Gut Reactions – Topics in Functional Gastrointestinal disease

What is Pelvic Pain?

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Many patients complain of chronic pelvic pain. True pelvic pain is commonly felt deep within the bony pelvis or below in the area known as the perineum. However, it may also be felt in the lower abdomen. Thus pelvic pain and abdominal pain may be confused. For our purposes the pain can be said to be chronic when it has been present continuously or intermittently for at least 3 months. In this way, acute illnesses such as infections or surgical emergencies are excluded from this discussion.

Where does the abdomen end, and the pelvis begin?

The pelvis is that part of the body encased in the pelvic bones, and lies below an imaginary line drawn from the top of the sacrum to the pubic bone. The pelvis contains the bladder, the reproductive organs and the rectum. However, the lower abdomen lies behind the pelvis, so that it's not difficult to see that pain emanating from any of these organs might produce lower abdominal pain.

Causes of lower abdominal pain

Many articles have appeared in IFFGD publications about the functional gastrointestinal disorders, including irritable bowel syndrome (IBS). These pages have contained several discussions about how to distinguish the abdominal pain of IBS from other diseases of the intestines such as Crohn's disease, diverticulitis, or bowel obstruction. However, pains originating in the bladder or reproductive tract are very common too, and must also be distinguished from IBS. We must also remember that the muscles and skin of the anterior abdomen can also be a source of abdominal pain.

Gynecological pain

If a patient is deemed to have pelvic pain she may be referred to a gynecologist. Usually this is appropriate, and the diagnosis turns out to be "dysmenorrhea" endometriosis, or other disease of the female reproductive organs. However, sometimes the cause is not in the pelvis at all, and the disease may be in the gastrointestinal tract. Crohn's disease is an example. What concerns us here is that many patients referred to gynecologists for pelvic pain actually have irritable bowel syndrome. It is well known that patients with IBS are more prone than others to have their reproductive organs surgically removed. Moreover, studies in Britain and America indicate that many patients complaining of pelvic pain and undergoing a laparoscopic examination by a gynecologist (where nothing abnormal was found), in fact had IBS.

Urological pain

Disease of the bladder such as cystitis may also cause 'pelvic' pain. Here also, if the patient and their doctor do not consider the possibility of IBS, the patient may be inappropriately referred to a urologist.

Clues that pelvic pain might have a gastrointestinal cause.

When experiencing chronic abdominal pain that needs medical attention, it is important to try and determine the source of the pain. In general, pain from the reproductive organs may be related to menstruation, menopause, or sexual activity. Vaginal bleeding or discharge, and menstrual or sexual dysfunction are other clues. (It is however common to experience bowel symptoms during the menses.) Men are obviously less likely to have their lower abdominal pain misinterpreted, but diseases of the bladder or prostate may also be felt in the abdomen. Bladder pain is often associated with urination. A family doctor or internist can deal with many of these problems. Some will require referral to a gynecologist or urologist, and they will not be further discussed here.

Our concern is that pelvic pain originating from the gastrointestinal tract is recognized as such and not mistaken for a gynecological or urological disorder. This is best accomplished by searching for symptoms that are typical of gut disease. These include rectal pain or bleeding or passage of pus, diarrhea, constipation or both, and upper gut symptoms such as vomiting or loss of appetite.

The pain itself may have subtle features that point to the gut. It may be felt in the upper as well as the lower abdomen. Pain that comes on in waves or cramps may result from the intestines struggling to move matter past a diseased area. Most importantly, the pain may be related to gut activity. It may occur predictably after meals, or be associated with defecation. The Rome criteria for IBS remind us that the pain in that disorder is often relieved by defecation or existing with looser or harder and more or less frequent passage of stools. There are also sensations of incomplete rectal evacuation, rectal urgency or straining at stool, mucus in the stool, and abdominal bloating.

It is also important to note if members of the family – that is blood relations – have had chronic gastrointestinal diseases. These include inflammatory bowel disease (Crohn's disease and ulcerative colitis), colon cancer, and celiac disease. If someone over the age of 45 presents with gut symptoms, colon cancer must be thought of and appropriate investigation undertaken.

The physician's role

Only by means of a careful history can doctors make the distinction between a gut and other source of a patient's lower abdominal pain. Since the history depends upon the patient's description, the individual can help by describing any of the associations their pain may have that we discussed above. Moreover, by carefully examining the abdomen and pelvic organs – for enlargements, tumors, or tender areas – the doctor may identify the source of the pain. Thus a carefully described and interpreted history of the pain, and a good physical examination offer the best chance that a patient's "pelvic" pain will receive the appropriate tests and treatments.

Conclusions

This brief article illustrates how pain in the lower abdomen may mistakenly be thought to be pelvic in origin and possibly due to gynecological or urological diseases. The opposite may occur as well. Identification of symptoms unique to the gut, associations of the pain to gut activity, recognition of gut disease in the family, and examination of the involved area help prevent misattribution of the pain to sources outside the gut.

Suggested IFFGD Reading

Al-Chaer, E. *Sex differences in abdominal pain*. IFFGD Fact Sheet No. 223, 2013.

Further Reading

1. Hogston P. Irritable bowel syndrome as a cause of chronic pain in women attending a gynaecology clinic. *Br Med J* 1987; 294:934-935.

2. Longstreth GF, Preskill DB, Youkeles L. Irritable bowel syndrome in women having diagnostic laparoscopy or hysterectomy. *Dig Dis Sci* 1990; 35:1285-1290.

3. Longstreth GF, et al. Irritable bowel syndrome and chronic pelvic pain. *Obstet Gynaecol Survey* 1994; 49:505-507.

4. Prior A, Whorwell PJ. Gynaecological consultation in patients with the irritable bowel syndrome. *Gut* 1989; 30:996-998.

5. Walker AE, Gelfand AN, Gelfand MD, Green C, Katon WJ. Chronic pelvic pain and gynaecological symptoms in women with irritable bowel syndrome. *J Psychosom Obst Gy* 1996; 17:39-46.

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The International Foundation for Gastrointestinal Disorders (IFFGD) is a 501(c)(3) nonprofit education and research organization. We work to promote awareness, scientific advancement, and improved care for people affected by chronic digestive conditions. Our mission is to inform, assist, and support people affected by gastrointestinal disorders. Founded in 1991, we rely on donors to carry out our mission. Visit our website at: www.iffgd.org or www.aboutIBS.org.

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