelvic lesion. A full bladder is felt anterior to the uterus and is tender on palpation. Rectal examination may reveal a mass or stricture. Pain and restriction of joint movements suggest referred pain to the pelvis. Tenderness in the pelvis is caused by endometriosis. adenomyosis. pelvic adhesion, PID diverticulitis and urinary infection. Ovarian pain is located at the junction of the middle and inner two-third of a line between the anterior superior iliac spine to the umbilicus, and tenderness can be elicited here.

Conclusion:

There are a plethora of pathologies that can cause a pelvic pain in the female patient. Prompt Management which include the correct diagnosis and treatment for the cause is the need of the hour.

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