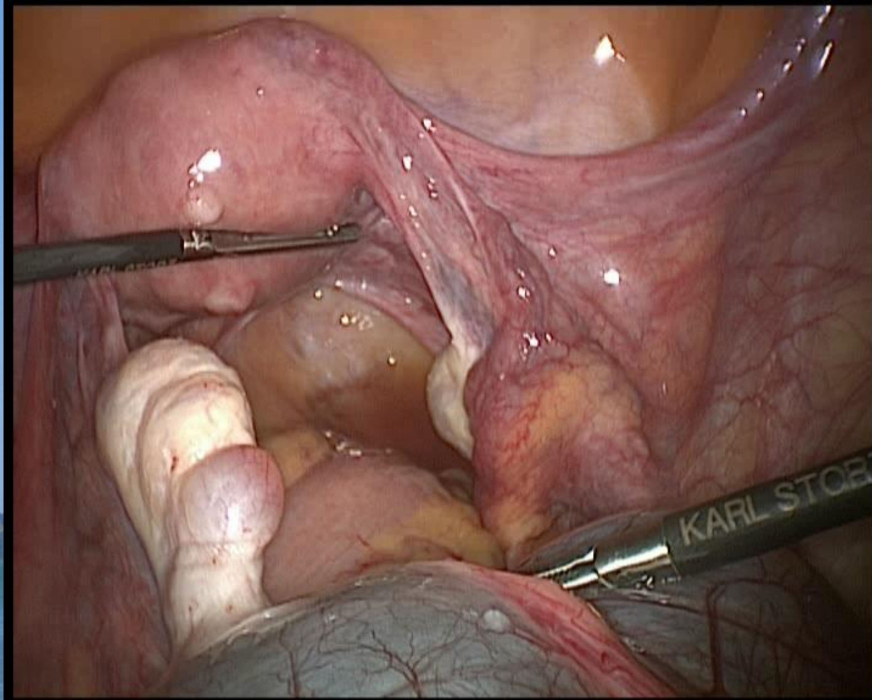
Simon Edmonds
Middlemore Hospital
Ascot Central Women’s Clinic
Auckland

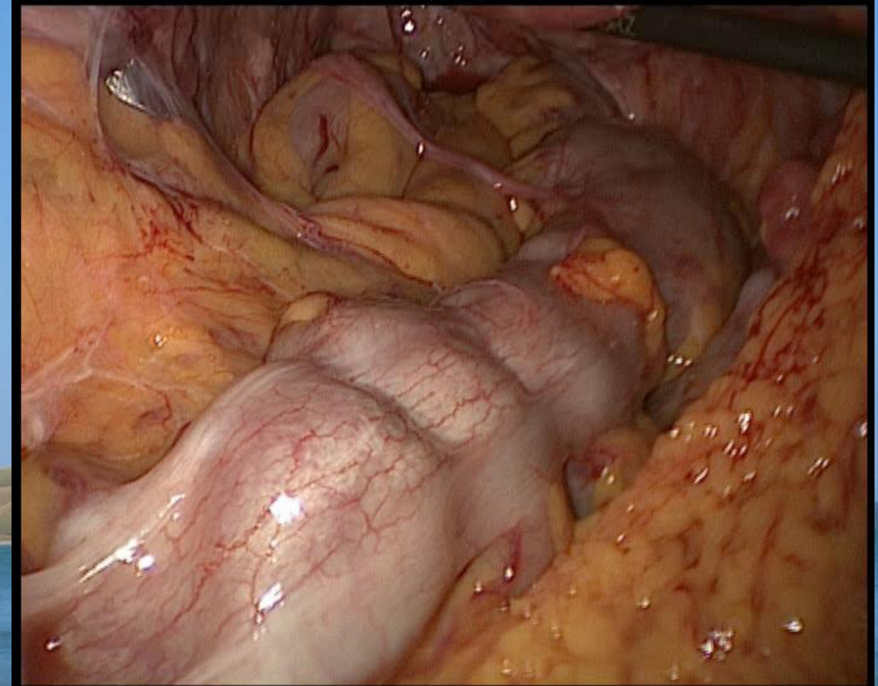
Objectives

- How to identify true cause of pain
- Treatments available in primary care
- When to refer
- Chronic pain and the team approach

What’s in there?



Gynae bits..

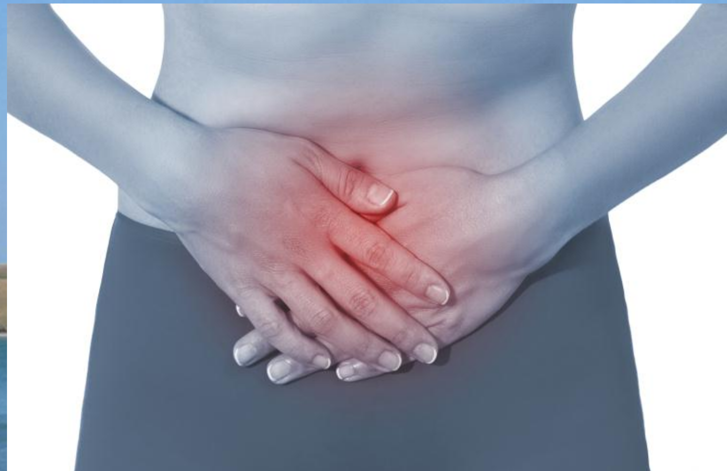


Surgical bits..

Don’t forget the ureters and bladder….

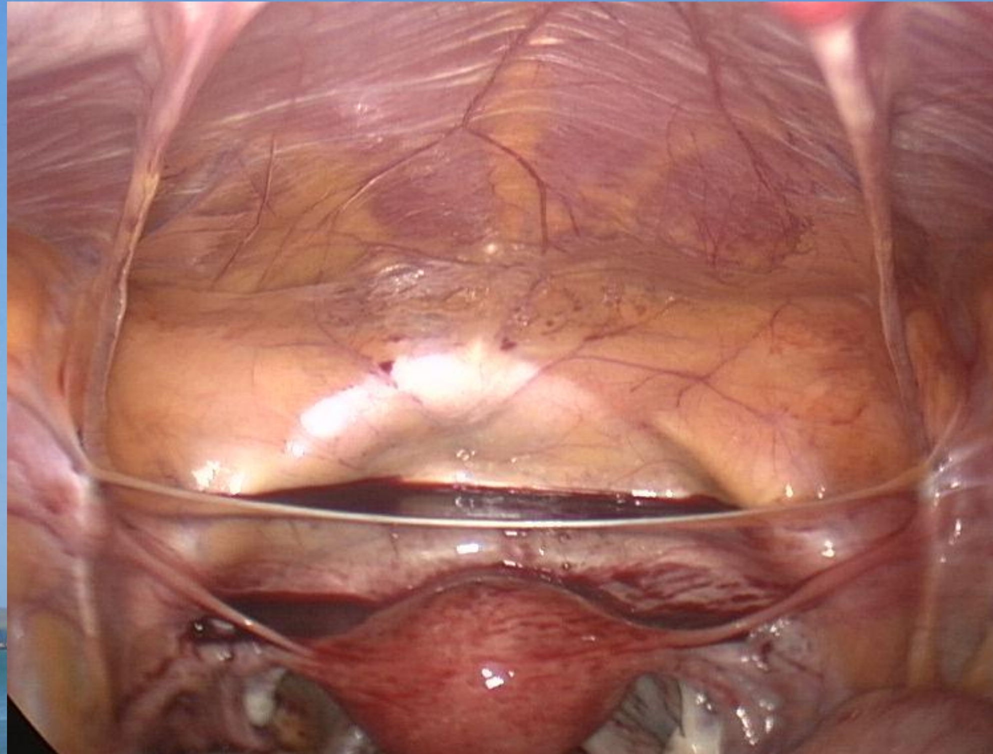
Presentation?

- Acute Pain
- Menstrual Pain
- Chronic Pain



Acute pain
Free blood in the pelvis

Acute pain



Menstruation

Ruptured corpus luteum or haemorrhagic ovarian cyst

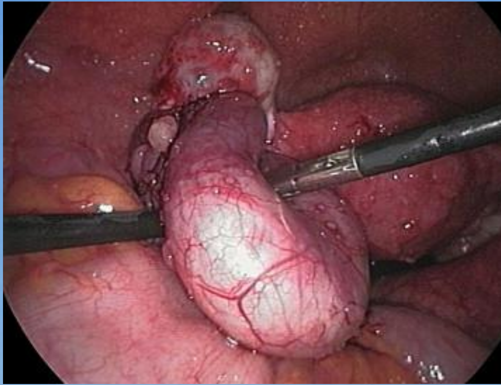
Ruptured ectopic pregnancy, miscarriage

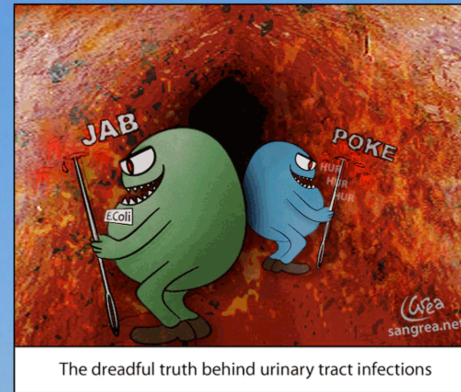
Acute pain

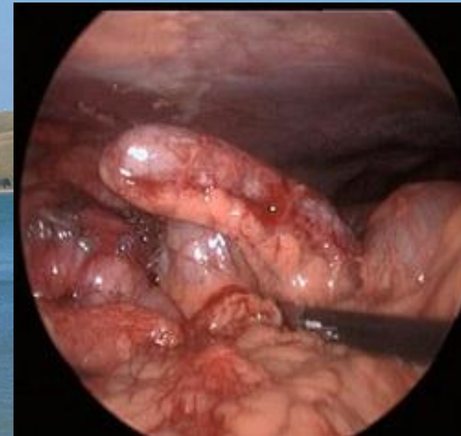
Free blood in the pelvis

Infection – STI or UTI or gastroenteritis or appendicitis

Acute pain (2)







Infection – PID/UTI/Gastroenteritis/Appendicitis

Acute pain

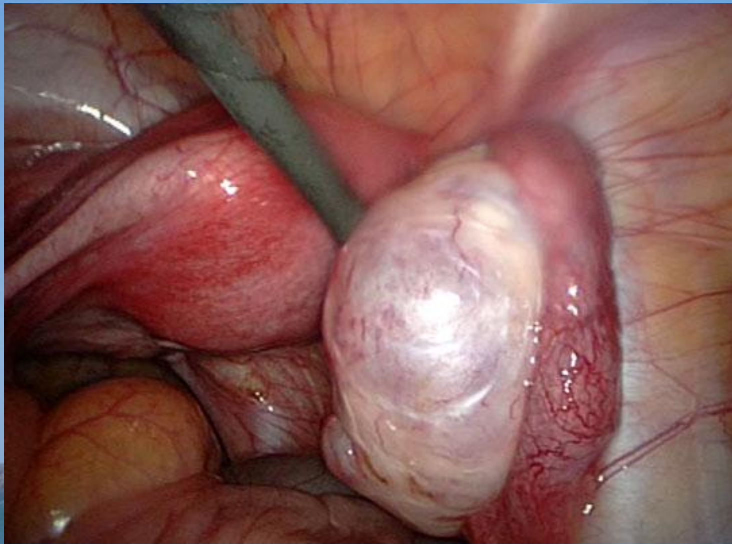
Free blood in the pelvis

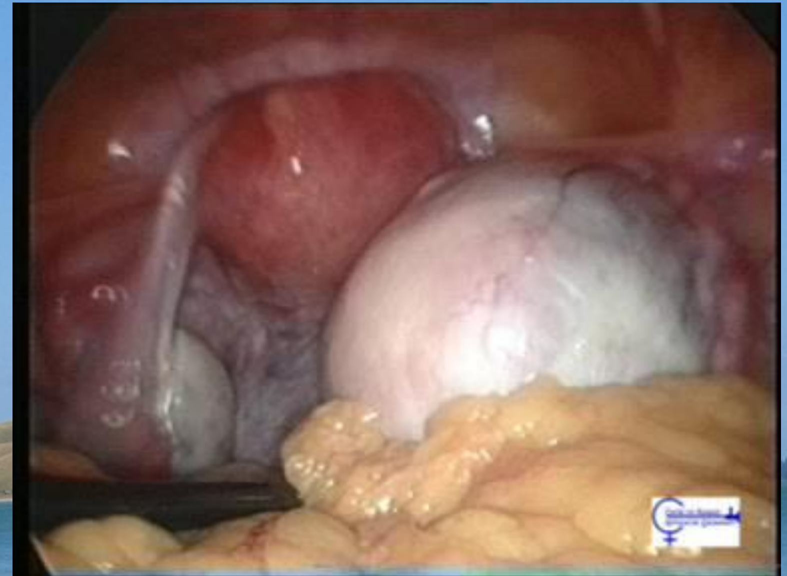
Infection – STI or UTI or gastroenteritis or appendicitis

Ovarian cyst torsion/bleed <3cm – normal

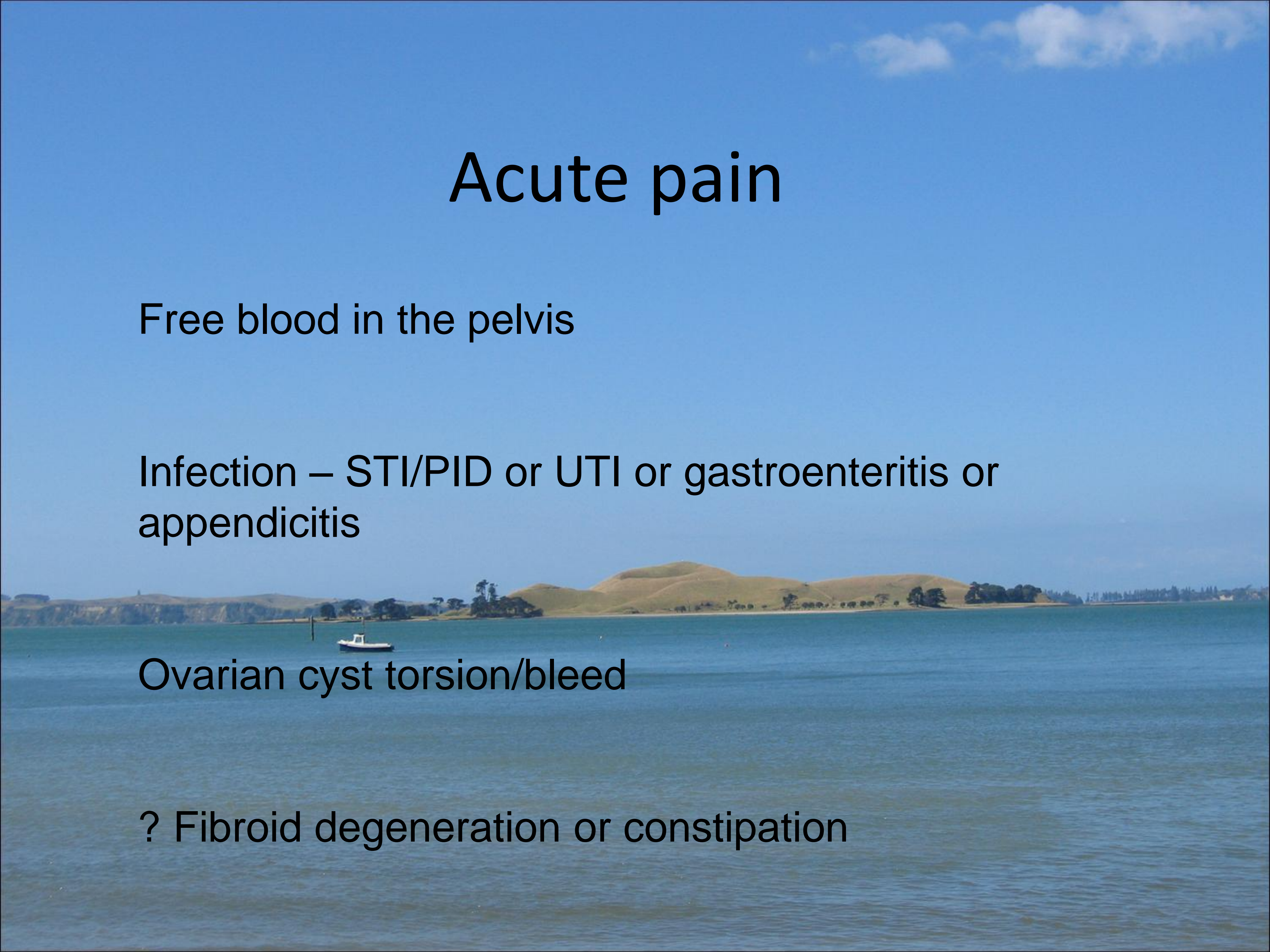
>5cm - refer

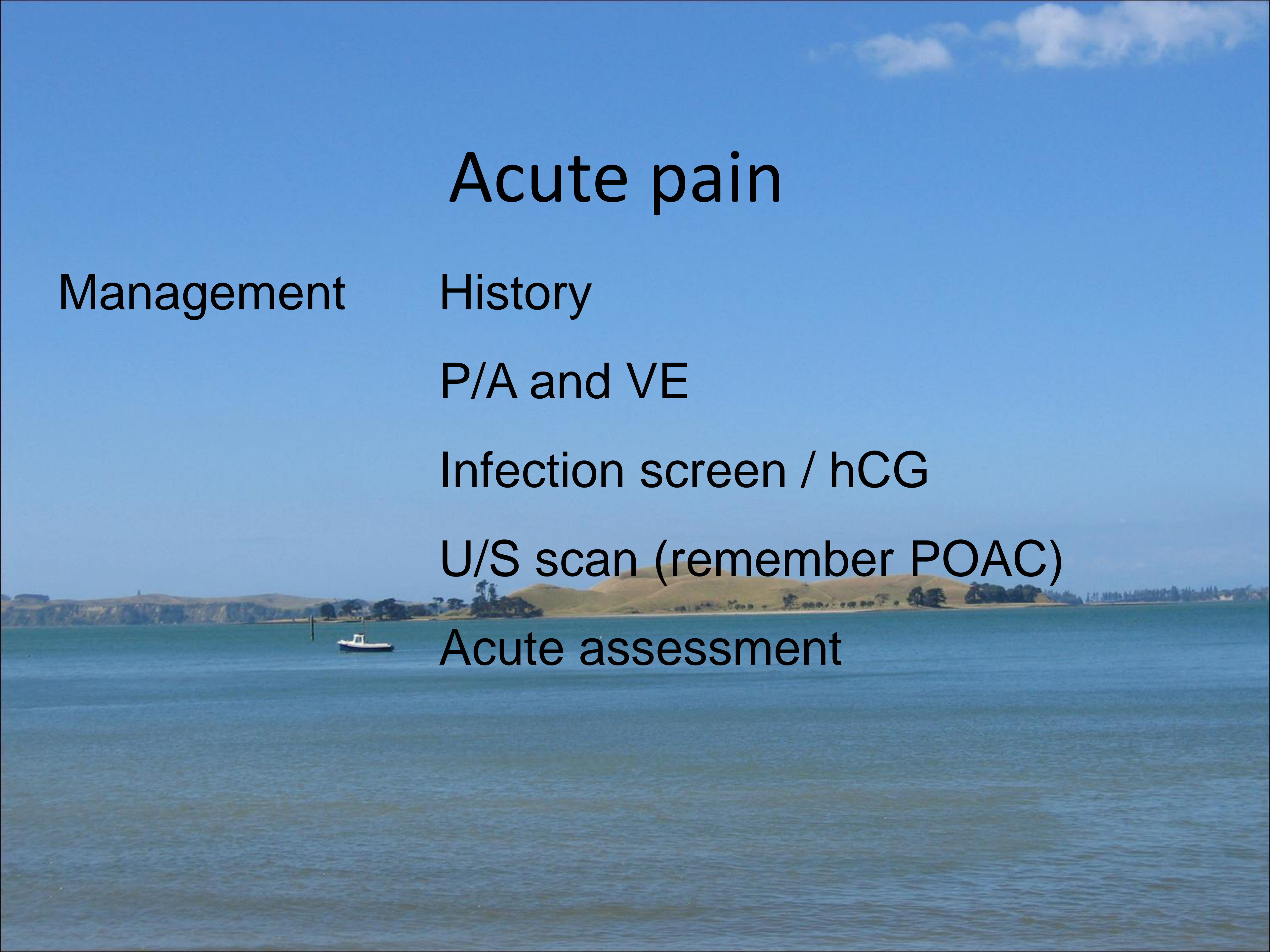
Simple cyst and dermoid





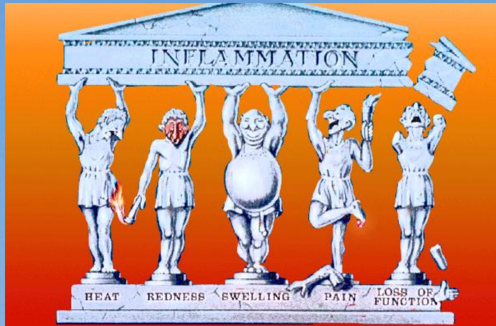
Does the size of the cyst matter?


Acute pain
Free blood in the pelvis
Infection – STI/PID or UTI or gastroenteritis or appendicitis
Ovarian cyst torsion/bleed
? Fibroid degeneration or constipation


Acute pain
Management
History
P/A and VE
Infection screen / hCG
U/S scan (remember POAC)
Acute assessment

Menstrual pain

Aetiology



Prostaglandins

Or Endometriosis

Menstrual pain
remember the 4 D's

Dysmenorrhea

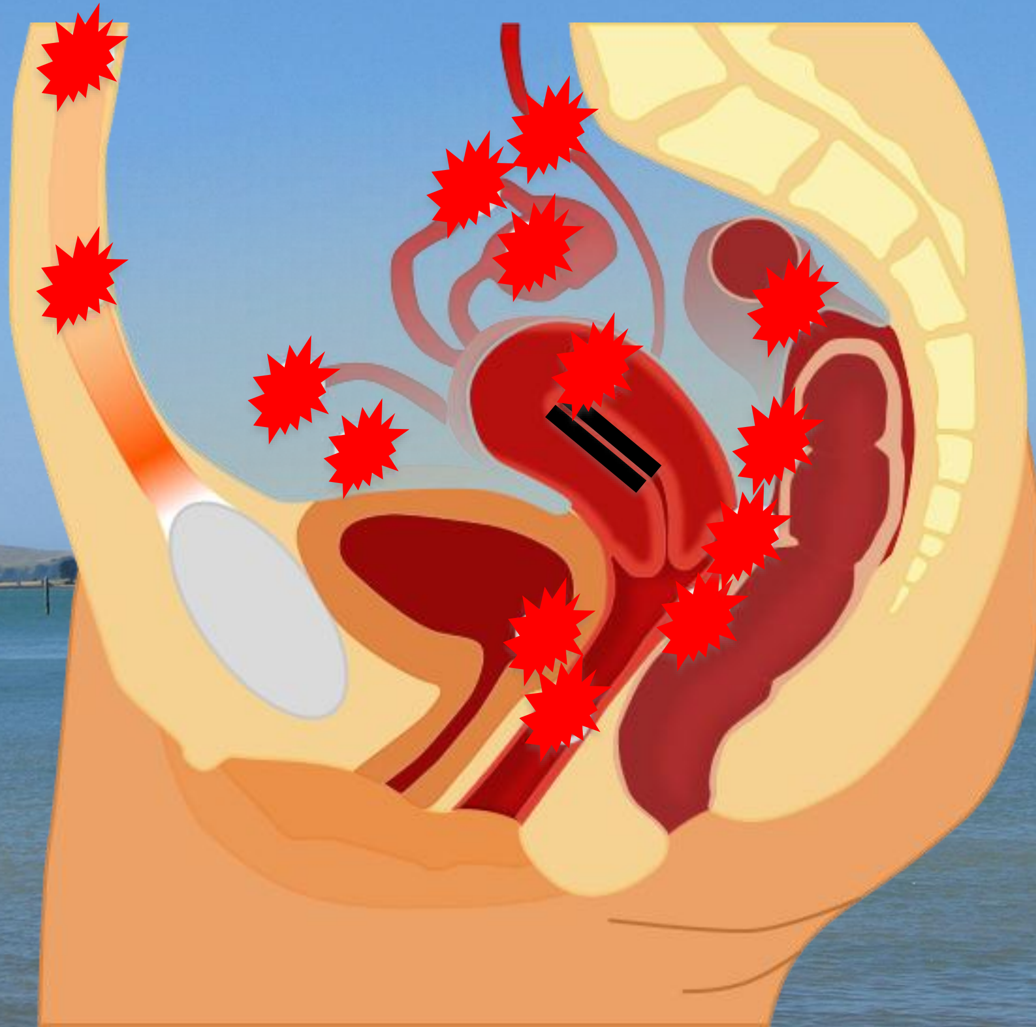
Dyspareunia

Dyschesia

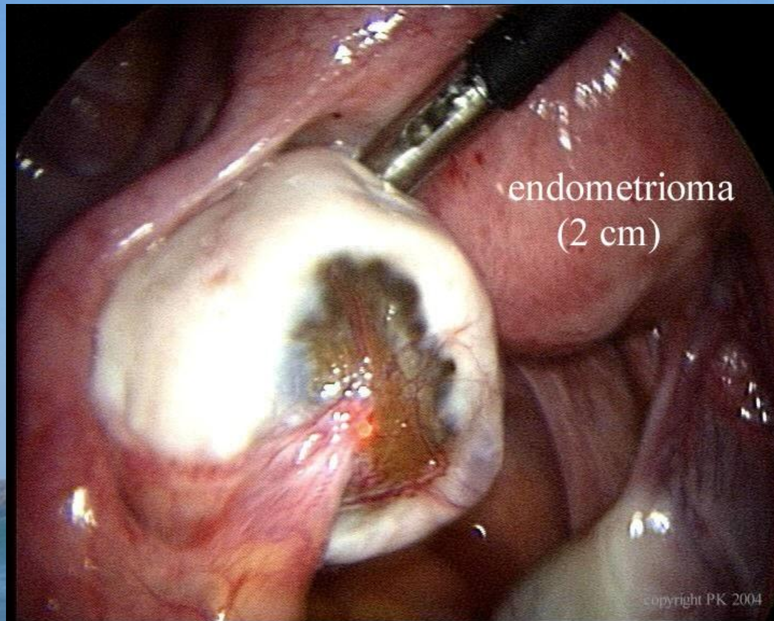
Distended and bloated abdomen

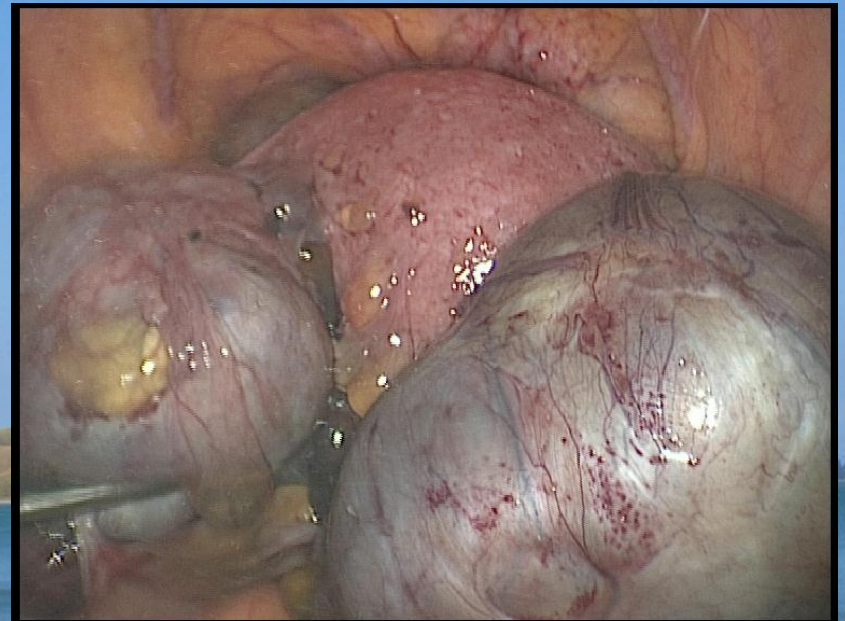
Endometriosis and Adenomyosis chronically underdiagnosed

What is endometriosis?



Endometrioma

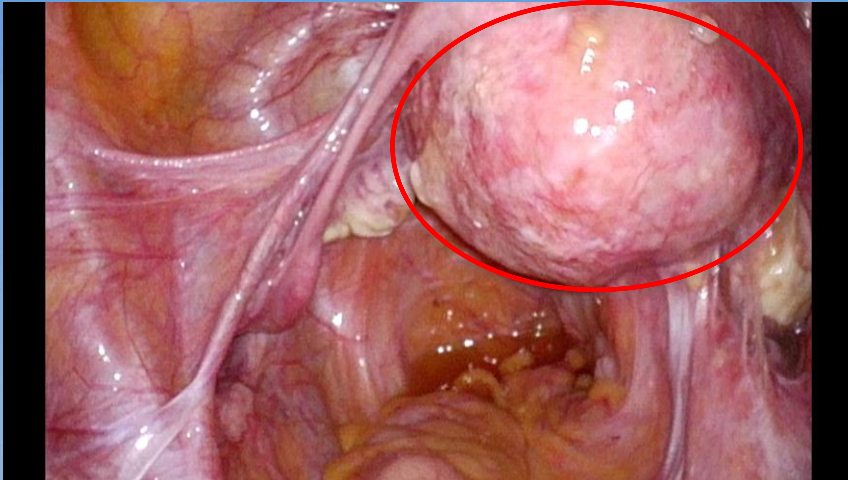


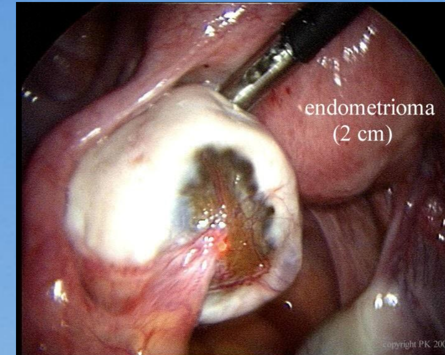


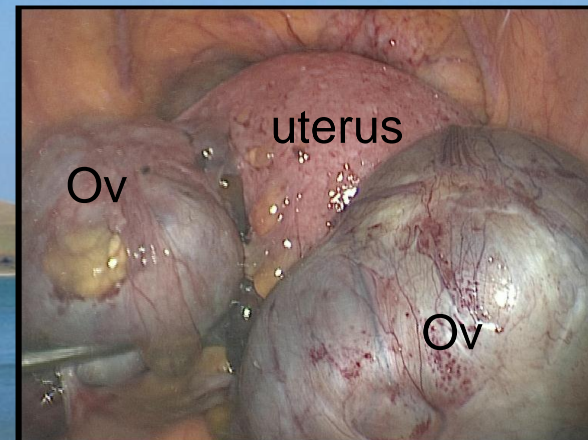
Easily seen on ultrasound

Adenomyosis

Endometrioma

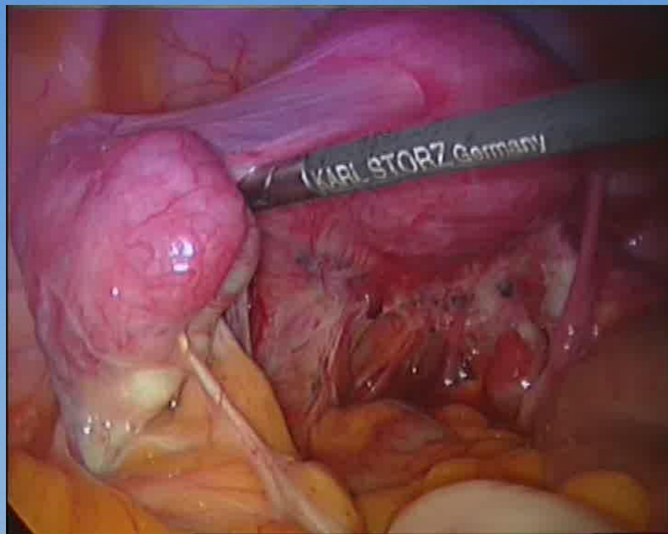


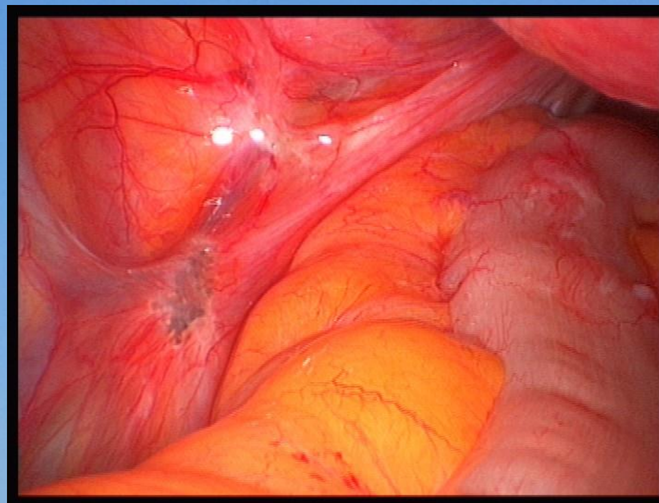


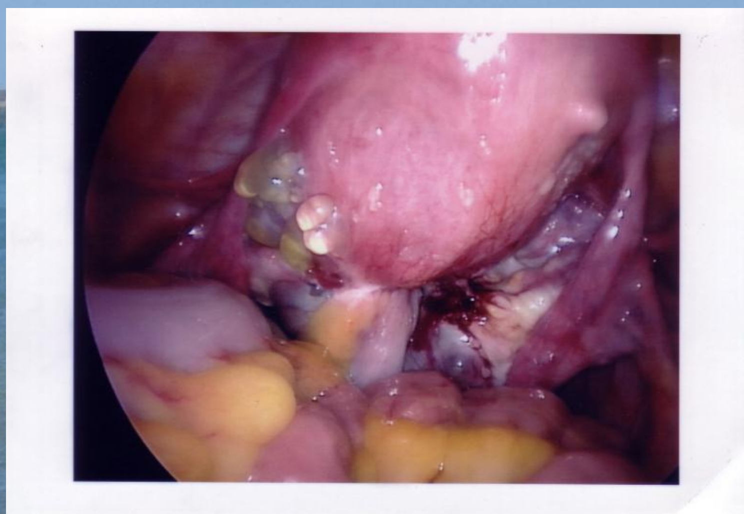


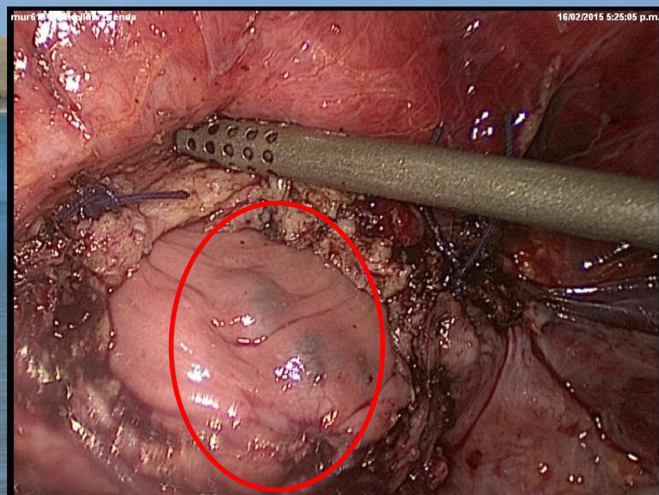
These are easily seen on ultrasound

Endometriosis

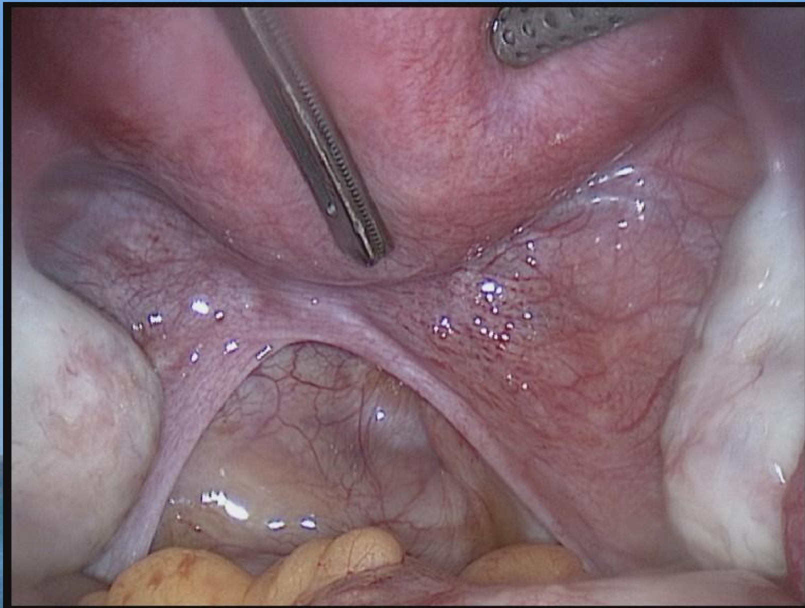


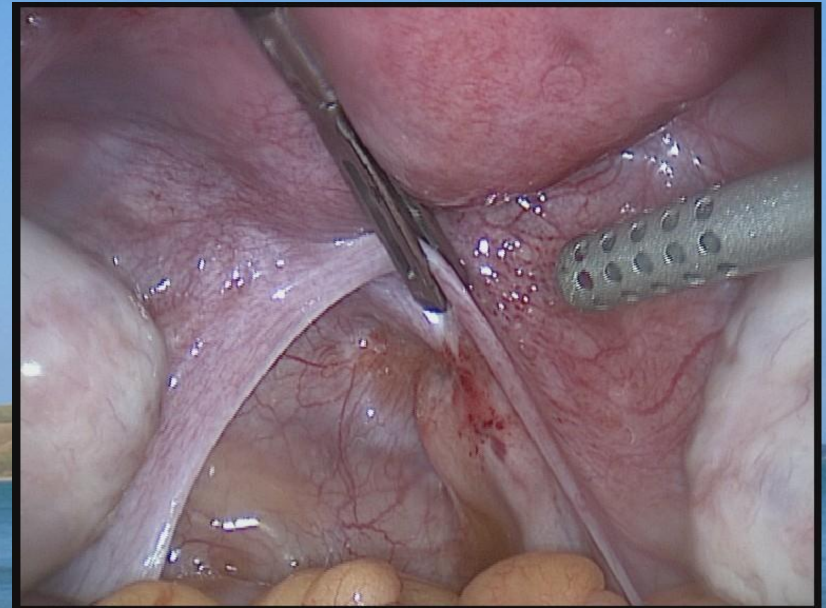






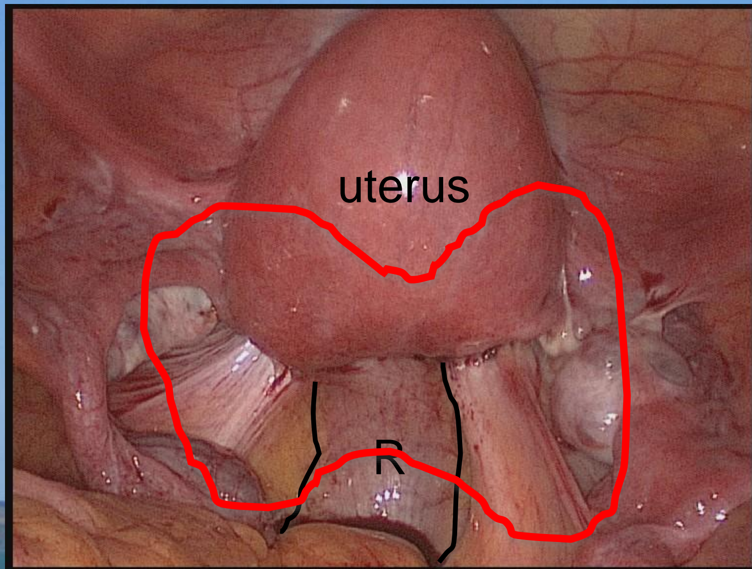
Endometriosis

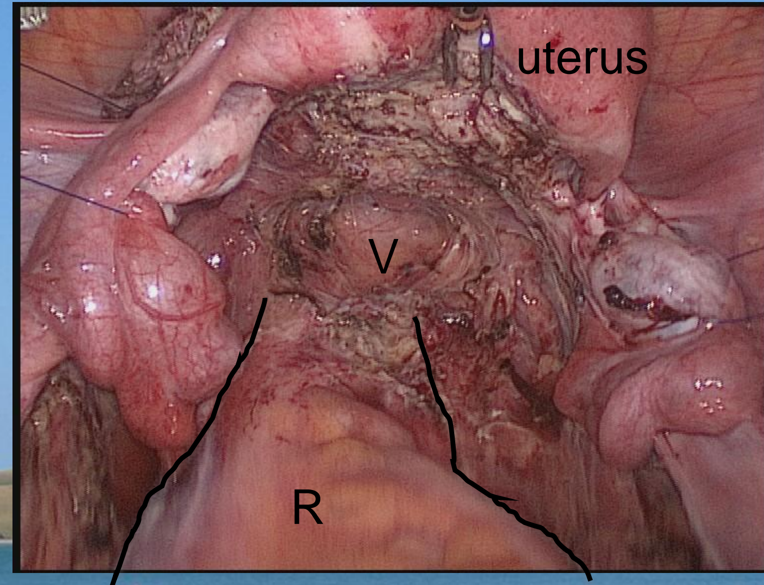




Dyspareunia and may be tender on VE

Severe endometriosis

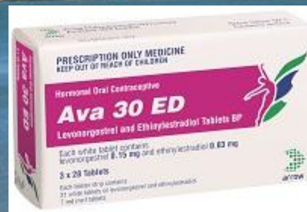


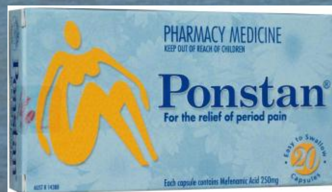


What can a GP do 1st?

20 year old lady
Dysmenorrhea
Premenstrual bloating
Occasional dyspareunia

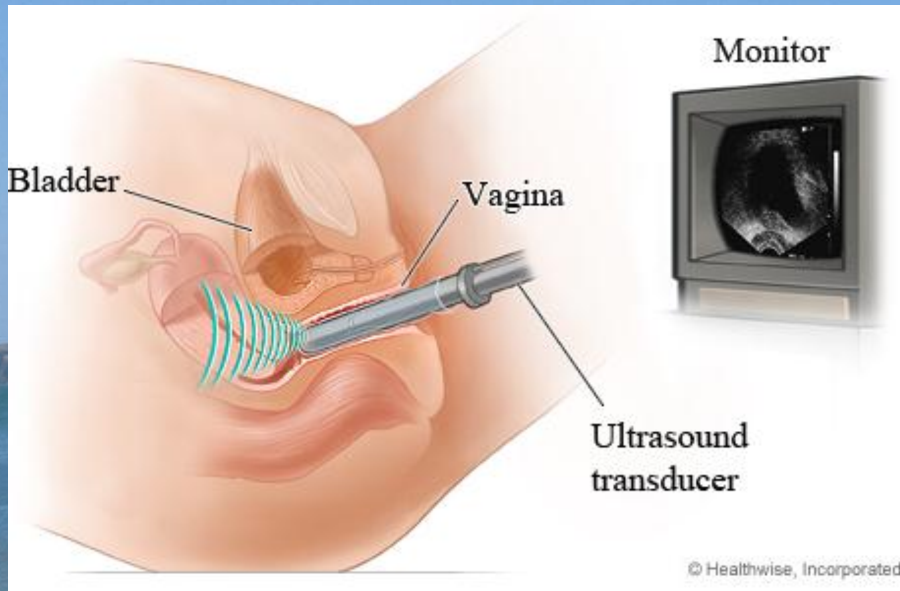
No significant findings clinically…………..





What can a GP do 1st?

TV Ultrasound scan?

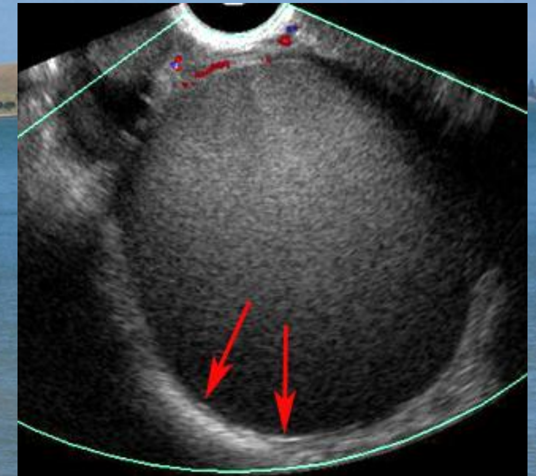


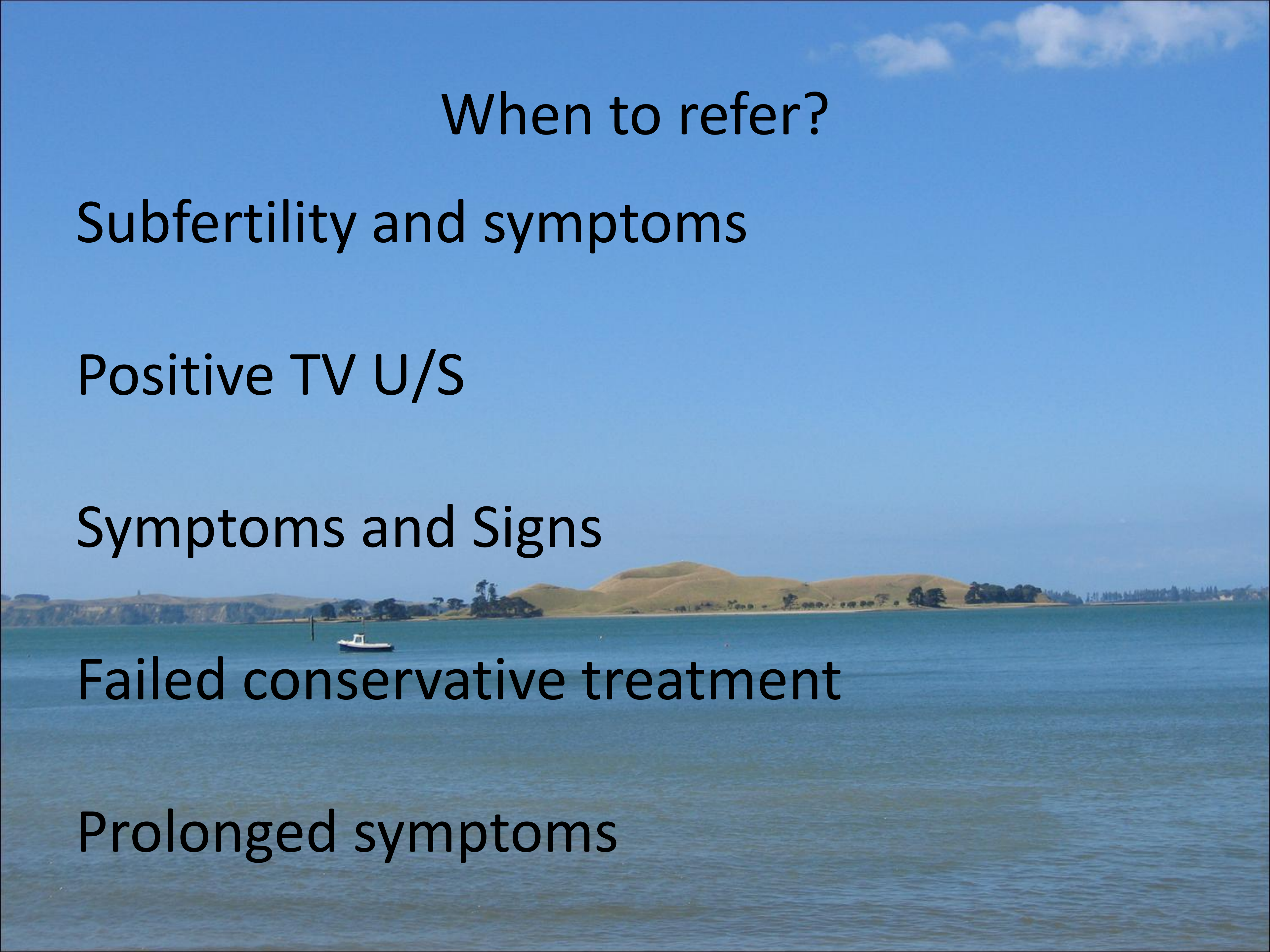
Palpable mass / acute pain / d/w SMO….

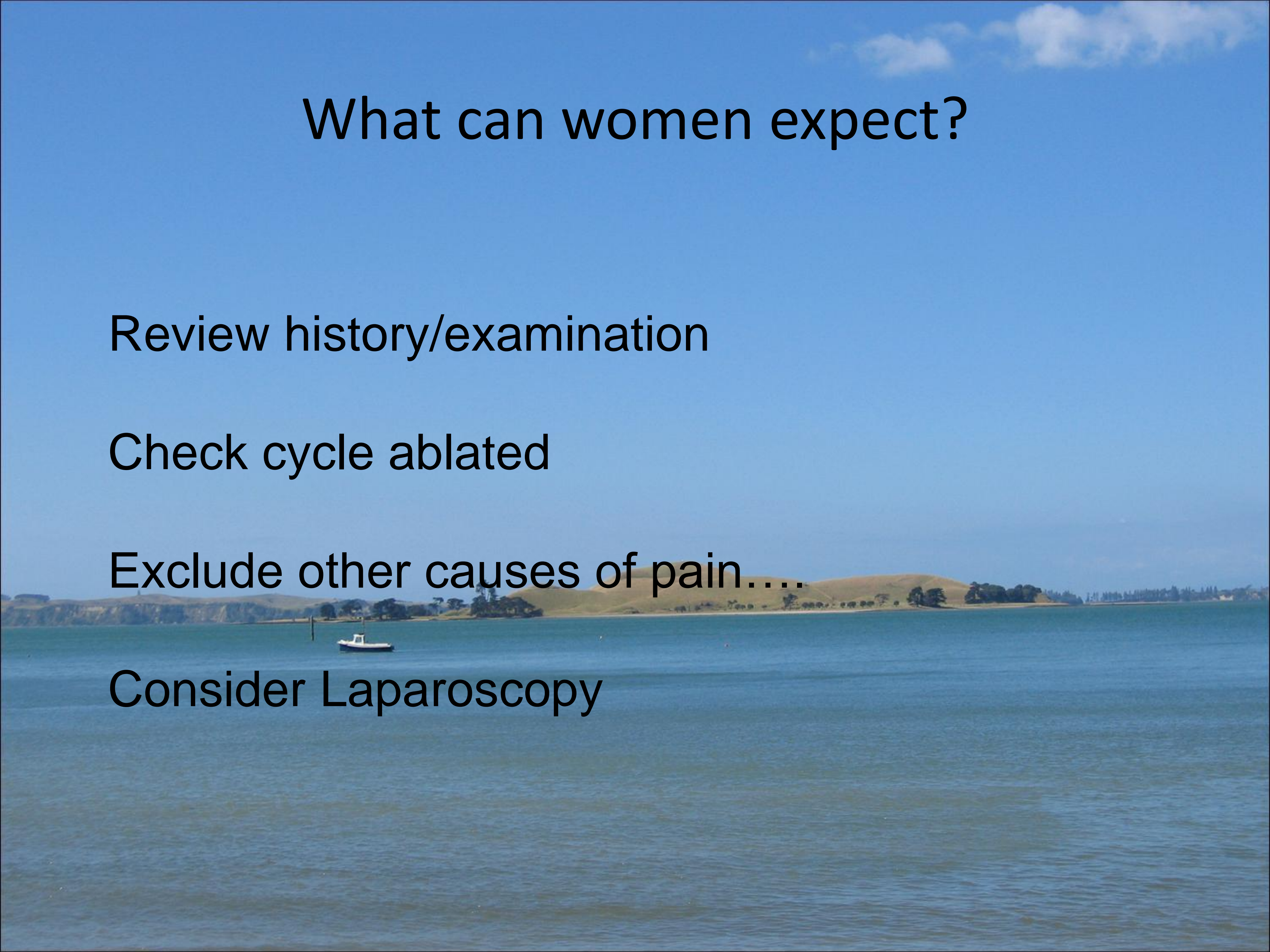
TV Ultrasound

Often normal
TV probe tenderness
Fixity of ovary to uterus
Good for adenomyosis
Diagnoses endometriomas

Excludes other pathology




When to refer?
Subfertility and symptoms
Positive TV U/S
Symptoms and Signs
Failed conservative treatment
Prolonged symptoms

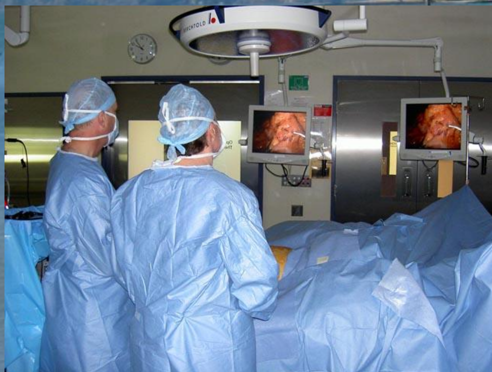

What can women expect?
Review history/examination
Check cycle ablated
Exclude other causes of pain….
Consider Laparoscopy

Gynaecological Advice

"Go and get pregnant"

"It is normal to have pain"

Hysterectomy and removal of both ovaries



Diagnosis by laparoscopy

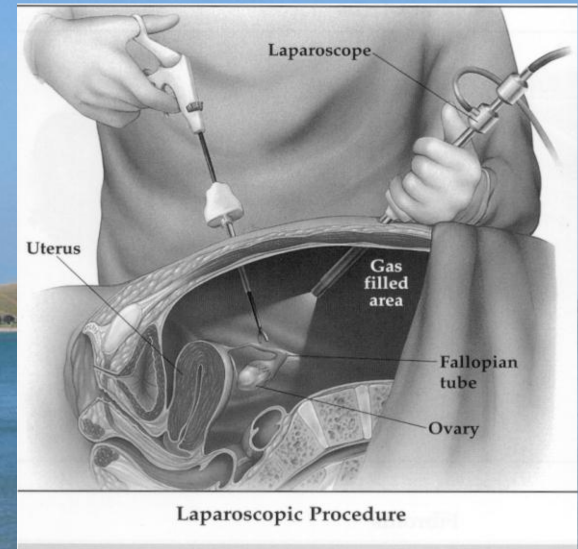
Ablation or Excision of endometriosis - "fertility sparing"

Allied health professionals support – team approach

Progress

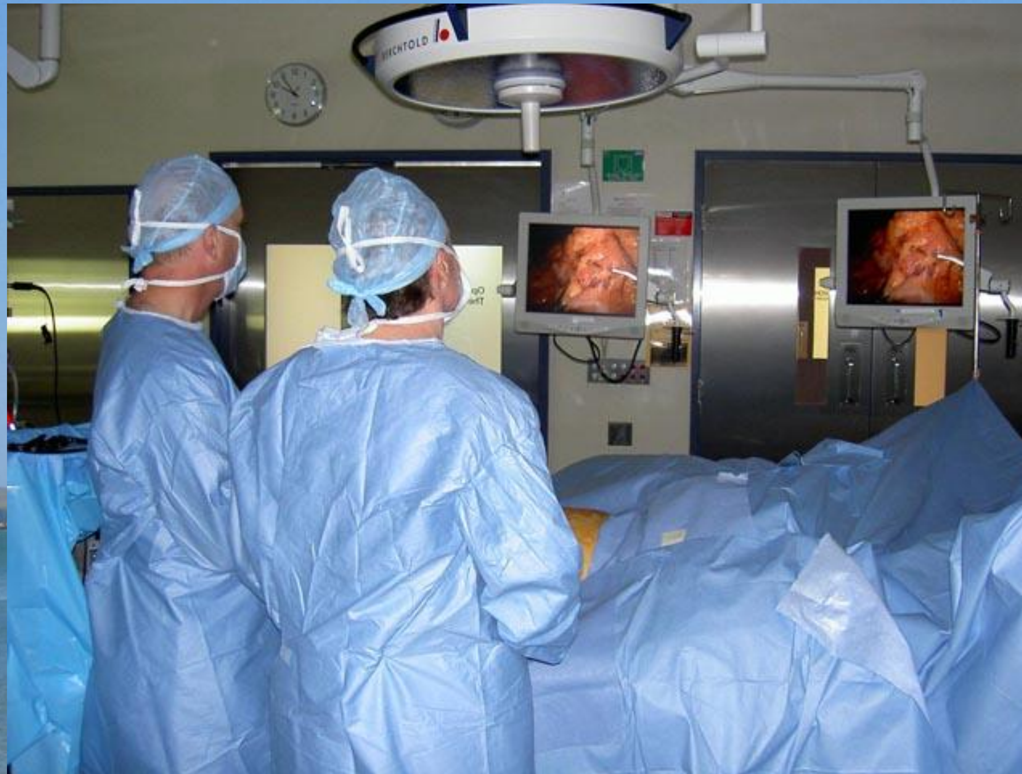
1940s Raul Palmer – Gas insufflation

1960s Kurt Zemm - laparoscope



"Only a person with brain damage would perform laparoscopic surgery"

Digital theatres



Multidisciplinary approach

General Practitioners, gynaecologists, surgeons, gastroenterologists, urologists, anaesthetists, physiotherapists, psychologists, dieticians……..

Benefits of laparoscopy

- Excellent close up views
- Minimal skin incision
  - Cosmetic
  - Faster recovery
- Less complications
- Faster return to normal daily activities
- Less chance of adhesions – pain/fertility

Chronic Pelvic Pain

Occurs as frequently in primary care as migraine or low back pain

Heavy economic and social burden

http://www.rcog.org.uk/files/rcog-corp/CPP_GTG2ndEdition230512.pdf

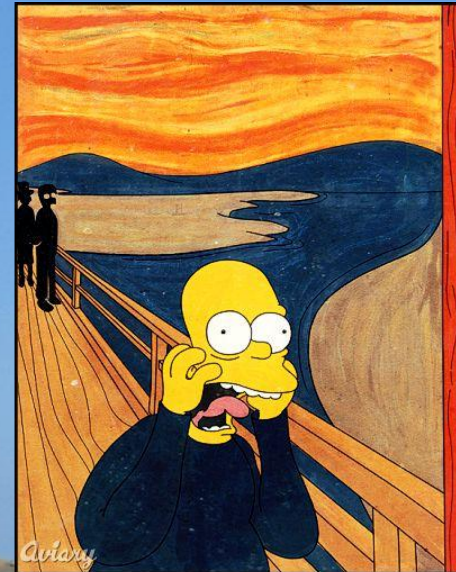
Chronic Pelvic Pain (2)

"Intermittent or constant pain in the lower abdomen or pelvis, of at least 6 months duration, NOT occuring exclusively with menstruation or intercourse"

Not necessarily dysmenorrhea or dyspareunia

http://www.rcog.org.uk/files/rcog-corp/CPP_GTG2ndEdition230512.pdf

Womens Biggest fear..



"The Dr did not take me seriously"

"They didn't believe me and thought I was being pathetic"

"Nobody listened to me"

"They said it was in my mind and I should see a psychologist"

Aetiology

Not always organic

Multifactorial – physical / psychological / social

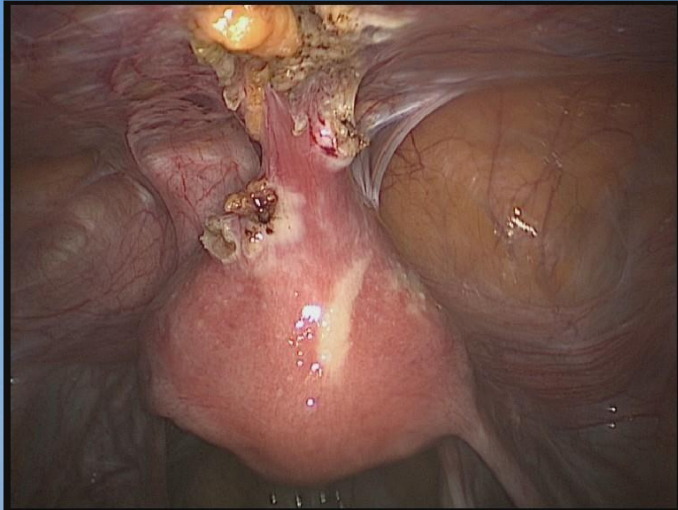
Aim to identify contributory factors rather than a single pathology

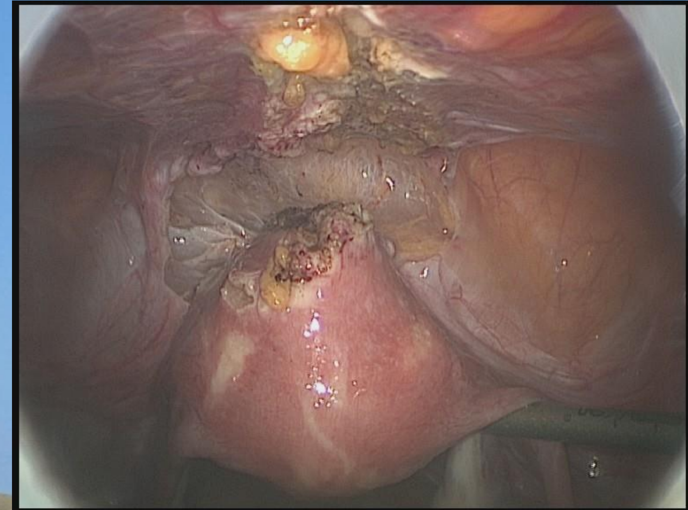
Exclude more easily treatable causes:

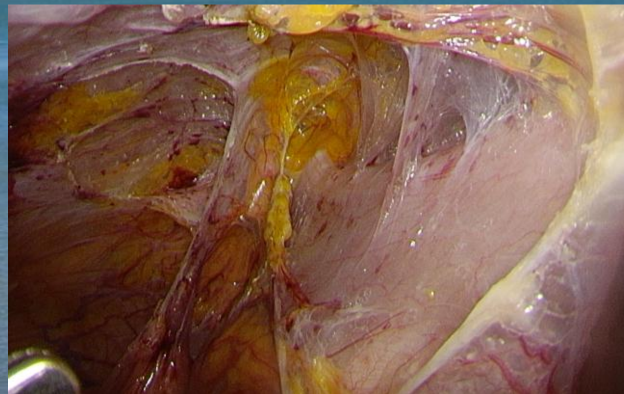
- Endometriosis and adenomyosis
- Adhesions due to PID/Surgery

Not PCOS

Dense Adhesions







Chronic Constipation

Diet / Lifestyle / fluids / Bulking agents / Laxatives / Check medications

IBS and Interstitial Cystitis

Much higher incidence of these in women with CPP cf population

Huge overlap with endometriosis and dysfunctional PG dysmenorrhea

The FODMAPS Diet

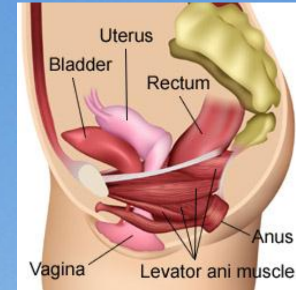
excess fructose	lactose	fructans	galactans	polyols
fruit apple, mango, nashi, pear, tinned fruit in natural juice, watermelon **sweetners** fructose, high fructose corn syrup, concentrated fruit sources, large servings of fruit, dried fruit, fruit juice **honey** corn syrup, fruisana	**milk** milk from cows, goats or sheep, custard, ice cream, yogurt **cheeses** soft unripened cheeses, such as cottage cheese, cream, mascarpone, ricotta	**vegetables** asparagus, beetroot, broccoli, brussel sprouts, cabbage, eggplant, fennel, garlic, leek, okra, onion, shallots, spring onion **cereals** wheat and rye **fruit** custard apple, persimmon, watermelon **misc.** chicory, dandelion, inulin	**legumes** baked beans, chickpeas, kidney beans, lentils	**fruit** apple, apricot, avocado, blackberry, cherry, lychee, nashi, nectarine, peach, pear, plum, prune, watermelon **vegetables** cauliflower, bell pepper, mushroom, sweet corn **sweetners** sorbitol, mannitol, isomalt, maltitol, xylitol

Rx
- Dietary modification FODMAP
- Antispasmodics
- Stress management

Rx
- Alkalinisation of urine
- Dietary modification
- Bladder drill
- ?H2 blockers
- Bladder ‘stretch’, Botox

Musculoskeletal

Abdominal wall



Pelvic floor spasm

trigger points identifiable

post partum levator ani disruption sig. increased

Treat: NSAID

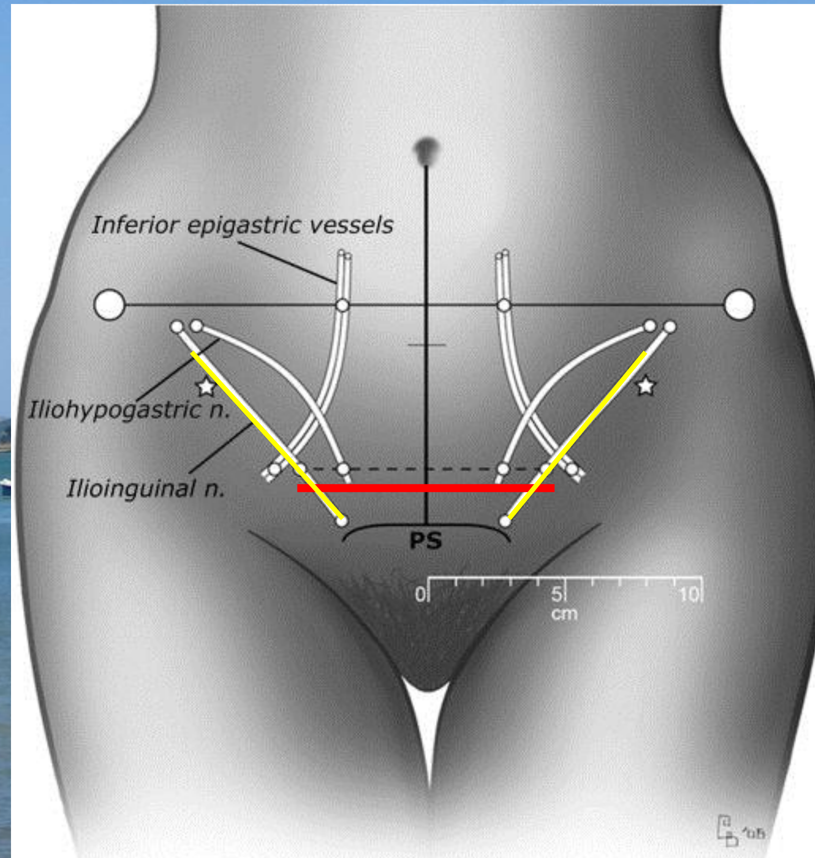
Graded exercise to improve function

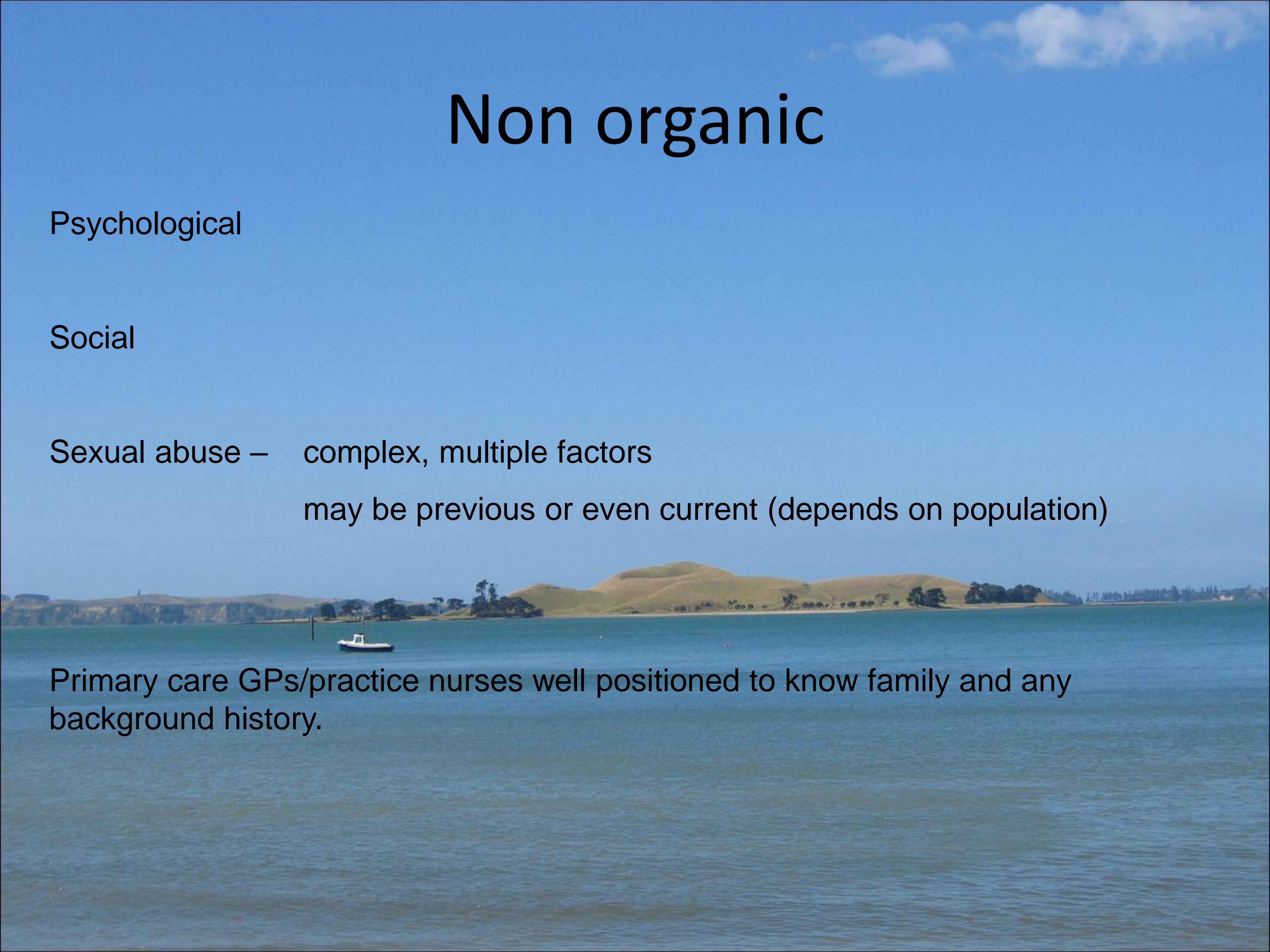
Womens Health Physio and directed PFE/relaxation

Botulinum injections

Nerve entrapment

3.7% at 6 weeks post 1 Pfannensteil incision




Non organic
Psychological
Social
Sexual abuse – complex, multiple factors
may be previous or even current (depends on population)
Primary care GPs/practice nurses well positioned to know family and any background history.

Investigations

Hx relating to potential aetiology

Clinical examination – often normal or just ‘generalised pain’

STI screen

MSU

TV U/S – often normal

probe tenderness or poor ovarian mobility better markers

good for adenomyosis

Diagnostic laparoscopy – Gold standard

keep as 2nd line

false positive findings

Treatments

Consider ablating menstrual cycle – POP/COCP/Depo P/Jadelle/Mirena

Dietary adjustments – wheat/alcohol/caffeine/meal times

involve a dietician

Bladder ‘drill and care’

Pelvic floor physio and trigger point release

Treatments (2)
Reassurance but also recognition of severity of pain
Chronic pain team
anaesthetist
Psychologist
Distraction and behavioural techniques
Avoiding multiple speciality and individual consults (ED plans)

...AND THAT IS WHY WE LIFT ON THREE...
COMMUNICATION
©DOLIGHAN
dolighan.com

Conclusions
• Relate initially to the menstrual cycle - treatable
• Have a list of standard screening tests
• Don’t forget the 4 D’s
• Involve other allied health professionals

Patient Education

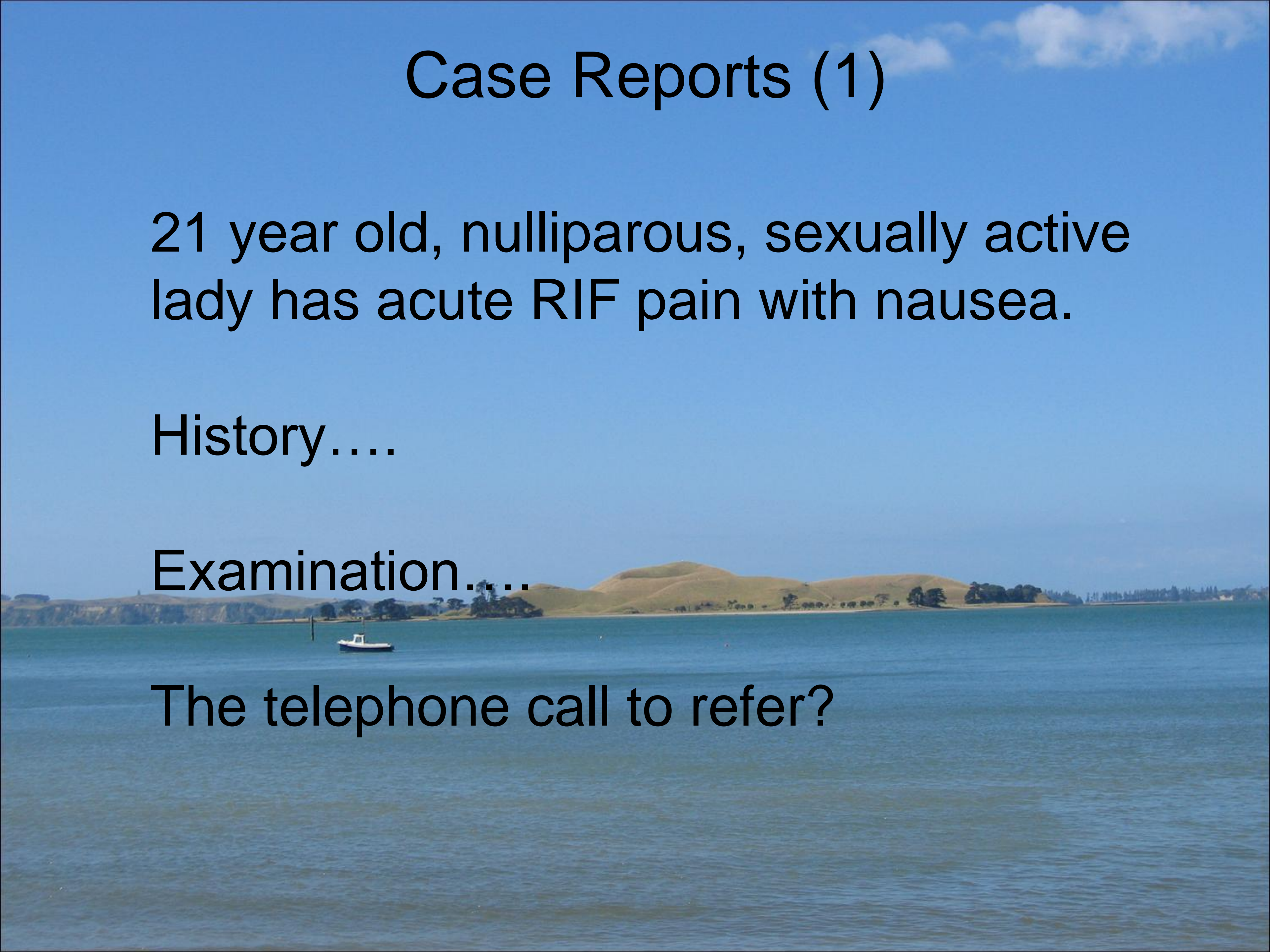
Endometriosis New Zealand www.nzendo.co.nz

IBS www.theibsnetwork.org/
www.patient.co.uk/health/Irritable-Bowel-Syndrome.htm

Pelvic pain www.pelvicpain.org.uk

GP Information

www.healthpoint.co.nz/ CMDHB/Womens Health/obstetrics + gynaecology


Case Reports (1)
21 year old, nulliparous, sexually active lady has acute RIF pain with nausea.
History….
Examination….
The telephone call to refer?

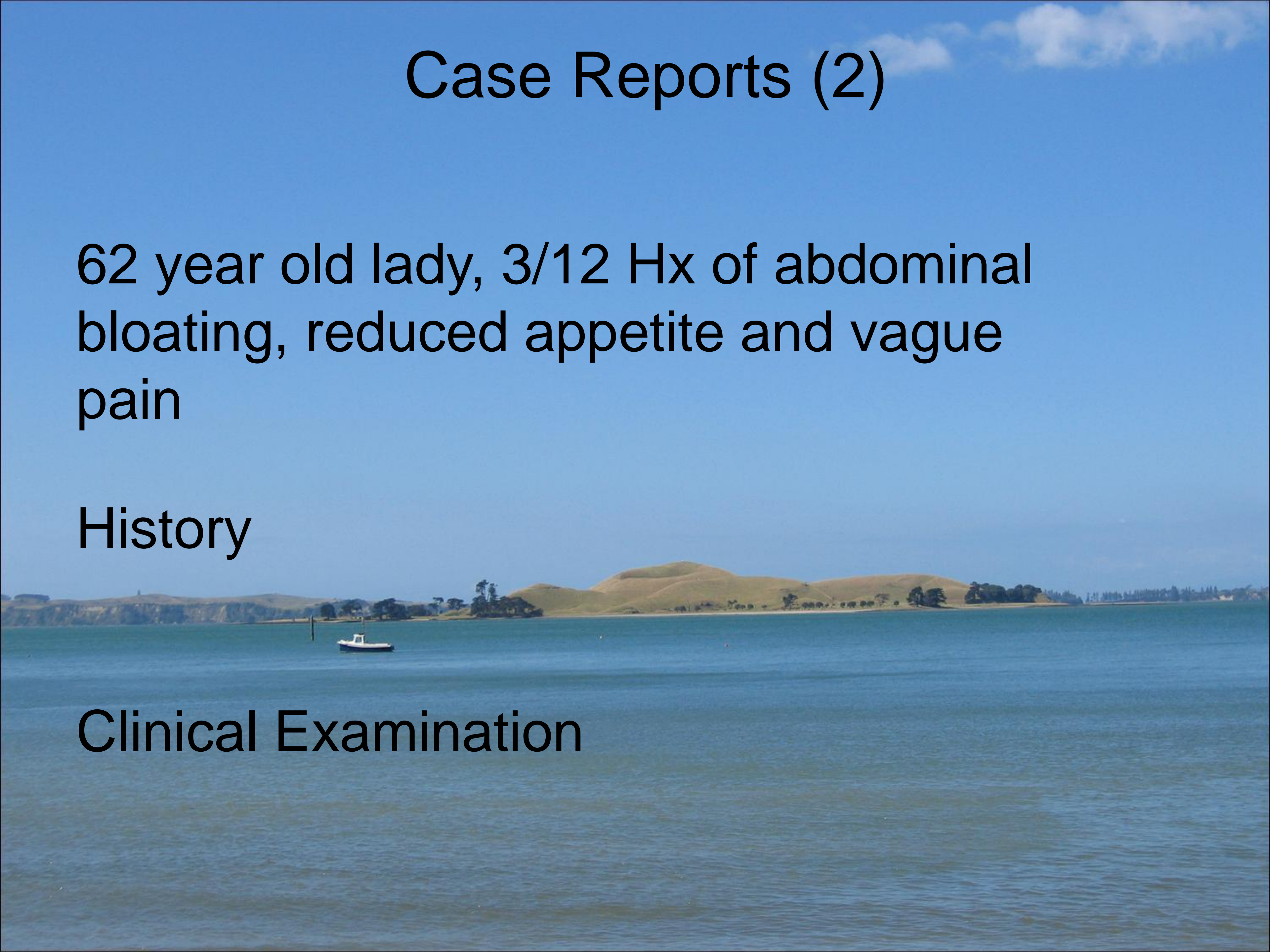
Case Reports (1) Learning Points

Sudden pain with acute spasm and nausea = ovarian cyst torsion

Beware the diagnosis of ‘free fluid’ on TV U/S

Dilemma between Sx or gynae refferal

Small functional cysts common – don’t label


Case Reports (2)
62 year old lady, 3/12 Hx of abdominal bloating, reduced appetite and vague pain
History
Clinical Examination

Case Reports (2) Learning Points

Ovarian cancer less common than bowel cancer

Consider Family History

Consider CA125/CEA/Ca19.9

TV U/S is diagnostic test - funding FCT

RMI