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WOMEN'S HEALTH

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SQUARE

Inaugural Issue

Editorial Note:

Dear Doctor, It's our immense pleasure to inform you that we have published our new newsletter, "Women's Health". In this newsletter we will concentrate on different news, publications, update on drugs, diseases, etc. related to women's health. Your comments and suggestions will enrich our upcoming issues. Please participate in quiz competition and win prizes.

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Chronic Pelvic Pain in Women

Chronic Pelvic Pain (CPP) is defined as recurrent pain of at least 6 months' duration, unrelated to periods, intercourse or pregnancy. The pain may be steady or it may come and go. It can feel like a dull ache, or it can be sharp. The pain may be mild, or it may be bad enough to interfere with normal daily activities. It is a frequent complaint encountered at the gynecological outpatient department worldwide.

Clinical Assessment:

For patients presenting with CPP, the gynecological history needs to be sufficiently broad keeping the different causes of CPP in mind. Table-1 gives an idea about the common gynecological as well as common non-gynecological causes of CPP. While it is comparatively easy to diagnose the cyclic CPP, it is indeed difficult at times to reach a diagnosis of acyclic and the non-gynecological group. Usually a meticulous history taking, a thorough abdominal and vaginal examination and appropriate investigations are enough to reach the diagnosis.

A detailed pain history needs to include the onset and duration of symptoms, the exact location and radiation of pain, factors associated with exacerbation and relief and the relationship of pain to the menstrual cycle. Dysmenorrhoea may be a related or separate symptom. Dyspareunia may include pain during intercourse, but for many women a particular unpleasant symptom is post-coital pain and specific enquiry should be made about this. Any history suggestive of pelvic inflammatory disease (PID) or chronic ectopic should be explored. History of using intrauterine contraceptive device is important.

Physicians can ask the patients following the general guideline:

- Is the pain related to your menstrual cycle?
- Is it related to bowel movements?
- Does it hurt during urination or sexual activity?

Table-1. Potential Causes of Chronic Pelvic Pain

Uterine
▫ Dysmenorrhea (primary or secondary, eg, cervical stenosis)
▫ Adenomyosis
▫ Fibroids
▫ Positional (prolapse)
▫ Pelvic congestion
Adnexal
▫ Adhesive disease (infection, postsurgical)
▫ Neoplasm
▫ Functional ovarian cysts
▫ Endometriosis
Peritoneal
▫ Endometriosis
▫ Adhesive disease
GI
▫ IBS
▫ Other bowel disease (eg, colitis)
Urinary
Musculoskeletal
Psychogenic (eg, sexual abuse)
Congenital/anatomic
Neurologic (eg, neuroma)

- Have you had an infection?
- Have you had surgery in your pelvic area?

Many women with CPP will finally turn out to have irritable bowel syndrome (IBS) as their primary problem. Therefore it is particularly important to take a detailed history.

Bladder symptoms such as urinary frequency and urgency with a tendency of exacerbation of pain associated with a full bladder indicate cystitis.

Sometimes when there is a dilemma about the exact etiology leading to CPP, many gynecologists prefer to do the following guidelines:

Table-2: Rome II criteria for diagnosis of irritable bowel syndrome

At least 12 weeks, which need not be consecutive, in the preceding 12 months of abdominal discomfort of pain that has two out of three of these features:

1. Relieved with defecation
2. Onset associated with a change in frequency of stool
3. Onset associated with a change in form (appearance) of stool

Pessary test:

Usually applied in case of a retroverted uterus or a slight degree of uterine descent. If symptoms are relieved after pessary insertion, surgical correction is advised.

Combined Oral contraceptive pills (OCP):

Prescribed when functional cysts are suspected to be the cause of CPP. OCPs are given for 3 months in that hope that the cyst will possibly regress leading to relief of symptoms.

Physical examination:

The abdominal examination should focus on distinguishing visceral from abdominal wall tenderness. Vaginal examination should commence with a careful inspection of the vulva and introitus. A gentle one finger digital examination commences with palpation of the pelvic floor muscles. Focal tenderness may be present, indicting a primary musculoskeletal problem that should prompt referral to a pelvic floor physiotherapist for further assessment. As with vestibulodynia, pelvic muscle tenderness may be a residual secondary response to pain from other part of the pelvis, for example, a previous episode of pelvic infection. Further digital examination may reveal nodularity in the pouch of Douglas or restricted uterine mobility suggestive of endometriosis. Adenomyosis may be suggested by a bulky tender uterus. Uterine retroversion should be noted although its relevance to dyspareunia is debatable. Adnexal rather than uterine tenderness may point to pelvic congestion syndrome.

Investigations:

- Endocervical Swabs:

  It is often useful to exclude the possibility of ongoing pelvic infection such as by clamydia.

- Ultrasonography:

  Abdominal as well as the transvaginal (TVS) sonographic examination may be useful in identifying uterine or adnexal pathology and has been shown to be an effective means of providing reassurance. The presence of dilated veins may indicate pelvic congestion but a recent study using USG power Doppler suggested that the primary value of sonography was to identify the characteristic multicystic ovarian morphology seen in this condition.

- Transuterine venography:

  It is of limited value in routine clinical practice but is technically simpler than selective catheterization of the ovarian vein.

- MRI:

  It provides the opportunity to identify adenomyosis but is not routinely indicated.

- Laparoscopy:

  It is commonly undertaken as the investigation of choice for CPP. The aims are to give a diagnosis but also to provide 'one-stop' treatment for endometriosis and adhesions where these are identified.

  A negative finding can also assures the clinician and relieve the phychosomatic factor related with CPP.

American College of Obstetricians and Gynecologists (ACOG) guideline for diagnostic algorithm for CPP is shown in Figure 1.

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Specific treatments for CPP: Evidence from randomized trials

Limited randomized controlled trial (RCT) evidence is available to guide treatment decisions in CPP.

- Treatment is generally directed towards the cause if any is found.
- Hormonal therapy aims to achieve benefit in a non specific manner by inhibiting ovarian activity, based on the observation that many patients with CPP experience resolution at the time of the menopause.
- Relaxation exercises, biofeedback (treatment to control emotional states using electronic devices) and physical therapy aim to enhance coping skills and reduce pain-associated distress.
- NSAIDs are effective to relieve pain.
- Low dose tricyclic anti-depressants are useful for chronic neuropathic pain.
- Multidisciplinary approach (progerterone + psychotherapy + mood elevators) proved to be useful in some cases.
- Surgical:

  Patients with severe adhesions showed improvement following adhesionolysis but patients with mild adhesions did not show a significant benefit for surgery.
- Static magnetic therapy:

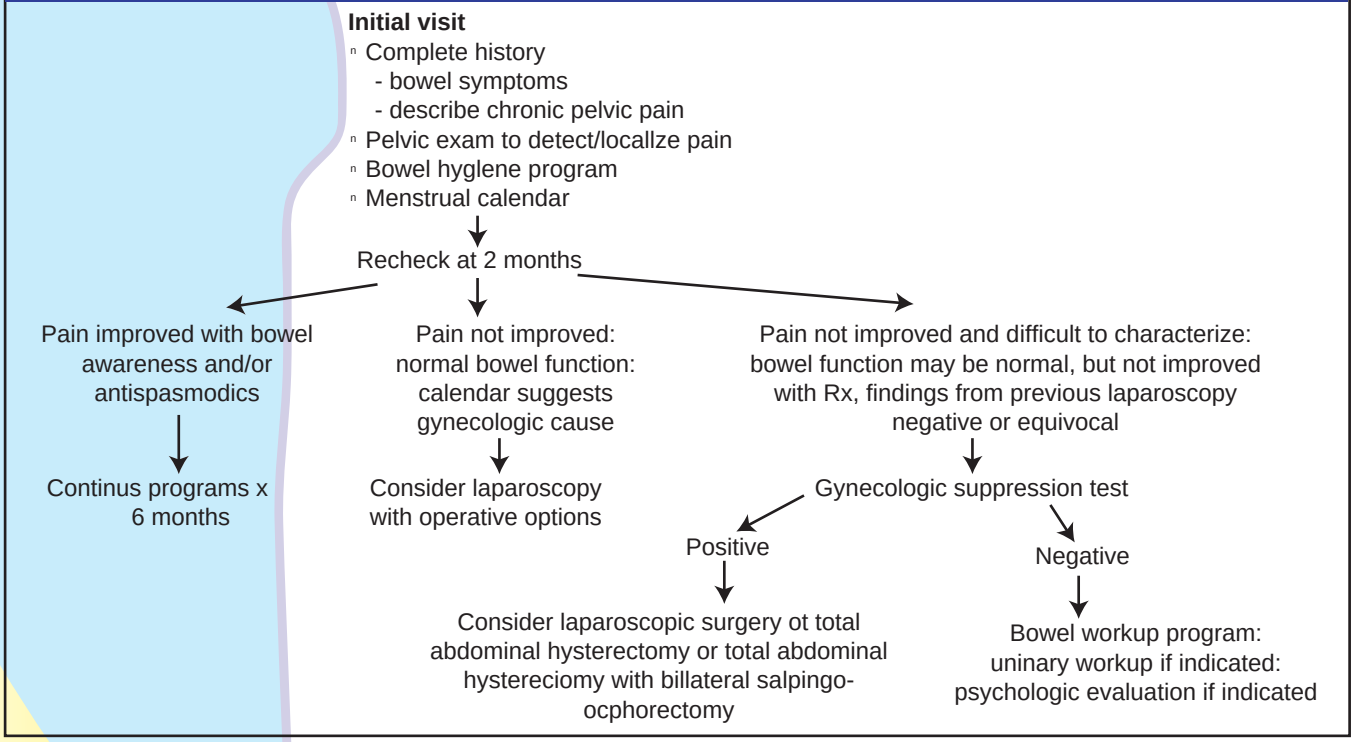
  The effects of wearing small magnets as therapy for CPP versus placebo showed some significant improvement after 4 weeks use.
- Treatment dilemmas:

  Women may seek hysterectomy and oophorectomy as a solution to long-standing CPP. The evidence from observational studies is encouraging but this is naturally a treatment of last resort.
- Radiological embolization:

  Embolization of pelvic varices now offers a promising result.

Source: OBGYN.net

Figure 1. Diagnostic algorithm for chronic pelvic pain



Pelvic Congestion Syndrome

Non-Surgical Procedure is Effective Treatment for Painful Ovarian Varicose Veins

It is estimated that one-third of all women will experience chronic pelvic pain in their lifetime. Many of these women are told the problem is "all in their head" but recent advancements now show the pain may be due to hard to detect varicose veins in the pelvis, known as pelvic congestion syndrome.

The causes of chronic pelvic pain are varied, but are often associated with the presence of ovarian and pelvic varicose veins. Pelvic congestion syndrome is similar to varicose veins in the legs. In both cases, the valves in the veins that help return blood to the heart against gravity become weakened and don't close properly, this allows blood to flow backwards and pool in the vein causing pressure and bulging veins. In the pelvis, varicose veins can cause pain and affect the uterus, ovaries and vulva. Up to 15 percent of women, generally between the ages of 20 and 50, have varicose veins in the pelvis, although not all experience symptoms.

The diagnosis if often missed because women lie down for a pelvic exam, relieving pressure from the ovarian veins, so that the veins no longer bulge with blood as they do while a woman is standing.

Many women with pelvic congestion syndrome spend many years trying to get an answer to why they have this chronic pelvic pain. Living with chronic pelvic pain is difficult and affects not only the woman directly, but also her interactions with her family, friends, and her general outlook on life. Because the cause of the pelvic pain is not diagnosed, no therapy is provided even though there is therapy available.

Prevalence

- Women with pelvic congestion syndrome are typically less than 45 years old and in their child bearing years.
- Ovarian veins increase in size related to previous pregnancies. Pelvic congestion syndrome is unusual in women who have not been pregnant.
- Studies show 30% of patients with chronic pelvic pain have pelvic congestion syndrome (PCS) as a sole cause of their pain and an additional 15% have PCS along with another pelvic pathology.

Risk Factors

- Two or more pregnancies and hormonal increases
- Fullness of leg veins
- Polycystic ovaries
- Hormonal dysfunction

Symptoms

The chronic pain that is associated with this disease is usually dull and aching. The pain is usually felt in the lower abdomen and lower back. The pain often increases during the following times:

- Following intercourse
- Menstrual periods
- When tired or when standing (worse at end of day)
- Pregnancy

Other symptoms include

- Irritable bladder
- Abnormal menstrual bleeding
- Vaginal discharge
- Varicose veins on vulva, buttocks or thigh

Treatment Options

Once a diagnosis is made, if the patient is symptomatic, an embolization should be done. Embolization is a minimally invasive procedure performed by interventional radiologists using imaging for guidance. During the outpatient procedure, the interventional radiologist inserts a thin catheter, about the size of a strand of spaghetti, into the femoral vein in the groin and guides it to the affected vein using X-ray guidance. To seal the faulty, enlarged vein and relieve painful pressure, an interventional radiologist inserts tiny coils often with a sclerosing agent (the same type of material used to treat varicose veins) to close the vein. After treatment, patients can return to normal activities immediately.

Additional treatments are available depending on the severity of the woman's symptoms. Analgesics may be prescribed to reduce the pain. Hormones such birth control pills decrease a woman's hormone level causing menstruation to stop may be helpful in controlling her symptoms. Surgical options include a hysterectomy with removal of ovaries, and tying off or removing the veins.

Efficacy

In addition to being less expensive to surgery and much less invasive, embolization offers a safe, effective, minimally invasive treatment option that restores patients to normal. The procedure is very commonly successful in blocking the abnormal blood flow. It is successfully performed in 95-100 percent of cases. A large percentage of women have improvement in their symptoms, between 85-95 percent of women are improved after the procedure. Although women are usually improved, the veins are never normal and in some cases other pelvic veins are also affected which may require further treatment.

Source: 2008 Society of Interventional Radiology website

Smoking, Alcohol Among Risk Factors for Vulvar/vaginal Carcinoma

Risk factors for invasive squamous cell carcinoma of the vulva and vagina include human papillomavirus (HPV) infection, tobacco smoking, and alcohol consumption. In a population-based, case-control study, Dr. Morten Frisch, of Statens Serum Institut in Copenhagen, and colleagues looked for etiological factors that might influence the risk of vulvar and vaginal squamous cell carcinomas (VV-SCC). They also tried to determine identify etiological differences between cases with vaginal involvement (VV-SCCvagina) and cases restricted to the vulva (VV-SCCvulva). Between July 1997 and July 2002, the researchers interviewed 182 women with invasive VV-SCC (116 with VV-SCCvulva and 66 with VV-SCCvagina), 164 control subjects with uterine corpus cancer, and 518 population controls. Eighty-seven (48%) of the VV-SCC cases had tissue samples examined for HPV DNA by polymerase chain reaction. The researchers report that specimens from 54 (62%) women were positive for HPV types associated with a high risk of cervical cancer and one (1%) was positive for a low-risk HPV type. Overall, 89% of tumors from patients with VV-SCCvagina were high-risk HPV-positive, compared to 50% of those from patients with VV-SCCvulva ($p<0.001$). The research strongly suggests that HPV vaccination is also likely to protect against a noticeable proportion of vulvar and vaginal cancers.

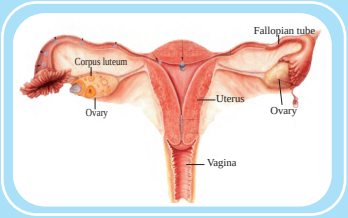
Source: Int J Cancer 2008;122:2827-2834.

Metformin May Enhance Weight Loss in Female Adolescents

The addition of metformin to a lifestyle modification program may help female adolescents lose weight if they also make dietary changes. In a randomized, double-blind study, Dr. Kathryn Love-Osborne, of Denver Health and Hospitals, Colorado, and colleagues evaluated the effect of adding metformin versus placebo to a program of personal diet and exercise goal-setting for 85 obese adolescents with insulin resistance. The subjects were an average of 15.7 years old, and had a mean body mass index of 39.7. Of the 85 subjects, 71% were female, 58% were Hispanic, and 34% were African American. The researchers report that goal-setting alone did not lead to significant weight loss in this population. No overall differences were observed between the metformin and placebo groups in weight loss or measures of glucose metabolism. However, a significant decrease in body mass index was seen in females receiving metformin but not in those taking placebo. Sixty percent of participants who were metformin-adherent and who decreased food portion sizes had a decrease in body mass index of more than 5%. Current options for weight loss medications are fairly expensive. As such, medications are not readily accessible to low-income patients who are at higher risk for obesity-related complications. The availability of a safe, inexpensive medication that might provide added benefit for patients that are motivated to make modest lifestyle changes would be a welcome addition to the options available to primary care providers working to improve the health of obese teens.

Source: J Pediatr 2008;152:817-822.

Primary Amenorrhea and PCOS Tied to Metabolic Syndrome



Young women with primary amenorrhea as a manifestation of polycystic ovarian syndrome (PCOS) appear to be at increased risk for aspects of the metabolic syndrome. The study provides a clinical, metabolic and ultrasonographic description of an uncommon presentation - primary amenorrhea - of a common condition - PCOS. Dr. Rachmiel of Tel Aviv University, Zerifin and colleagues conducted a retrospective study of 9 adolescents with primary amenorrhea and PCOS and 18 randomly chosen controls with oligomenorrhea or secondary amenorrhea along with PCOS. Those with primary amenorrhea were older at pubarche, had higher androstenedione levels, and were more likely to have a family history of obesity than subjects in the other group. They also had more features associated with the metabolic syndrome, such as higher diastolic blood pressure and lower HDL cholesterol levels. The study emphasized that adolescents with primary amenorrhea and PCOS may have a higher risk for developing features of the metabolic syndrome compared to those with the common presentation of oligomenorrhea. This is something physicians and patients should be aware of and primary amenorrhea with PCOS should encourage early aggressive follow up and treatment intervention.

Source: Arch Pediatr Adolesc Med 2008;162:521-525.

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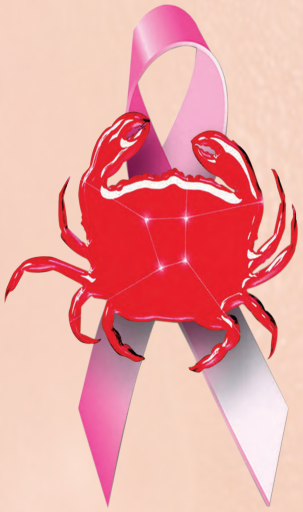

- US FDA approved for the treatment of early invasive breast cancer after surgery & also for metastatic breast cancer
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For further information: Product Management Department, Square Centre, 48, Mohakhali C/A, Dhaka-1212

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