Lower abdominal pain in women can be gastrointestinal, gynecologic, urinary, or musculoskeletal in origin. A careful history and physical, as always, is crucial in finding the etiology of the discomfort, but often needs augmentation with labs and/or imaging.

Step 1: Is the patient pregnant?
- If so this raises the concern for complications of pregnancy, but don’t forget that the pain may be unrelated to the pregnancy
  - Life threats vary based on pregnancy stage
    - First trimester: ectopic, molar pregnancy, septic abortion
    - Second/third trimesters: premature labor, abruption
  - Labs to get: quantitative hCG, CBC, chem, UA, ABO/Rh (if bleeding)
  - Imaging: bedside US for FHTs, pregnancy location, and placental lie

Step 2: Is the patient febrile?
A fever suggests infection rather than structural pathology such as torsion or ectopic pregnancy
- GI or urinary infections: appendicitis, perirectal abscess, pyelonephritis, infected stone
- Gyn infections: TOA, PID, septic abortion, retained products of conception, endometritis

Step 3: Where is the pain?
- Adnexal tenderness suggests ovarian or tubal pathology, but may also be present in e.g. appendicitis or diverticulitis
- Diffuse tenderness suggests bladder or uterine pathology, e.g. cervicitis, endometritis, PID, endometriosis, etc.

Step 4: Does the patient need imaging?
- If gyn pathology is highest on the differential, ultrasound should be the modality of choice, as it has higher specificity than CT for ovarian and uterine pathology
- If GI or GU pathology is highest on the differential, CT is preferred
  - If the patient is pregnant, MRI is preferred given its lack of ionizing radiation

Step 5: Does the patient needs to be seen by a specialist?
- Emergent gyn:
  - Pregnant: ectopic, abruption, missed/septic abortion, IUFD, labor
  - Non-pregnant: ovarian torsion, TOA, endometritis, cyst with large bleeding
- Emergent surgery: appendicitis, complicated diverticulitis
- Emergent urology: infected stone

References: