Management of Gynae Problems in Primary Care

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Pelvic Pain

- Challenge to the physician
- In UK 1 Million sufferers
- 20% of all gynae consultations
- Prevalence of dyspareunia 8%
- Dysmenorrhoea 45-97%
- Lower abdominal pain 23-29%

Aetiology

- Usually multifactorial
- Diagnosis is NOT easy
- Symptoms often correspond poorly with pathology if identified
- Gynaecological, Gastrointestinal, Urological, Neurological or Musculoskeletal systems

Causes of pelvic pain

Gastrointestinal causes

- Appendicitis
- Acute non-specific abdominal pain
- Gastroenteritis
- Irritable bowel syndrome
- Chronic constipation
- Inflammatory bowel disease
- Postoperative adhesions

Urinary tract disorders

- Urinary infection
- Interstitial cystitis

Musculoskeletal disorders

- Discitis
- Herniation of intervertebral disc
- Congenital spinal disorders
- Myofascial pain

Psychological causes

- Sexual abuse
- Depression

Interstitial Cystitis

- Cystitis symptoms – frequency, urgency, suprapubic pain, dysuria
- Negative MSU's
- Trigger factors
- Diagnosis

IC Rx

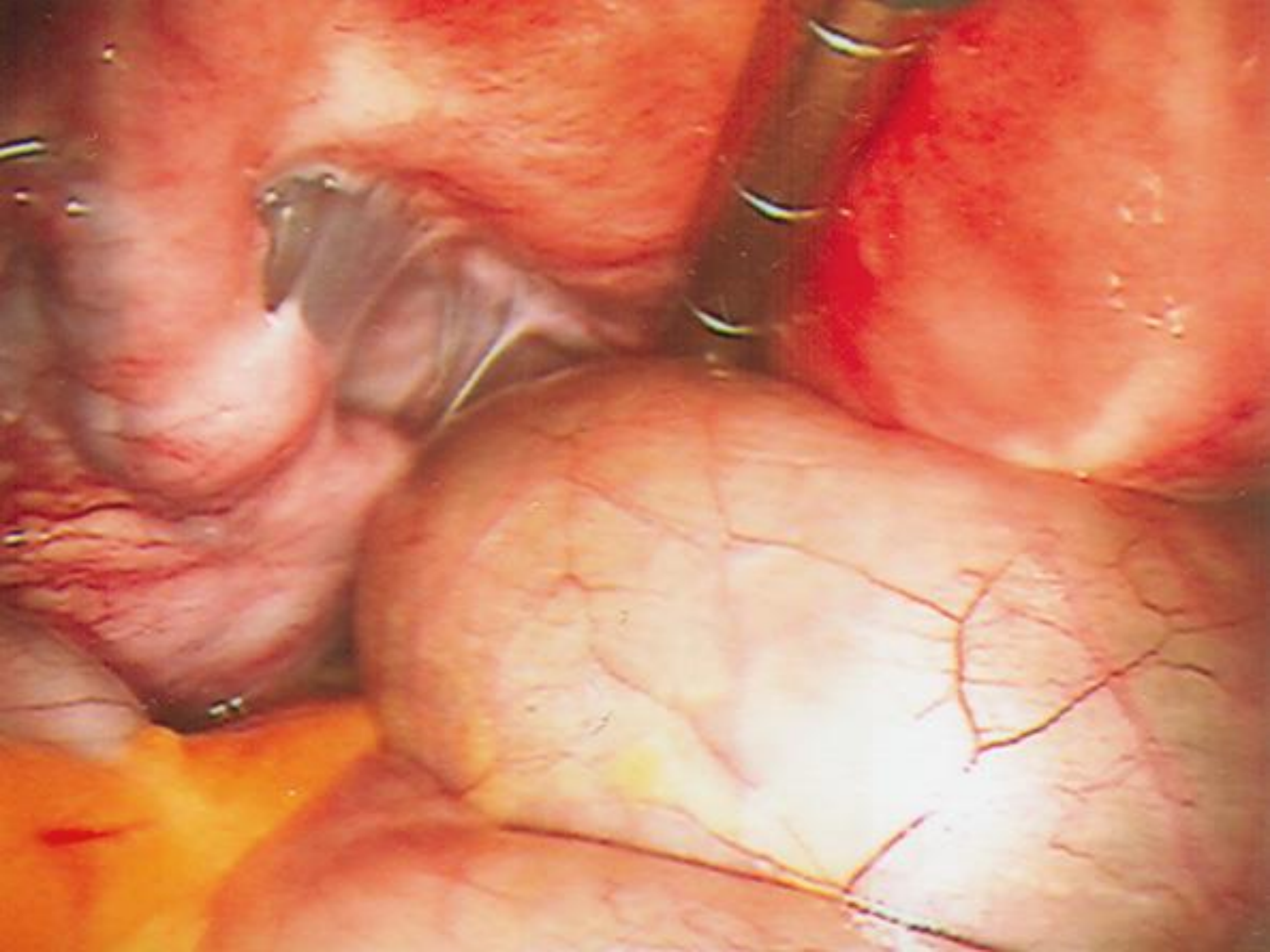
- Avoidance of triggers
- Antihistamines
- Cimetidine
- Hydrodistension
- Bladder instillations
- Uracyst (chondroitin sulfate) , Cystistat (Sodium Hyaluronate) iAluRil
- www.ichelp.org   www.cobfoundation.org

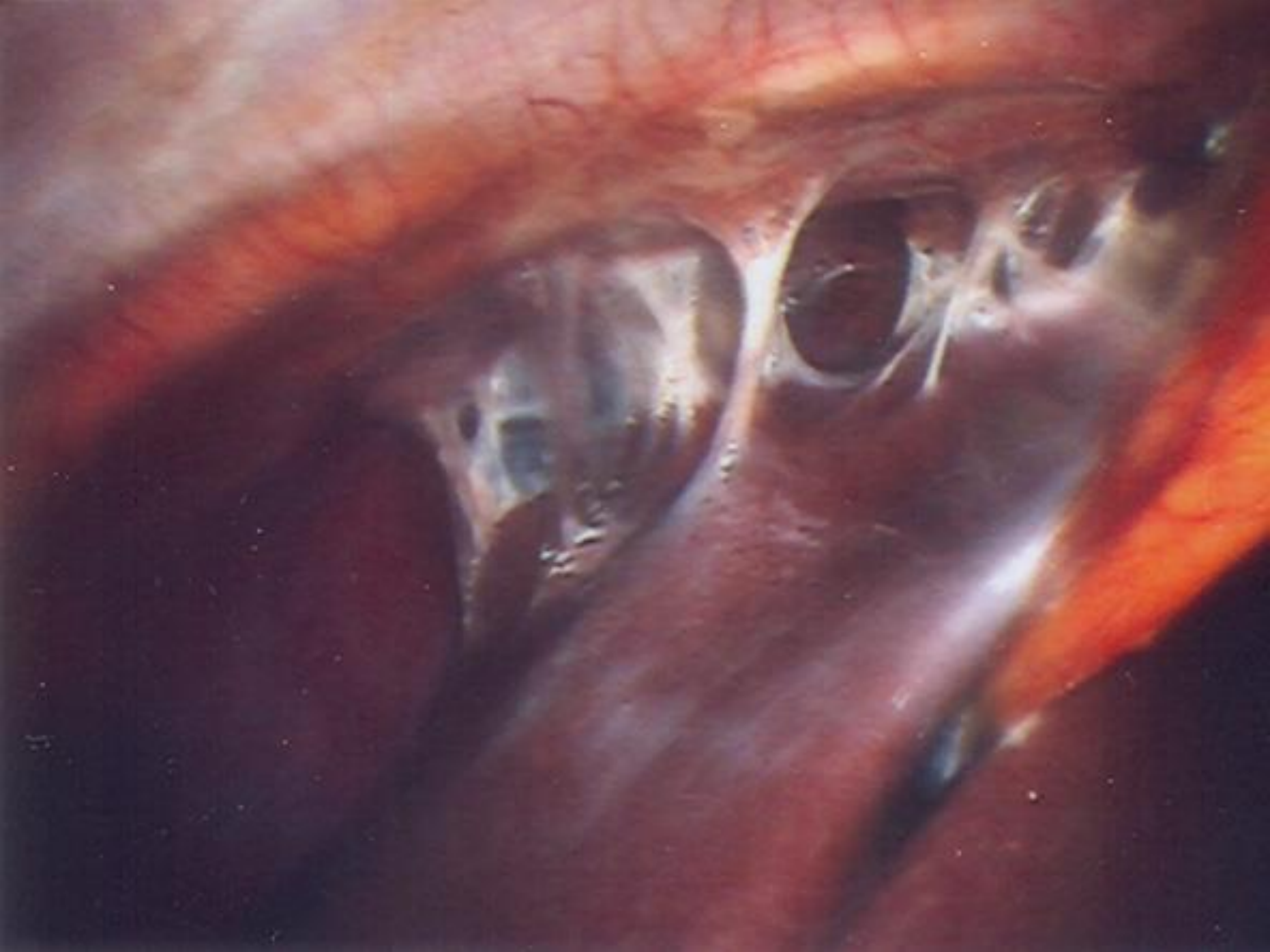
Gynaecological Disorders

- Pelvic Inflammatory disease
- Endometriosis
- Adenomyosis
- Fibroids
- Ovarian cysts
- Adhesions
- Mittelschmertz

Pelvic adhesions

- Symptomatic when under tension
- Exacerbated by sudden movements, exercise
- Pain is consistent with location
- Hx of PID, endometriosis, perforated appendix, previous surgery, inflammatory bowel disease
- Tx Laparoscopy & adhesiolysis





Ovarian cysts

- Rupture of physiological ovarian cyst
- May occur mid cycle or start of menses
- Expectant management
- Increasing symptoms consider haemorrhage, torsion or ectopic pregnancy

Cyclical pain

- Dysmenorrhoea
- Primary – no pathology
- Secondary – endometriosis, adenomyosis, fibroids
- Usually responds to suppression of ovarian function.

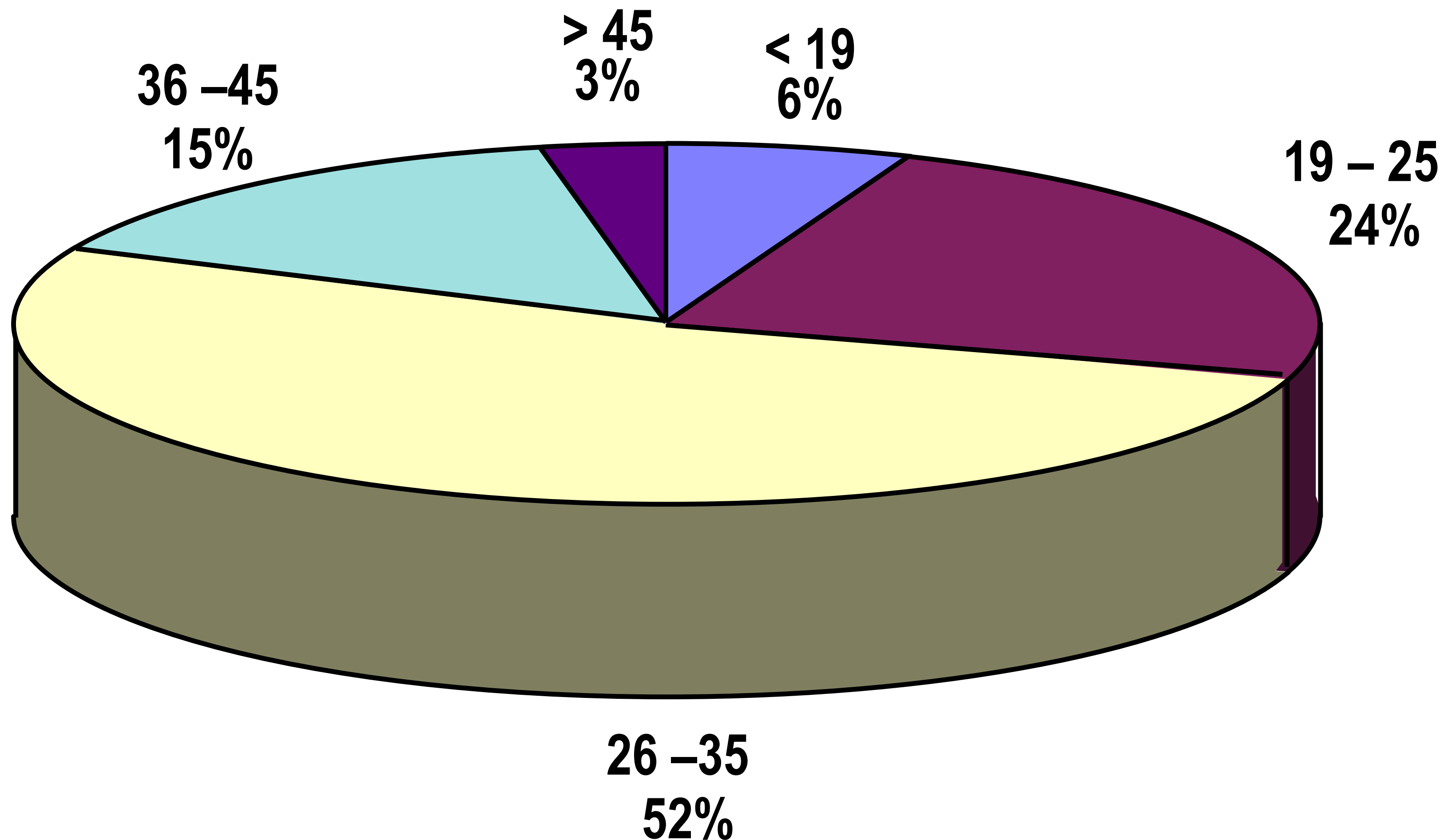
Endometriosis

- Characterised histologically by presence of endometrial glands and stroma outside the uterine cavity
- Prevalence in adolescence 4-10%
- Women with infertility 15-35%
- Hereditary factors: 5.8% of siblings, 8.1% in mothers

Endometriosis

- No complete understanding of aetiology, its development or recurrence
- High recurrence rate of symptoms
- 10% at 1 year, 25% at 2 years, 45% at 5 years
- The patho-physiology leading to pain and infertility is not clear
- Variety of symptoms does not correlate with extent of disease

Age at Diagnosis



Symptomatology

% of total

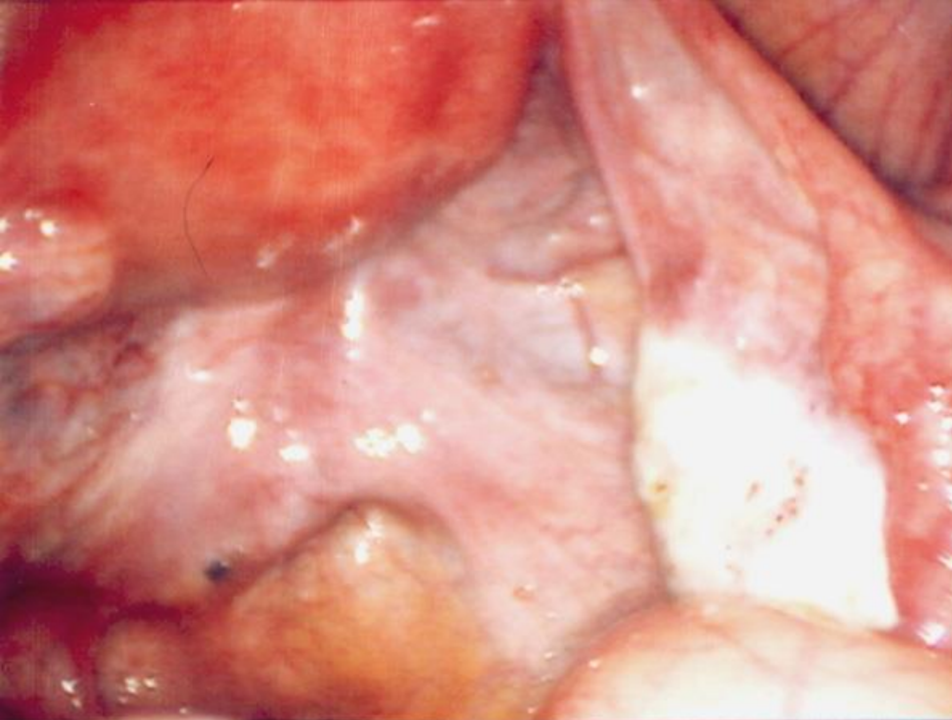
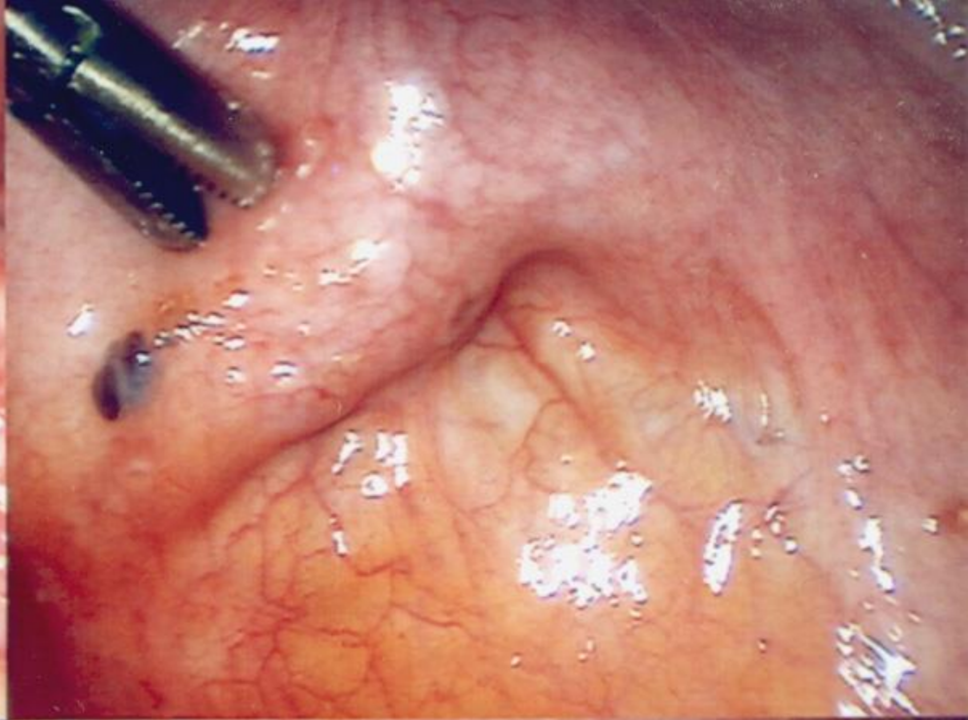
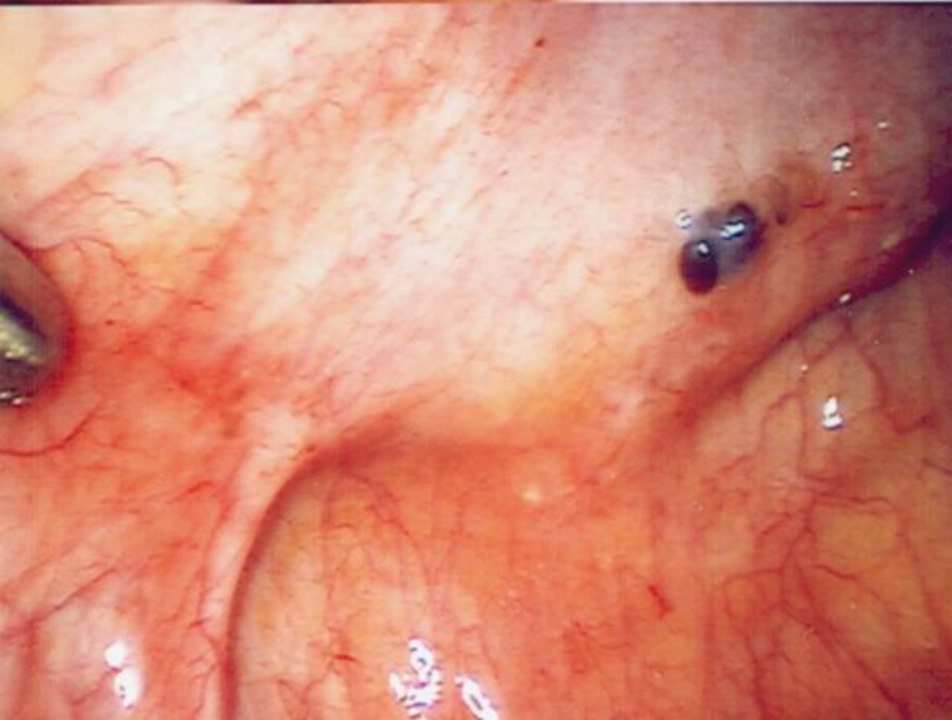
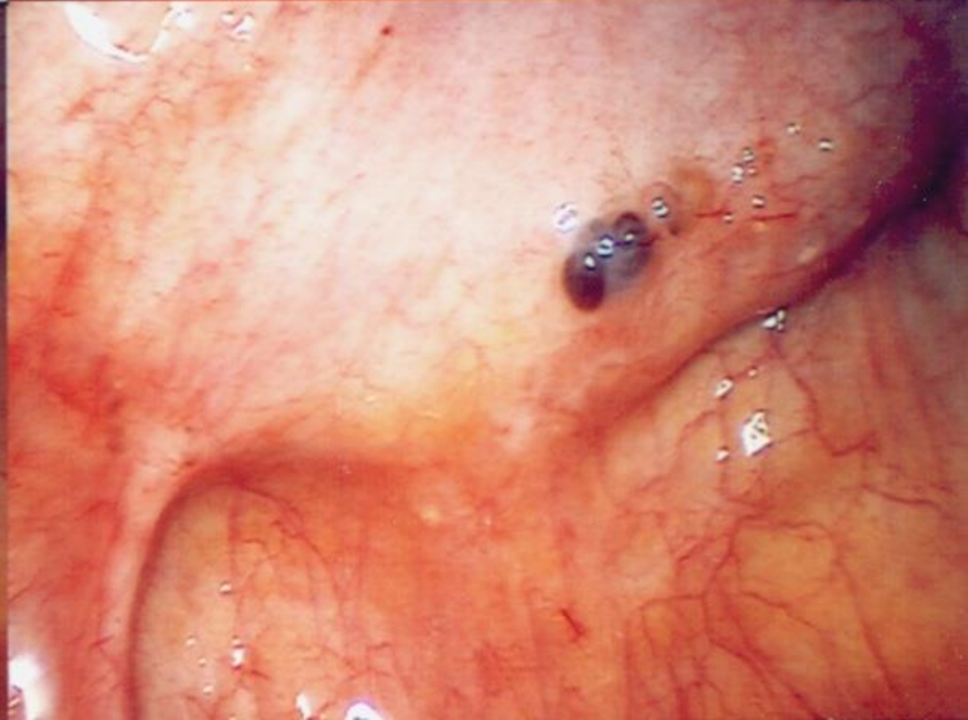
Symptom	% of total
Dysmenorrhoea	95
Fatigue, exhaustion, low energy	87
Diarrhoea, painful bowel movements	83
Abdominal bloating	84
Menorrhagia	65
Deep dyspareunia	64

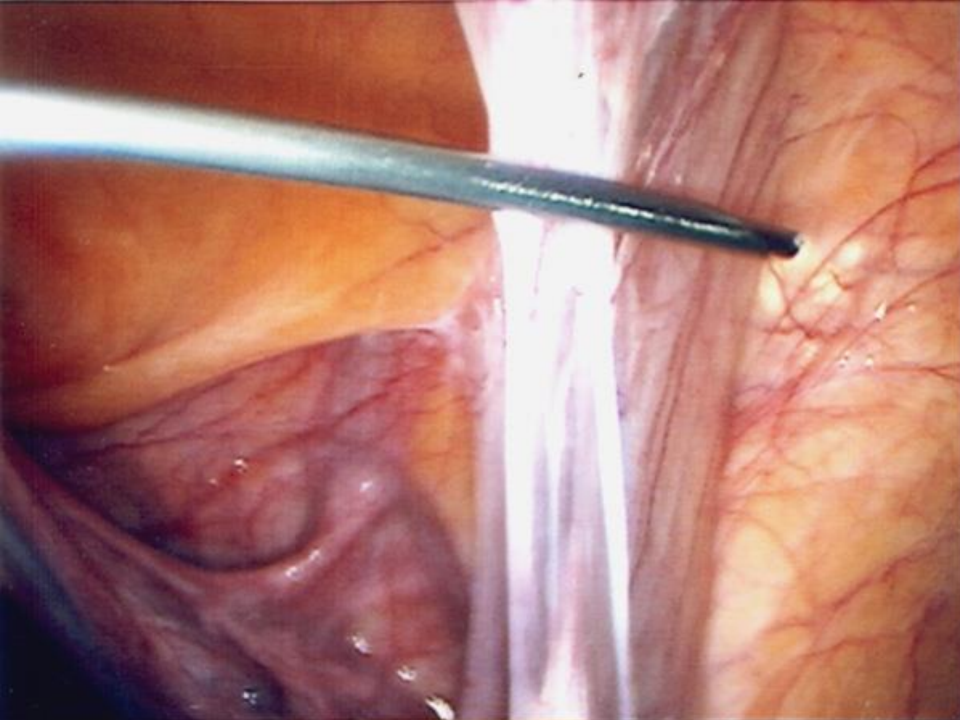
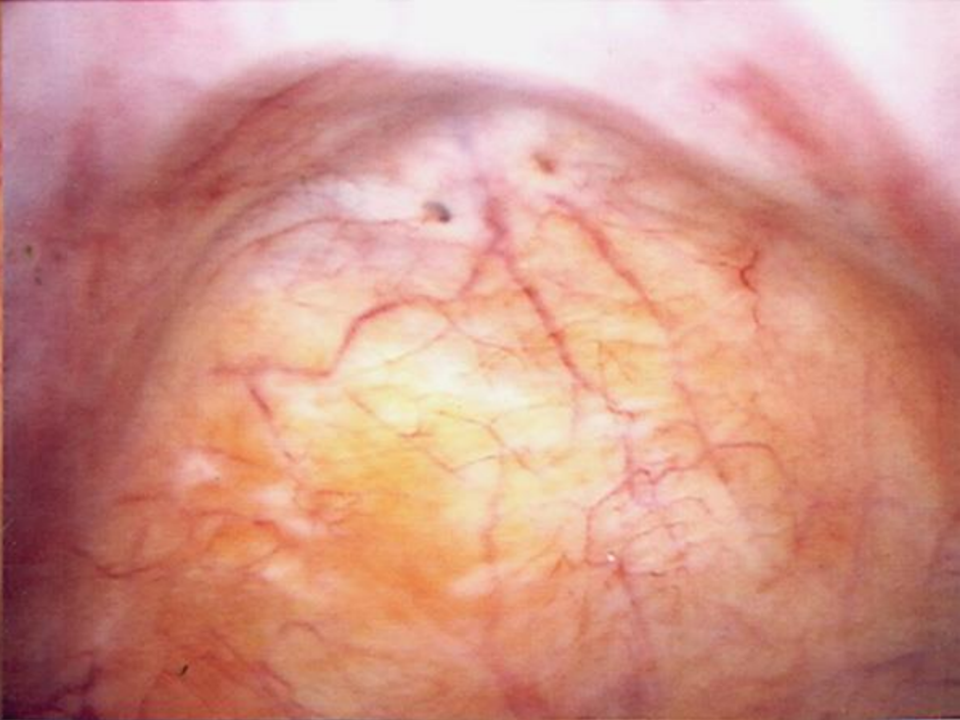
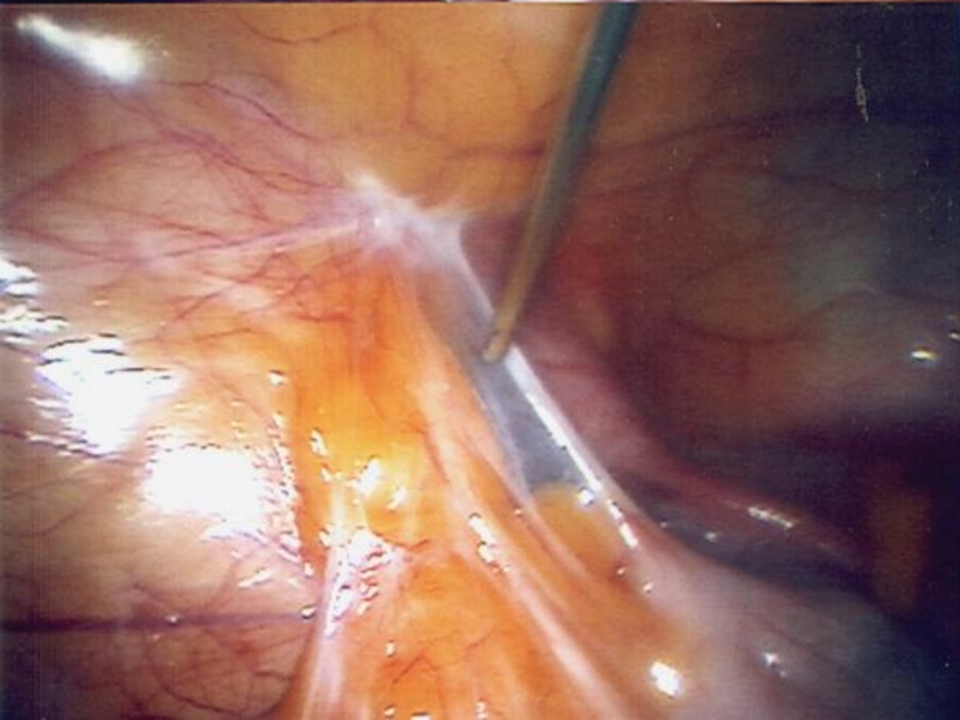
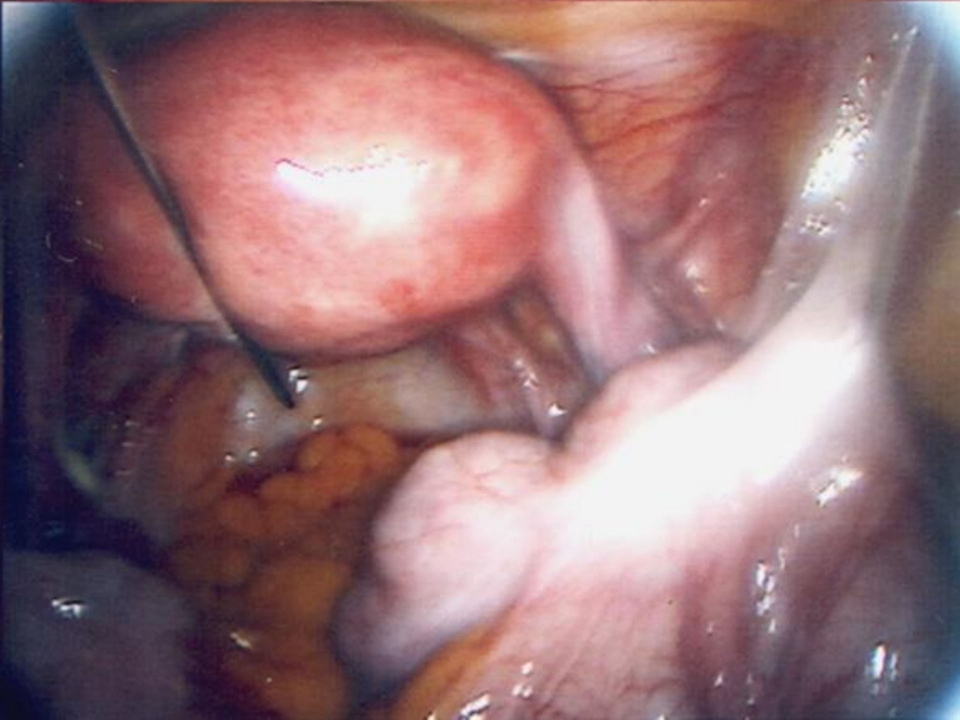
Physical Examination

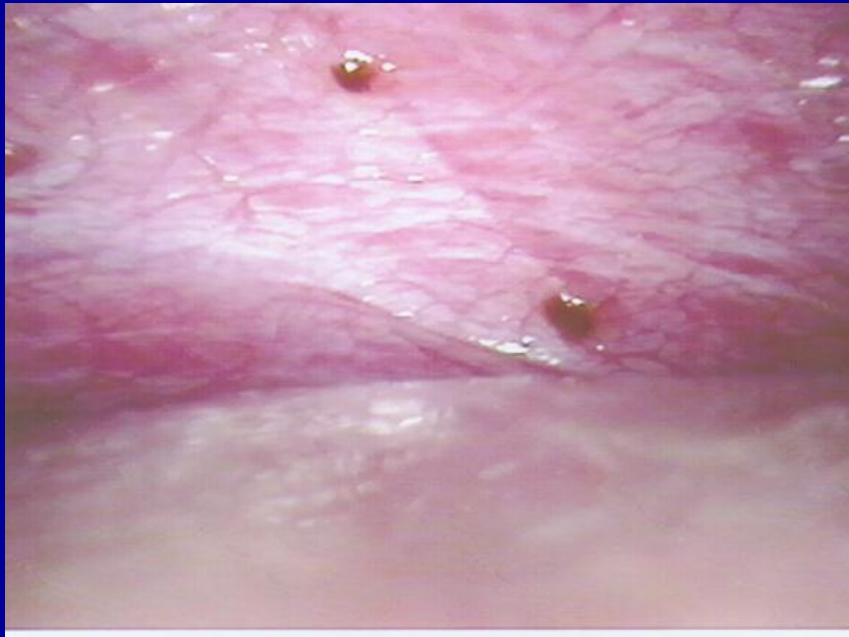
- Majority have normal examination
- Tender in pouch of Douglas
- Nodules palpable along uterosacral ligaments
- Retroverted fixed uterus
- Ultrasound is often unremarkable

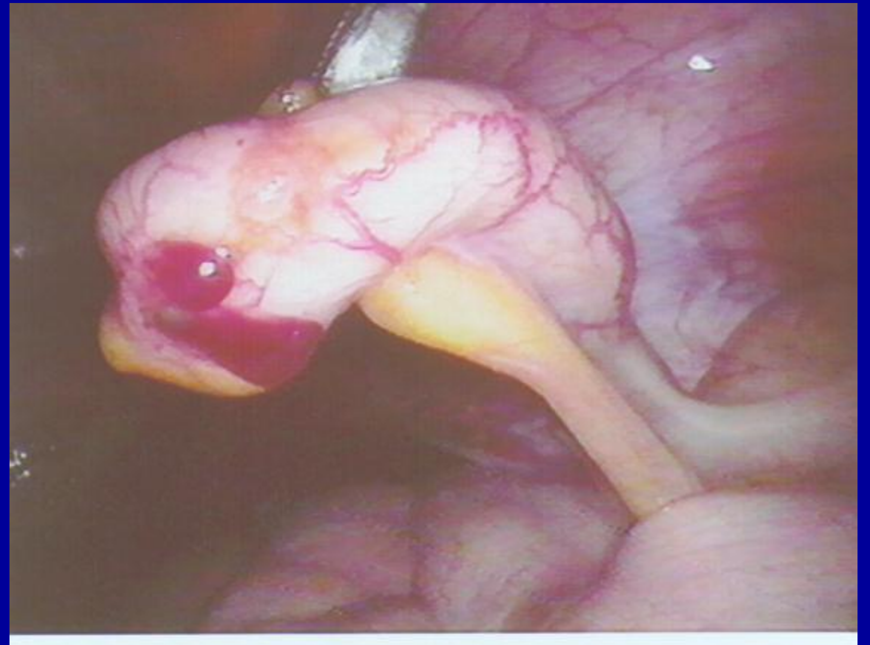
Diagnosis

- Laparoscopy – Gold Standard
- Diathermy- laser ablation - excision





Medical Treatment

- Combined oral contraceptive
- Progestogens
- Danazol
- Gonadotrophin releasing hormone analogues (LHRH)

Progestogens

- Oral medroxyprogesterone, Depoprovera, Megestrol acetate, Dydrogesterone.
- Pseudo-pregnancy state and anti-oestrogenic effect
- Side effects of weight gain, acne, bloating, depression and break through bleeding
- Mirena IUS

Levonorgesterol Intrauterine System

- Used for >10 years for contraception
- Direct effect through peritoneal fluid possibly by haematogenous spread
- Reduced size of endometriotic nodules
- Reduced pain scores

LHRH analogues

- Pseudo menopausal state
- Reduction of BMD 3-4% in 6 months
- Add back therapy
  - Combined oestrogen & progestogen
  - Progestogen alone
  - Tibilone

Summary

- Can be difficult to diagnose
- Therapeutic challenge to treat
- Multidisciplinary approach

Q & A