Case Report

# A HOUSEWIFE WITH RECURRENT PELVIC PAIN

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A 45-year-old Malay housewife was seen at a health clinic with the chief complain of recurrent lower abdominal pain for 9 months. The pain was colicky in nature and occasionally it radiated to the back. There was no history of fever, vaginal discharge or any urinary or bowel symptoms. She had been using an intrauterine contraceptive device (IUCD $Cu^{250}$) for the past 5 years. The last change of the IUCD was 2 years ago. Her annual pap smear results were normal. She had been to many primary care clinics and was reassured by the doctors that her symptom was due to her IUCD. She was prescribed mefenamic acid repeatedly for the past 9 months. However her symptoms worsen and she was worried because prior to this she did not have similar problems.

Her physical examination was unremarkable. On pelvic examination, the IUCD string was visualised, indicating that her IUCD was still in-situ. Her cervix was pink and healthy. There was no abnormal vaginal discharge.

## Was her lower abdominal pain due to IUCD?

Common causes of recurrent pelvic pain include: pelvic inflammatory disease (PID), endometriosis, adenomyosis, ovarian mass, uterine fibroids, cystitis, ureteric or bladder calculi.[1] Although the use of IUCD is relatively safe, there are a few significant complications that are associated with pelvic pain. In long term IUCD users, uterine perforation may produce little symptoms and patients merely notice the absence of the IUCD string.[2] Another complications is bladder perforation where the patient presents with recurrent urinary tract infection soon following insertion of IUCD.[2] PID associated with an IUCD usually occurs in the first few months after insertion. It should be suspected if the patient presents with pelvic pain and vaginal discharge.[3]

The aforementioned complications are uncommon; more commonly IUCD is associated with menorrhagia and dysmenorrhoea. It was reported that the 5-year cumulative termination rate because of these problems is up to 20% for the copper IUCD.[4] Although IUCD is a cause of recurrent abdominal discomfort and dysmenorrhoea, the history of abdominal pain presented by this patient did not suggest so. She had been well several years after the insertion of the IUCD and the onset of her abdominal pain was just 9 months ago. Patients with dysmenorrhoea or IUCD associated discomfort usually respond to oral NSAID, but for this patient, her symptoms worsen. Other differential diagnoses must be considered in her.

Her initial investigations are shown in Table 1 and Figure 1.

Table 1: Laboratory investigations

| Blood count and ESR | Urinalysis |
|---|---|
| Haemoglobin: 11.1 g/dL<br>Total white count: 8,000/dL<br>ESR: 20 mm/hr | Specific gravity: 1.005<br>pH: 5.5<br>Bilirubin: Negative<br>Ketones: Negative<br>Protein: 1+<br>WBC: 2+<br>RBC: 3+<br>Nitrite: Negative |

Figure 1: Plain bdominal radiograph

Interpretations

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Her urinalysis showed significant haematuria. The plain abdominal radiograph showed the IUCD in-situ and it is in vertical position. In a women with absent IUCD string and the IUCD is at the transverse position, uterine perforation should be suspected.[2] All these features were not present in this patient. There was an oval opacity at her lower left lumbar region, situated at the tip of the transverse process of the Left L5 vertebra. In view of the history of pelvic pain, haematuria and the radiograph findings, the most likely diagnosis was left ureteric calculi. A plain radiography of the abdomen had a sensitivity of 69% and specificity of 82% in diagnosing urinary tract calculi. Urinalysis had a sensitivity of 69% and specificity of 27%. The sensitivity increased to 89% if both test was positive.[5]

This patient was subsequently referred to the urologist at the hospital for further management. Further investigations performed in the hospital include ultrasound of the renal system and intravenous pyelogram, which confirmed a left ureteric calculi. She underwent extracorporeal shock wave lithotripsy (ESWL). Since then she had no more recurrent abdominal discomfort.

## What can we learn from this case?

At first glance, it is somewhat unusual for a symptomatic ureteric stone to be missed for so long. However, the typical history of loin-to-groin pain associated with frank haematuria or the passing of stone was not present. The history of IUCD use somehow has misled several doctors to regard it as the cause of the pelvic pain. The fact that the patient was symptom-free for in the first few years of IUCD use was not taken note of. The lack of continuity of care in the primary care (possibly compounded by "doctor-hopping") does not allow proper evaluation and follow up of this patient's problem. It is important for primary care doctors to entertain alternative diagnoses when the symptom is recurrent, persistent or progressive.

References

1. Lifford KL, Barbieri RL. Diagnosis and management of chronic pelvic pain. Urol Clin N Am 2002 Aug;29(3):637-47 [PubMed]
2. Lawrence LL. Unusual presentations in obstetrics and gynecology. Emerg Med Clin North Am 2003 Aug;21(3): 649-65 [PubMed]
3. Epperly ATA, Viera AJ. Pelvic inflammatory disease. Clinics in Family Practice 2005;7:67-78
4. Weir E, Society of Obstetricians and Gynaecologists of Canada. Preventing pregnancy: a fresh look at the IUD. CMAJ. 2003 Sep 16;169(6):585 [Full text]
5. Eray O. The efficacy of urinalysis, plain films, and spiral CT in ED patients with suspected renal colic. Am J Emerg Med 2003 Mar;21(2):152-4 [PubMed]