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Gynecologic Emergencies

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Gynecologic Emergencies

APPROACH TO THE PATIENT

Evaluation of gynecologic complaints in women presenting to the emergency department (ED) requires accuracy and expediency as well as compassion and sensitivity. A missed diagnosis could lead to compromised future fertility, chronic pelvic pain, or even death. Three life-threatening gynecologic conditions that should always be considered are ruptured ectopic pregnancy, ruptured hemorrhagic ovarian cyst, and ruptured tubo-ovarian abscess. External hemorrhage from the genital tract is more apparent but also can be life threatening.

Historical information may assist in the diagnosis of the patient with a gynecologic complaint. Menstrual history and timing of symptoms with respect to the menstrual cycle should be elicited. A focused sexual history, including use of contraception, is essential. Any history of sexually transmitted diseases (STDs), pelvic inflammatory disease (PID), or gynecologic surgeries/procedures may be relevant. The physical examination should assess general appearance, vital signs, hemodynamic stability, and hydration status. A gentle but thorough pelvic examination is indicated, including a rectovaginal examination to thoroughly evaluate the posterior pelvis. A pregnancy test is warranted for reproductive-age women presenting with abdominal pain, pelvic pain, or vaginal bleeding due to the risk of ectopic pregnancy. In addition, a woman's pregnancy status may influence the evaluation and management of other disorders, including use of certain tests or radiographic procedures. This manual reviews gynecologic emergencies in women with a negative serum or urine pregnancy test. Emergencies associated with pregnancy have been previously reviewed in Volume 3, Part 2 of the *Hospital Physician Emergency Medicine Board Review Manual*.

PELVIC PAIN

A woman presenting with pelvic pain can pose a diagnostic challenge since pelvic pain is associated with many gynecologic and nongynecologic conditions (Table 1). Furthermore, the finding of pelvic pathology on examination does not always lead to the correct diagnosis for the pain. Patients with acute abdominal pain or

with unstable vital signs require immediate resuscitation, stabilization, and early consultation.

OVARIAN CYSTS

Ovarian cysts can result from normal gynecologic processes (functional cysts) or from pathologic processes such as neoplasms or endometriosis. Ovarian cysts are typically asymptomatic unless they are very large or unless rapid growth, rupture, hemorrhage, or torsion has occurred.

Functional cysts may be either follicular or corpus luteum cysts. Timing of symptoms with respect to the menstrual cycle can help differentiate between them. Some patients experience sharp, unilateral pelvic pain at midcycle with the rupture of a follicular cyst and extrusion of the oocyte (mittelschmerz). Larger follicular cysts can result from anovulation. When larger cysts rupture, follicular fluid may cause peritoneal irritation, resulting in pelvic pain. Symptoms can last up to 3 days, with associated nausea, malaise, and abdominal tenderness. Rupture of a corpus luteum cyst presents similarly but usually occurs later in the menstrual cycle. Findings include pelvic tenderness, often lateralized, and occasionally a mass. Intraperitoneal bleeding may occur, resulting in peritoneal signs and even hemorrhagic shock.

Endometriomas (cysts resulting from endometriosis) and dermoid cysts are benign tumors of the ovary that can cause a chemical peritonitis when ruptured, resulting in prolonged pelvic pain, fever, and sometimes ileus. Surgery to irrigate and cleanse the peritoneal cavity may be necessary.

Enlargement of ovarian cysts or tumors may result in pelvic pain. Growing cysts can stretch ligaments, compress adjacent organs, or cause increasing abdominal girth due to the mass itself or to ascites (in the case of ovarian cancer). Patients may experience abdominal or pelvic pressure, bloating, weight gain, or changes in bladder or bowel habits. Signs suggestive of malignancy include large (>5 cm) bilateral, fixed adnexal masses; ascites; and pelvic nodularity. A palpable ovary in a premenarchal or postmenopausal female requires further evaluation to rule out malignancy, as these ovaries should be too small to palpate. Unless the patient has a need for hospitalization, outpatient gynecologic referral should be arranged for further evaluation of an adnexal mass. If malignancy is suspected, the referral should be expedited. A patient with a mobile unilateral mass of small size (<5 cm) should