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SYDNEY WOMEN'S ENDOSURGERY CENTRE

Sydney Women's Endosurgery Centre

What's new in Gynaecology?

Pelvic pain in the young woman by Dr David Rosen

As gynaecologists, we are often asked to see young women with pelvic pain, the assumption being that endometriosis is the cause. Of course often it is, and the great advantage of laparoscopy is that the diagnosis can be made easily, without a laparotomy scar and with minimal interruption to work, school or study. In the right hands, endometriosis can also be completely excised in a day surgery setting. There are a number of issues worthy of consideration when considering pelvic pain in the young woman:

Is it endometriosis?

Endometriosis is defined as the growth of endometrial tissue (glands/stroma) outside its location within the endometrial cavity. This may involve superficial deposits on peritoneal surfaces or deeper infiltrating nodules of the uterosacral ligaments, ovaries or bowel. It is progressive, can be recurrent, has a genetic component and is estimated to effect 10-25% of all women. It can present in many ways (see box 1) but we must always remember that whilst a gynaecological diagnosis primarily, many patients come to us via gastroenterologists as up to 30% of symptoms may be out of phase with the menstrual cycle.

How to diagnose endometriosis?

As with any condition, a diagnosis of endometriosis is based on a good history, examination, appropriate investigations and diagnostic tests. Often, especially with younger women who have not yet commenced sexual activity, a full pelvic examination is neither possible or appropriate, whilst ultrasound can be transabdominal only. Ultrasound for endometriosis is suitable for detecting suspected endometriomas (ovarian cysts caused by the disease) and in some cases and in expert hands, can detect nodular disease in the pouch of Douglas between the cervix and rectum however it is not useful for the diagnosis of superficial disease.

Symptoms of endometriosis

1. **Recurrent menstrual pain**
2. **Heavy periods**
3. **Intermenstrual bleeding**
4. **Pain with intercourse**
5. **Painful bowel motions**
6. **Nausea and or vomiting with menses**
7. **Pain radiates to thighs, back, buttock or epigastrium**
8. **Family history (sisters, mother)**

In all cases, laparoscopy is the gold standard to make the diagnosis and provide treatment.

Why laparoscopy?

No gynaecological condition is better suited to laparoscopic treatment than endometriosis. The absence of laparotomy scars in young, figure conscious women, the reduction in post-operative adhesions, enhanced surgical view and full access to all pelvic structures makes laparoscopy eminently suitable for the diagnosis and treatment of endometriosis. Thirty years ago, a young woman with cyclical pelvic pain may well have been commenced on the oral contraceptive pill or even told to soldier on because a diagnostic laparotomy was seen, quite appropriately, as overly invasive. Laparoscopy allows a diagnosis to be made easily with minimal. This provides for early intervention, medical therapy for ongoing discomfort and can often arrest the disease before it can progress to cause major pelvic adhesions and infertility.

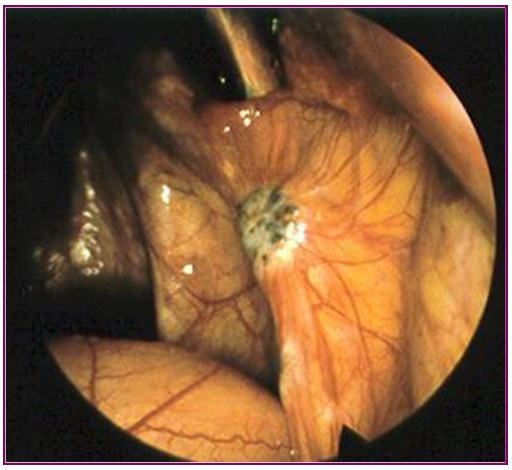

Fig 1. Puckered lesion of right uterosacral ligament

Risk factors

All surgery carries risk. The major risk factors of laparoscopy are those of entry (getting the gas into the peritoneal cavity) After that, it is the nature, location and severity of endometriosis that conveys the risk factors. Even superficial (peritoneal disease Fig 1.) can be located close to sensitive structures such as the ureter, bladder or major vessels. With deeper infiltrating disease it can cause the ovaries to adhere to the pelvic sidewalls (often directly over the course of the ureters), the bowel to adhere to the back of the cervix, the ovaries and tubes to stick together in the midline (so-called "kissing" ovaries) and so on (Fig 2 & 3).

At SWEC, we approach every case of pelvic pain as if severe endometriosis is present. This allows treatment of even the most difficult cases at the primary operation in over 98% of cases.

We feel strongly that;

a. endometriosis should be completely excised not simply buzzed with a diathermy, as the depth of the lesion cannot be otherwise determined and deep disease can be missed.
b. A complete and thorough search must be made, as deposits can be subtle, hidden beneath the sigmoid colon high up on the left pelvic brim or in the pararectal region (Fig 4)
c. Lesions close to the ureter, rectum or uterine arteries should and must be excised. "Too dangerous" is not an excuse to leave disease in a young woman—if one is not comfortable operating in these locations then why subject a young woman to surgery in the first place?
d. Pelvic pain in general and endometriosis in particular require a team approach. A colorectal surgeon or urologist may need to be consulted if the ureter, bladder or rectosigmoid are involved. Pain management may be an issue, or the diagnosis may lie elsewhere and referral to our gastroenterological colleagues may be necessary. Pelvic floor physiotherapy, fertility advice and dietary modifications also play important roles in the ongoing management of women with endometriosis and at SWEC we have immediate access to these facilities for our patients.

What else could it be?

The differential diagnosis of pelvic pain in a young woman will, as with all diagnoses, depend on the history and presenting signs and symptoms (see Box 2). It will vary with the duration and chronicity of symptoms, associated features such as painful or altered bowel motions or changes in micturition and radiation amongst other features. For gynaecological review, a pelvic ultrasound is often the first and best investigation to organize prior to consultation. Ovarian tumour markers, specifically the Ca125 antigen, will be raised in cases of endometriosis but it's presence does not replace a good history and examination.

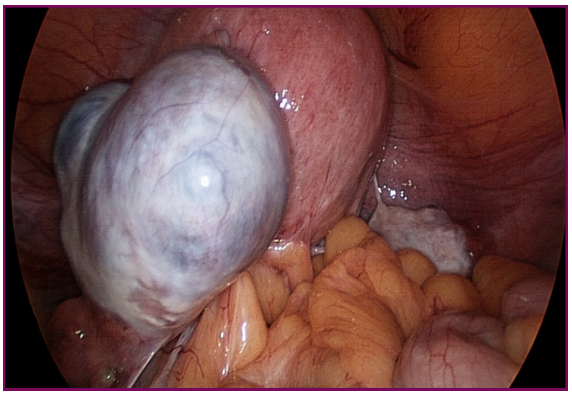

Fig 2. Left endometrioma adherent to pelvic sidewall and sigmoid colon, rectosigmoid adherent to posterior uterus

Pelvic pain in young women:

1. **Endometriosis**
2. **Irritable Bowel Syndrome**
3. **Inflammatory Bowel Disease**
4. **UTI**
5. **Interstitial cystitis**
6. **Adhesions**
7. **Pelvic Inflammatory disease**
8. **Ovarian cysts**
9. **Adnexal torsion**
10. **Ectopic pregnancy**
11. **Miscarriage**
12. **Musculoskeletal pain**
13. **Appendicitis**
14. **Primary dysmenorrhea**

Is surgery the only option?

Medical therapy has an important place in the management of endometriosis, for long-term maintenance therapy and reduction in dysmenorrhea. Nonetheless, it should only be used *after the* diagnosis is made. In addition, if fertility is the desired goal hormonal therapy has a very limited place and surgery for removal of endometriosis

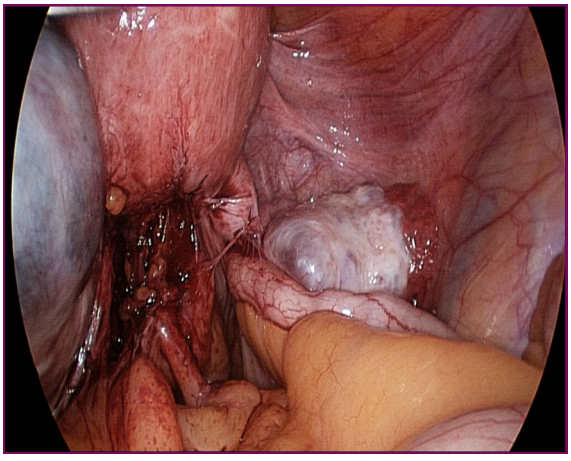

Fig 3. Patient from Fig 2. Appendix adherent to right ovary and pelvic sidewall requiring appendicectomy prior to commencing removal of endometriosis

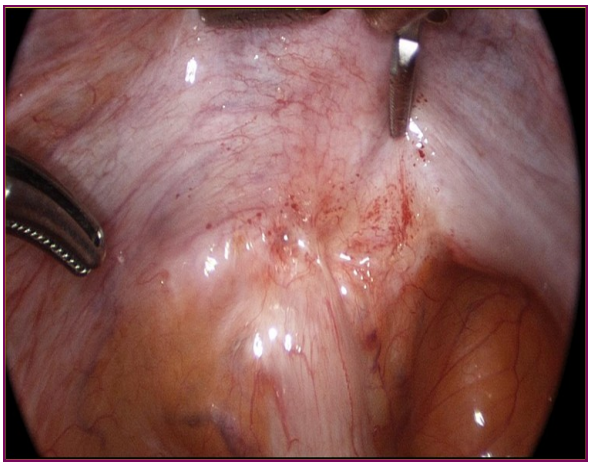

Fig 4. Subtle lesion in the Pouch of Douglas. This patient had a 3cm nodule involving the posterior vaginal wall and rectum requiring resection of both structures

and restoration of normal anatomy is indicated.

Often, we will recommend the Mirena IUCD to be inserted at the time of surgery. This has a number of advantages;

- Easier to insert under GA especially in nulliparous women
- Provides for a reduction in menstrual flow and menstrual discomfort post-operatively whether endometriosis is found and removed or if primary dysmenorrhea is the diagnosis
- An excellent and rapidly reversible contraceptive
- For younger women, does not require daily adherence to pill taking and provides benefit regardless of other medications or social activities

Alternatively, the OCP will provide similar benefits if suitable and can be cycled to miss 1 or 2 periods in a row. Finally, GnRH analogs are used for short term (up to 6 months) therapy, usually prior to definitive surgery to reduce inflammation and potential bleeding with surgery. It can also be used to minimize discomfort whilst on a waiting list for surgery and is usually combined with "addback" HRT therapy to reduce menopausal symptoms such as hot flushes without affecting the endometriosis reducing effects.

In future editions of this newsletter, we will focus on the latest research and up to date news on endometriosis and how it affects our patients.