

Embolotherapy Eases Pain From Pelvic Congestion

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

Pelvic congestion syndrome is a real disease entity that affects up to 16% of American women, and can be successfully treated with transfemoral embolotherapy, according to researchers who presented data at the annual meeting of the Society of Interventional Radiology.

About 10% of gynecologic visits are due to chronic, noncyclic pelvic pain of greater than 6 months' duration, and a third of gynecologic laparoscopies are performed to investigate such pain. The differential diagnosis usually includes endometriosis, fibroids, adenomyosis, cysts, and tumors, among other potential causes. Pelvic congestion syndrome (PCS)—pelvic vein insufficiency that causes pooling of blood in the uterine and ovarian veins—is not often on the list, said Hyun S. "Kevin" Kim, M.D., of Johns Hopkins University, Baltimore.

Even standard imaging studies don't always identify the disorder, Dr. Kim said in an interview.

"Only 40% of laparoscopic studies were able to visualize abnormal veins. On MRI, only 59% were diagnosed."

Because PCS is difficult to diagnose, many physicians write off the symptoms—dull, typically unilateral pain that worsens during the day and with standing, dyspareunia, and dysuria—as psychosomatic, Dr. Kim said.

Varicocele, the male counterpart of PCS, has no such stigma, he added. In men, the gonadal vein terminates in the testicle, so the painful venous abnormalities are usually visually apparent. "This condition is accepted in men, because it occurs outside the body and we can see it. In women it's hidden, and this, I think, is part of the reason for misdiagnosis or underdiagnosis."

The best way to diagnose PCS is with direct venography, said Dr. Kim, who presented the re-

sults of his long-term follow-up study on transcatheter embolization for the disorder at the meeting.

He performed 262 transfemoral ovarian venographies on 131 women (mean age 34 years) with chronic pelvic pain. Overall, 20% had a prior hysterectomy. About one-third of the patients had previous pregnancies; the rest were nulliparous. Venography confirmed the clinical suspicion of PCS in 127 of those women. The diagnostic criteria for PCS are:

- ▶ Ovarian vein, uterine vein, and utero-ovarian arcade venous engorgement greater than 5 mm in diameter.

- ▶ Free reflux of contrast in ovarian vein with incompetent valves.

- ▶ Filling of veins across the midline or filling of vulvar and/or thigh varicosities.

- ▶ Stagnant clearance of contrast from pelvic veins (more than 1 minute).

Patients with a confirmed diagnosis underwent baseline levels of follicle-stimulating hormone, estradiol, and luteinizing hormone, and transcatheter embolotherapy of the insufficient veins. This was done as an outpatient procedure.

There were no major complications.

By a mean 45 months' follow-up, there was a mean pain decrease of 4.7 points on a visual analog scale. Most of the patients (85%) reported improvement, which was significant in 80%, moderate in 14%, and mild in 6%. There was no change in 12%, and pain was worse in 3%.

Women who reported pain improvement also reported significant improvement in symptoms such as dyspareunia, urinary frequency, and menstrual pain. A comparison of patient subgroups showed no differences in outcome between the nulliparous women and those with prior pregnancy.

There were no differences between preoperative and follow-up hormone levels; four patients attempted to conceive after the procedure, and two successful pregnancies resulted. ■

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Lower Leg Pain Alleviated By Pelvic Congestion Tx

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

Pelvic pain related to pelvic venous congestion often occurs in women with symptomatic lower extremity venous reflux. Treating ovarian venous incompetence with embolotherapy can not only reduce associated pelvic pain, but can also significantly reduce the pain associated with lower extremity reflux, according to Carl M. Black, M.D.

Because the disorders occur together in so many women, he recommends that women with complex nonsaphenous superficial lower extremity venous insufficiency be questioned regarding concomitant symptoms of pelvic congestion.

"These are some of the most complex varicose vein patients you will ever see," Dr. Black of the Intermountain Vein Center, Provo, Utah, said in an interview. "It's very, very hard to make them happy and their problems tend to get worked up piecemeal and a more comprehensive approach may significantly improve their ultimate outcome."

Symptoms of pelvic congestion syndrome are heaviness in the pelvis with standing, low abdominal pain, painful varicosities in branches around the labia and vulva, and varicosities that emerge from the gluteal region and extend into the legs.

"About 16% of the women with varicose veins will say they have pelvic pain that cycles with their leg pain—when their pelvis feels bad, their leg veins bulge

more and feel worse," Dr. Black said. "As you define it more, it is classical pelvic congestion."

At the annual meeting of the Society of Interventional Radiology, Dr. Black presented the results of a study evaluating transcatheter embolization in patients with both disorders.

The study group consisted of 160 women with symptomatic lower extremity superficial reflux. Their mean age was about 39 years, with a mean of three pregnancies. Each patient received a thorough lower extremity venous duplex ultrasound, which included evaluation of atypical transpelvic venous reflux. Clinical and ultrasonographic findings suggested pelvic congestion syndrome in 26 (16%) of the women. All 26 had complex nonsaphenous patterns of lower extremity venous reflux.

Twenty-four of these patients then underwent venography, which confirmed ovarian venous insufficiency in 22 (94%). These 22 patients had embolotherapy on the insufficient pelvic veins. Embolization was successful in 100%.

After pelvic embolization, 19 (86%) reported relief or significant reduction in pelvic pain and 14 (63%) reported reduction of both pelvic and lower extremity pain. After subsequent comprehensive treatment of remaining identifiable sources of lower extremity venous reflux, 20 of the 22 patients (91%) reported sustained overall treatment satisfaction at follow-up with approximately 60% of patients having been followed out to between 6 and 12 months.

Age-Appropriate Cervical Screening Guidelines Called For

BY NANCY WALSH
New York Bureau

NEW YORK — With revisions to the consensus guidelines for the management of women with cervical cytological abnormalities expected in 2006, experts are taking a hard look at ways the guidelines might be tailored to be more age specific.

Much less is known about the natural history of cervical intraepithelial neoplasia (CIN) in young women, compared with older women. The 2001 guidelines do not provide specific recommendations for adolescents and young women, and the result today "is that we are probably doing a lot more harm than good," Thomas C. Wright, M.D., said at a gynecology conference sponsored by Mount Sinai School of Medicine.

Screening as it is practiced today is generating a large number of false positives,

particularly among younger women. In adolescents aged 16-18 years, 1 in 10 will have a false-positive result, and the cost implications are significant, Dr. Wright said.

Why all the false positives? High-risk strains of HPV are "essentially ubiquitous" among sexually active young women. "I have looked at young women serially over a period of 2-3 years, and found that two-thirds became HPV-DNA positive," said Dr. Wright, director of the division of gynecologic and obstetric pathology, Columbia University College of Physicians and Surgeons, New York City.

In another study, more than 80% of college-aged women were HPV positive when tested monthly, but the vast majority are transient infections and clear spontaneously. In a study from Rutgers University, New Brunswick, N.J., where two-thirds of the female participants were HPV positive, by 1 year, 70% of infections

had cleared, and by 2 years, 92% had spontaneously cleared. Other studies have shown similar results, he said.

Certain aspects of follow-up and management have been evolving differently for younger women. Among 18-year-olds with Pap smears classified as atypical squamous cells of undetermined significance (ASCUS), 71% will be positive for high-risk HPV and two-thirds will continue to be abnormal on a repeat Pap smear. "So anything you do in this population means that the bulk of them are going to end up getting sent for colposcopy," he said.

"We don't have a recommendation on how you should manage ASCUS, but I can tell you that in an 18-year-old it is probably not wise to be doing HPV-DNA testing. What we are doing at Columbia is following up with repeat cytology," he said.

For low-grade squamous intraepithelial lesions (LSIL), the options are to repeat the

Pap smear, perform HPV testing, or to do a colposcopy. "HPV testing in a young woman with LSIL is a complete waste of time, as 87% are going to be HPV-DNA positive. If you repeat the Pap smear, 81% are going to remain abnormal unless you wait years for the infection to clear," he said. Therefore, most [physicians] believe adolescents with LSIL should undergo colposcopy, he said.

Colposcopy is also advised for high-grade squamous intraepithelial lesions. "But if the lesions are not biopsy-confirmed CIN 2 or 3, rather than doing a loop electrosurgical excisional procedure, we can follow them by doing colposcopy and cytology at 4- to 6-month intervals provided the colposcopy is satisfactory, the endocervical curettage findings are essentially negative, and the patient accepts the risk of possible occult disease," Dr. Wright said. ■