BACKACHE FROM PELVIC CAUSES

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It has been estimated that 25%—24·5% in a series of 943[1] of women suffer more or less continuously from a backache varying in intensity from a dull discomfort to a continual ache with exacerbations. It is so common a symptom that it tends rather to be disregarded or accepted as "usual" by the patient unless it is really severe; thus the aggregate of avoidable suffering and disability is very large, and for its relief depends on a correct diagnosis, which in its turn demands a sound knowledge of medicine, orthopaedics, and gynaecology.

It is the purpose of this paper to deal with the gynaecological aspect, but it must be realised at the outset that an ache arising from a pelvic cause is often complicated by postural defects or fibrositic conditions, and that rectification of the pelvic element will not necessarily entirely relieve it, and furthermore the number of cases which are purely pelvic in origin is comparatively small.

Backache due to pelvic causes is rarely acute. It is described as being a discomfort, a dull ache, a bearing down or a heavy weight across the lower back, sometimes throbbing in character. The Irish cook[2] who said "I declare to you, Major, and to you, Ma'am, that I have a pain switching out through my hips this minute as would bring down a horse", knew a thing or two about backache. The pain is referred to the upper third of the sacrum or 5th lumbar vertebra, is usually bilateral, and may radiate down the thighs, while if the ovaries are particularly involved the pain seems to shoot through the sacro-iliac joints and across the back about the level of the 2nd piece of the sacrum. Thus the pain is characteristically low down—McKane[3] states that no ache above the lumbo-sacral region is pelvic in origin. No especially tender spots can be found, and the pain is not aggravated by movement but in most cases it is relieved by rest.

The chief causes are congestion of or pressure upon pelvic organs and traction on ligaments and supports of those organs.

Congestion.—1. *Retroversion and retroflexion of the uterus.*—When the condition is of the congenital type and the uterus is in other respects normal, this displacement causes no symptons. When however it is due to puerperal causes with subinvolution the uterus is bulky, varicose veins appear in the broad ligament, and often the tubes and ovaries share in the misplacement, one appendage frequently lying in the pouch of Douglas under the uterine fundus. Backache in such a case is usually severe and intractable, but if untreated, disappears after the menopause.

2. *Chronic cervicitis,* especially that type with hypertrophy, studded with cysts and with a large granular erosion, can cause an ache by itself, but it is usually found in association with the former group.

3. *Tubal inflammation* particularly in the sub-acute and chronic stages, with or without tubo-ovarian abscess.

4. *Ovarian follicular or chocolate cysts.*

5. *Cystitis.*

Any of the above may be aggravated by a loaded pelvic colon increasing the pressure and congestion and by the congestive effect of menstruation. For the latter reason, the backache improves or disappears after the menopause.

Pressure by a large solid tumour such as a fibroid—especially if degenerating—or an ovarian growth incarcerated in the pelvis. In such cases the backache is relieved if the growth becomes large enough to rise into the abdomen, and this is also true of a retroverted gravid uterus.

Traction.—Backache is liable to occur in most cases of uterine and vaginal prolapse from the traction on ligaments and peritoneum during the descent of the structures involved. Quite small degrees of laxity may be responsible for considerable pain, and many patients have been incidentally cured of backache by a small anterior repair for strain incontinence. On the other hand, Lynch,[4] in a series of cases, noticed that the smallest percentage of backache was to be found in patients with complete prolapse, an observation a little difficult to interpret otherwise than as the effect of extreme stretching on the nerve supply of the structures involved.

New Growth.—As a general rule fibroids and ovarian solid and cystic tumours are more likely to cause backache if they are accompanied by adhesions to other viscera or the parietal peritoneum. This is probably a "drag" effect. Endometrioma, especially of the recto-vaginal

septum, give rise to a dull ache with exacerbations at the menses, and if provoked by intercourse or the passage of a bulky motion. Carcinoma of the uterus does not cause backache in its early stages. Indeed the degree of pain can give some indication as to operability, for in the later stages it is usually very severe.

Several workers have investigated the incidence and causation of gynaecological backache, and of these Lynch's results may be taken as representative. In a series of 1,041 cases 49 % complained of backache, and of these, in a one to eight year follow-up, 76·5 % were relieved of their pain by operation. His results may be summarised as follows:—

No. of cases	*Pathology*	*Percentages with backache*	*Percentages whose ache cured by opn.*
28	Ovarian tumours	15·4	50
101	Fibroids	34	80
434	Pelvic inflamation	49	72
290	Retroversion and flexion	61	81
125	Marked vaginal relaxation	71	79
63	Complete prolapse	22	37

Treatment.—As indicated by the above table, operation offers the best chance of cure, but palliative treatment is often of great value and should always be tried first. For instance, an extended course of pelvic heat by hot douching or diathermy will considerably improve most cases of pelvic inflammation. The retroverted uterus may often be put forward and held by a pessary, when, the congestive effect of the twisting of the broad ligament being removed, the organ has a better chance to settle down to a normal state. Vaginal laxity and early prolapse can be controlled by a ring pessary as a rule, but unless there are contra-indications, such as an active child-bearing age or some cardiac or other reason, operation in these cases should always be advised, for a ring pessary is not a cure, and only slows down the prolapsing process.

REFERENCES.

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VITAMINS AND MILK STANDARDS

We have been asked to publish the two following reports, issued by the British Paediatric Association, in order to lay before the profession, in the briefest possible way, the results obtained, following careful investigations on the two questions of Vitamin D and milk supplies. These results have a most important bearing upon the health of the rising generation, to whom we look to take up the struggle after "the sweat, the toil, the tears and the blood" of this present war are past. They, the rising generation, must be given the opportunity of sustaining this great heritage of ours for which we now fight. To do that, they must be blessed with a healthy mind and body.

The recommendations laid down in these reports are, therefore, worthy of close attention, because the prevention of illness in early years is surely a most valuable contribution to the future health of our young population.

1. REPORT ON THE INVESTIGATION INTO THE STANDARD OF MILK SUPPLIED TO CHILDREN

(*Dr. A. G. Watkins, Cardiff.*)

Conclusion of the Survey.

1. There is no available evidence of an increase in milk-borne diseases since the outbreak of the war. The shifting population makes accurate statistical figures difficult to obtain, though in some areas there is formed a clinical impression of an increase in tuberculosis of the glands of the neck.

2. There is a definite lowering of the bacteriological quality of milk as supplied since the outbreak of war.

3. Frequent comments are made by Medical Officers of Health, concerning the unsatisfactory pasteurisation of milk at the present day.

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Postgrad Med J 1942 18: 203-204
doi: 10.1136/pgmj.18.204.203

Notes