Managing Endometriosis & Pelvic Pain in Primary Care

Tuesday 12 November 2024

phn GOLD COAST
An Australian Government Initiative

Elysian WOMEN'S HEALTH

MEDICAL SUPER CLINIC BENOWA

Acknowledgement to Country

Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and the traditional practices of the families of the Yugambeh Language Region of South East Queensland and their Elders past, present and emerging.

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Artist: NARELLE URQUHART, WIRADJURI WOMAN

Housekeeping

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- In the case of an emergency evacuation, please remain calm and await instructions from staff.

- Please keep mobile phones switched to silent, and answer any urgent calls outside the room.

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Agenda

Opening Ella Baitieri, Gold Coast Primary Health Network and Dr Kenneth Loon, Medical Super Clinic Benowa	6.30 – 6.40pm
Video address from Assistant Minister Ged Kearney	6.40 – 6.45pm
Latest medical treatments for endometriosis for General Practitioners Dr Natasha Gould, Medical Super Clinic Benowa	6.45 – 7.10pm
Education and information on the surgical management of endometriosis Dr Gary Swift, Pindara Private Hospital	7.10 – 7.35pm
Physiotherapy in the management of pelvic pain and pelvic floor dyssynergia Phoebe Armfield, Medical Super Clinic Benowa	7.30 – 8.00pm
Endometriosis, Persistent Pelvic Pain and EPPICS Dr Angela Model, Staff Specialist, Obstetrics and Gynaecology, Gold Coast Health; and Carmen Ryden, Clinical Nurse Consultant, EPPICS	8.00 – 8.25pm
Q&A Panel All presenters	8.25 – 8.55pm
Closing remarks Dr Kenneth Loon, Medical Super Clinic Benowa	8.55 – 9.00pm
Event close	9.00pm

Video address: Assistant Minister Ged Kearney

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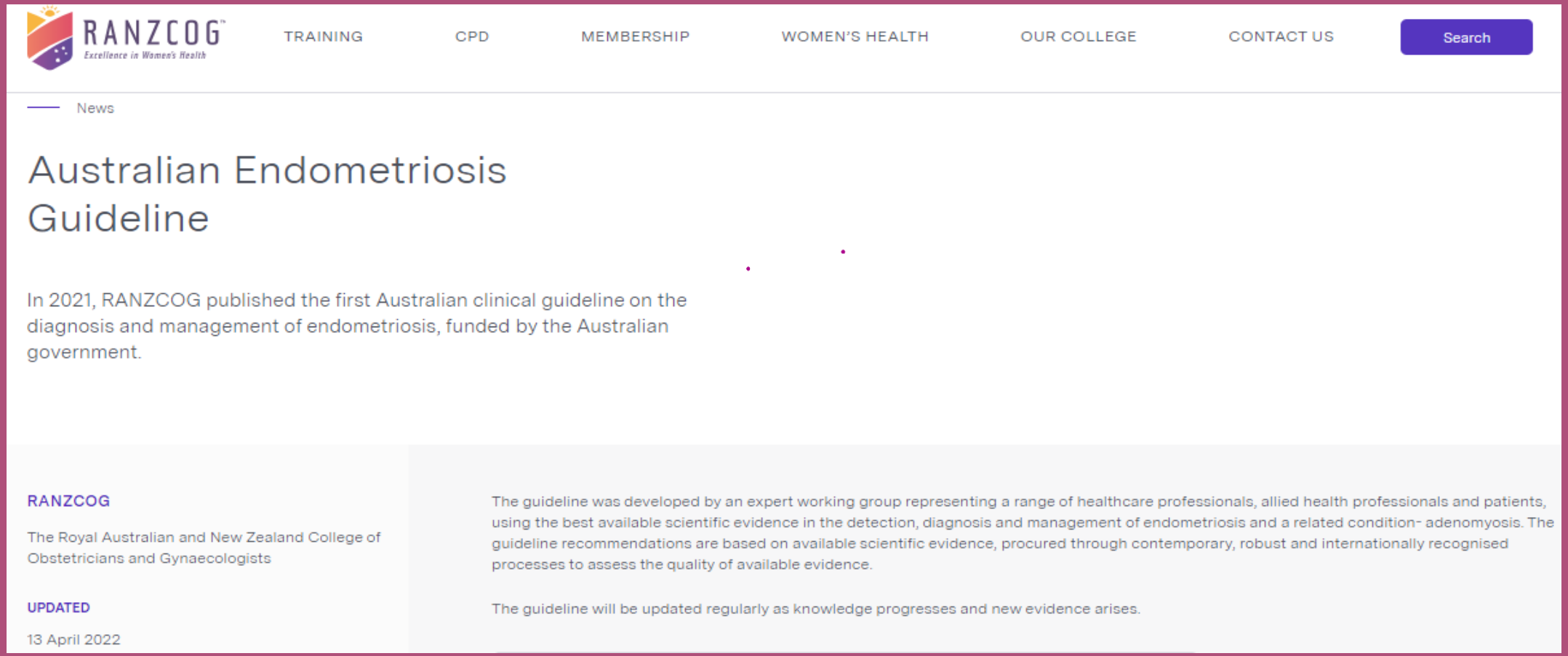
Latest medical treatments for endometriosis for GPs

Dr Natasha Gould

GP with special interest in women’s health

Recent guidelines



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News

Australian Endometriosis Guideline

In 2021, RANZCOG published the first Australian clinical guideline on the diagnosis and management of endometriosis, funded by the Australian government.

RANZCOG

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

UPDATED

13 April 2022

The guideline was developed by an expert working group representing a range of healthcare professionals, allied health professionals and patients, using the best available scientific evidence in the detection, diagnosis and management of endometriosis and a related condition- adenomyosis. The guideline recommendations are based on available scientific evidence, procured through contemporary, robust and internationally recognised processes to assess the quality of available evidence.

The guideline will be updated regularly as knowledge progresses and new evidence arises.

Evidence-based *Moderate*	Offer hormonal treatment (for example, the combined oral contraceptive pill or a progestogen as an oral form, a subcutaneous implant or intrauterine device [IUD] form[14]) to people with suspected, confirmed, or recurrent endometriosis. The choice of hormonal treatment should be in a shared decision-making approach, recognising that no hormonal treatment has been demonstrated to be superior.	Adapted

- **COCP (often 1st choice)**
- **POP**

GnRH combination therapy = new medication

- **used for severe cases of endometriosis**

“I heard about a new medication for endometriosis”

Ryeqo
- contains 3 active ingredients:

- **Relugolix**
- **Estradiol**
- **Norethisterone**

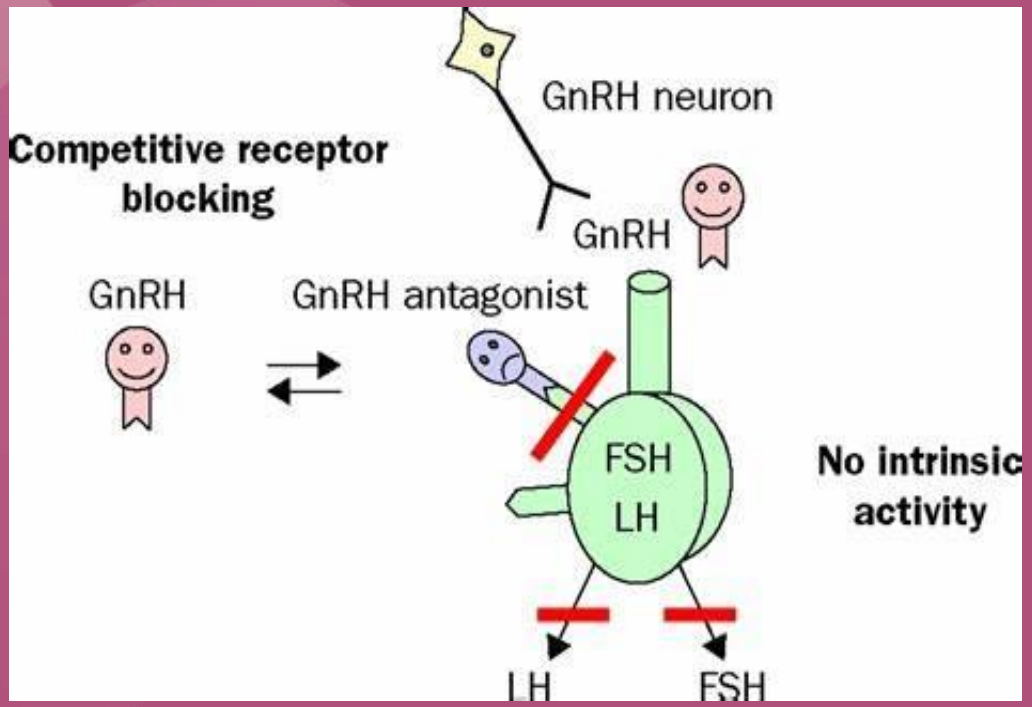
- can use as contraceptive after 1 month

Relugolix

- oral nonpeptide GnRH receptor antagonist
- monotherapy not suitable for long-term use

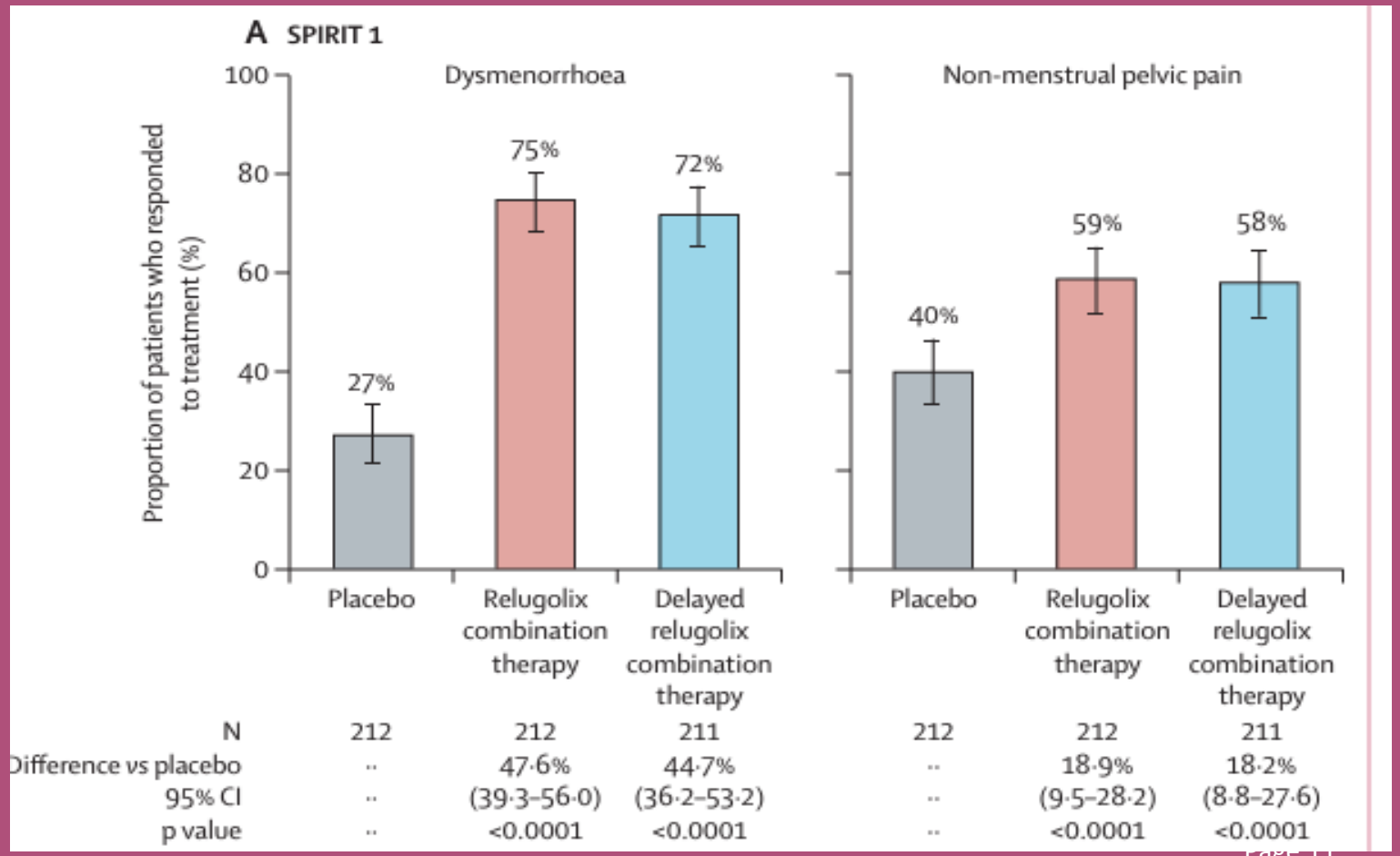
Combination therapy:

- estradiol concentrations consistent with follicular stage of menstrual cycle



SPIRIT 1, SPIRIT 2 trials

- Moderate to severe dysmenorrhea
- Moderate to severe pelvic pain
- Aged 18-50



Source:

Ryeqo

- Non-PBS, cost ~ $ 135 - $140 per month
- ADRs – most common – headaches, nasopharyngitis
- CIs:
  - VTE
  - OP
  - Migraines with aura
  - Breastfeeding

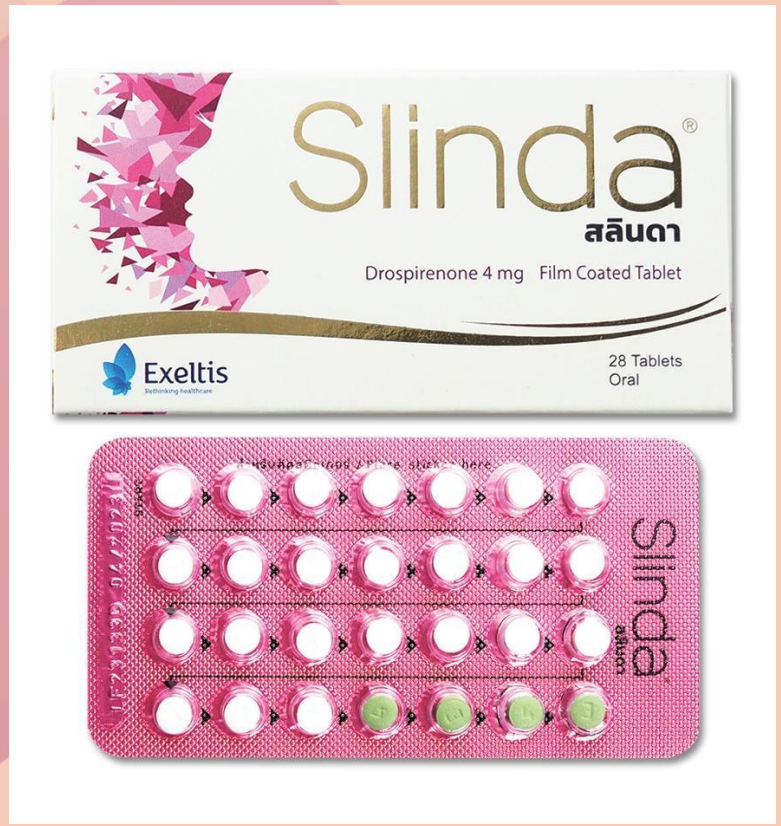
Ryeqo

What about Bone Density?

- Mean decrease in 1st year of treatment was 0.69%
- >3% reduction in 21% of women
- Hx of low trauma # recommended to assess benefit vs risk of Tx
- Do baseline BMD, then annually

Slinda (Drospirenone)

- POP
- Prog used in Yaz and Yasmin
- Contraceptive – 24-hour window, more flexibility compared to other POPs
- Non-PBS



Thank You

Education and Information on the Surgical Management of Endometriosis

Dr Gary Swift

MBBS FRANZCOG MReprodMed

12th November 2024

Swift Holland Evans

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SHE MEDICAL

Dr Gary Swift

- Graduated MBBS UQ 1988, FRANZCOG 1999, MReprodMed(UNSW) 2011
- Fellow in Advanced Laparoscopic Gynaecologic Surgery 1999 Certified Level 6
- Private and Public Practice on Gold Coast since 24/1/2000
- Founding partner Queensland Fertility Group Gold Coast 2001
- VMO Supervisor AGES Advanced Laparoscopic Surgery Fellowship GCUH 2015-2020
- Qld Councillor RANZCOG 2018-2023
- Senior Specialist GCUH Advanced Laparoscopic Surgery (EPPICS) - 2011-Present
- The "S" in SHE O&G Medical Group at Pindara Private Hospital with Drs Holland and Evans

Outline

- Endometriosis (The Disease)
- Economic Burden
- Clinical, Staging and Surgery
- Education & Information
- Special types
- Organisations and Guidelines
- National Action Plan 2018 -
- Government Funding
- Pain syndromes and other relevant diagnoses

Endometriosis - The Disease

- A disease affecting 1:9 reproductive age females where "endometrial like tissue" grows outside the endometrial cavity, most commonly in the pelvis but also other sites, causing pain, subfertility via inflammation and anatomical distorsion.
- Symptoms (Pain, Infertility) cause major QOL impact and economic burden,.which can vary with the site and stage of the disease but the correlation is poor
- Diagnostic delay remains a historical challenge with a paucity of non-invasive modalities (CA125, USS, MRI)
- USS useful and increasingly so, but Laparoscopy remains the "Gold Standard" for diagnosis and excisional surgery (currently considered the optimal therapeutic approach)
- The role of Laparoscopic Surgery fundamentally relies on the concept of early diagnosis and surgical intervention to alter the natural course of the disease and improve QOL and Fertility

Magnitude of the problem in Australia

GIRLS

- **1 in 10 girls** experiences pelvic pain that severely impacts their schooling, career path, social growth and participation.

WOMEN

- **1 in 10 women** suffer from endometriosis
- Up to **1 in 3 women** with endometriosis have fertility problems
- **7-12 years** is the average delay between onset and diagnosis
- Endometriosis is **often associated** with decreased social and economic participation, co-morbitities and progression to chronic pelvic pain

RELATIVES

- Women and girls who have close relatives with endometriosis are up to **7-10 times** more likely to develop it.

COSTS

- Endometriosis is reported to **cost more than 7.7 billion** in healthcare, absenteeism and lost social and economic participation.

Endometriosis Clinical

- Pain and Infertility are main clinical issues dictating treatment
- Dysmenorrhoea, Dyspareunia, Subfertility - classic triad
- Dysuria, Dyschezia, Chronic Pelvic Pain (Cyclical & non-cyclical), Fatigue and less well defined S&S
- Pain is site specific for the most part but may be poorly localized or referred
- No reliable blood marker (CA125)
- Imaging for Diagnosis, Suspicion and Surgical Planning
- USS - static and dynamic information (primary, secondary and tertiary level examinations & reports)
- MRI static & high resolution (Colorectal, Urological, Extra-pelvic disease)

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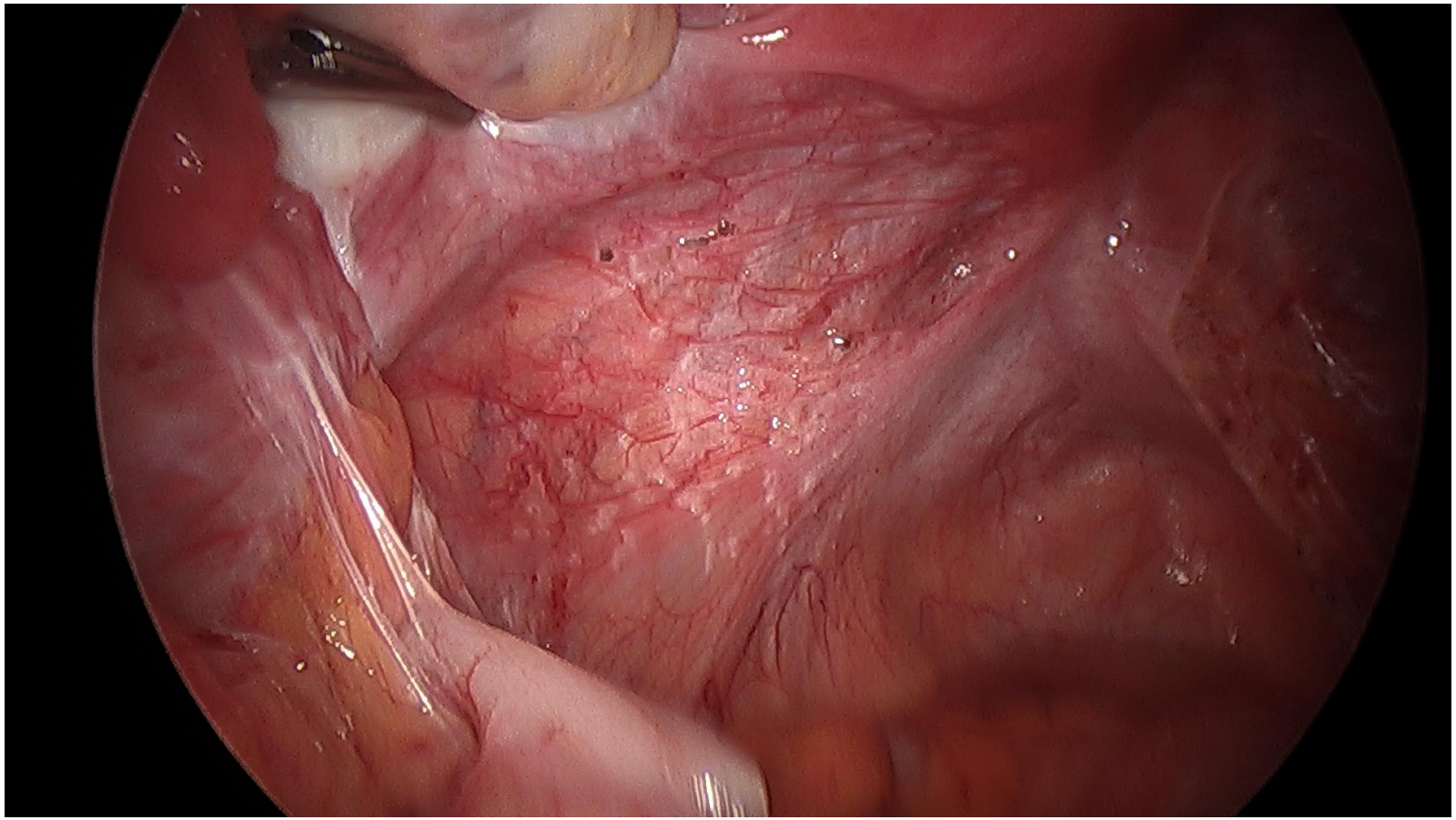
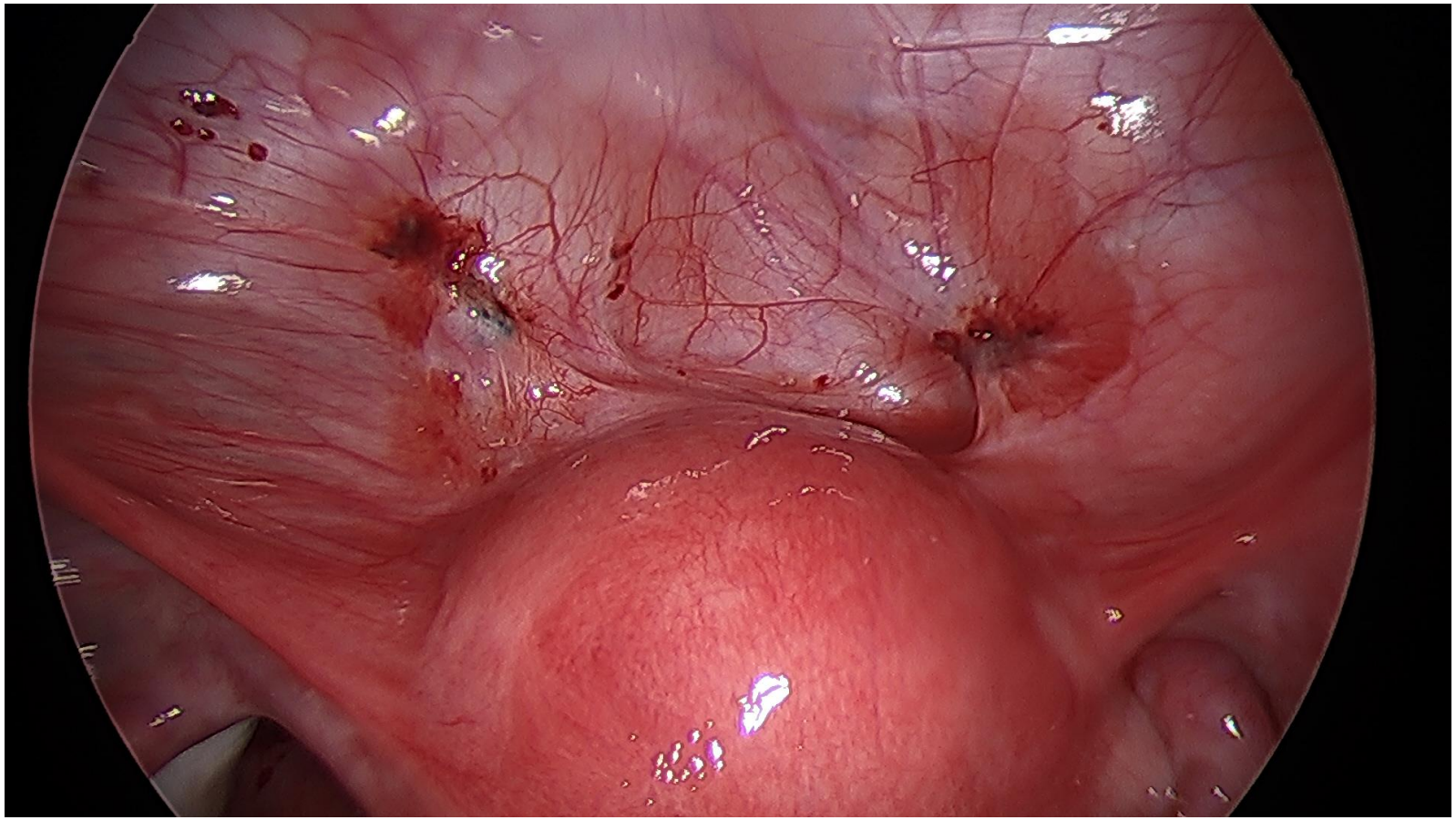
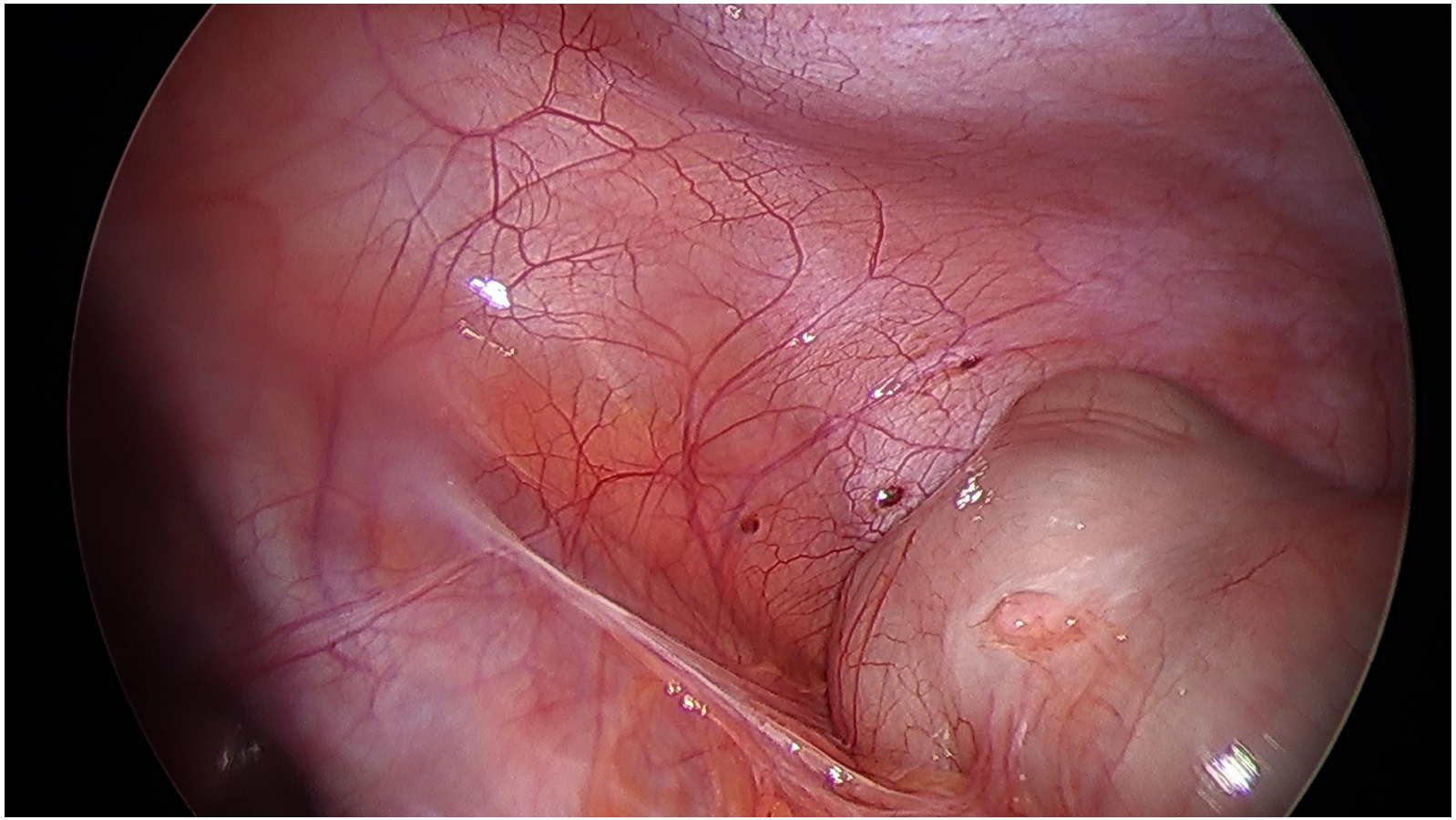
Ovarian Fossa, Sidewall Endo



Bladder Serosal Endometriosis



RIF Deposits



Patient Awareness, Education & Information

- Symptoms don't equal disease but should raise the suspicion
- Patients now most likely to have used internet or social media resources, Googled or Chat GPT'd symptoms and have some awareness of the likely diagnoses and other people's on line opinion on treatment modalities (Medical & Natural therapies, Mirena)
- May have already accessed resources
  - Private : Q Endo, Endometriosis Australia, Jean Hailles Foundation, Oractitioners & IVF Unit's Websites
  - RANZCOG, Government Funded
- Clinical consultation often later in the process (GPs and other health professionals)
- Specialists and Specialised Clinics (EPPICS)

Self Assessment Tools

RAISING AWARENESS
Tool for Endometriosis

Over 830,000 Australians have endometriosis and diagnosis can take up to 6.5 years.

Use RANZCOG's RATE self-assessment tool to help your doctor diagnose and manage your symptoms.

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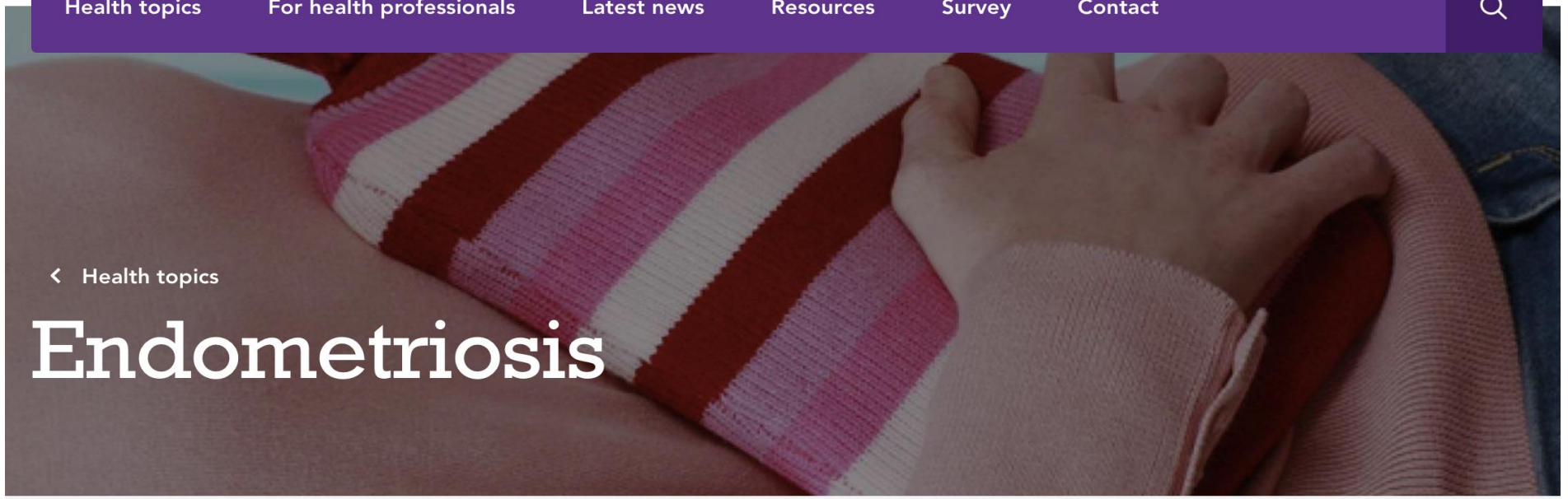

Health topics

Endometriosis

Endometriosis is a condition that occurs when cells similar to those that line the uterus are found in other parts of the body.

Preoperative

- Who to operate on?
- Should anyone with pelvic pain have a laparoscopy (diagnosis, staging, therapeutic)?
- Teenagers (up to 50% negative at 15-16yo), Family Hx relevant, Reaching potential academically
- Impacted QOL (severity of symptoms)
- Failed Medical Therapy (Initial response with breakthrough or inadequate primary effect)
- Previous Suboptimal surgery (Positive diagnostic procedure w/o excision)

Consent and Counselling

- "All surgery carries risk"
- Serious Complications (Life Threatening): injuring bowel, bladder, blood vessels, ureters 1:500-1000 - increased with previous surgery and/or anatomical distorsion
- Minor (Nuisance) Complications (delay recovery but not a threat to life): Bleeding, infection, scarring, wound healing, transfusion, open procedure 1%
- Bowel preparation- important for bowel surgery, some benefit for access, recovery, unexpected findings
- Accelerated Recovery Protocols (Dex)

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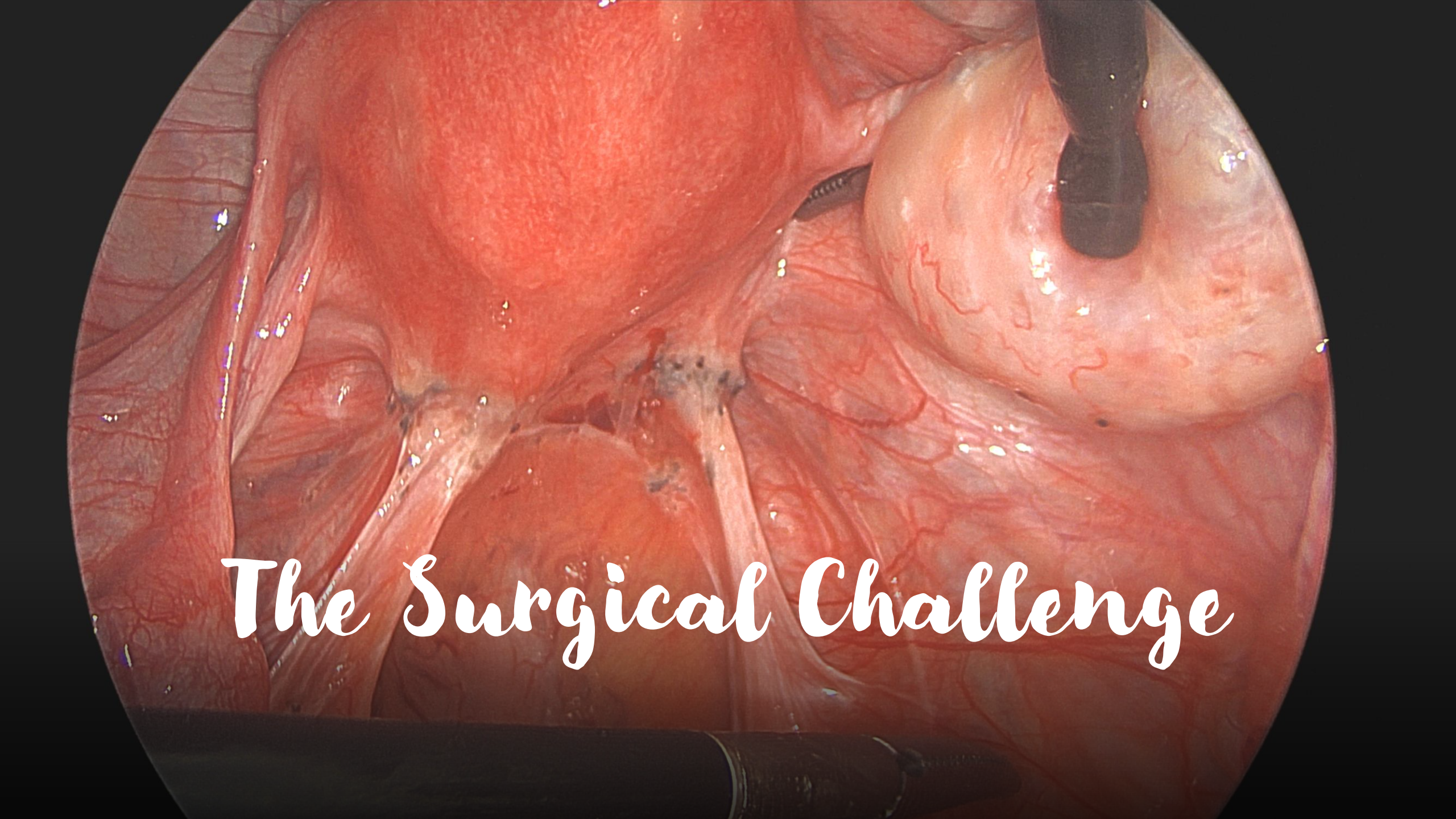
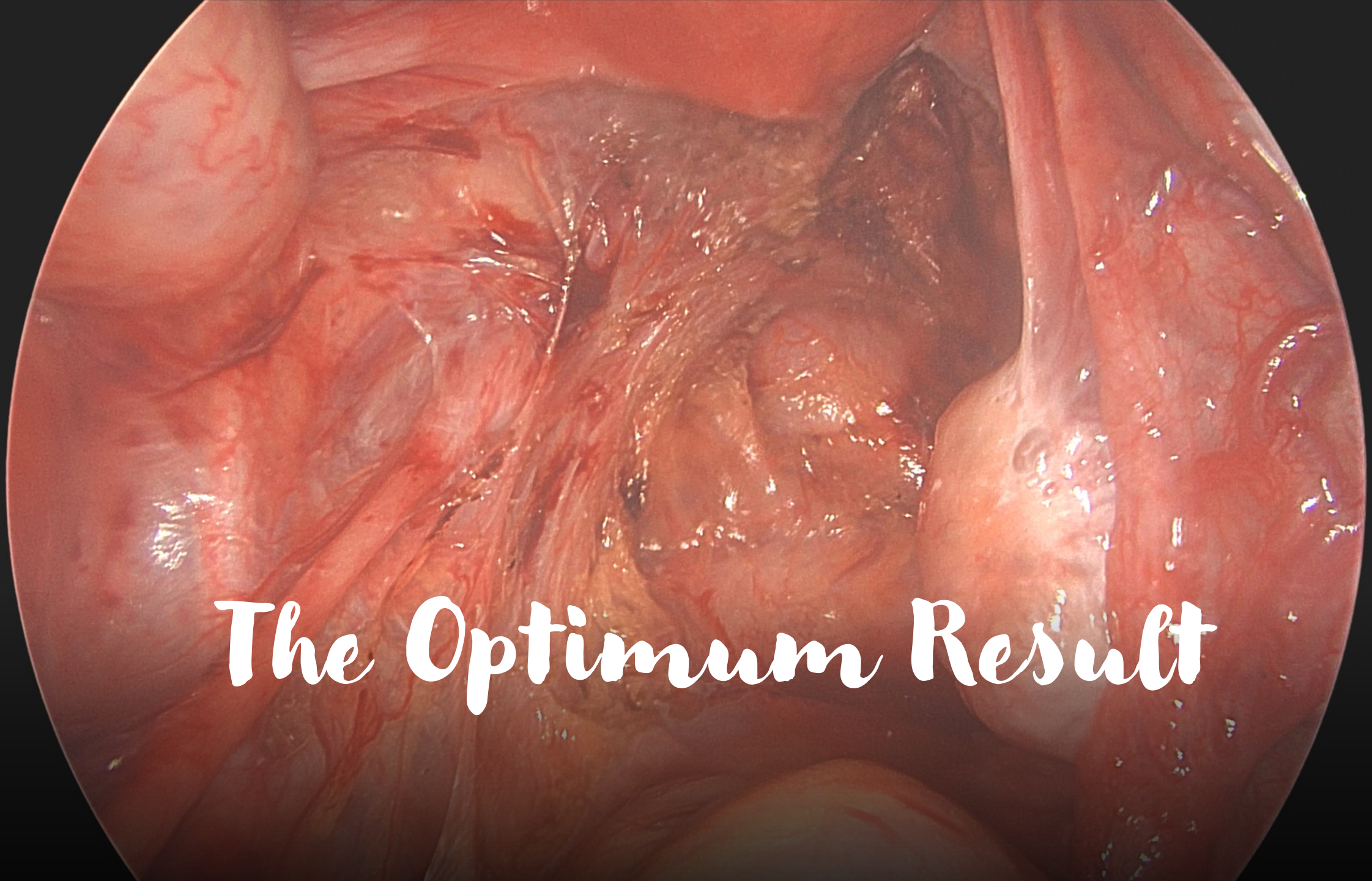
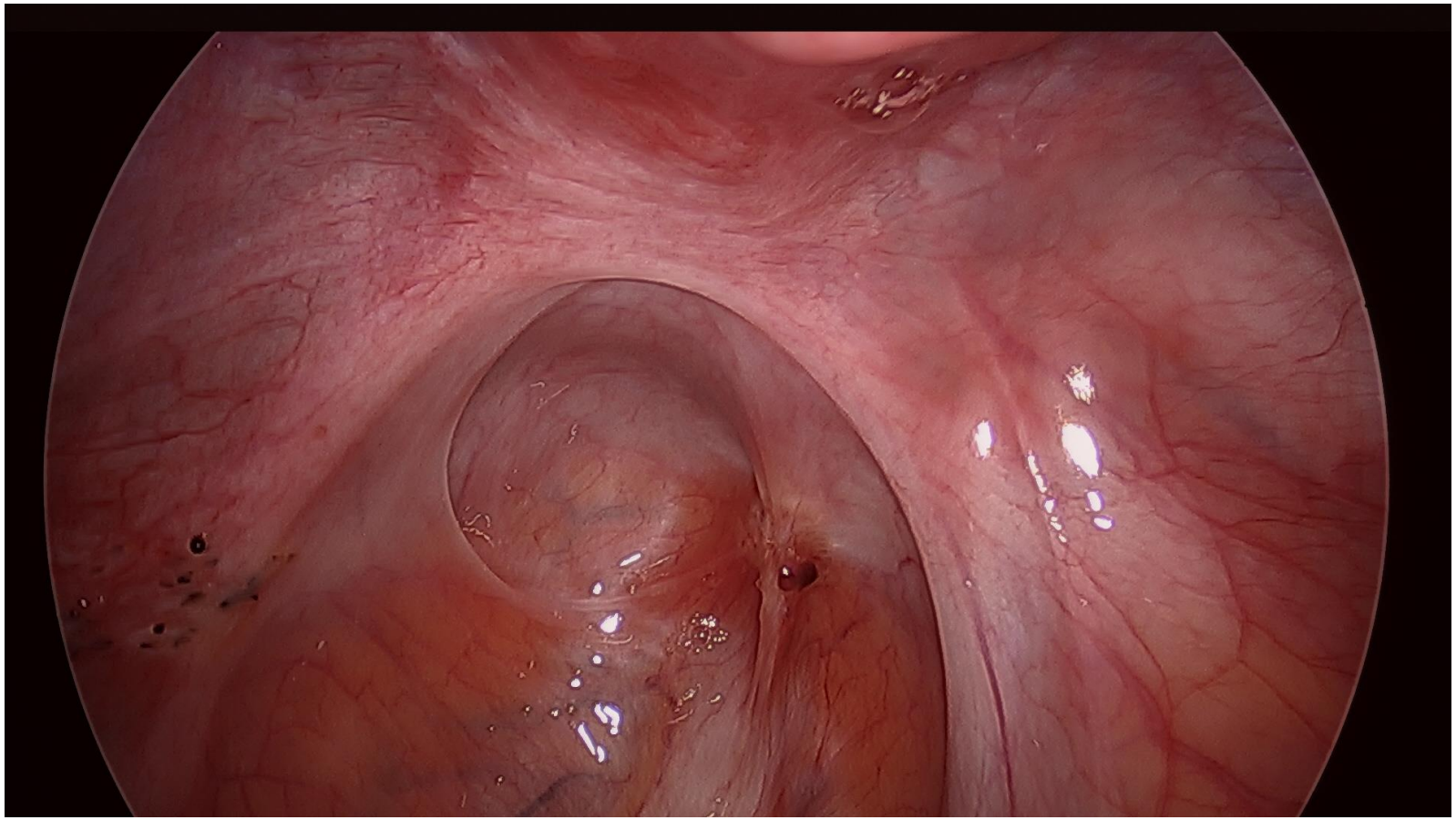
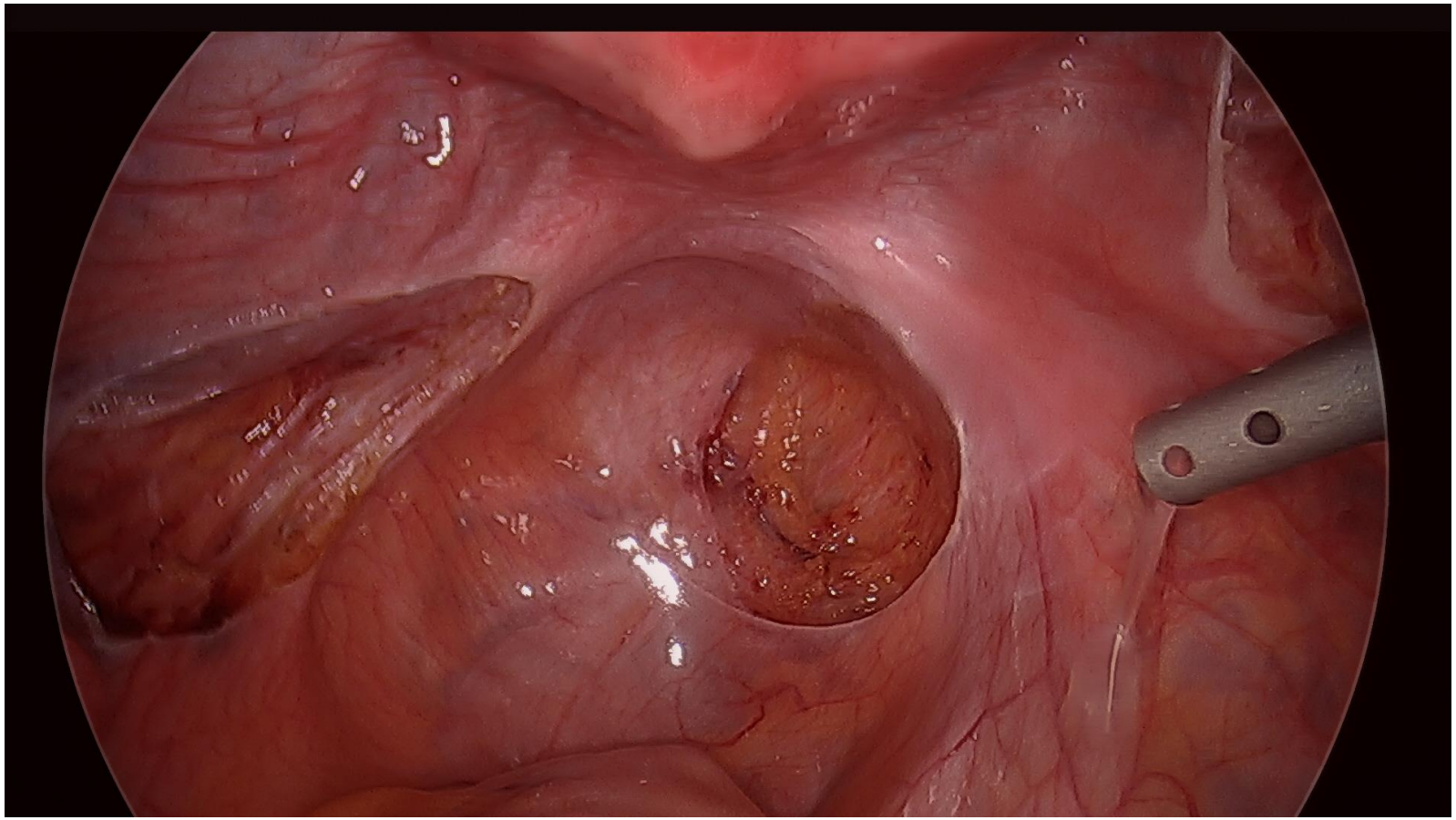

The Surgical Challenge


The Optimum Result

POD and Uterosacral Endo



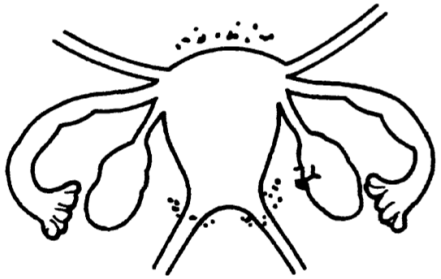
Excisional Surgery



Complex Staging System

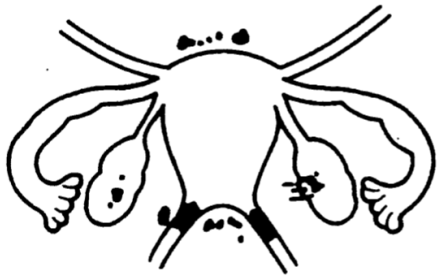
EXAMPLES & GUIDELINES

STAGE I (MINIMAL)



PERITONEUM			
Superficial Endo	–	1-3cm	- 2
R. OVARY			
Superficial Endo	–	<1 cm	- 1
Filmy Adhesions	–	<1/3.	- 1
TOTAL POINTS			4

STAGE II (MILD)

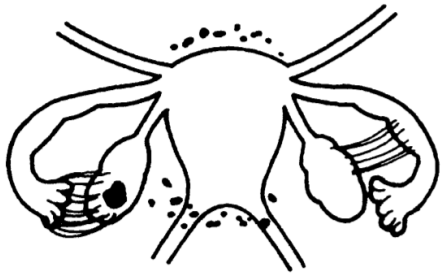


PERITONEUM			
Deep Endo	–	>3cm	- 6
R. OVARY			
Superficial Endo	–	<1cm	- 1
Filmy Adhesions	–	<1/3	- 1
L. OVARY			
Superficial Endo	–	<1cm	- 1
TOTAL POINTS			9

STAGE III (MODERATE)

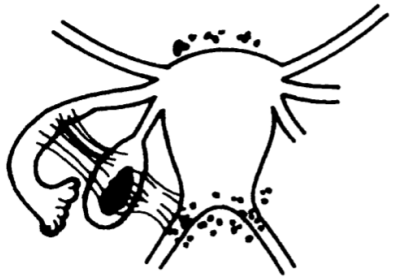
PERITONEUM			
Deep Endo	–	>3cm	- 6
CULDESAC			
Partial Obliteration			- 4
L. OVARY			
Deep Endo	–	1-3cm	- 16
TOTAL POINTS			26

STAGE III (MODERATE)



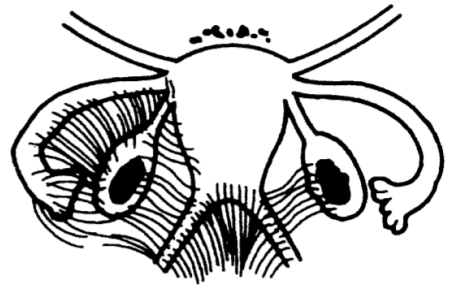
PERITONEUM			
Superficial Endo	–	>3cm	- 4
R. TUBE			
Filmy Adhesions	–	<1/3	- 1
R. OVARY			

STAGE IV (SEVERE)



PERITONEUM			
Superficial Endo	–	>3cm	- 4
L. OVARY			
Deep Endo	–	1-3cm	- 32 **
Dense Adhesions	–	<1-3	- 8 **

STAGE IV (SEVERE)



PERITONEUM			
Deep Endo	–	>3cm	- 6
CULDESAC			
Complete Obliteration			- 40
R. OVARY			

ARSM ENDOMETRIOSIS STAGES:

Endometriosis Stage	Manifestation of the Condition
Stage I (1-5 points)	• Minimal • Few superficial implants
Stage II (6-15 points)	• Mild • More and deeper implants
Stage III (16-40 points)	• Moderate • Many deep implants • Small cysts on one or both ovaries • Presence of filmy adhesions
Stage IV (>40 points)	• Severe • Many deep implants • Large cysts on one or both ovaries • Many dense adhesions

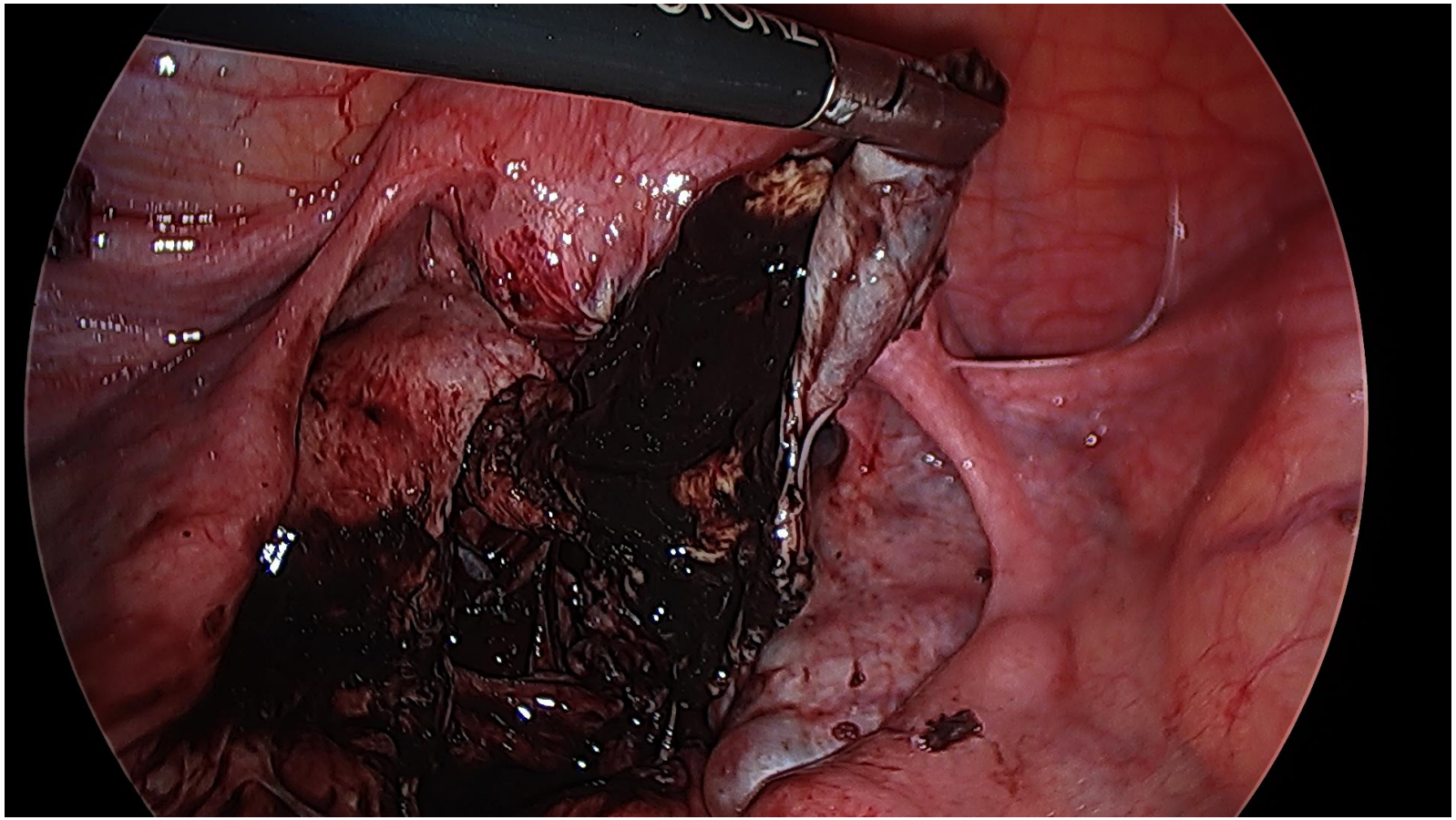
Special Types of Endometriosis

- Ovarian Endometriomas
- Deep Infiltrating Endometriosis (DIE)
  - Colorectal: Superficial, Muscularis, Cicatrising, Multi level
  - Urological: Bladder superficial & deep, Ureteric encasing, obstructive
- Concurrent Adenomyosis
- Extrapelvic Disease (Upper abdomen, Thoracic cavity, elsewhere)
- Caesarean Scar Endometriomas

Ovarian Endometriomas

- Large, multiple and bilateral main concern re fertility and impact of expectant and surgery
- Ovarian Endometriomas greater than 3cm excision recommended
- Drainage waste of time 80-100% recuurence
- Preop AMH should be considered for all Ovarian disease with or without surgery
- Preop Oocyte cryopreservation should be discussed
- Surgery for Ovarian Endometriomas has not been shown to improve the outcome of IVF but it does reduce oocyte reserve with fertility and age of menopause implications

Ovarian Endometriosis



Deep Infiltrating Endometriosis

- Rectovaginal Septum, Bowel, Bladder
- Excision recommended for pain management
- Recommendations lack concensus for Infertility
- Specific training and expertise required (Tertiary units with MDTs)
- Risks of complications of surgery may adversely affect subsequent fertility (Bleeding, infection, adhesions, anastamotic leaks, neurologic injuries: bladder and rectal dysfunction)

Endometriosis & Infertility

- All stages lower the monthly chance of pregnancy
- Multiple mechanisms:
  - Anatomical
  - Oocyte reserve
  - Follicular development, tubal transport, sperm phagocytosis, Endometrial receptivity (crossover studies)
- Surgery may be effective but also carries risk
- Much more likely to need ART/IVF and success rates often adversely impacted
- Ovarian disease lowers AMH/Ovarian Reserve
- Concurrent Adenomyosis negatively impacts on implantation
- Co-existent PCOS may partly compensate for reduced ovarian reserve in some women

Hysterectomy for Endometriosis

- Agreement that it is last line after family complete
- Curative for Adenomyosis
- Requires concurrent removal of endometriotic tissue to be effective in pain management otherwise just stops menstrual bleeding
- Concensus: Laparoscopic techniques superior to open
- Variations in recommendations for Ovarian removal and subsequent HRT regimes with or without Progesterone
- Overall 15% persistence/recurrence of pain if ovaries retained

Endometriosis Challenges

- Despite increasing awareness and Government funding challenges remain:
- Awareness for Medical Practitioners and Patients to minimise diagnostic and therapeutic delays
- Diagnosis: considerations for young teens, economic factors (public vs private)
- Training specialists for optimal surgical outcomes (RANZCOG, AGES, Covid Hangover)
- Post surgical
    - Fertility and the role of IVF and Assisted Reproductive Technologies (ART)
    - Residual pain syndromes with no residual macroscopic disease (after optimal surgery)
    - Adenomyosis

Pain Syndromes

- Require an intact neural system including the brain
- Usually some noxious stimulus to peripheral nerves (inflammatory)
- Altered processing at central level with persistence despite excision/resolution of primary stimulus
- Clinically pain onset soon after menses, possibly modulated by COC, persistence or breakthrough, Laparoscopy excision/ablation, rapid recurrence (faster than disease recurrence)
- Thereafter labelled as Endometriosis after Laparoscopic diagnosis no matter what stage
- Challenge begins at this point, Paradoxical effects of Narcotics on Neural sensitivity

Diagnosing Pain Syndromes

- Multiple Procedures (ideally from appropriately qualified Medical Specialists)
- It is very easy for ED doctors to label pelvic pain Endometriosis as a repetitive diagnosis
- Rapid recurrence of symptoms after optimal treatment of Stage 1, 2 disease (<12-18m)
- Increasing use of narcotic analgesia (which is counter-productive in neuropathic or functional pain syndromes)
- Normal (quality) USS and MRI results
- These girls/women need specialized Pain management after the surgery is "optimal".

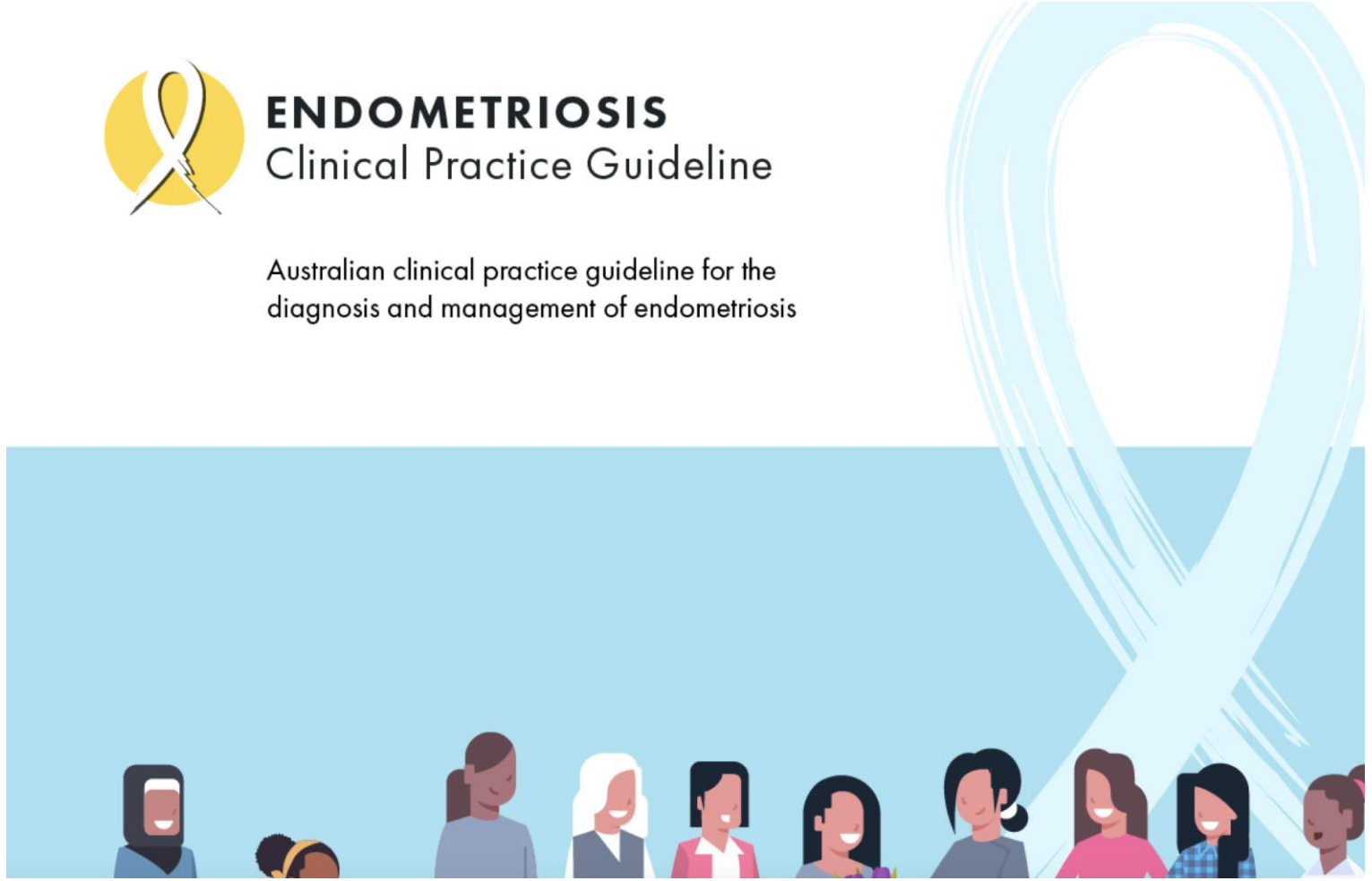
Managing Pain Syndromes

- MDTs are essential
- Optimal surgery Dx and Rx
- Then Specially trained Doctors, Nurses, Psychologists, Physiotherapists, other Allied Health Professionals
- Narcotics are counter productive
- Wholistic approach: diet exercise, lifestyle, etc
- CBT

National Action Plan July 2018 Minister Greg Hunt

- ACE – Australian Coalition for Endometriosis (comprising the following organisations)
  - Canberra Endometriosis Network
  - EndoActive
  - Endometriosis Australia
  - Pelvic Pain Foundation of Australia
  - Qendo – Queensland Endometriosis Association
- Australian Gynaecological Endoscopy and Surgery Society Limited
- Australian Longitudinal Study on Women's Health
- Canberra Endometriosis Centre
- Hudson Institute of Medical Research
- Jean Hailes for Women's Health
- Mercy Health
- Monash University
- Parliamentary Friends for Endometriosis Awareness Group
  - Gai Brodtmann MP
  - Nicolle Flint MP
  - The Hon Catherine King MP
  - Nola Marino MP
  - Maria Vamvakinou MP
- Pelvic Pain SA
- Robinson Research Institute
- The Royal Children's Hospital Melbourne
- The Royal Hospital for Women, Sydney
- The Royal Women's Hospital Victoria Australia
- The University of Adelaide
- The University of Melbourne
- The University of Queensland
- University of New South Wales
- WHoA! – Women's Health of Australia
- World Endometriosis Society

RANZCOG Australian Guidelines



Multiple Guidelines

Kalaitzopoulos *et al. BMC Women's Health* (2021) 21:397
https://doi.org/10.1186/s12905-021-01545-5

BMC Women's Health

REVIEW Open Access

Treatment of endometriosis: a review with comparison of 8 guidelines

Dimitrios Rafail Kalaitzopoulos[1,3*], Nicolas Samartzis[1], Georgios N. Kolovos[1], Evangelia Mareti[2], Eleftherios Pierre Samartzis[3], Markus Eberhard[1], Kostantinos Dinas[2] and Angelos Daniilidis[2]

Abstract

Background: Endometriosis, the presence of endometrial-like tissue outside the uterus, is a common clinical entity between women of reproductive age, with a prevalence of about 10%. Due to the variety of endometriosis-associated symptoms, a great variety of treatments have been implemented. The aim of this review is to give an overview on therapeutical approaches of eight national and international widely used guidelines.

Methods: Six national (College National des Gynecologues et Obstetriciens Francais, National German Guideline (S2k), Society of Obstetricians and Gynaecologists of Canada, American College of Obstetricians (ACOG) and Gynecologists, American Society for Reproductive Medicine (ASRM) and National Institute for Health and Care (NICE) and two international (World Endometriosis Society, European Society of Human Reproduction and Embryology) guidelines are included in this review.

Endometriosis Guidelines

- WES (World Endometriosis Society)
- ESHRE (European Society for Human Reproduction & Embryology)
- ASRM (American Society for Reproductive Medicine)
- NICE (National Institute for Health and Care UK)
- ACOG (American College of Obstetrics & Gynecology)
- SOGC (Society of O&G Canada)
- CNGOF (France)
- National German Guideline (S2K)

Guidelines

- Agree on role of Combined Oral Contraceptives and Progestins in Pain Management
- No Concensus on role of surgery for Infertility
- Discrepencies in role of second and third generation therapies
- Robotic Vs Laparoscopic (No benefit, longer operating times in Robotic)
- Avoid Multiple Surgeries (Adhesions, Ovarian Reserve considerations)
- Mild Endometriosis Excision recommended Live Birth Ratio increased 1.95

Government Funding

Australia

The government has announced record funding for endometriosis support. Does it go far enough?

Experts say while the federal government's announcement of $58 million in funding to improve diagnosis, treatment and support for people with endometriosis is welcome, there's still a long way to go.

7 min read

Published 25 March 2022 at 8:49pm

By Amy Hall

Source: SBS

Tags

Morrison Govt Plans 22-23 Budget $58M

$16.4M for Specialised Endometriosis and Pelvic Pain Clinics in every State and Territory

$25.2M for MRI scans to assist Dx

$5.1M Endometriosis Management Plans in Primary Care

$5.1M Research Scholarships , National Endometriosis Clinical and Scientific Trials

$2.5M for Australian Clinical Practice Guidelines (Living Guideline - Best Practice Updates)

$2M for awareness and education through Australian Coalition for Endometriosis and Workplace Assistance

$300k for MBS and PBS items for diagnosis and treatment

Albanese Government 2022-3

Ministers
Department of Health and Aged Care

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Improving fertility outcomes for women with endometriosis

The Australian Government is providing almost $700,000 to fund new research investigating the impact of endometriosis on women's fertility.

Print

The Hon Ged Kearney MP
Assistant Minister for Health and Aged Care

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Albanese Labor Government 23

The Albanese Government is providing almost $700,000 to fund new research investigating the impact of endometriosis on women's fertility.

Endometriosis is a painful, often debilitating and incurable condition which affects 1 in 9 Australian women. Sufferers can experience a range of symptoms that impact their daily lives, including severe pelvic pain and struggling to fall pregnant.

Despite affecting so many women, it is not fully understood what impact endometriosis has on women's fertility, implications for fertility treatments, outcomes during pregnancy and for their newborn babies.

This important research will advance our understanding of the condition in order to inform better treatment and care.

The EndoLinked project will study reproductive and maternal outcomes, including the effect of fertility treatments, for Australian women with endometriosis compared with those of women without the condition.

The project will also assess any health impacts for newborn babies born to women with endometriosis and determine if there are any linked issues.

Women with endometriosis often undergo surgery to remove the tissue and cysts which grow on on the ovaries and other organs, sometimes requiring multiple surgeries. The EndoLinked project will compare women who have had surgery with women who have not had surgery, to see if there are different results with fertility treatments.

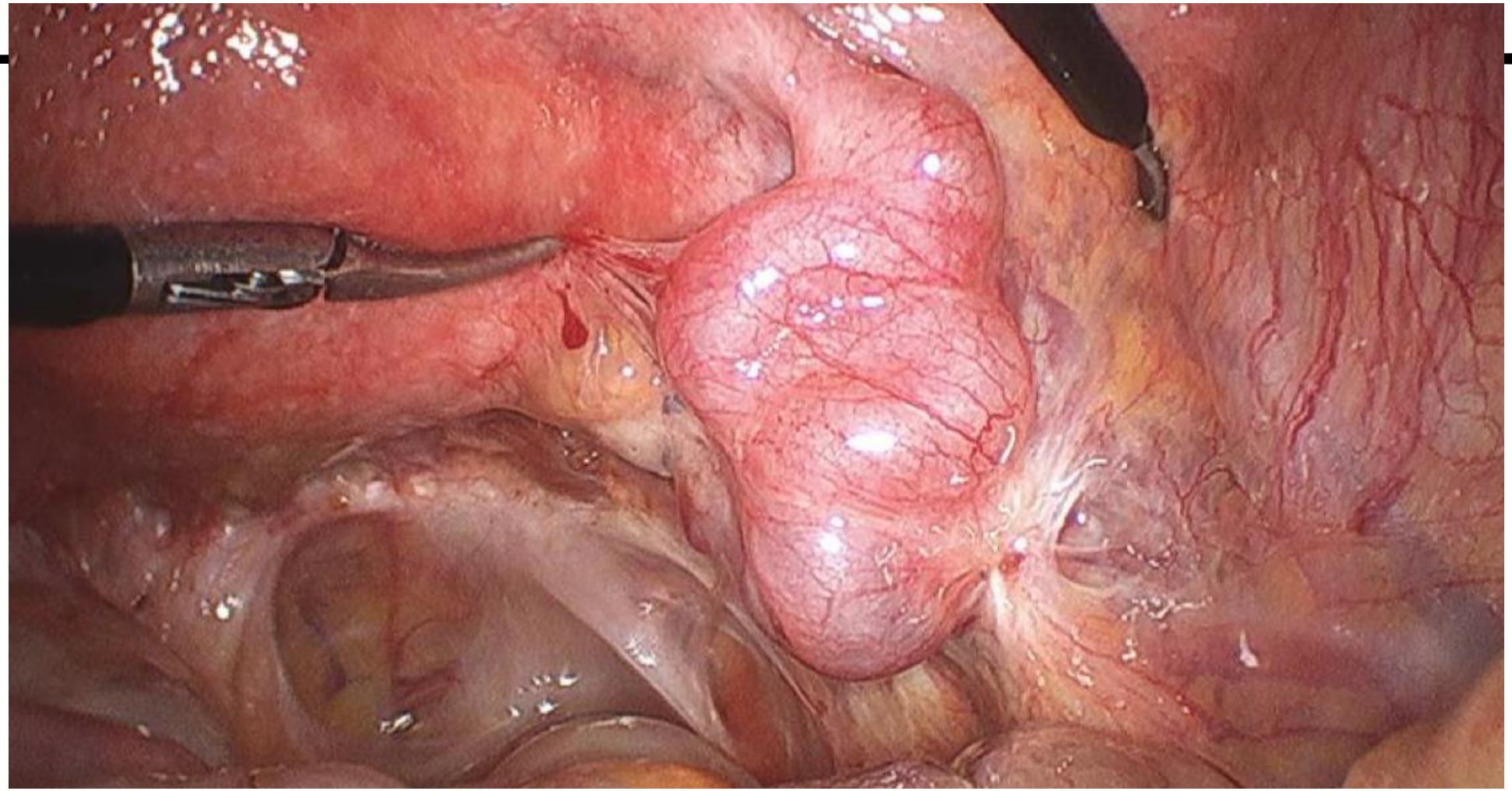
The EndoLinked project will also inform the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Endometriosis Clinical Practice Guidelines which will help doctors diagnose and manage endometriosis with their patients. This will more broadly help all women living with endometriosis.

This important investment is from the Australian Government's $20 billion Medical Research Future Fund, is part of the Research Data Infrastructure grant opportunity, which provided more than $12.2 million across five medical research projects.

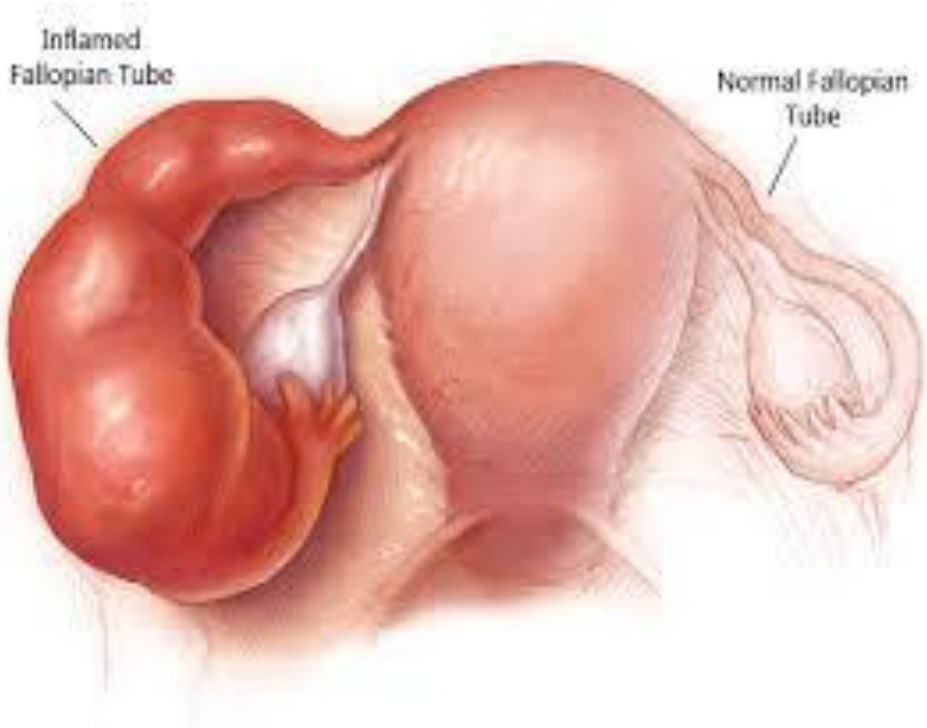
Other Causes of Pelvic Pain

- PID - Acute and Chronic
- Adenomyosis
- Congenital anomalies - obstructive
- PCOS ??
- Fibroids??
- Non Gynae - IBS, IBD
- Pain Syndromes, Psychosomatic (Sexual Assault/Trauma/Abuse)

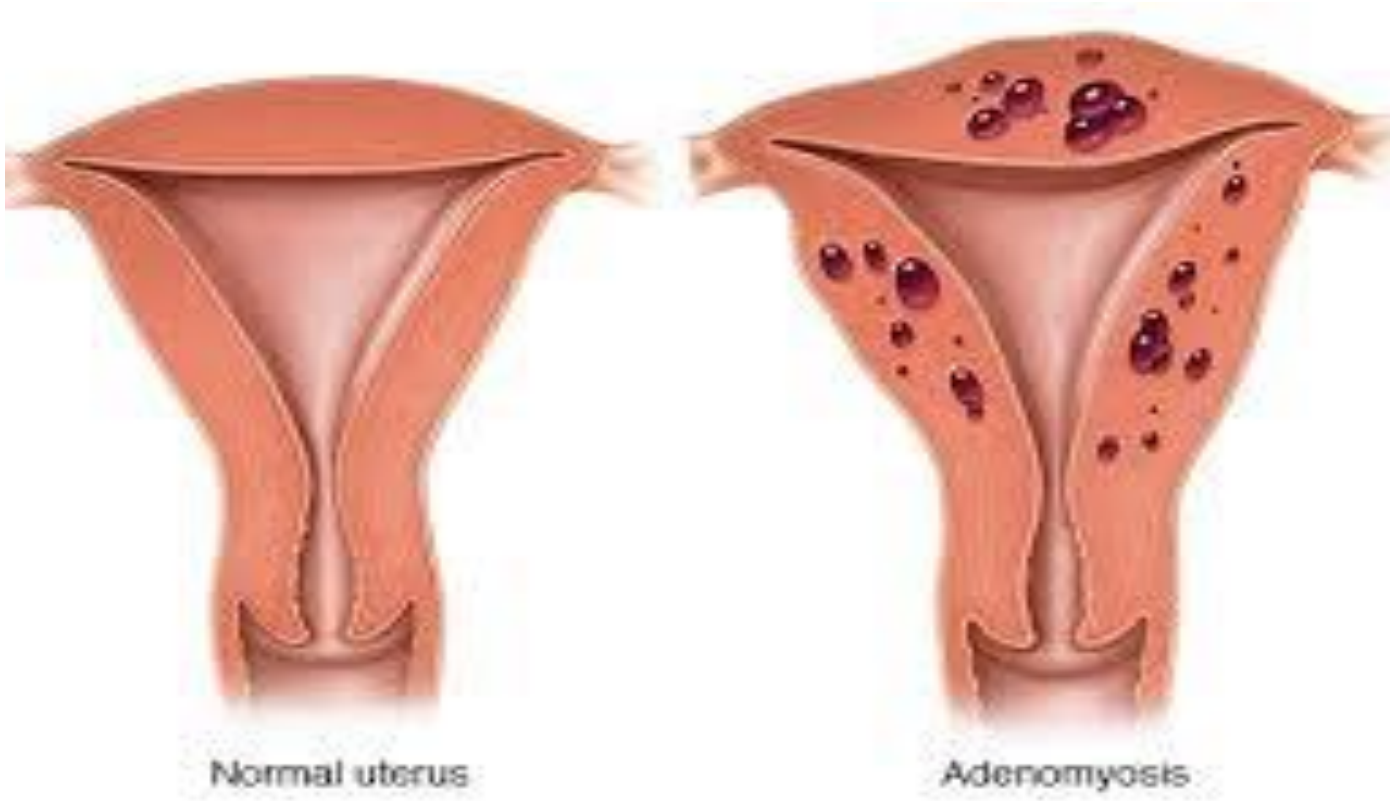
PID



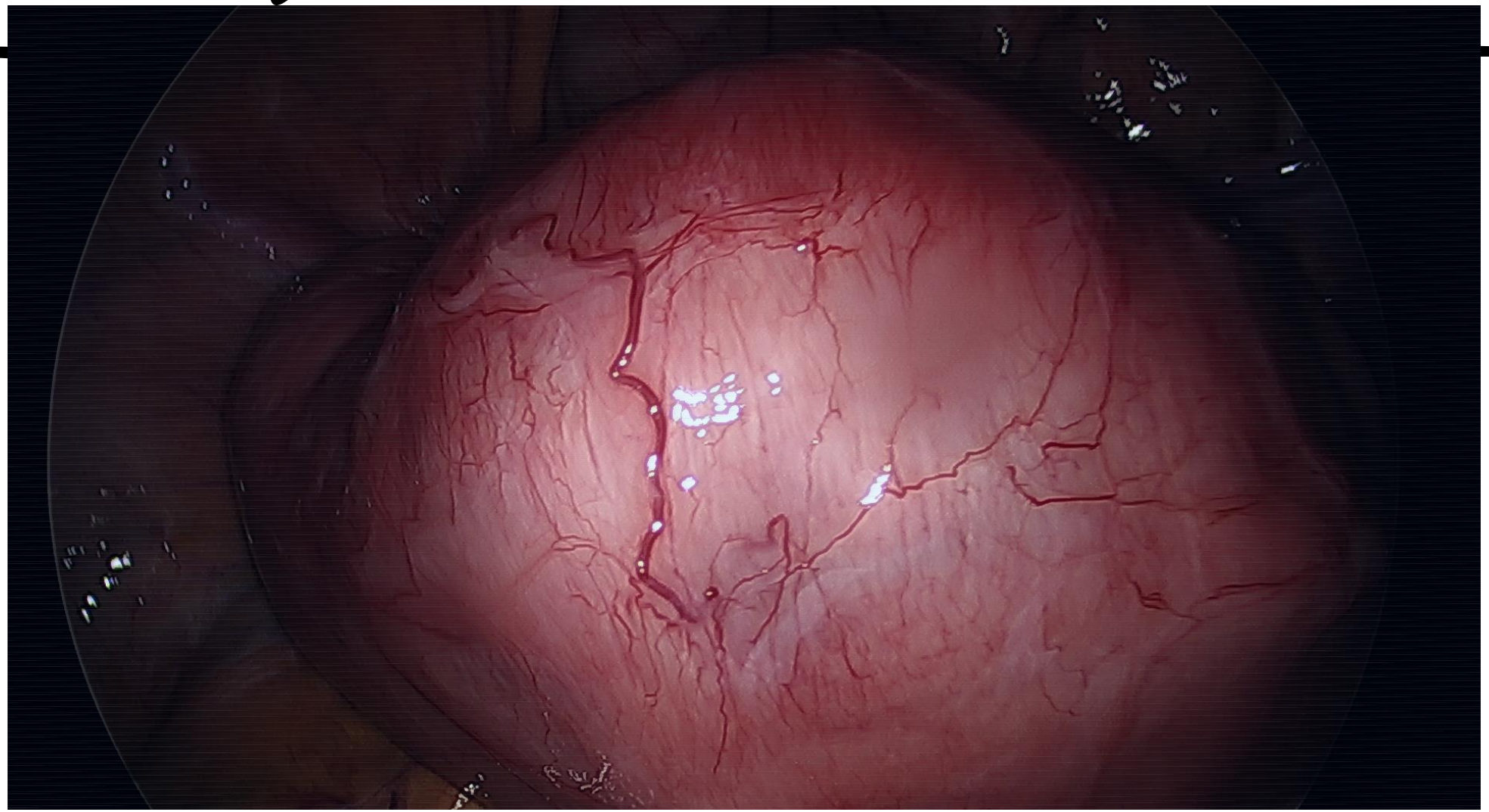
PID



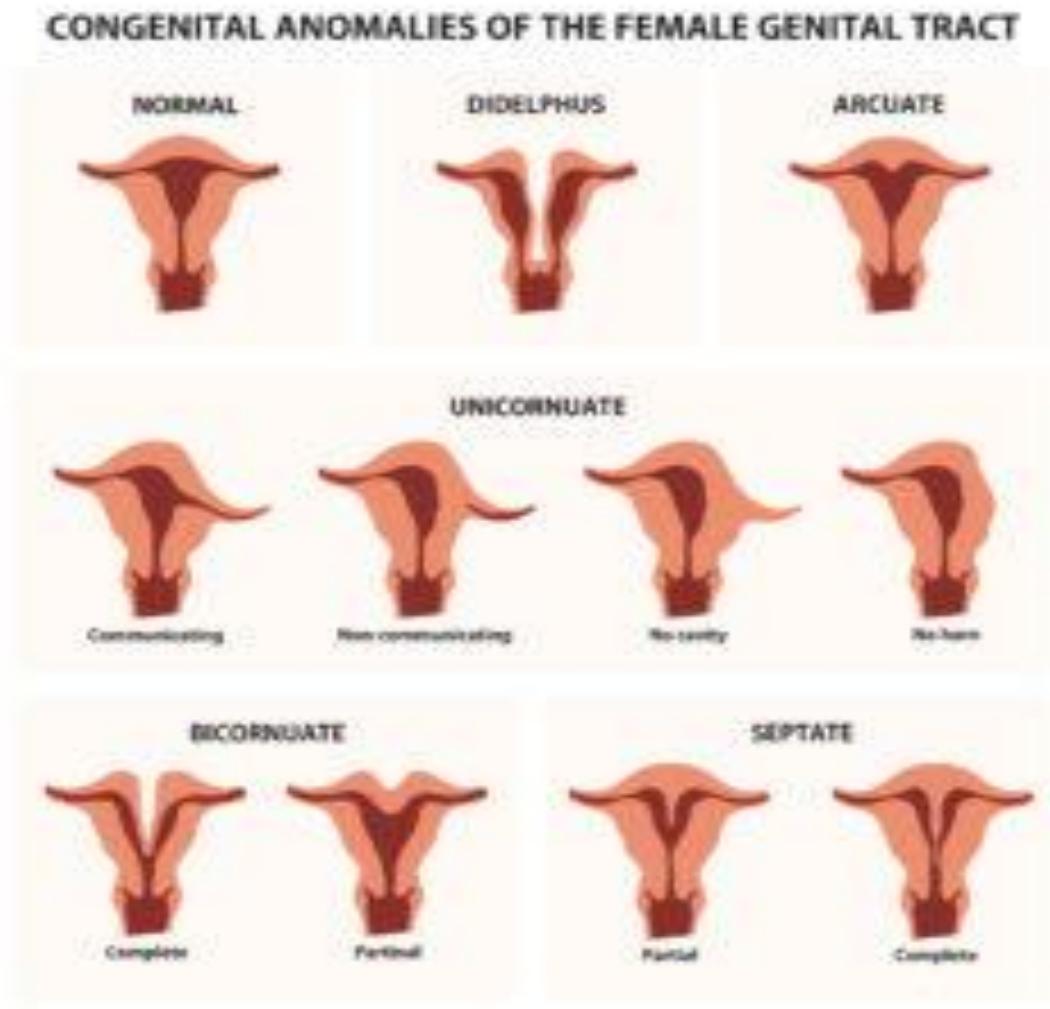
Adenomyosis



Adenomyosis



Congenital Anolmalies



Take Home Messages

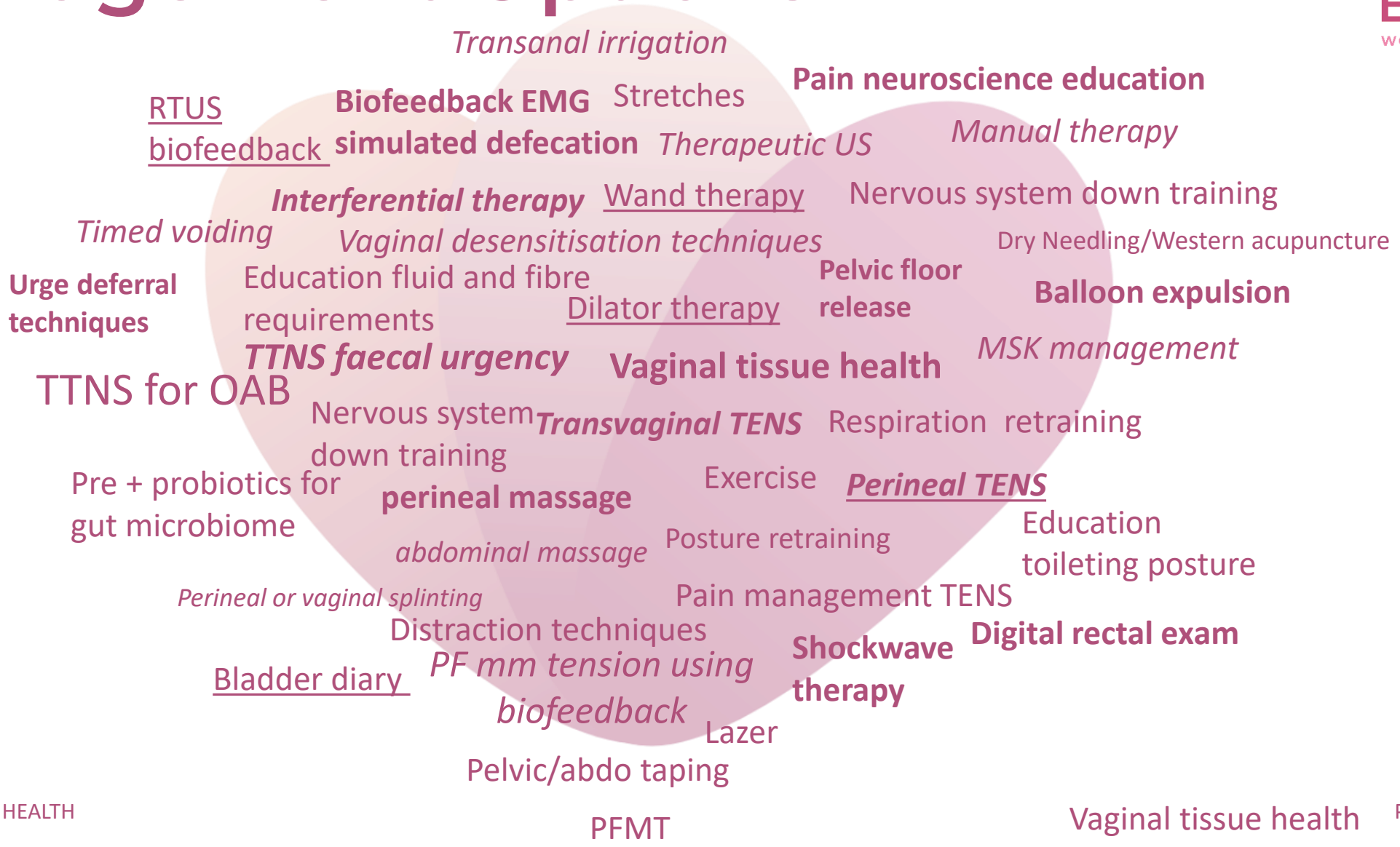
- Suspect Endometriosis in reproductive age women with appropriate symptoms
- Investigate first line Examination, Imaging (USS, MRI) & Exclude alternate causes (PID, GIT)
- First line empirical management Vs refer for definitive diagnosis
- Laparoscopy for Diagnosis and Optimal Surgical Management, Fertility assessment (AMH)
- Ongoing management
  - Cycle suppression/Symptom management
  - Fertility planning
  - Recurrent disease/symptoms/Pain syndromes

FERTILITY · OBSTETRICS · GYNAECOLOGY
SHE MEDICAL

Physiotherapy management of Pelvic Pain

Phoebe Armfield

Pelvic Physiotherapy Management Options



Pelvic Floor Dyssynergia

Types of dyssynergic defecation

Type I: Abdominal pushing force is adequate, but is associated with a paradoxical increase in anal sphincter pressure.
Type II: Inadequate abdominal pushing force, and a paradoxical anal sphincter contraction.
Type III: Abdominal pushing force is adequate but, either there is absent or incomplete anal sphincter relaxation.
Type IV: Inadequate abdominal pushing and absent or incomplete anal sphincter relaxation.

Tantiphlachiva K, Rao P, Attaluri A et al. Digital rectal examination is a useful tool for identifying patients with dyssynergia. Clin Gastroenterol Hepatol. 2010;8(11):955–960.

Bowel involvement in Endometriosis

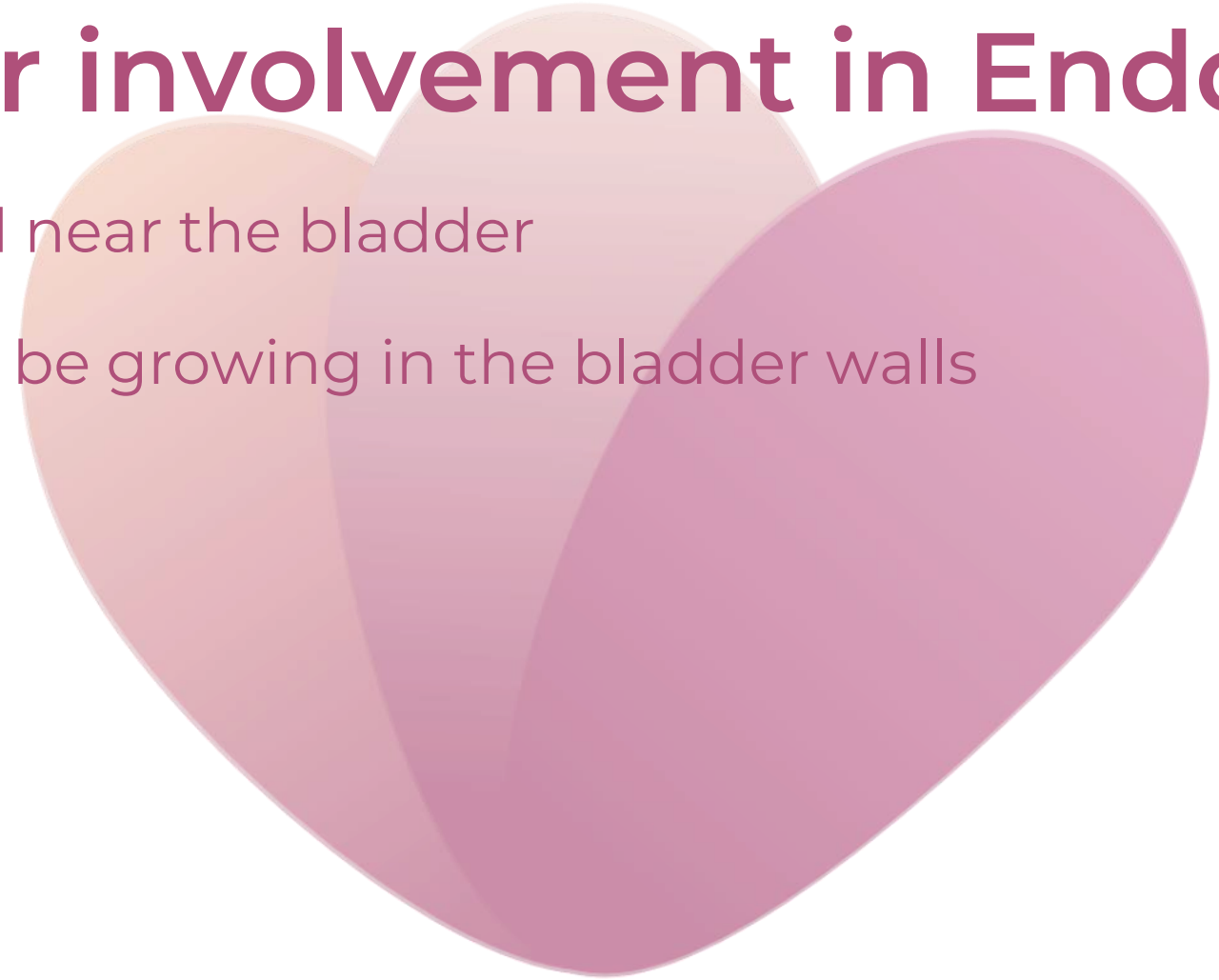
3-37% bowel infiltration involvement (Wolthuis et al 2014)

80-90% Bowel Symptoms (Centreforendo.com 2023)

Bladder involvement in Endo

20-50% found near the bladder

1-6% found to be growing in the bladder walls



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How do we manage pelvic floor dyssynergia?

Case Study

23 year old female

C/O abdominal pain RLQ and LLQ and bloating, vulva and rectal pain during flare up

Hx: dysmenorrhea, dyspareunia, childhood traumatic car accident, hypermobility

Ex gymnast, menses began at 16 painful from onset, in long term relationship with supportive partner

Meds: sporadic coloxyl with senna when feeling constipated, sporadic pain relief, previous marina and oral contraceptive pill but has ceased both

Bladder Sx: urine frequency 10-12 times 24/24, urgency when bladder is full or will leak

Bowel Sx: opens bowels daily, strains, incomplete evacuation sometimes, Type 2 & 7 BSS

Sexual function: deep pain on penetration at certain times especially around her period

Ax: Anal manometry: rectal hypersensitivity, anismus

Faecal loading on RTUS

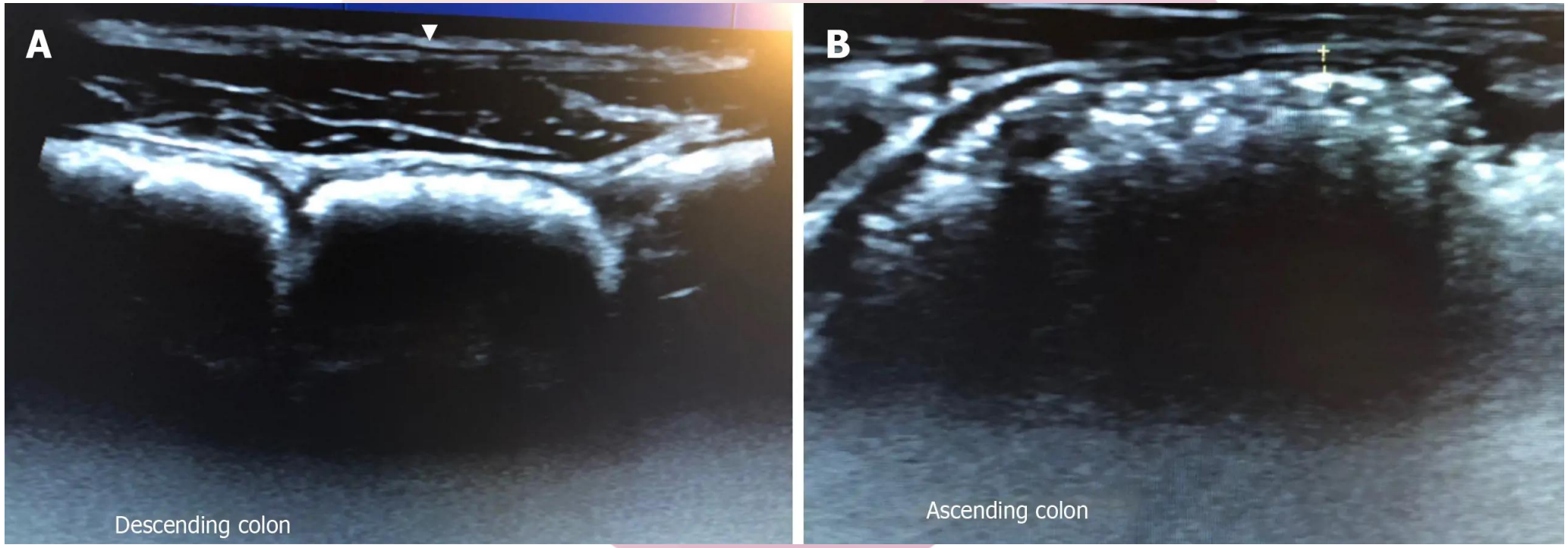
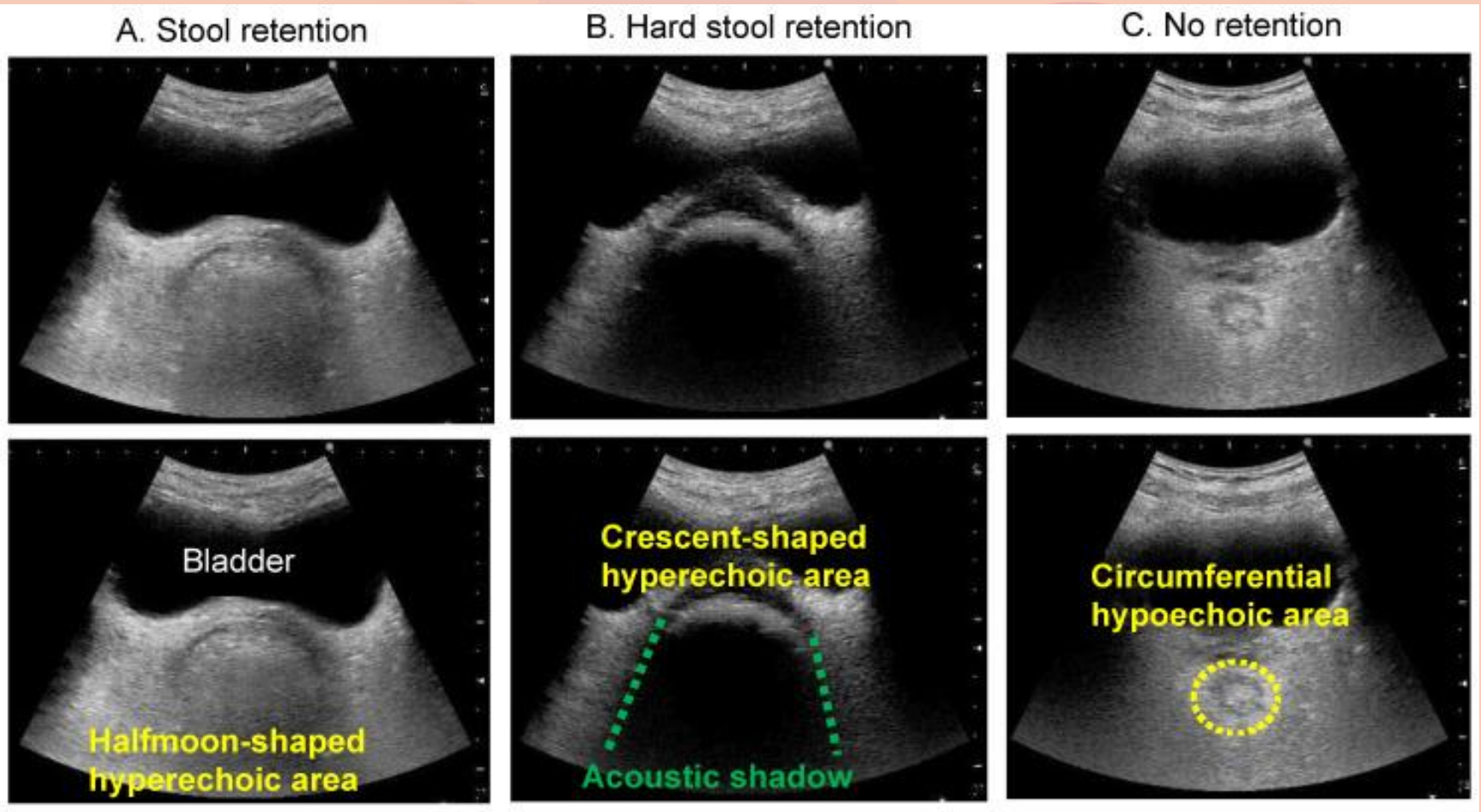


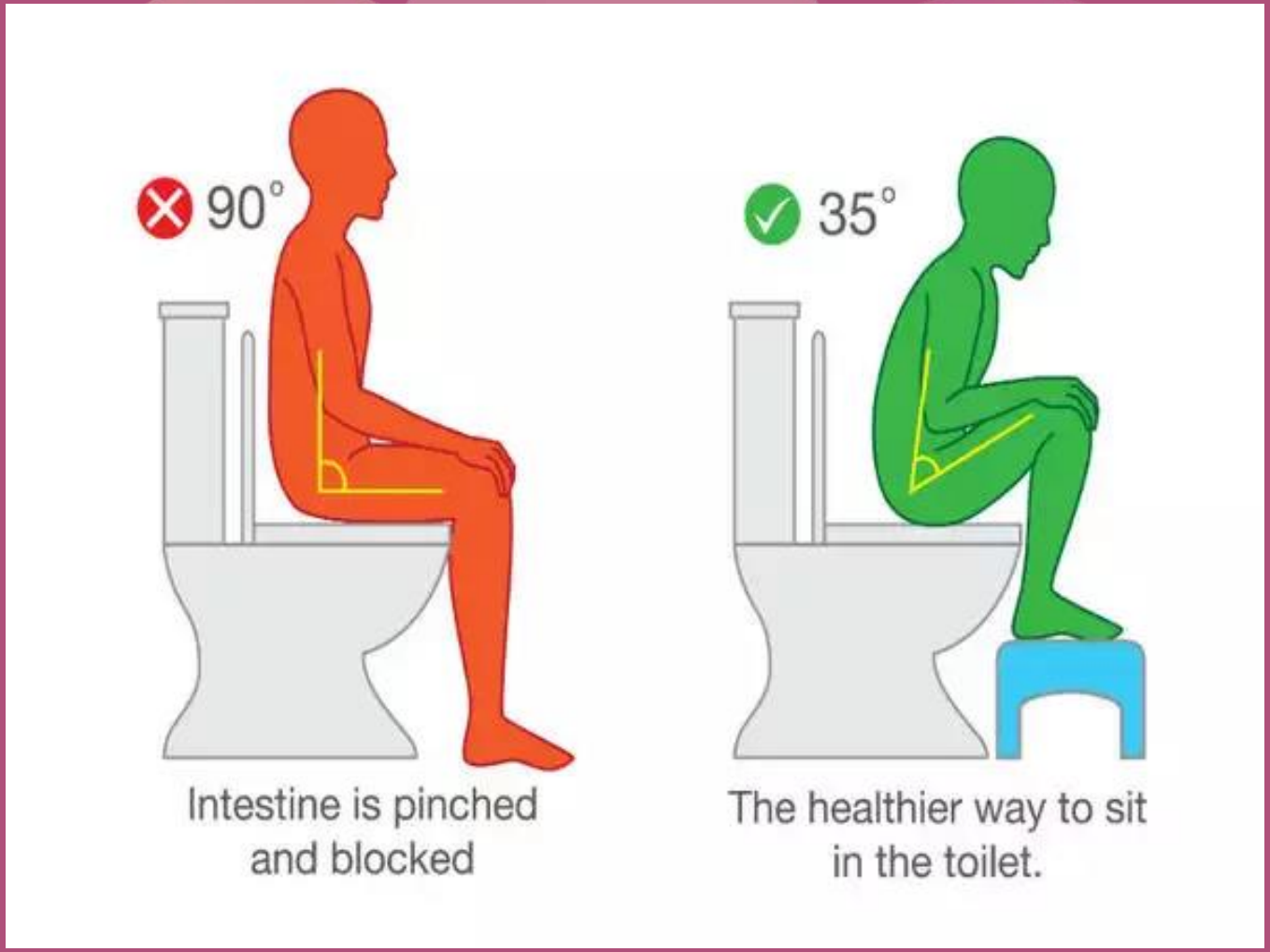
Image: Utility of gastrointestinal ultrasound in functional gastrointestinal disorders: A narrative review

Faecal loading in rectum



Measuring the rectal dome on transabdominal ultrasound can help assess faecal loading in the rectum. Joensson et al (2008)

Toilet postures & defecation

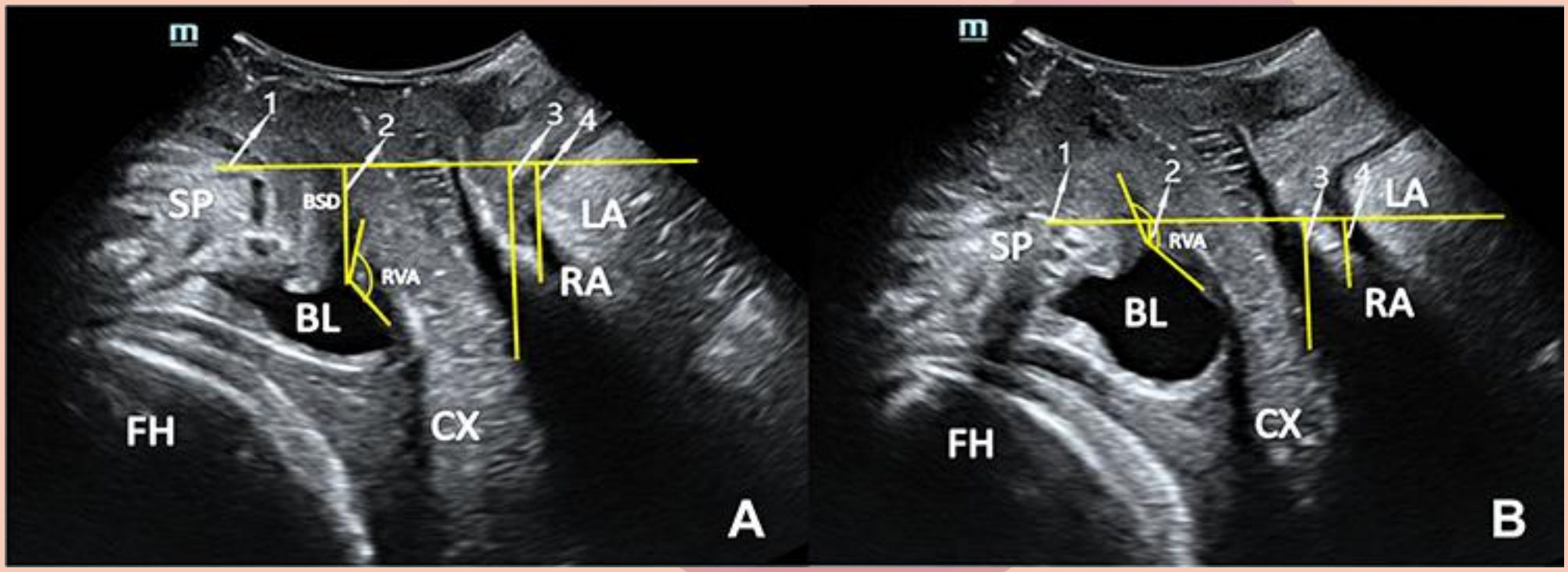


EMG Biofeedback

Biofeedback using EMG is effective in improving symptoms and anorectal function caused by paradoxical puborectalis contraction. Glia et al (1997)

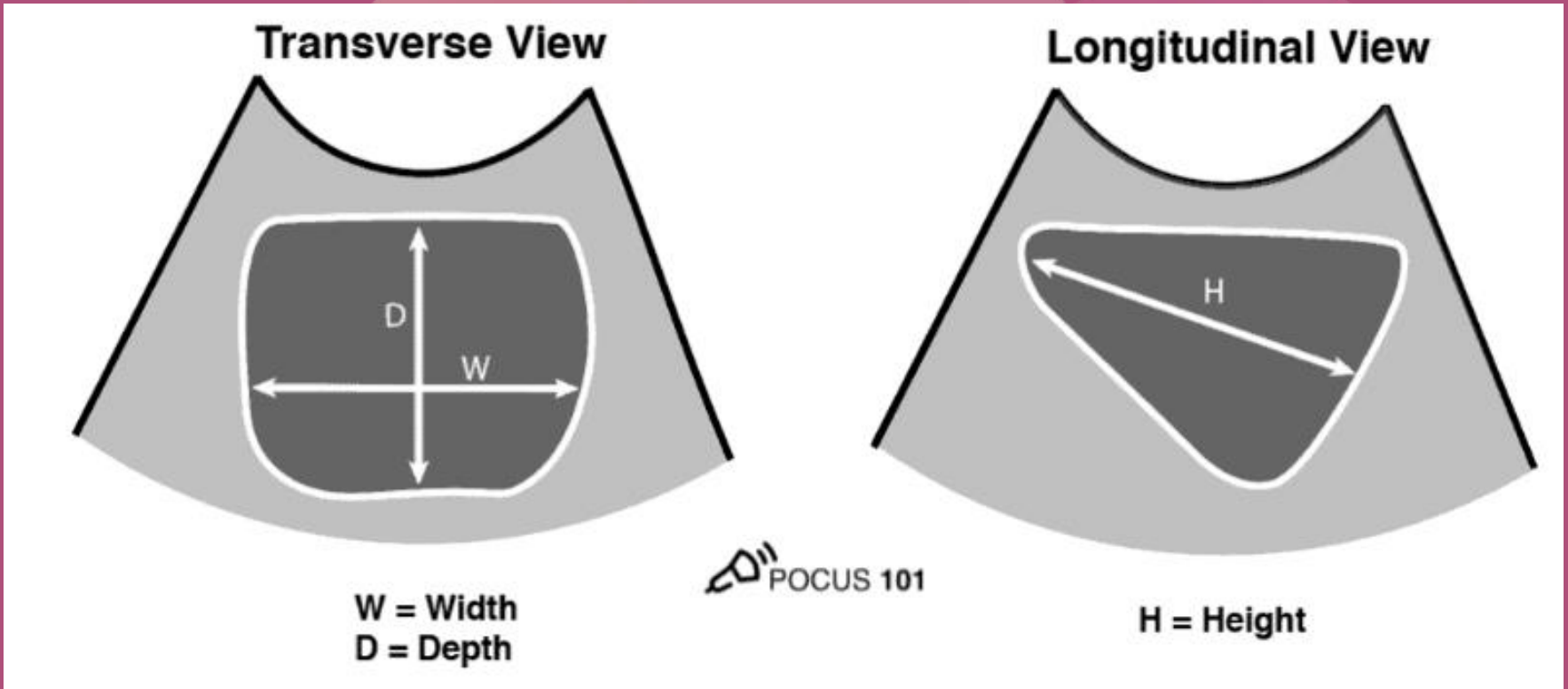
EMG Biofeedback

Transperineal US



Transperineal US is a useful tool to assess and retrain anorectal angle during simulated defecation
García-Mejido et al (2022)

Transabdominal Bladder US



https://www.pocus101.com/bladder-volume-ultrasound-calculator/

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Thank You

Q & A Panel

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Elysian WOMEN'S HEALTH

MEDICAL SUPER CLINIC BENOWA

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