Neurological Pelvic Pain: Case II in the Series

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(Note: Case I was "Myofascial Pain Syndrome Presenting as Chronic Pelvic Pain," Dynamic Chiropractic, April 17, 2000.)

Neurologic disease as a cause of chronic pelvic pain may be more common than we think. Here is a case in which a patient with complaints of pelvic pain was subsequently found to have neurologic disease involving the lumbar spine. In this case, the presenting features were complaints of lower abdominal pain attributed to uterine fibroids by the OB/GYN. Only when conventional therapies failed to resolve the pain was a local chiropractor consulted. A magnetic resonance imaging (MRI) of the lumbar spine showed a disk herniation. Evolving lumbar disk disease in the upper lumbar area, while rare, can produce symptoms interpreted as pelvic pain.

Chronic pelvic pain appears as a common and serious problem among women, with an estimated prevalence of 14.7 percent in households in the United States. Causes of chronic pelvic pain may be multiple, including endometriosis; pelvic adhesive disease; uterine and ovarian tumors; inflammatory bowel disease; and urinary tract disease causes. Travell and Slocumb have described a pelvic pain syndrome associated with local abdominal wall trigger points.

Case History

C.C., a 45-year-old woman, presented with a two-year history of lower abdominal pain. She described the pain as constant, vague, right-sided, not aggravated by menses; and unknown if aggravated by intercourse (though the patient stated she abstained from this activity).

The patient denied any gastrointestinal or urinary tract symptoms. Oral antibiotics had previously been prescribed for presumed pelvic infection within the last six months. At antibiotic completion, the patient was moderately improved, but continued to have mild discomfort in the lower right quadrant of the abdomen and right groin. When seen at my practice, the pain had worsened and was described as dull, aching, and continuous. On examination, she was afebrile, with moderate tenderness in the lower groin. Her
OB/GYN reported that pelvic examination previously had showed a tender adnexa. No masses were palpable; pelvic ultrasonography was negative for any mass.

Her menses had become progressively heavier over the past two years, which was attributed to uterine fibroids. A total abdominal hysterectomy and bilateral salpingo-oophorectomy was performed at a hospital; the tissue report showed benign uterine fibroids, secretory endometrium, and ovaries with no pathologic change. C.C. reported that she insisted upon the surgery because she could "no longer live with the pain." The patient derived relief from the lower abdominal pain for about three weeks after the surgery. She was ecstatic that the pain was gone, but when she resumed her normal level of activity, the pain returned.

On referral to this practice six months after hysterectomy, the patient was complaining of constant pain in the lower back and the right lower quadrant of the abdomen. During careful questioning of the patient about the location and character of the pain, she admitted to intermittent numbness and pain in the right thigh and groin (the latter which she perceived as driving from the hip). A neurologic examination was negative for sensory or motor deficits. Magnetic resonance imaging of the lumbosacral spine showed a 4 mm right-sided disk herniation at L1-L2, and disk bulge involvement at the L5-S1 region. A neurosurgical consultation recommended laminectomy; the patient initially refused.

For the next six months, she received conservative chiropractic care, and was much improved with minimal discomfort in the left groin. Today, she remains relatively pain-free and requires chiropractic care every eight to 12 weeks for residual pain, with treatment emphasis on the lumbar and sacroiliac region. Follow-up neurological referral is maintained currently (every six months) to monitor disk herniation progression, if any.

**Discussion**

The severe and persistent lower back pain radiating into the buttock/hip postoperative hysterectomy was inconsistent with the findings at surgery on medical record review, and neuropathy was suspected. However, this patient complained of lumbosacral pain before the surgery. Investigation of this pain might have prevented the surgery.

In this case, an evolving disk herniation of the lumbar spinal segments, by exerting pressure on dorsal afferent spinal nerve roots, produced a pain syndrome before the development of pain typically associated with radiculopathy,
Pain and numbness in the right groin and thigh, which prompted MRI, was minimally symptomatic, compared with the pain that she perceived to arise from the pelvis. Pelvic pain was attributed to uterine fibroids and resulted in the hysterectomy, possibly unnecessarily, which failed to ameliorate the symptoms.

Disk herniation or degenerative disk disease constitutes greater than half of the cases of chronic lower back pain. Careful neurologic examination is usually helpful in localization, although initially, pain can be nonspecific. Local back pain is usually associated with position and is aggravated by coughing, sneezing, and straining with defecation or by trunk motion and relieved by bed rest. Tenderness or tautness is occasionally felt on the spine due to spasm of paraspinal muscles or local lesions. Passive straight leg-raising is often positive. Specific combinations of paresthesiae, weakness, and hyporeflexia indicate certain root involvement, but may not always be present at the time of examination. A high index of clinical suspicion is required. L4 root compression is manifested by the combination of diminished knee reflex, weakness in the quadriceps, and anterior thigh and leg numbness. This type of root compression is all too familiar to doctors of chiropractic. However, the L2 root lesion should be also suspected when radiating pain and numbness of the lateral hip and thigh are persistent.

To identify the location of the pain complaint, it is recommended that outcome assessment forms such as pain drawings be utilized as well as asking the patient to "show-and-tell"; to "point with one finger only and trace the area of pain or numbness." Magnetic resonance imaging of the spine is the diagnostic test of choice to rule out neurologic disease when the clinical situation warrants.

Neurologic disease should be considered, especially in cases of atypical pelvic pain, or in patients who fail to respond to conventional therapies. Get to know the OB/GYNs in your practice area and inform them of your abilities as doctors of chiropractic within the clinical arena.

In working closely with my OB/GYN medical practitioners, I have discovered that about 30 percent of their patients with pelvic pain belong in my practice, and conversely, some of mine in theirs. This recognition has afforded mutual respect, opportunity for co-referrals and mutual cooperation when it comes to patient care.

References


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