Week 2 Discussion: Lumbosacral Radiculopathy and Pelvic Inflammatory Disease

Lumbosacral radiculopathy and pelvic inflammatory disease (PID) can both cause lower-body discomfort, but they differ in demographics, onset, clinical history, diagnostic findings, and management. Lumbosacral radiculopathy is a neurologic pain syndrome caused by irritation or compression of a lumbosacral nerve root, whereas PID is an infectious inflammatory disorder of the upper female reproductive tract, most often associated with an untreated sexually transmitted infection (Khorami et al., 2021; Yusuf & Trent, 2023).

Comparison of client presentation.

Lumbosacral radiculopathy commonly occurs in adults with degenerative spinal conditions or mechanical injury. The onset of symptoms may be acute after lifting, twisting, or other physical strain, or it may develop gradually in individuals with degenerative disc disease. Patients typically report lower back pain radiating into the buttock or leg, following a dermatomal patterns, and may also experience numbness, tingling, or muscle weakness. Risk factors include disc herniation, spinal stenosis, obesity, repetitive heavy lifting, and occupational physical stress (Khorami et al., 2021).

In contrast, pelvic inflammatory disease most frequently affects sexually active women, particularly younger women. Symptoms generally develop due to ascending infection from untreated sexually transmitted infections. Patients often present with lower abdominal or pelvic pain, abnormal vaginal discharge, dyspareunia, fever, and irregular bleeding. Risk factors include multiple sexual partners, previous sexually transmitted infections, inconsistent barrier protection, and delayed treatment of genital infections (Yusuf & Trent, 2023). While radiculopathy presents primarily as neurologic pain radiating down the leg, PID typically presents as pelvic pain and reproductive tract infection symptoms.

Comparison of diagnostic criteria.

Current clinical practice guidelines support the diagnosis of lumbosacral radicular pain based on a focused history and neurologic examination. Key assessment findings include dermatomal pain, sensory deficit, weakness, altered reflexes, and reproduction of symptoms with the straight- leg raise or crossed straight-leg raise test. Pain mapping and gait assessment also support the evaluation. Routine imaging is not consistently recommended during the initial workup unless symptoms persist, neurologic deficits progress, or red-flag findings suggest structural pathology; in those cases, MRI may be appropriate (Khorami et al., 2021).

Pelvic inflammatory disease is primarily diagnosed clinically. According to the Centers for Disease Control and Prevention (CDC), the minimum diagnostic criteria include cervical motion tenderness, uterine tenderness, or adnexal tenderness during pelvic examination. Additional findings may include fever, abnormal cervical discharge, elevated inflammatory markers, and positive testing for gonorrhea or chlamydia.

Diagnostic testing may also include pregnancy testing to exclude ectopic pregnancy and pelvic ultrasound when complications such as tubo-ovarian abscess are suspected (CDC, 2021).