Gynaecology update: *"treat or refer"*

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Ovarian Cysts

- Woman of reproductive age
  or post menopausal woman?
- Benign or malignant?

Ovarian cyst in women of reproductive age

Symptomatic cyst (eg. pain) – emerg referral

Asymptomatic cyst

Simple cyst *(unilocular, no solid components)*

< 5 cm – rescan in 6-8 weeks, if cyst persist consider referral

> 5 cm – consider referral /surgery

Ovarian cyst in women of reproductive age

Haemorrhagic cyst

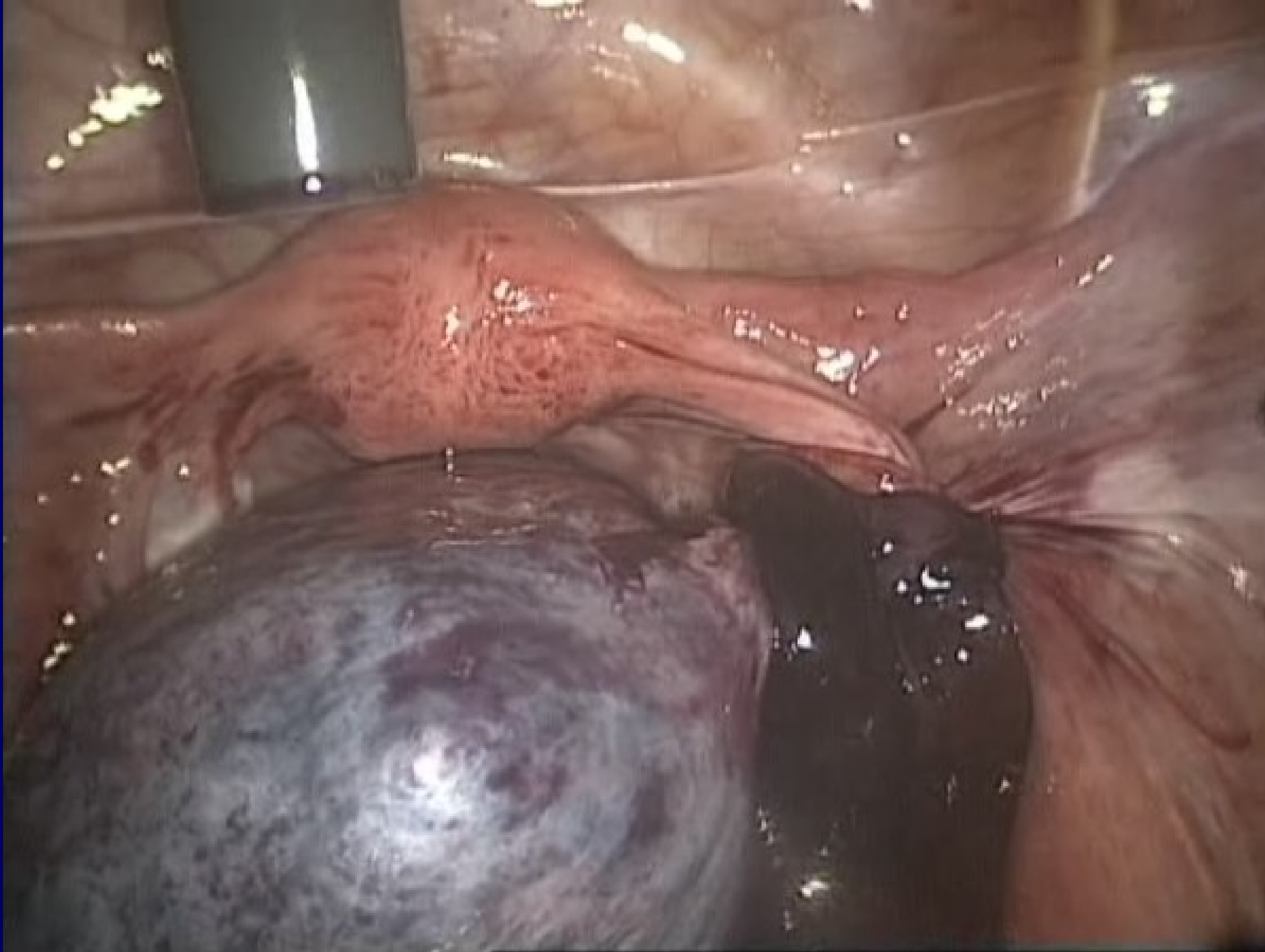
- rescan in 6-8 wks to ensure resolution,
- if cyst persist likely to be endometrioma

Dermoid cyst – referral / surgical removal

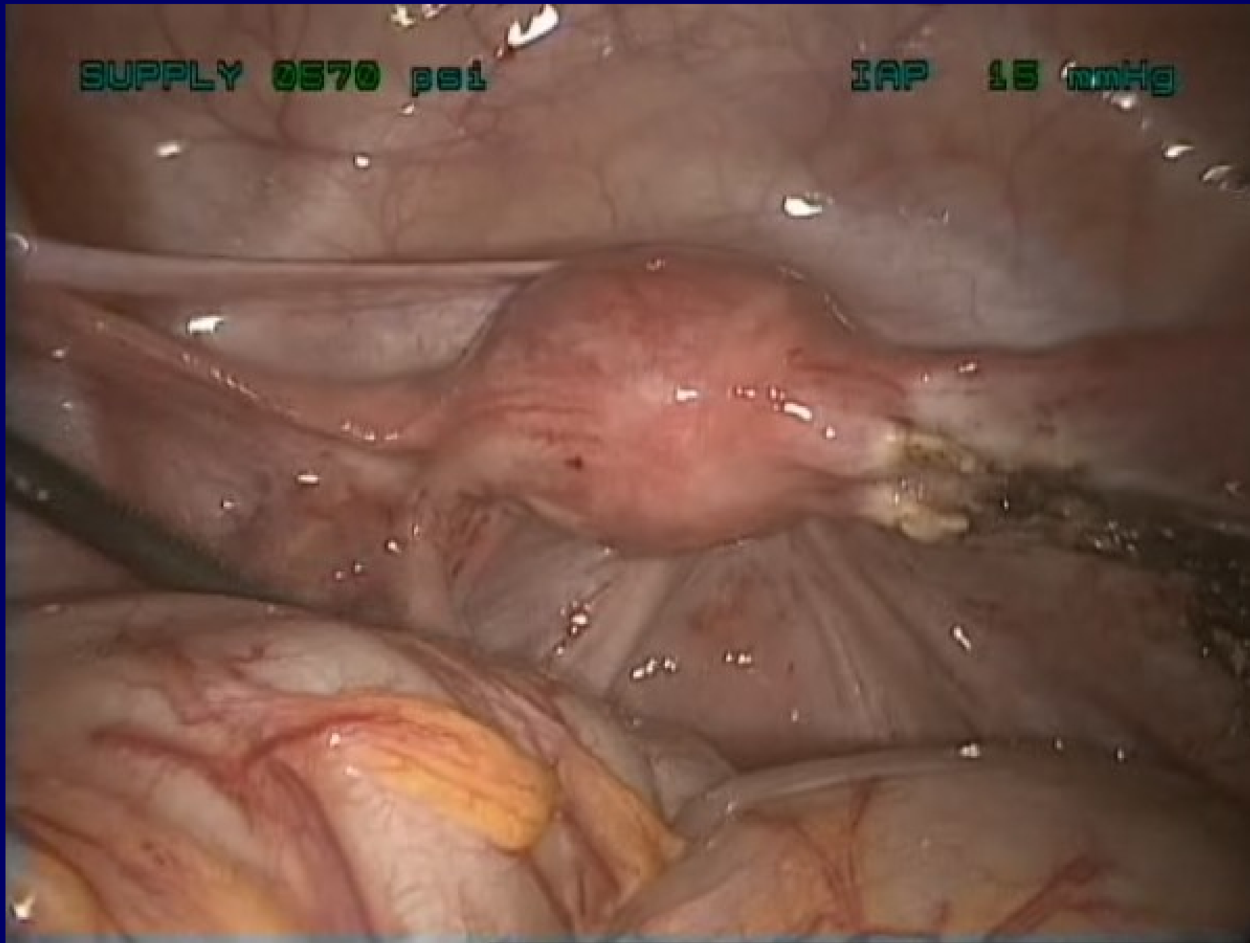
Endometrioma – consider surgery,

- Re-scan in 6 weeks to ensure that a hemorrhagic cyst has not been mistaken for an endometrioma

Ovarian torsion



Laparoscopic oophorectomy



Ovarian cyst in women of reproductive age

- Ovarian cancer is rare in young women
- However, complex cysts with radiological characteristics worrisome for malignancy *(eg, presence of ascitis or invasion into adjacent organs)* warrant urgent referral to the gynaeoncologist at the Cancer Centre

Ovarian cyst in women of reproductive age

- Non-epithelial Ovarian cancer tend to occur in women of reproductive age
  - Germ cell tumouors
  - Sex cord-stromal tumours
  - Lymphomas
- Therefore if < 40y.old – need bHCG, aFP, LDH as well CA 125

Ovarian cyst after menopause

- 64 y. old, had 1 day bleed, now settled

USS – normal 2 mm endometrium, 4 cm simple unilocular ovarian cyst

CA 125 – normal

- **Mx**

Repeat USS + CA 125 every 4 months for 1 year

If no change – no further follow up

Ovarian cysts after menopause

- Simple unilateral unilocular ovarian cysts of 5 cm or less have a low risk of malignancy.

- In the presence of a normal serum CA125 levels(<30iu), they can be managed conservatively*.

**Ref: Royal College of Obstetricians and Gynaecologists. Guideline No. 34. Ovarian cyst in post menopausal women*

Ovarian cyst in postmenopausal woman

- Conservative management entails repeat USS and serum CA125 every 4 months for one year.
  - if cyst remains unchanged and CA125 within normal - cease scanning/CA125 after 3
- If the cyst does not fit the above criteria or if the woman requests surgery then laparoscopic oophorectomy is acceptable.

Risk of Malignancy Index

U x M x CA125

U = USS (0-3; pt for multilocular, solid areas, metastases, ascites, bilateral)

M = menopausal (1 pre, 3 post)

<25 low risk, >250 high risk

PMB

- 60 y.old, menopause 52,
- presents with 2 day history of bleeding, now stopped.
- On examination cervix atrophic

PMB

- USS (first line investigation)
  - Endometrium = < 3 mm in non-HRT user*
  - Endometrium = < 5 mm in HRT user
- Hysteroscopy + endometrial biopsy (LA or GA)

**Investigation of Post-Menopausal Bleeding. SIGN Publication No. 61*

Menstrual Disorders

- Amenorrhoea
- Polymenorrhoea
- Menorrhagia
- Dysmenorrhoea

Investigations

- Amenorrhoea: Endocrine profile, USS
- Polymenorrhoea: USS, Endo biopsy
- Menorrhagia: USS
- Dysmenorrhoea: USS/MRI, Laparoscopy

Secondary Amenorrhoea

(no menstruation for 6 months)

- Commonest causes:
  - PCOS
  - Weight loss/gain
  - Hyperprolactinaemia
  - Premature menopause

Secondary Amenorrhoea

(no menstruation for 6 months)

- Exclude pregnancy
- History: weight changes, thyroid symptoms
- Hormone profile: LH, FSH, Prolactine, T4, TSH, testosterone, oestrogen
- USS: PCO, endometrial thickness

Case scenario

- 23yo, menarche 14, presents with 2 year history of amenorrhoea, previously menstruated every 2-3 months. No wish to conceive at present
- Ix:
  - Hormone profile
  - USS
- Ds: PCOS

PCOS management*

- Endometrial protection
  - 3 periods/year to prevent endometrial hyperplasia
  - COCP
  - induction of withdrawl bleeds with progestogens
- Prevention of DM type 2
  - GTT if BMI > 30
  - Diet & exercise

**RCOG Green-top Guideline No. 33*

PCOS management*

Hirsutism or acne:

- oral contraceptive pills (Dianette)
- cosmetic measures (such as laser, electrolysis, waxing and shaving)
- topical facial eflornithine (Vaniqa®)

A combination of methods is often required

Non-licensed: spironolactone, antiandrogens (flutamide, finasteride) and high-dose cyproterone acetate

**RCOG Green-top Guideline No. 33*

Menorrhagia

- 42yo, presents with 2 year history of heavy monthly bleeding, 6/28, no IMB, family complete
- Investigations:
  - FBC
  - ?Thyroid function tests
  - USS - ?fibroids, ?polyps

Medical treatment*
(1st line, in primary care)

- Mirena coil
- Tranexamic acid / Mefenamic acid
- COCP
- Norethisterone (15 mg) daily from days 5 to 26 of the menstrual cycle
- Long-acting progestogens.

* *Heavy menstrual bleeding. NICE clinical guideline*

Menorrhagia

Endometrial biopsy to exclude endometrial cancer or atypical hyperplasia*.

Indications for a biopsy include*:

- persistent intermenstrual bleeding
- ineffective medical treatment in women aged 45 and over.

** Heavy menstrual bleeding. NICE clinical guideline*

Menorrhagia

- Surgical Treatment
  - Endometrial Ablation / Resection
  - Laparoscopic Hysterectomy

TCRE

- Day case procedure
- Success 70 – 80 % (30% amenorrhaec)
- Less successful if uterus > 12 wks
- Zoladex injection 1 month prior to treatment to thing endometrium

Lap subtotal hysterectomy

- 1-2 nights postop hospital stay
- 100% cure for menorrhagia
- 1-5% cyclical spotting from cervical stump

Dysmenorrhoea

- 24y.old, menarche 14,
- presents with 2 year history of painful periods, dyspareunia,
- 5/28, menstruation not heavy,
- no desire to conceive

Dysmenorrhoea

- Ix USS
- MRI – for adenomyosis
- Medical therapy:
  - COCP
  - Progestogens
  - Mirena coil
- Further Ix - laparoscopy

Asymptomatic cervical polyp

- 43yo, 5mm cervical polyp noted at time of smear,
- Regular cycle 6/28 with no IMB or PCB

Cervical “Polyps”

Risk of malignancy ZERO

USS – to exclude endometrial polyps

Can be easily removed under LA

Urinary incontinence

- Urgency, urge incontinence (OAB)
- Stress incontinence
- Mixed incontinence

NICE guidelines 2006

- Incontinence categorised as stress, mixed, or urge.
- Initial treatment started on this basis. In mixed UI, treatment directed towards the predominant symptom.
- Urodynamics not recommended before starting conservative treatment.

Case scenario

- 58 y.old, presents with 1 year history of urinary frequency, urgency and leaks 1-2 times per week.

Frequency, Urgency, Urge Incontinence (OAB)

Ix - urinalysis, diary

Rx – lifestyle, bladder retraining +/-
Anticholinergics for 3 months

Urge urinary incontinence: conservative treatments

- Behavioural therapy
  - Advice to consume 1–1.5l of liquids per day
  - Avoid caffeines (eg tea, coffee, cola) & alcohol
  - Various drugs, such as diuretics and antipsychotics, alter bladder function and should be reviewed
- Bladder retraining
  - The principles of bladder retraining are based on the ability to suppress urinary urge and extend the intervals between voidings
  - Reported cure rates 44–90%.

Anticholinergics

- Anticholinergic drugs block the muscarinic receptors that mediate detrusor smooth-muscle contruction and have a direct, relaxing effect on the detrusor muscle.
- The most widely used treatment for urgency and urge incontinence.

Detrusitol™ 2 mg
Tolterodine L-tartrate
2 mg
POM
56 tablets
Detrusitol™ 1 mg
Tolterodine L-tartrate
1 mg
POM
56 tablets
30 tablets
Once-a-day
DITROPAN XL
5 mg
alza
10 mg
10 mg
sanofi~synthelabo
60 tablets
regurin
20mg Tablets
GALEN
15MG
DETRUNORM
28 Coated Tablets
Schering-Plough

Adverse effects of anticholinergics

- dry mouth
- constipation,
- blurred vision,
- nausea, dyspepsia and flatulence,
- palpitation, arrhythmia, dizziness, insomnia
- skin reactions.

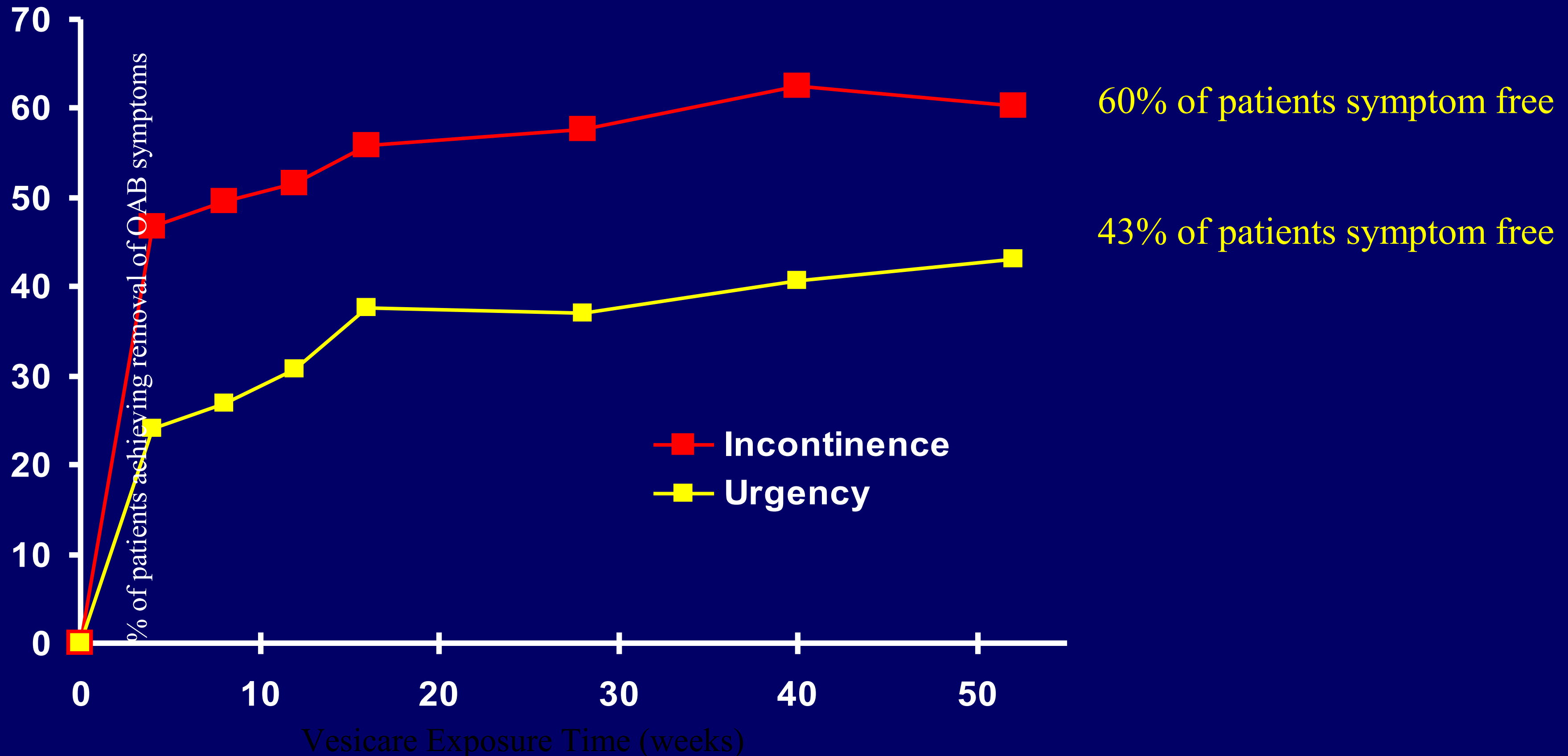
Solifenacin tolerability:
treatment related adverse event data Long term extension study

	On 5mg at onset of AE (n=1633)	On 10mg at onset of AE (n=1114)
Vision blurred	67 (4.1%)	49 (4.4%)
Constipation	80 (4.9%)	88 (7.9%)
Dry mouth	166 (10.2%)	194 (17.4%)

The discontinuation rate due to adverse events after 52 weeks was 4.7%[1,2]

1. Haab et al. Eur Urol. 2005 Mar;47(3):376-84.
2. Chapple et al. Eur Urol. 2005 Sep;48(3):464-70

Vesicare: Achieving freedom from symptoms*

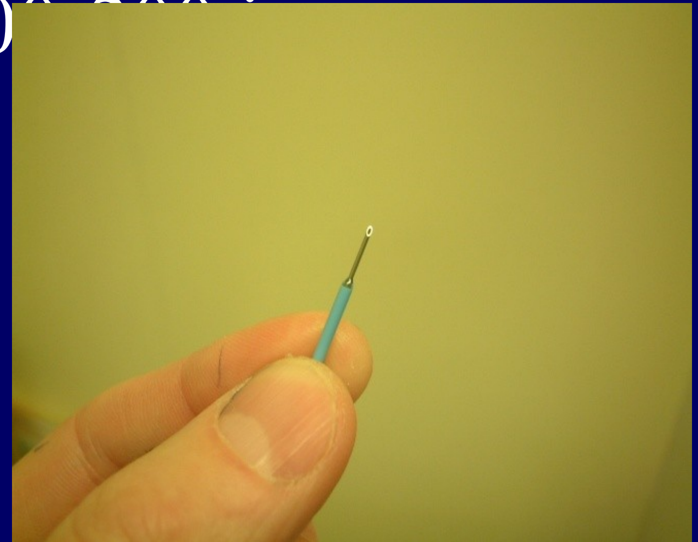


*Haab et al. Eur Urol. 2005 Mar;47(3):376-84

Cystoscopic Botulinum toxin injections

- Local anaesthetic – flexi-cystoscope
- Dysport –Ipsen (UK), 250-500 iu

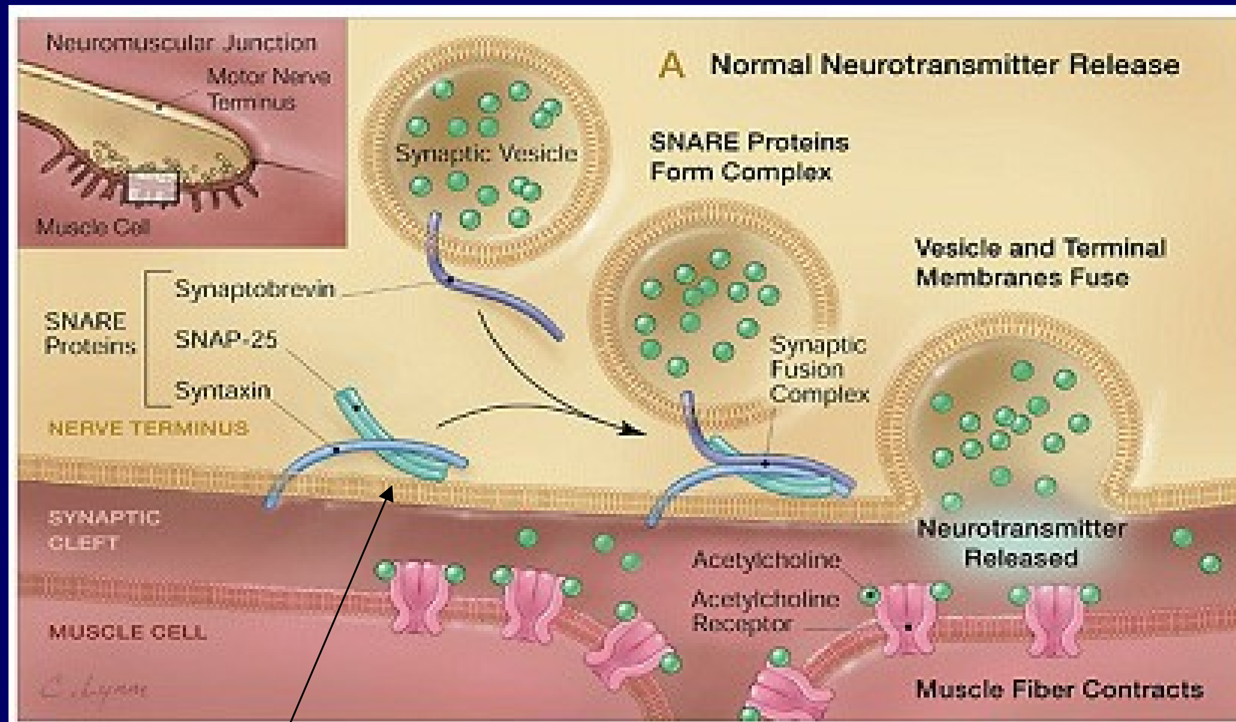
- Botox’ – Allergan (US), 0
- 80-90 % success
- Lasts for 6-12 months
- Risk of retention 5%



Mechanism of action botulinum toxin

- Blocks the release of acetylcholine at the neuromuscular junction
- This results in chemodenervation and paralysis
- Recovery occurs gradually, as new nerve terminals sprout, a process that take a few months

Botulinum toxin



Topical oestrogens

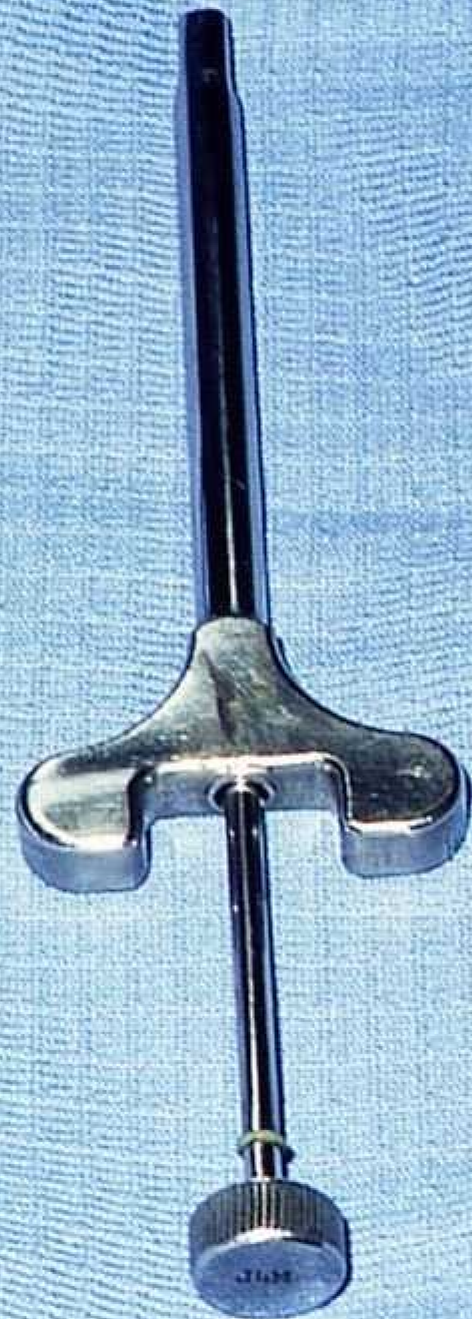
- Many women develop bladder-filling symptoms after the menopause.
- Oestrogen treatment improves symptoms of vaginal atrophy (dryness and irritation).
- In a review of 10 RCTs, vaginal oestrogen was found to be superior to a placebo for Tx of urgency, urge incontinence, frequency and nocturia.

Stress incontinence

- 35yo, leaking with sport and has given up tennis.
- Family complete

Stress incontinence

- Examination pelvic floor
- Physiotherapy/ Pelvic floor exircise
- Surgery?



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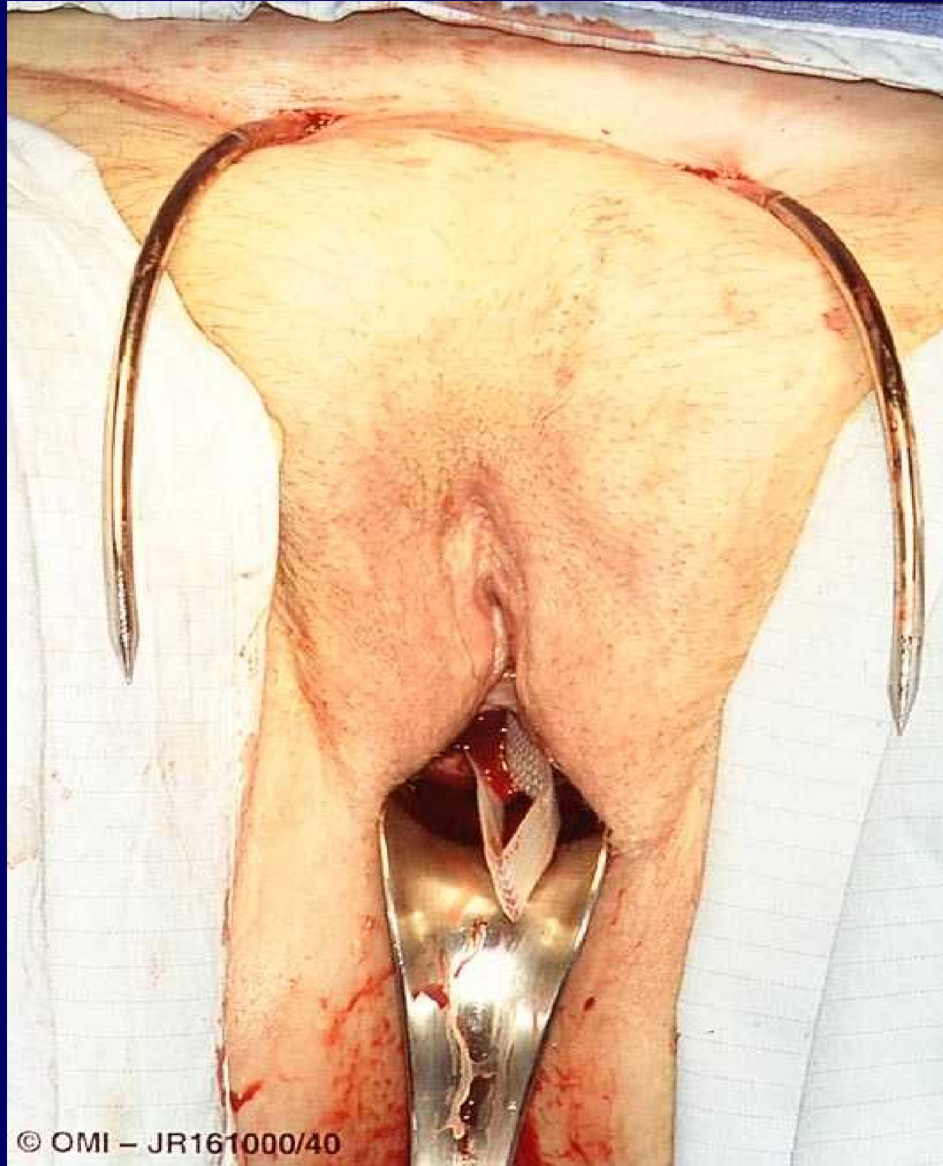
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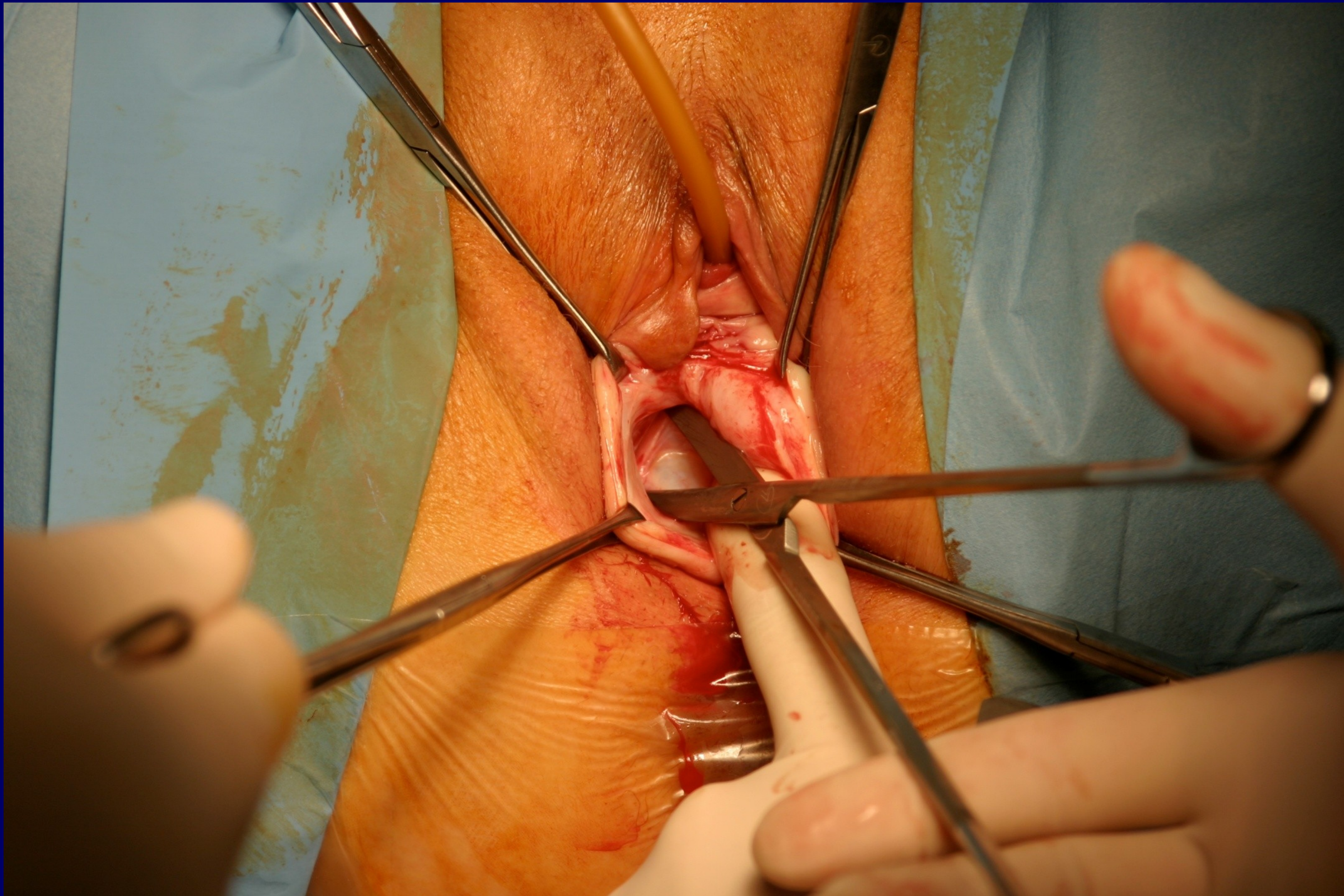
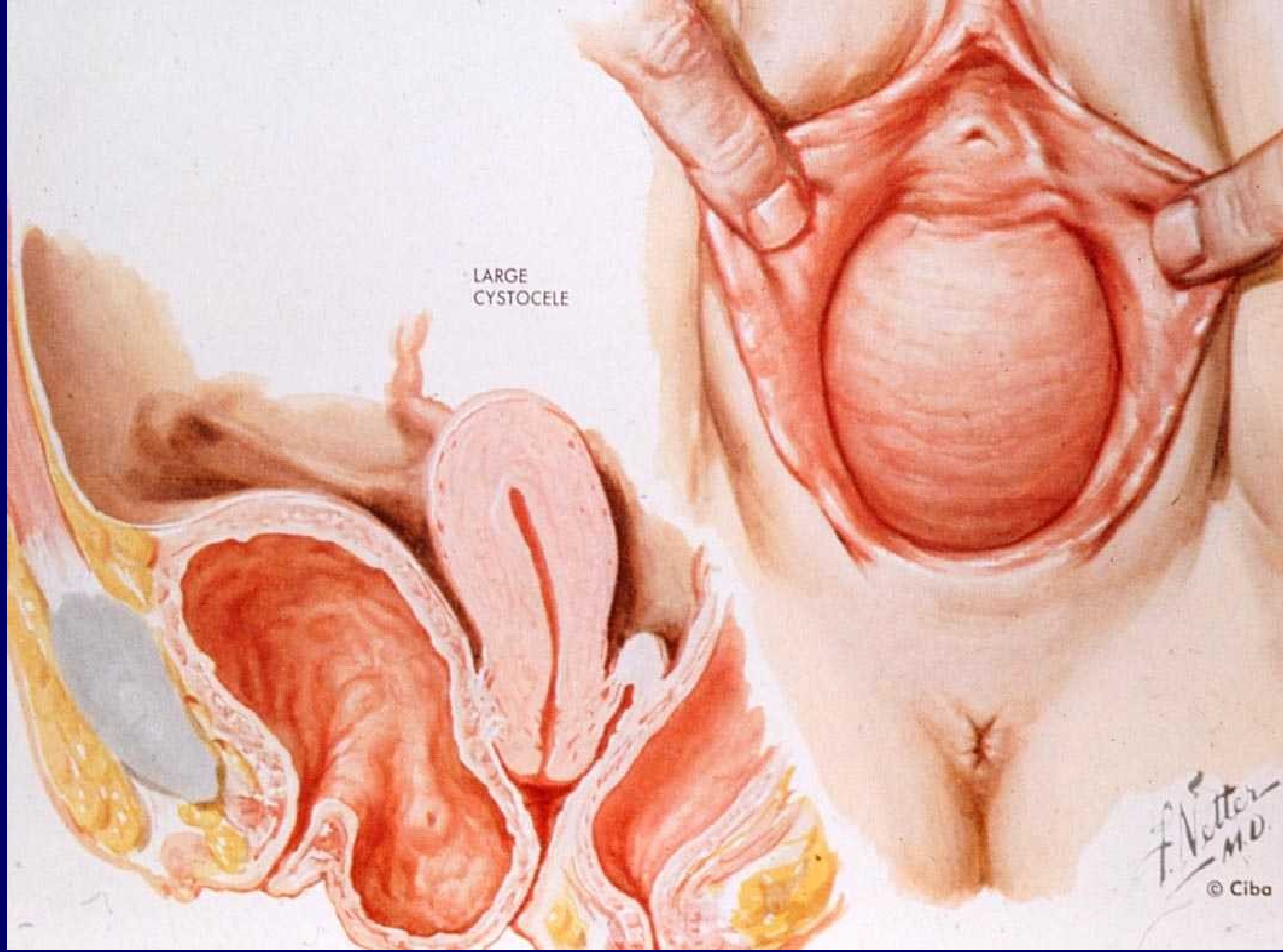
Prolapse

- Pessaries – high discontinuation rate
- Pelvic floor exercise/ Physiotherapy

- Surgery?




LARGE
CYSTOCELE
F. Netter M.D.
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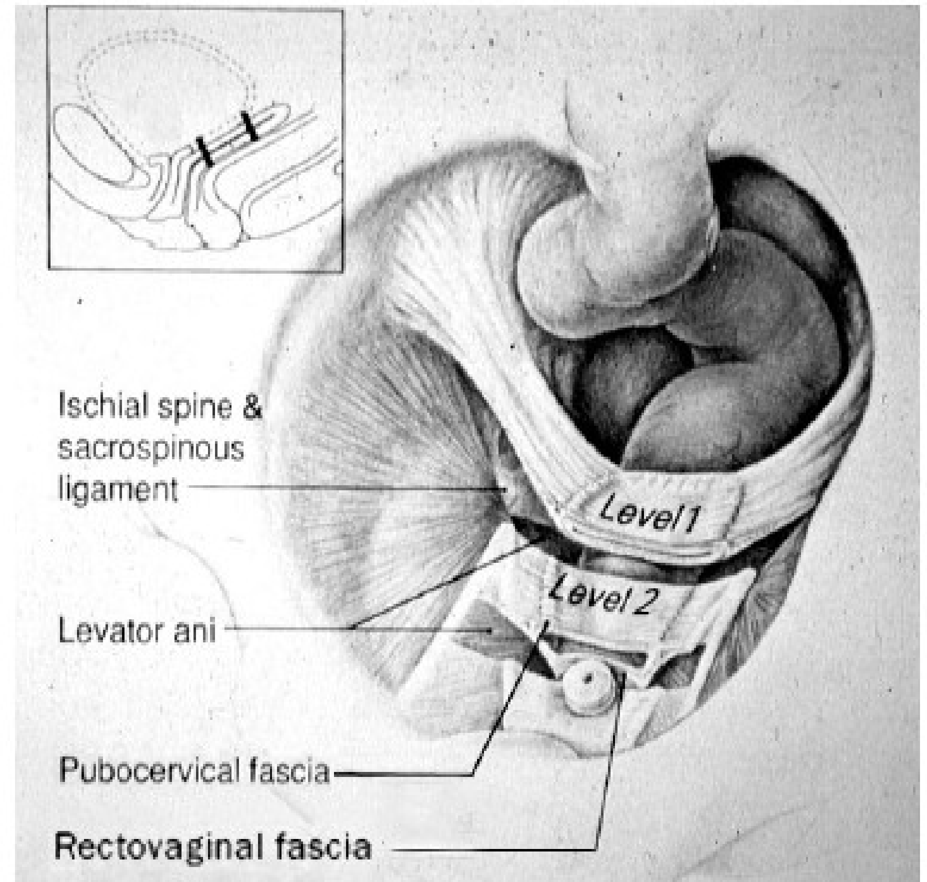
Importance of apical (uterine) support

- Level 1
  - Superior suspension of the vagina to cardinal-uterosacral complex
- Level 2
  - Fascial attachment to the pelvic side walls
- Level 3
  - Distal fusion of the vagina into the urogenital diaphragm and perineal body

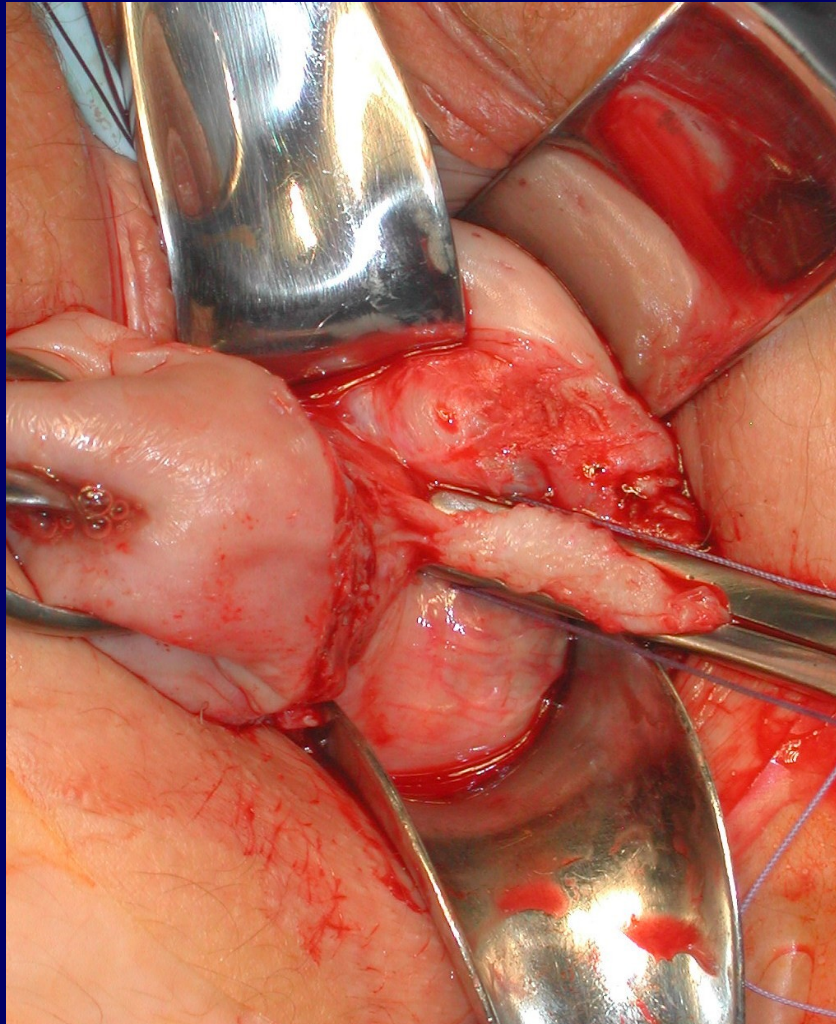


Uterine preservation

- "*The uterus plays a passive, not active, role in uterovaginal prolapse*"

Bonney V. J Obstet Gynaecol Br Empire 1934;41:669-83

Prolapse: why hysterectomy?



Laparoscopic hysteropexy

- In the majority of women in our study, restoration of uterine support has led to a reduction in anterior vaginal wall prolapse.

- This is consistent with DeLancey's findings that loss of apical support is involved with the occurrence of cystocele*.

**The relationship between anterior and apical compartment support . Summers & DeLancey. Am J Obstet Gynecol. 2006; 194(5): 1438–1443*

Recurrent Cystitis

- 57 y.old, menopause 53,
- presents with 2 year history of “cystitis”, dysuria and frequency
- Has had 4 courses of antibiotics in last 6/12

Recurrent Cystitis

- Ix? – Renal USS and cystoscopy
- Cranberry juice / hygienic measures
- Topical oestrogen + low dose prophylactic AB's

Multidisciplinary Teams

- Pelvic Floor Clinic
- Combined operating

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