PIPADOR REVISION

MRCOG Part 1 Revision Notes

Pelvic Pain

CLINICAL MANAGEMENT • LECTURE 457

VISUAL EXAMINATION REVISION NOTES

2026 Edition

457

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Pelvic Pain

Chronic pelvic pain and endometriosis — definitions, assessment and management in line with RCOG GTG 41 and NICE NG73

≥ 6 months	NICE NG73	TVS	MDT
Chronic pelvic pain	Endometriosis (2024 update)	Even if exam normal	Multifactorial pain

■ KEY FACTS: Learning objectives

- Define chronic pelvic pain, endometriosis and deep endometriosis.
- Describe the causes and assessment of pelvic pain (RCOG GTG 41).
- Describe diagnosis and management of endometriosis in line with NICE NG73.

457.1 Key definitions

Term	Definition
Chronic pelvic pain (CPP)	Intermittent or constant pain in the lower abdomen or pelvis of at least 6 months' duration, not occurring exclusively with menstruation or intercourse and not associated with pregnancy (RCOG GTG 41)
Endometriosis	A chronic inflammatory condition with endometrial-like tissue outside the uterus
Deep endometriosis	Lesions infiltrating > 5 mm, often involving uterosacral ligaments, rectovaginal septum, bowel, bladder or ureter
Endometrioma	Ovarian endometriotic ('chocolate') cyst
Central sensitisation	Amplified pain processing in the nervous system — pain persists beyond tissue injury

■ IN PLAIN ENGLISH: Pelvic pain

Chronic pelvic pain often has **more than one cause** (gynaecological, bowel, bladder, musculoskeletal, psychological). Endometriosis is common, but imaging can be normal — so **treat symptoms without waiting for a laparoscopy**.

457.2 Causes and assessment

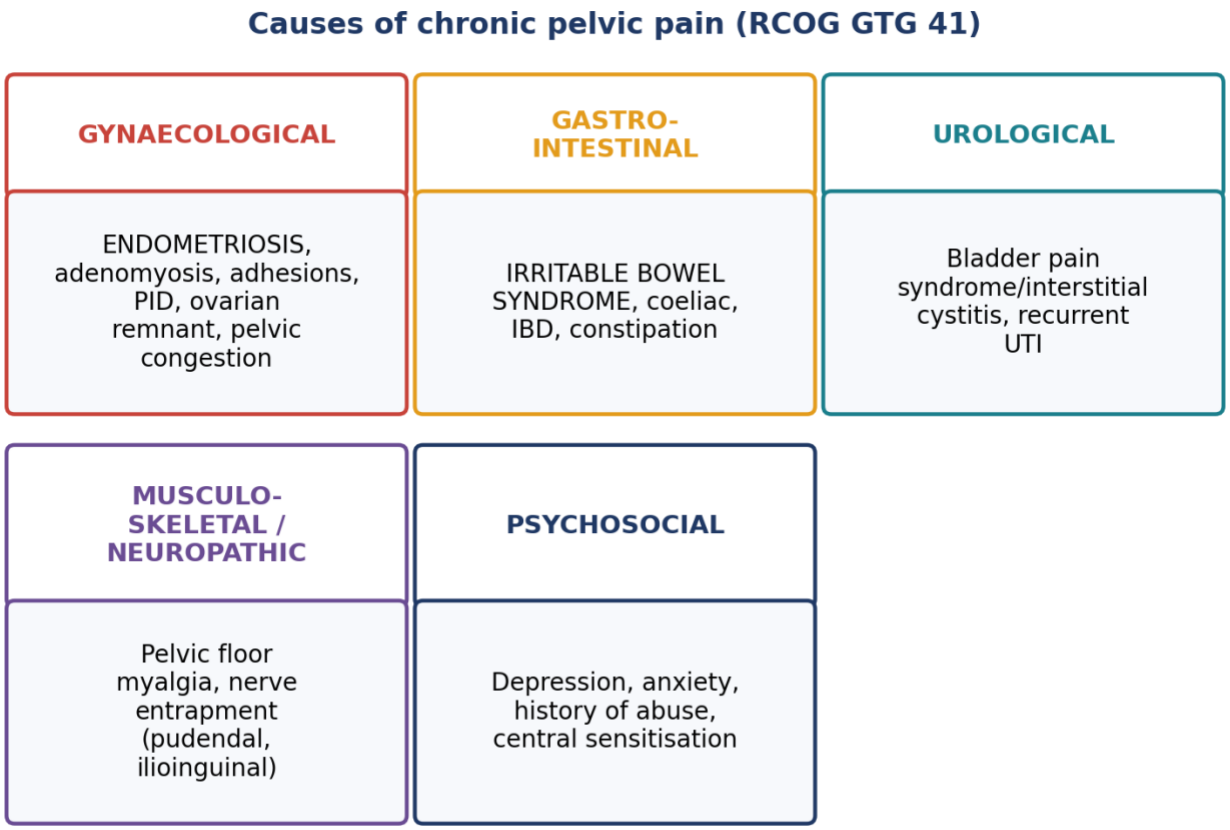


Figure 457.1 — Causes of chronic pelvic pain

- History: pain pattern (cyclical vs constant), dysmenorrhoea, dyspareunia
  - Bowel and bladder symptoms
  - Psychosocial factors (including abuse), impact
  - Pain diary.
- Examination: abdominal and pelvic (tenderness, nodules, fixed retroverted uterus, masses).
- Investigations: STI screen, TVS (also for suspected endometriosis even with a normal examination), MRI for suspected deep disease
  - Consider IBS/coeliac tests, urinalysis.

457.3 Endometriosis (NICE NG73)

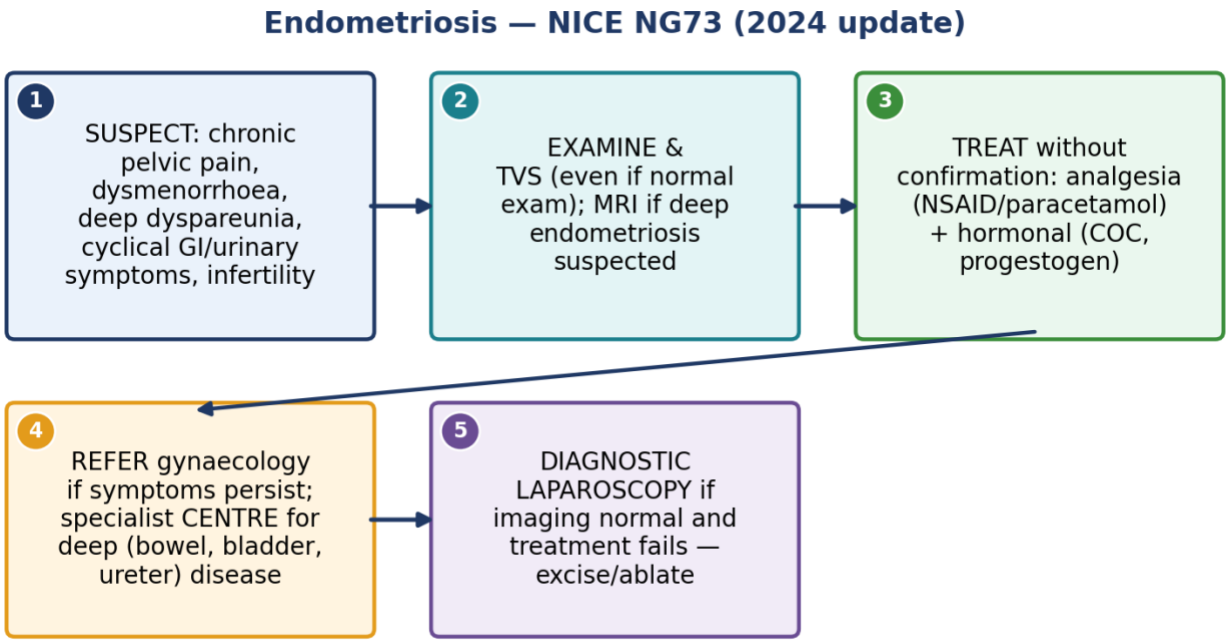


Figure 457.2 — Endometriosis care pathway

Management	Details
Analgesia	Short trial (e.g. 3 months) of paracetamol or an NSAID alone or in combination
Hormonal	• Combined hormonal contraception or progestogen (including desogestrel, LNG-IUS, DMPA, dienogest) — first-line hormonal • GnRH agonist/antagonist with add-back for second line
Surgery	• Laparoscopic excision or ablation of peritoneal endometriosis • Cystectomy (not drainage) for endometrioma — consider ovarian reserve (AMH) • Deep endometriosis in a specialist (BSGE) centre
Fertility	• Surgery for peritoneal disease improves spontaneous pregnancy • IVF if needed • Hormonal treatment does NOT improve fertility
Hysterectomy	• With excision of all visible endometriosis if family complete • ± oophorectomy (discuss HRT)
Support	Pain management services, psychological support, pelvic physiotherapy, patient organisations

■ COMMON PITFALLS

Waiting for laparoscopic proof before starting treatment.

Using hormonal suppression in women trying to conceive.

Ignoring IBS, bladder pain syndrome or pelvic floor causes.

457.4 Must-know summary

■ **EXAM TIP**

- CPP ≥ 6 months, multifactorial — assess gynae, GI, urological, MSK and psychosocial causes.
- Endometriosis (NICE NG73): suspect from symptoms; TVS even if exam normal; MRI for deep disease.
- Treat empirically: analgesia + hormonal (COC/progestogen); refer if persistent; specialist centre for deep disease.
- Diagnostic laparoscopy if imaging normal and treatment fails; cystectomy for endometrioma.

■ **MNEMONIC / MEMORY AID**

Endometriosis 'Ds' — Dysmenorrhoea, Dyspareunia, Dyschezia, Dysuria, Difficulty conceiving.