How To?
Mirena, Pipelle, Pessaries

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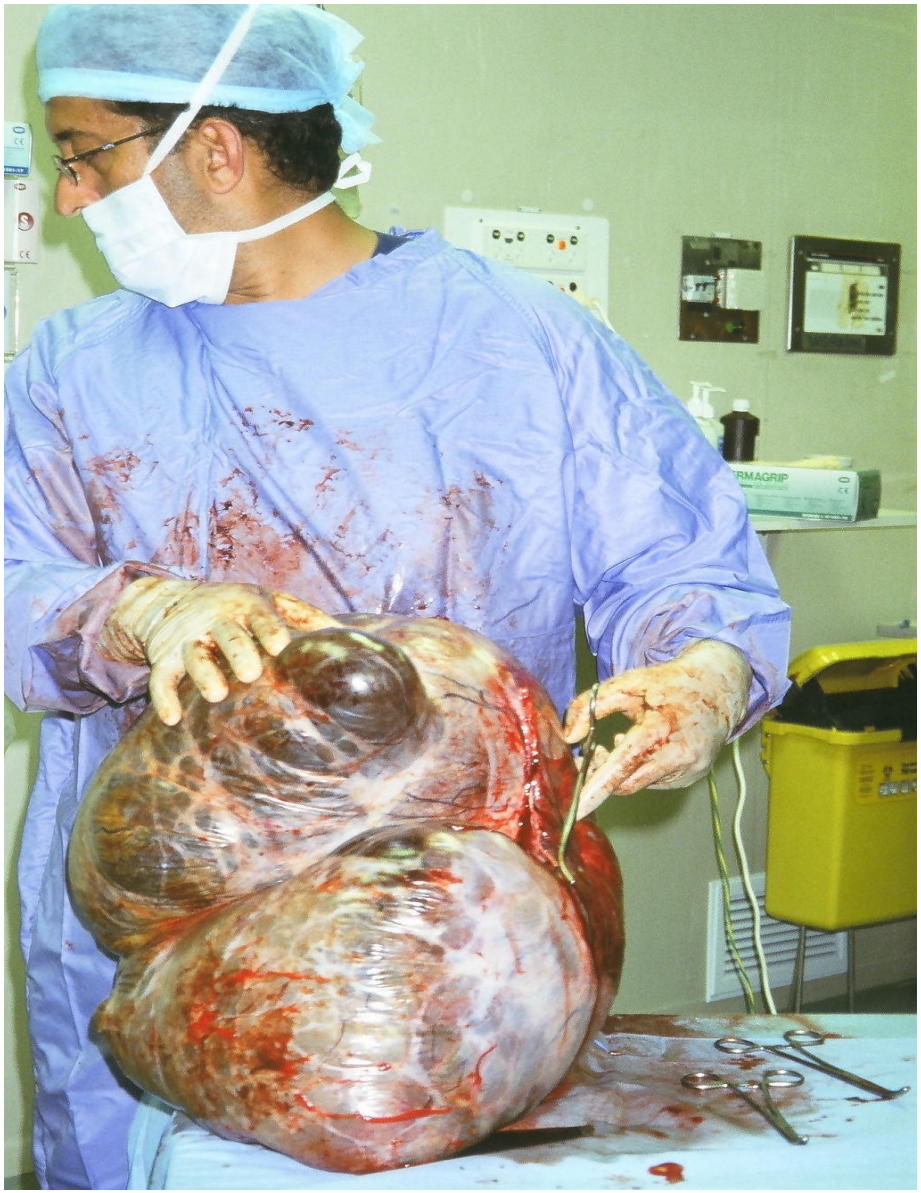

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Investigation

Overall incidence of endometrial carcinoma in premenopausal women is 14.3/100,000 women years in one UK paper

- Pipelle

  Quick, low risk, fairly accurate but ……

  Beware the ‘inadequate’ result

  Can miss focal cancers

  Mean pain scores higher than PV or smears (warn patient)

- TVS

  12 mm or greater is abnormal for premenopausal women

  (For PMB, an endometrial thickness of < or equal to 5mm in post menopausal women means <4% risk of cancer. ‘Virtually’ zero if < or equal to 4mm but again beware!)

Investigation

- Hysteroscopy D & C

  The ‘gold’ standard, well tolerated and safe

  In a series of 2500 outpatient hysteroscopies; 10% of pre and 22% of post menopausal women had polyps. Fibroids played a part in 25%.

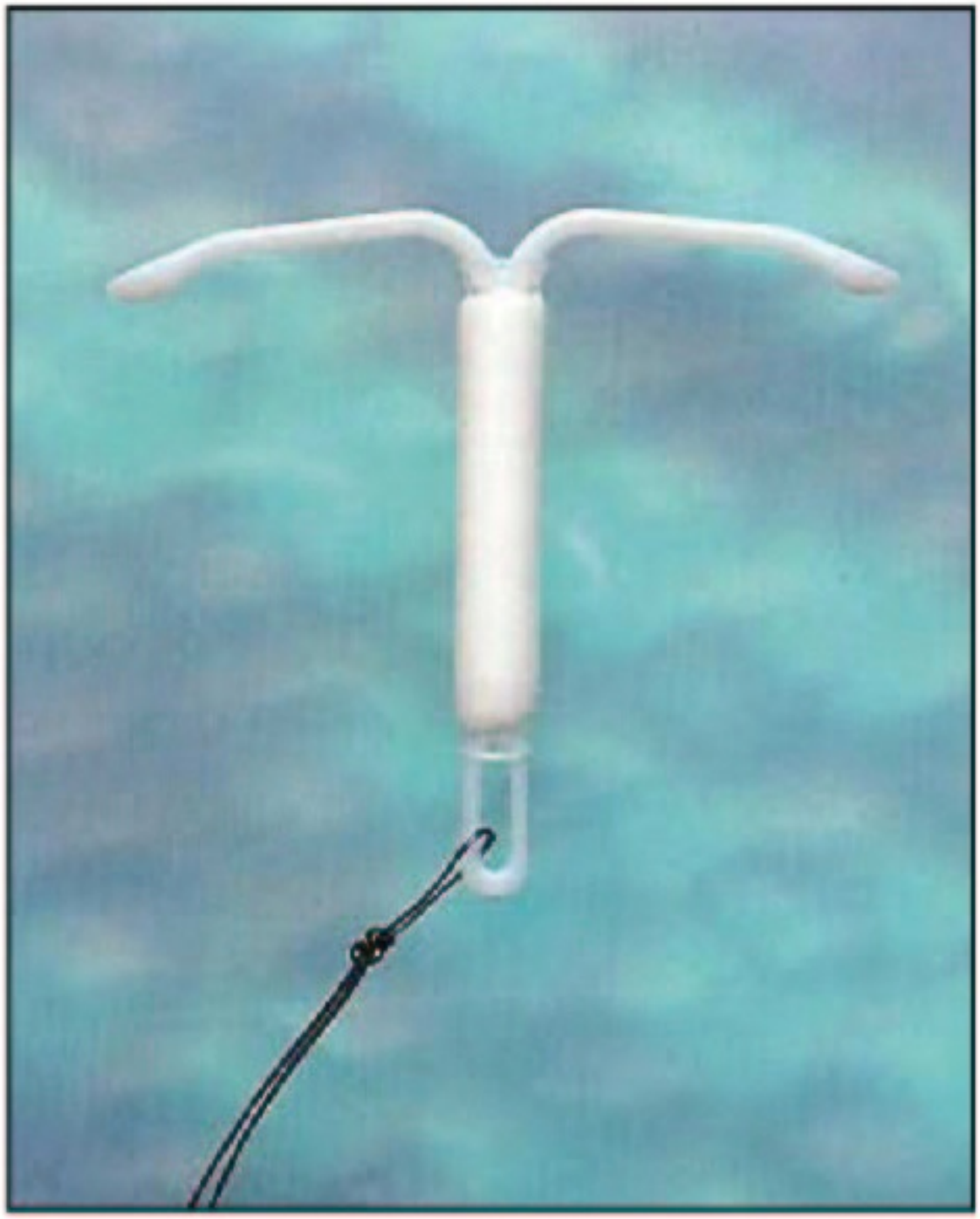
Treatment; Drugs

- Mirena
  pgs reduced, inactive endom, reduces fibrinolysis. Mbl down 86% after 3/12
- Cyclokapron 1-1.5 g up to qds during heavy days.
  Inhibits tissue plasminogen activator mbl down 50%
- NSAIDS e.g. Ponstan 250-500 mg tds during menses.
  Inhibits cyclo-oxygenase and blocks myo pge2 receptors mbl down 30%
- Progestagens e.g. NET 5mg tds
  For emergency use e.g. 30-50 mg provera/day for 3/52. No use for regular periods
- COCP

  20-30% reduction MBL
- Depo-provera?

Mirena

- Efficacy for HMB and dysmenorrhoea
- Some endometriosis
- Endometrial protectant
- Fibroids and Mirena
- ?Side-effects



Mirena in the Manawatu

A patient satisfaction questionnaire

- 78 women (70% regular, 30% irregular heavy periods and 10% had had it removed.
- 30% amenorrhoea
  30% minimal spotting
  20% irregular light periods
  10% still had heavy periods
- 80% had improvement in dysmenorrhoea
- 76% satisfied overall

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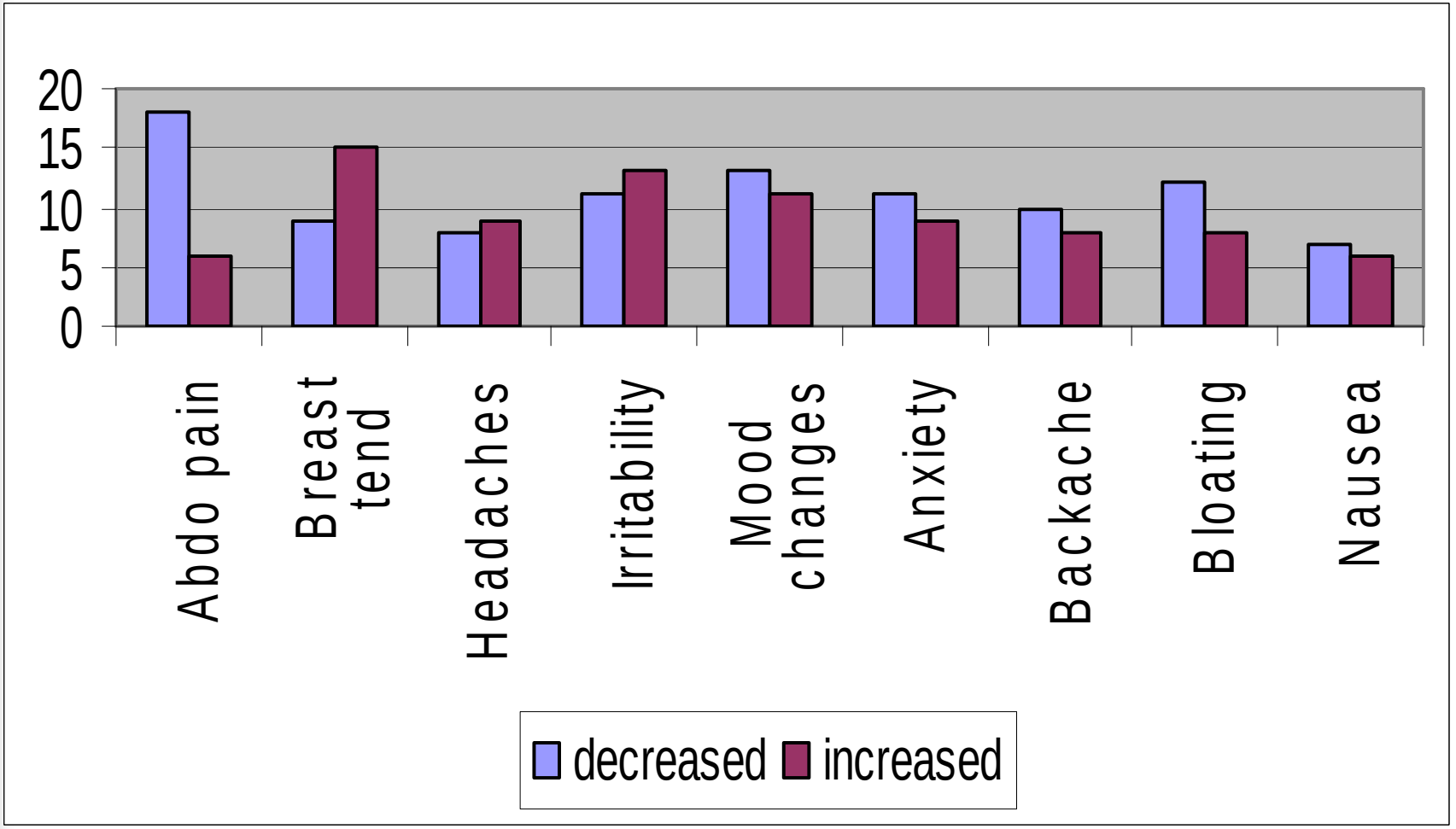
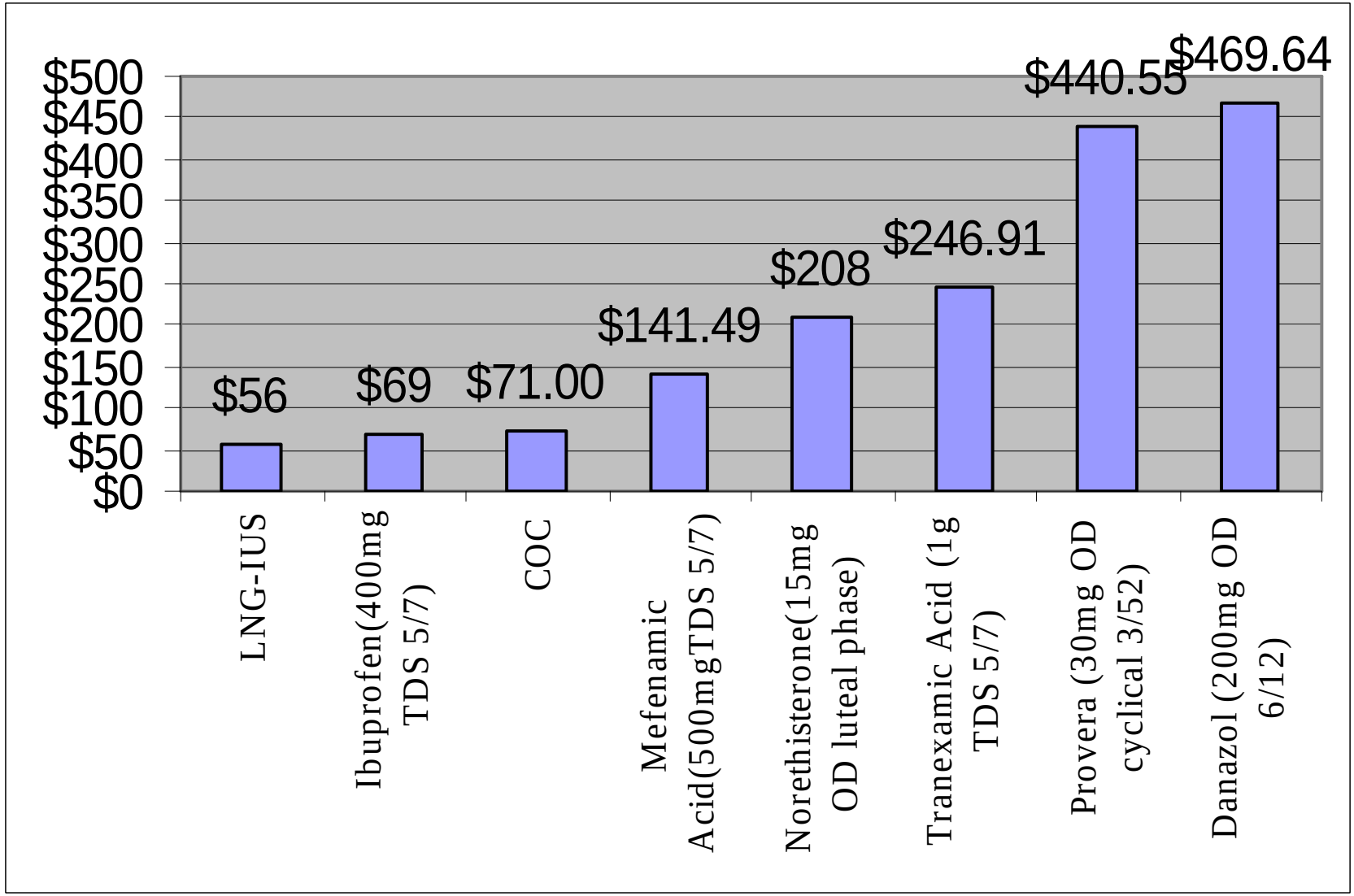
Effects

36/69 women continuing with it experienced ‘side-effects’, some experiencing more than one



Annual Costs of Medical Therapies



Summary of Management

based on NZGG and RCOG

- History
- General and abdominal examination
- Bimanual, speculum +/- smear
- FBC and ferritin
- TFTs only if hypothyroidism suspected
- Tests for coagulopathy only if suspected
- TVS and ? pipelle

Risk of Hyperplasia?

The Risk is less than 2% if;

- <90kg
- <45 years
- Parous
- No tamoxifen
- No PCO, no HNPCC or FH of Endom. Ca,
- Not on unopposed ERT

Otherwise greater than 2%, maybe 25% plus.

Management in Primary Care

- Normal sized uterus on PV
- Hb above 80g/l (treat anaemia) ?
- Regular cycles
- Low risk of hyperplasia
- Treat women at low risk and also refer treatment failures

Specialist Referral

- Irregular or prolonged periods
- Abnormal examination (abdo or pelvic)
- Hb < 80 ?90
- Inadequate response to initial treatment
- Endometrium > 12mm on scan
- All at ‘high’ risk of hyperplasia
- Abnormal pipelle

Pipelle

- Bimanual then speculum
- Clean cervix
- Pass device, hold gently
- If not use tenaculum to straighten axis
- Withdraw plunger
- Rotate as withdraw device
- ?tolerate 2nd pass
- USS?

Mirena

- Bimanual and speculum
- ?Pipelle or sound (clean cervix)
- Prepare Mirena, sterile trolley? Or not
- Insert device……?tenaculum
- Stop 1cm short and ‘open’ arms
- Move on further and release
- Withdraw applicator
- Cut threads
- ?LA ?dilators

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Pitfalls

- Passage difficult
- Think cervical fibroid, acute version or flexion, or false passage!
- Don’t open packet ‘yet’
- Applicator gets bent and will not release
- Cervical insertion and Peritoneal insertion

Ring Pessary

- History, examine, reduce prolapse
- Measure
- Explain it can fall out
- Bend it after warming if necessary
- ‘Front’ under Symphysis
- ?Ovestin
- See at 6/52 or sooner then 5-6/12

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Thank you

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