The medical care of patients presenting with acute exacerbations of chronic pelvic pain- a retrospective audit

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Introduction: Acute exacerbations of chronic pelvic pain present a clinical challenge to emergency and gynecology services and can be a costly burden if not well managed. There is currently no recognized guideline in the literature for managing these women.

Objectives: To describe the current practices for assessment and management of patients with acute exacerbations of chronic pelvic pain at Waitemata DHB, Auckland. Key areas of 1) Time to first analgesia 2) History taking 3) Examination 4) Investigations and 5) ongoing management were assessed to enable the development of a re-auditable evidence based pathway. No audit standard is available, but the RCOG Green-top Guideline No. 41 was followed where applicable.

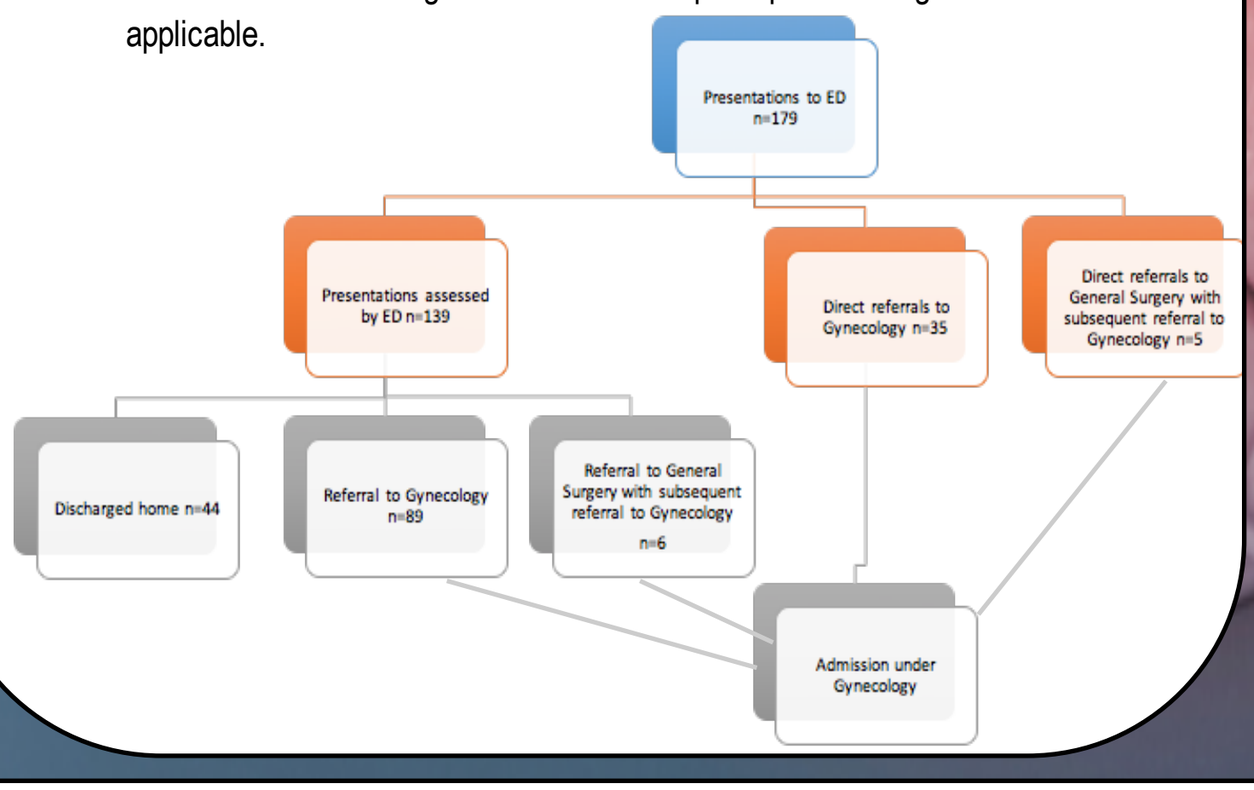
Methods: Retrospective audit conducted from 1 July 2017 – 31 March 2018 at a secondary level ED in Auckland.

- 366 patient encounters were acquired by discharge coding using the keywords endometriosis, abdominal pain NOS, pelvic pain NOS or ovarian cyst.
- **The following selection criteria was applied:**

Inclusion:
- Endometriosis or evidence of chronic pain (two or more presentations with non specific pelvic pain over a 6 month period, or previous referrals or outpatient clinic appointments mentioning long term pelvic pain issues)

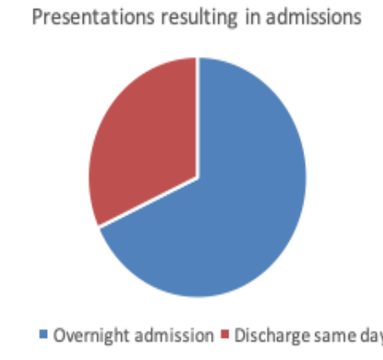
Exclusion:
- Proven pathology: Sepsis / Ovarian torsion / appendicitis/ large ovarian mass (not endometrioma)
- Pregnant
- Referred to a different specialty and care not taken over by gynaecology.
- Out of area

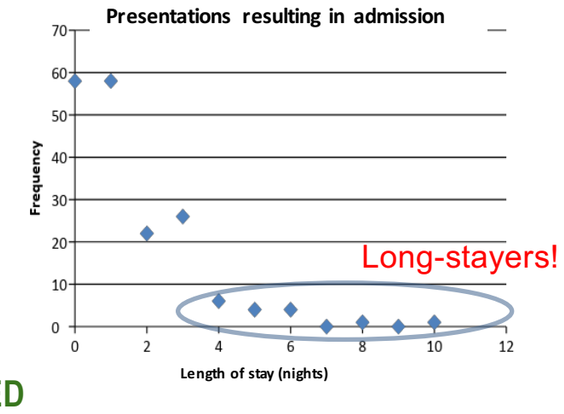
- 179 patient encounters, including 107 individuals, were audited.
- Data were collected from medical records and analyzed using descriptive statistics.
- 33 parameters relating to each patient encounter were collected from the patient notes. These parameters were chosen to reflect critical aspects of assessment and management based on expert opinion and guideline where applicable.



Key results:

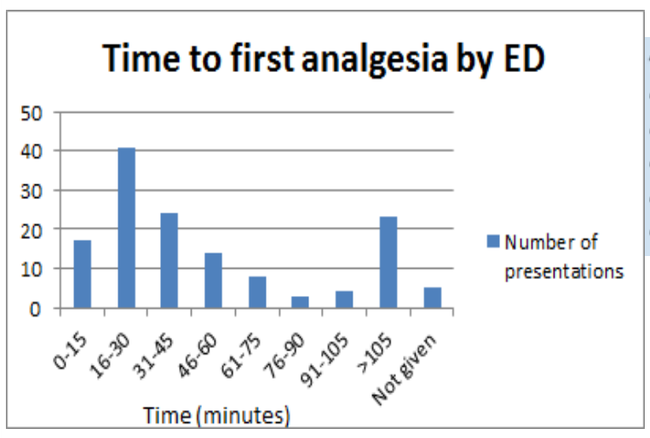
Majority admitted overnight 32% of patients were discharged on day of presentation. Once admitted, the average length of stay was 2.1 nights.





Slow time to first analgesia by ED

- Average time of 63 minutes, most presentations were triage category 3 or 4, with the aim to give analgesia within 30 minutes.
- 69% of women were given opioid analgesia.



1. Medications	
Opiate analgesia	123/179 (69%)
NSAIDs	94/179 (53%)
Trial of Diazepam	9/179 (5.0%)
Laxatives	77/179 (43%)
Hormonal treatment	85/179 (47%)**

Comprehensive history

Satisfactory in taking general gynecology history
Not consistent in asking about psychosocial factors or assessing for pelvic floor muscle spasm.

1. Menstrual history	123/135 (91%)
2. Bowel history	117/135 (87%)
3. Bladder history	114/135 (84%)
4. Sexual history	79/135 (59%)
5. History of anxiety and depression	37/135 (27%)
6. History of trauma, including sexual assault	5/135 (3.7%)
7. Effect of movement and posture on pain	43/135 (32%)

- Only 3.7% of women had a history of trauma or family violence taken.
- Only 27% had a history of anxiety and depression taken.

Appropriate examination:

- 58% of women had a bimanual examination.
- Only 2% of women were assessed for the presence of pelvic floor muscle spasm.

Appropriate investigations

- 53% of women had an inpatient ultrasound scan.
- 6% of women had a CT scan. Indications were:
  - ?appendix x3
  - ?diverticulitis ?cholecystitis
  - ?obstruction ?perforated bowel
  - ?renal colic x3
  - ?extent of endometriosis

1. Blood test	133/135 (99%)
2. Urine sample sent	117/135 (87%)
3. Vaginal swabs	86/135 (64%)

No CT scans resulted in a change in management.

- 4% of women had a diagnostic laparoscopy.

Clinic follow up

42% of patients did not receive follow up in gynecology Outpatient clinic.

Conclusion: main areas to target are

1) Decrease the time to first analgesia. The use of Diazepam for pelvic muscle spasm is underutilized and may result in faster first analgesia as it does not require IV access.
2) Increase education around the multifactorial nature of this presentation. Musculoskeletal pain is not identified or appropriately addressed in many cases.
3) Anxiety is a contributor to the severity of pain. Addressing this may decrease the length of stay and improve care in the long term.

Our current care does not demonstrate a modern approach to pelvic pain. Our hospital will benefit from a clinical pathway encompassing the multifactorial assessment and management of this presentation. This will both educate junior staff, ensure that patients receive the best care and possibly result in lower hospital expenditure.

References: [I] The initial Management of Chronic Pelvic Pain Green-top guideline No. 41 May 2012. [ii] Evans S. Management of persistent pelvic pain in girls and women. AFP 2015;44(7): 454 - 459. [iii] Grace VM, Zondervan KT. Chronic pelvic pain in New Zealand: prevalence, pain, severity, diagnoses and the use of health services. Australia NZ J Public Health 2004; 28: 369 – 75.