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Original article

Diagnosis of Chronic Pelvic Pain(CPP):USG V/S DL

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ABSTRACT:

Objective: To find out the correlation between two modalities i.e. USG and DL used in diagnosis of chronic pelvic pain.
Method: One hundred women with chronic pelvic pain attending Gynae OPD were included. They were examined clinically and subjected to USG and DL.
Results: Among the 78 patients with abnormal findings on laparoscopy only 45 had positive USG findings. Though USG had a higher sensitivity for ovarian cysts, laparoscopy was more predictive for other positive findings.
Conclusion: Diagnostic laparoscopy is more sensitive method for diagnosis of chronic pelvic pain.

KEYWORDS: Pelvic Pain; Laparoscopy; Ultrasonography; Chronic pelvic pain; USG; Gynaecological.

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INTRODUCTION

Chronic pelvic pain (CPP) is an intermittent or constant pain in lower abdomen at least for six months, not associated with pregnancy and not occurring exclusively with menstruation or sexual intercourse[1]. There is difficulty in delineating causes behind CPP. As there are many possible causes for the pain and several pathologies may co-exist. A recent systematic review estimated the prevalence of CPP to range between 8-18% worldwide[2]. The causes of CPP may be classified as gynecological verses non-gynecological. Gynaecological causes include endometriosis, adenomyosis, uterine fibroids, pelvic congestion syndrome, chronic pelvic inflammatory disease(PID) and adhesions which may be secondary to endometriosis, PID or after previous surgery. Non-gynaecological causes include irritable bowel syndrome (IBS), bladder pain syndrome(BPS), musculoskeltel, neuropathic and psychological conditions. Patients with CPP are frequently anxious and depressed and about 12% hysterectomies are performed for pelvic pain[3].

MATERIALS & METHODS

From 1st Aug 2014 to 31st Jan 2015 100 cases of CPP attending gynecological OPD at MMMC & H SOLAN (HP). AN ethical clearance has been taken from the institutional ethical committee. Detailed history was taken about the pattern of the pain and its association with other problems. These may include psychological, bladder, and bowel

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symptoms and the effects of movement and posture on the pain. After taking history clinical examination and routine investigations of blood, urine and stool were done. Pap's smears were also taken as on routine basis. Patients with non-gynecological etiology were excluded. Patients were investigated further by transabdominal sonography and diagnostic laproscopy

RESULTS

Duration of symptoms increased significantly with age.

Table 1. Shows age wise distribution.

AGE	NUMBER
21-30	28
31-40	60
>40	12

Associated complains like secondary dysmenorrhoea (34), menorragia (21), infertility (37) were found. Table 2 shows abnormal USG findings. Commonest being ovarian enlargement (17) followed by tubal pathology (15).

Table 2. Abnormal Ultrasound findings (n=45).

Structure	Abnormality	Number
Uterus	Enlarged	13
Ovaries	Enlarged	17
Tubes	Tubo Ov. Mass	9
	Hydrosalpinx	6

Table 3, Shows abnormal DL findings. Pelvic adhesions were found in 36 cases i.e most common of CPP, followed by Endometriosis (chocolate cysts and endometriotic nodules) in 33 cases, Pelvic congestion was found in 6 cases in form of general hyperemia and large dilated pelvic veins.

Table 3.Abnormal laproscopic findings(n= 78).

Structure	Abnormality	Number
Uterus	Enlarged	15
Ovaries	Chocolate cyst	18
	Poly cystic overy	12
	Functional cyst	7
Tubes	Tubo. Ov. Mass	14
	Hydrosalpinx	6
	Tortuos	7
Pouch of Douglas	Adhesives	36
	Endometriotic nodule	15
	Pelvic congestion	6
	S tran fluid	2

Endometrotic nodules, adhesions and pelvic congestion were detected only by laparoscopy, so compared to USG laparoscopy has a greater sensitivity. All 22 women with normal findings on laparoscopic examination were normal on USG examination also.

DISCUSSION

In our study maximum numbers of CPP belonged to 31-40 years of age group similar to the findings of Zondervan et al.[4] on laparoscopy, in 22% cases no visible pathology was detected, in Comparision to 24% reported by Kontovavdis et al.[5].

The commonest laparoscopic diagnosis was chronic PID IN 56% in comparison of 51% reported by Krolikowski et al. This was manifested as T.O mass, adhesion and pelvic congestion. The second most common abnormality was endometriosis in 59% in comparison of 80% by Carter JE[6]. Adhesion was also important laparoscopic finding in 50% in our study and 40% by Newham et al.[7]. Diagnostic laproscopy has been regarded as the Gold-Standard investigation for CPP. After careful pre-operative work-up, which involves a thorough history, physical examination and imaging in the form of pelvic ultrasound or pelvic magnetic resonance imaging, if necessary. However depending on the preceding work-up, upto 40% of diagnostic laparoscopic fails to show any pathological causes for the patients' pain[8]. Whilst laparoscopy is more invasive than USG in CPP, the technique allows surgical treatments to be effected enhanced by advances in instrumentation. Thus in an attempt to avoid multiple operations and their associated surgical e CPP and anaesthetic risks, see and treat. Therapeutic laparoscopies are considered preferable[9]. Laparoscopy can successfully diagnose adhesions and several types of endometriosis and their surgical treatment[10].

CONCLUSION

Laparoscopy is the gold-standard investigation to CPP. It enables, not only confirmation of USG diagnosis, but also detects causes of pain in many, where USG fail to diagnose.

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