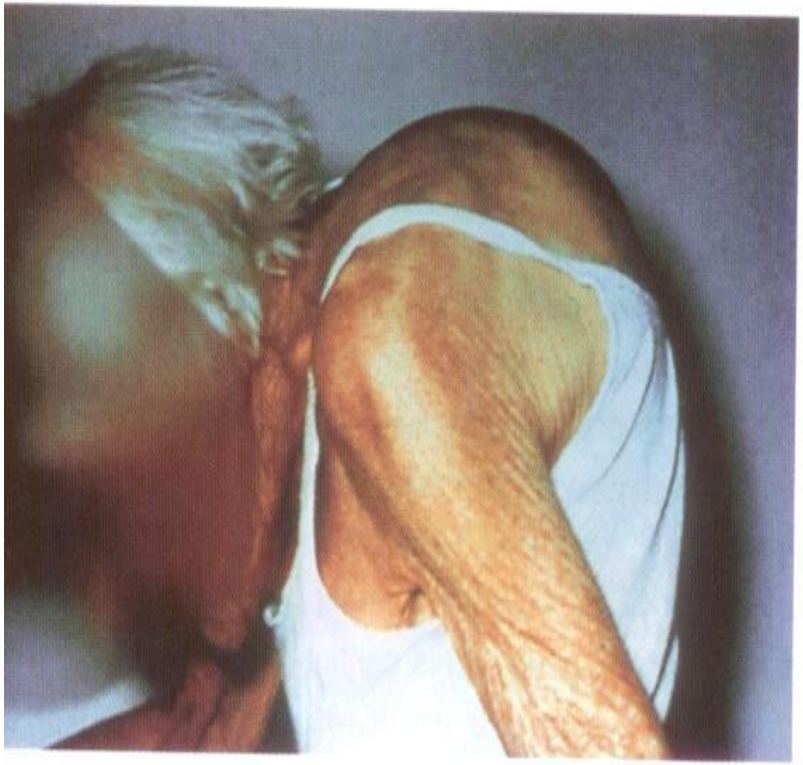
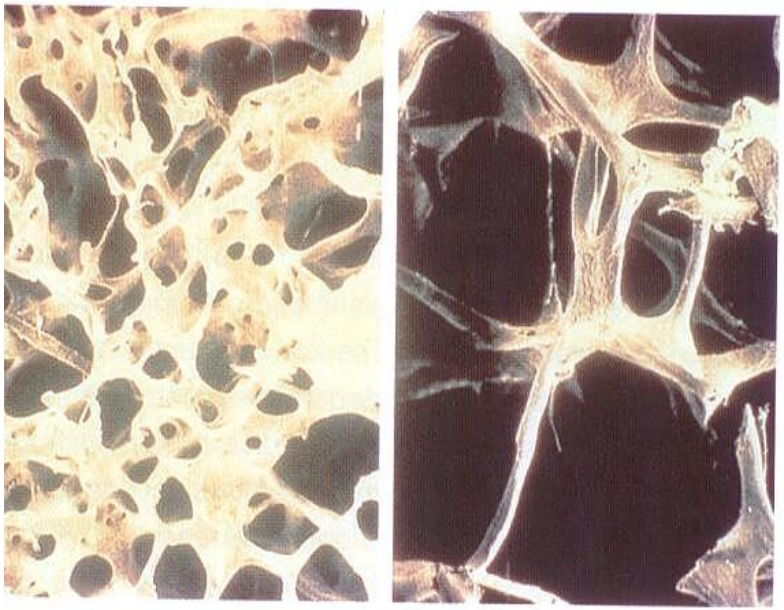
GYNAECOLOGICAL PROBLEMS IN THE ELDERLY

OSTEOPOROSIS:

- In the first 4 Years after menopause – annual bone loss of 1-3% fallen to 0,6% per year.
- ↑ Risk in – Wrist fractures
  - Vertebral Body
  - Upper femur
- 40% of patients > 65 year will have 1 or more fractures.
- Important consequence for women health
- UK 35 000 Post menopausal woman – hip fracture every year → 17% die in hospital



g. 18.2 **Severe osteoporosis of the spine.** (Reproduced with
rmission from slide set *A woman's guide to osteoporosis*, produced by



g. 18.1 **Normal (left) and osteoporotic (right) bone.**
eproduced with permission from Demoster D et al. *American Journal of*

UROGYNAECOLOGICAL PROBLEMS

- URINARY INCONTINENCE:

TYPES:

(1) Stress incontinence

(2) Overactive bladder

(3) Retention with overflow

(4) Fistula

STRESS INCONTINENCE (SUI):

- Commonness – 60 – 70% of cases
- SUI is a sign or a symptom
- SUI is leakage when there is rise in with abdominal pressure

OVERACTIVE BLADDER

- Incontinent in response to an involuntary detrusor contraction.
- 30% of cases.
- Women experience urgency, and she cannot reach toilet and the bladder contraction persist – she will be incontinent.
- Problem happens day and night – Complains of frequency and nocturia.

RETENTION AND OVERFLOW:

- Common in elderly female patients.
- Denervatred bladder continues to fill until it simply spills over.

TREATMENT OPTIONS FOR URINARY INCONTINENCE

1. Conservative treatment (lifestyle interventions and bladder retraining).
2. Physiotherapy.
3. Drug therapy.
4. Surgery.

DRUG THERAPY: (OAB)

- Conservative measurements + Physiotherapy – help 3 out of 4.

- <u>MEDICAL TREATMENT:</u>

- Antimuscarimes of anticholinergic agent.
- 50% of women up to 50% improvement.

SUI:

- Estrogens.

- Vaginal estrogens should be prescribed to all women with urinary incontinence who are post menopausal.

MANAGEMENT:

- SUI:

  (1) Anterior colporrhaphy.

  (2) Colposuspension (Burch).

  (3) TVT / T.O.T

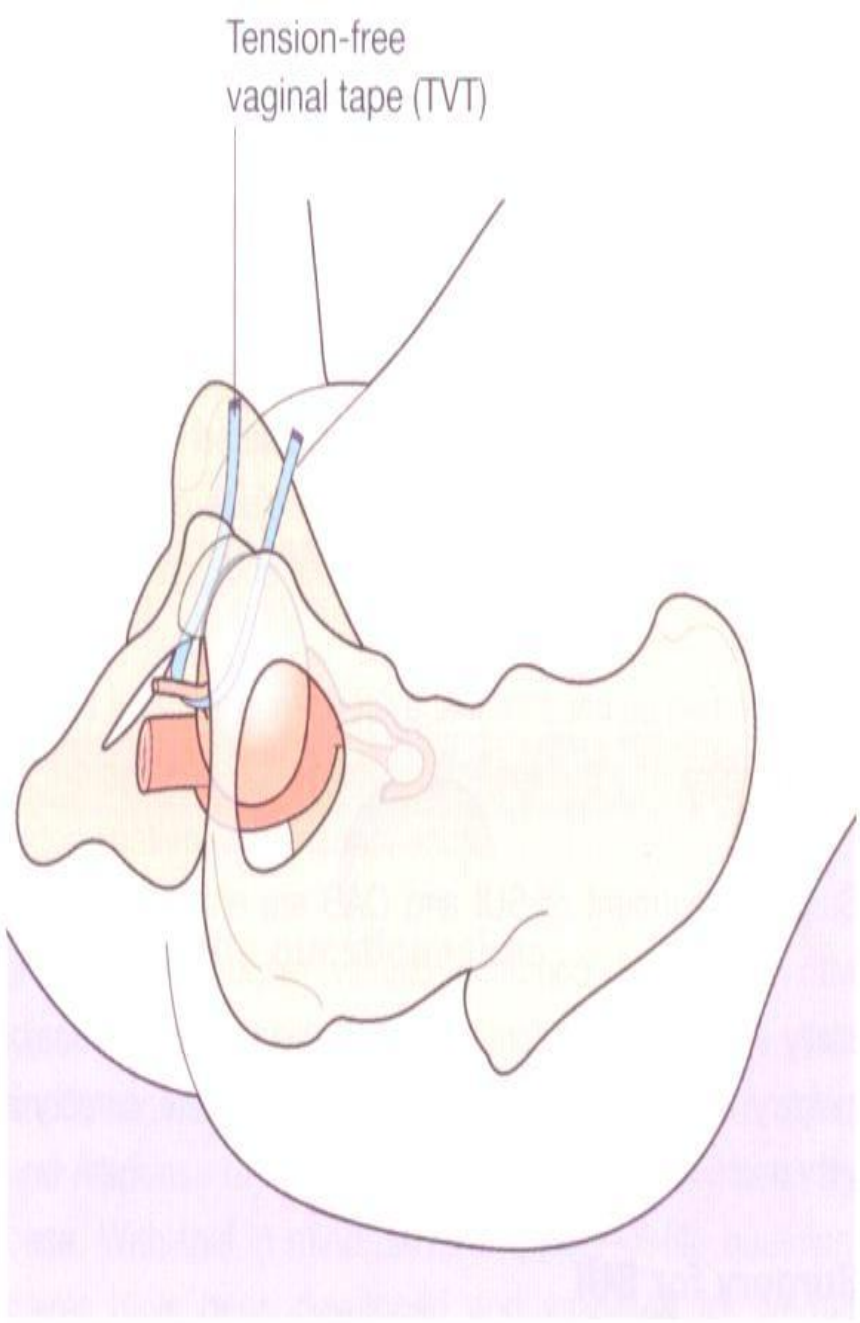


Fig. 20.1 Tension-free vaginal tape (TVT). © 2004 Gynecare, Worldwide, division of Ethicon Inc.

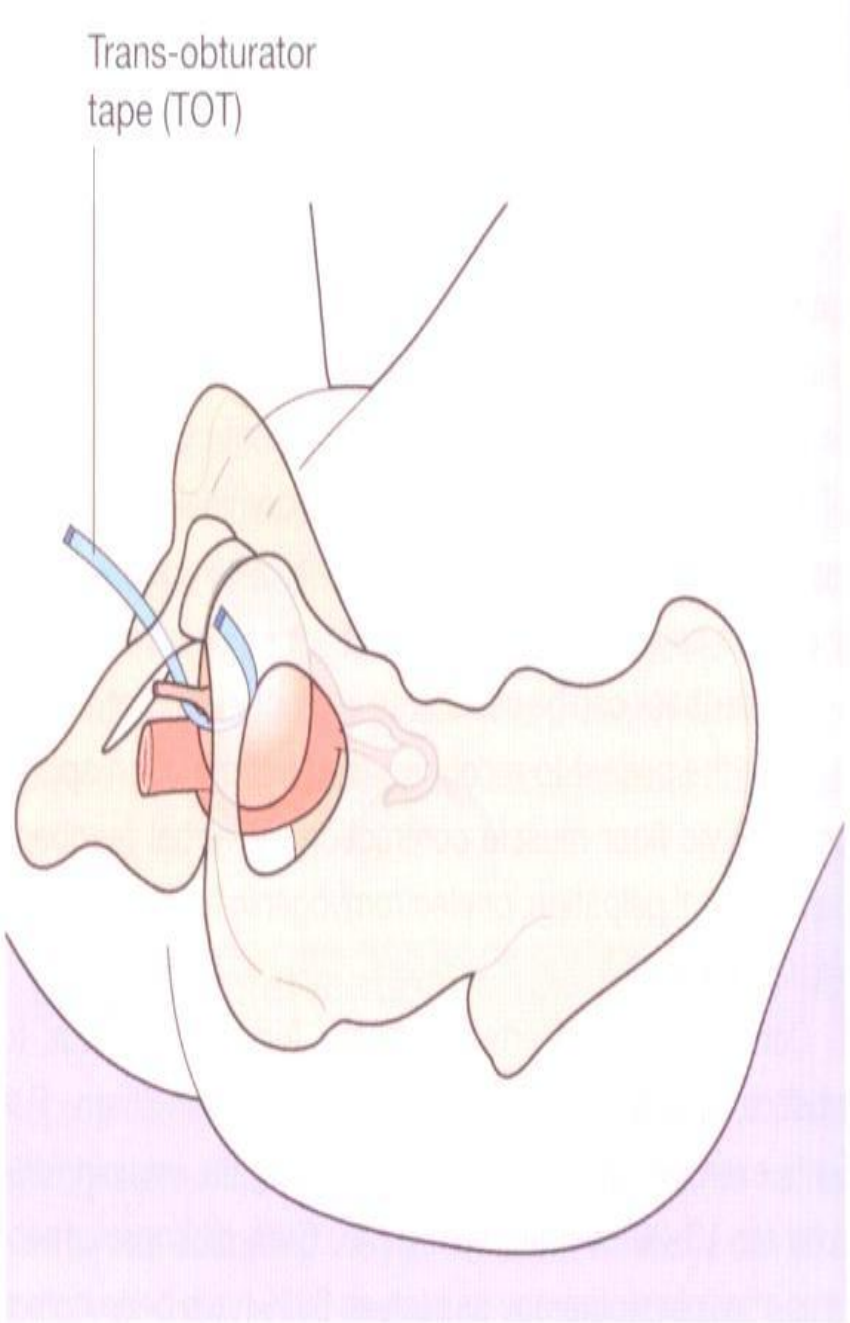


Fig. 20.2 Trans-obturator tape (TOT). © 2004 Gynecare, Worldwide, division of Ethicon Inc.

GENITAL PROLAPS:

Box 19.1

Factors predisposing to genital prolapse

- Childbirth
- Menopause
- Congenital
- Suprapubic surgery for urinary incontinence
- Genetic

Table 19.1

Types of genital prolapse

Original position of organs	Prolapse	Symptoms*
Anterior	Urethrocele and cystocele	Urinary symptoms (stress incontinence, urinary frequency)
Central	Cervix /uterus (1st, 2nd, 3rd degree and procidentia)	Bleeding and/or discharge from ulceration in association with procidentia
Posterior	Rectocele and enterocele	Bowel symptoms, particularly the feeling of incomplete evacuation and something having to press the posterior wall backwards to pass stool

*In addition to the general symptoms of discomfort, dragging, the feeling of a 'lump', and, rarely, coital problems.

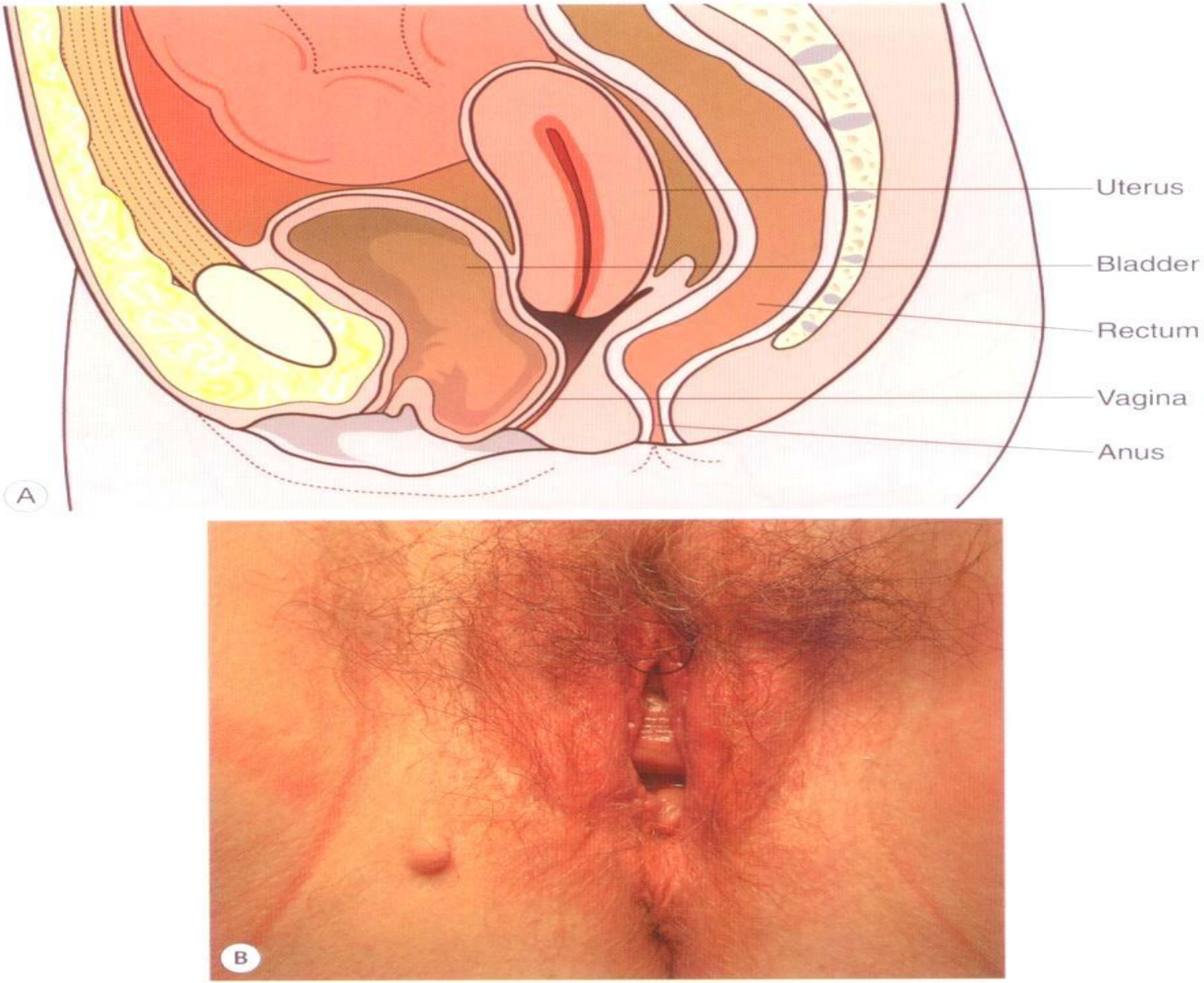


Fig. 19.1 Cystocele.

lump but may be also associated with non-specific lower

Examination in the left lateral position can also be he

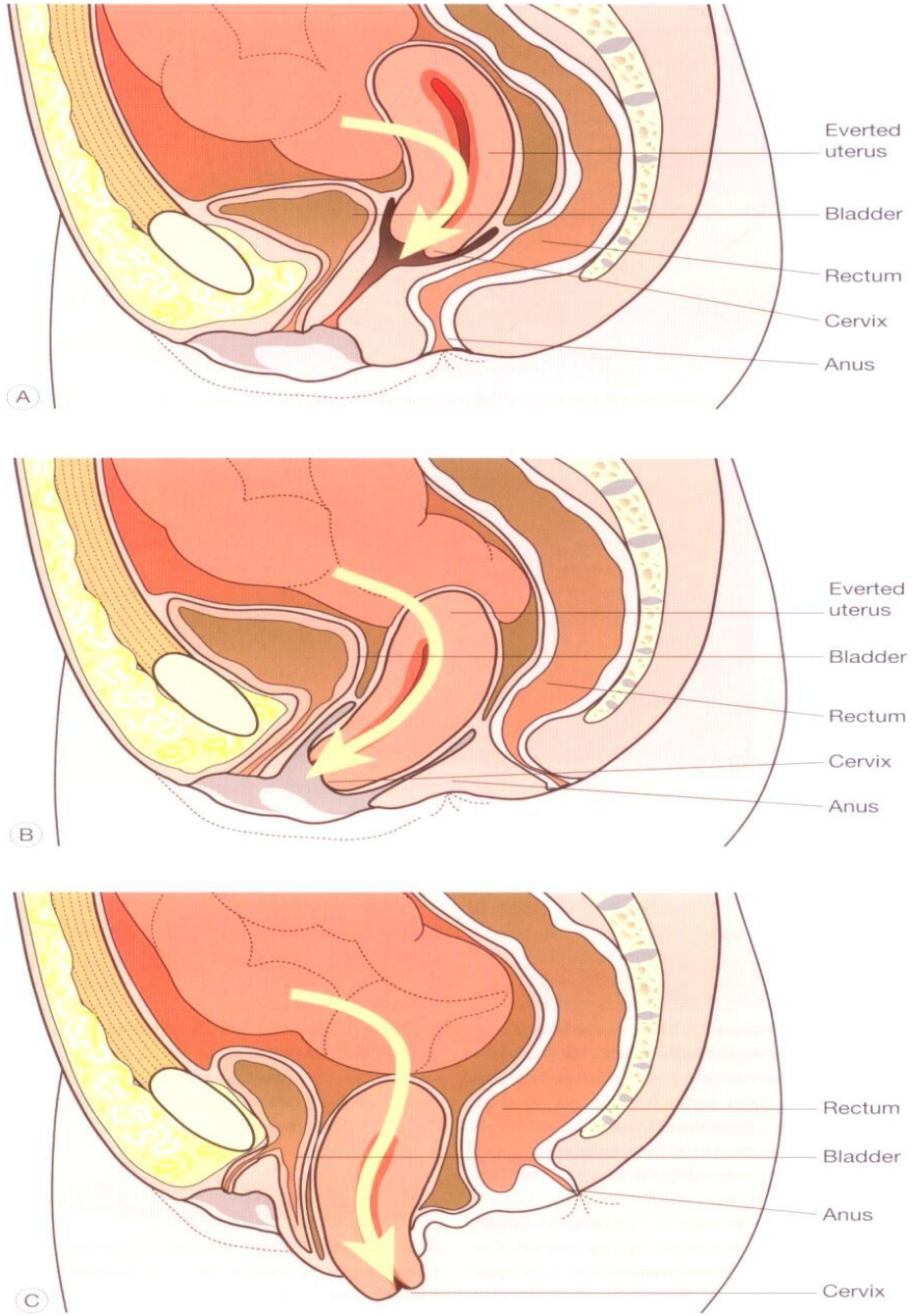


Fig. 19.2 Uterine prolapse. (A) First-degree, **(B)** second-degree, and **(C)** third-degree prolapse.

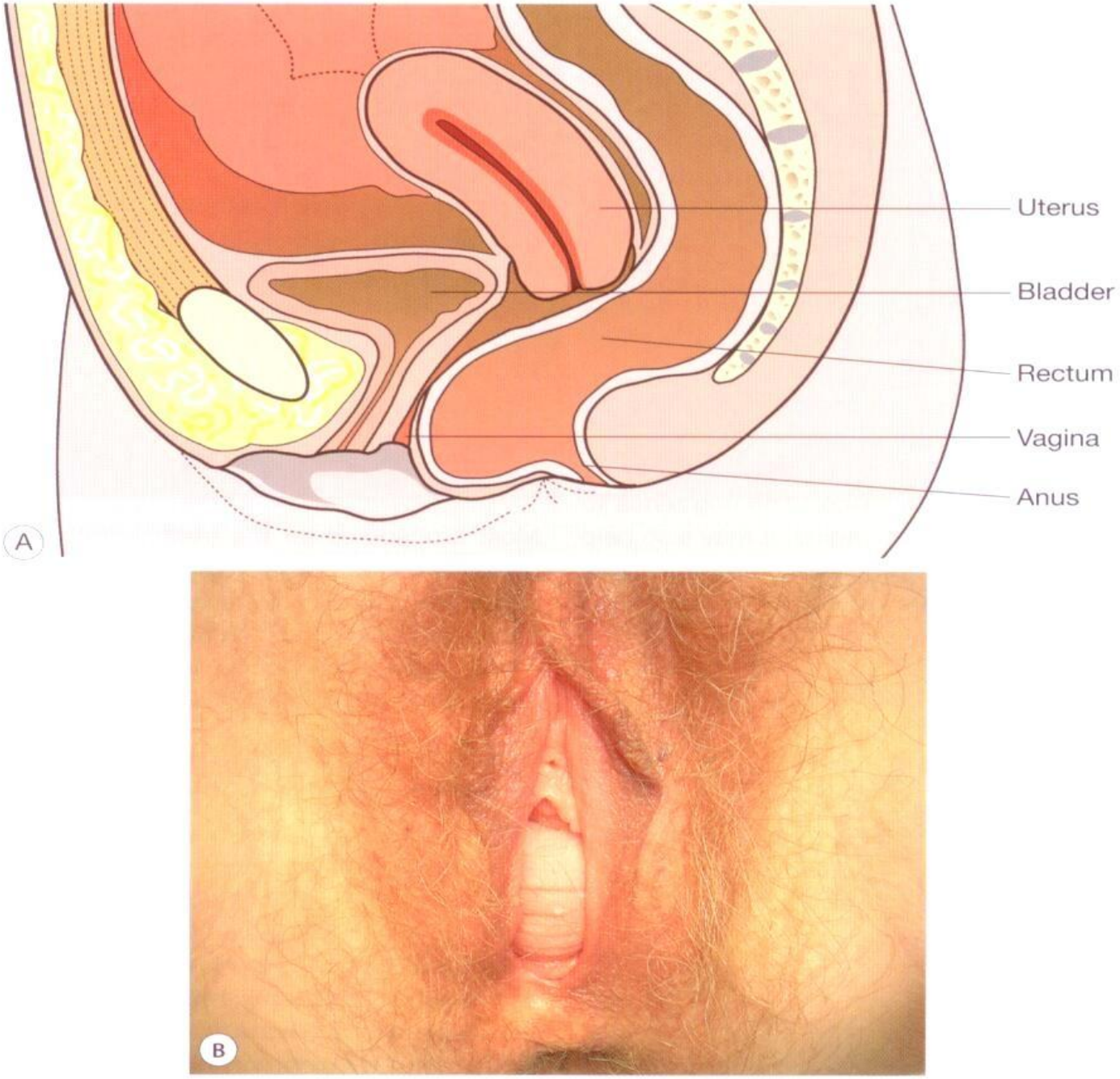


Fig. 19.3 Rectocele.

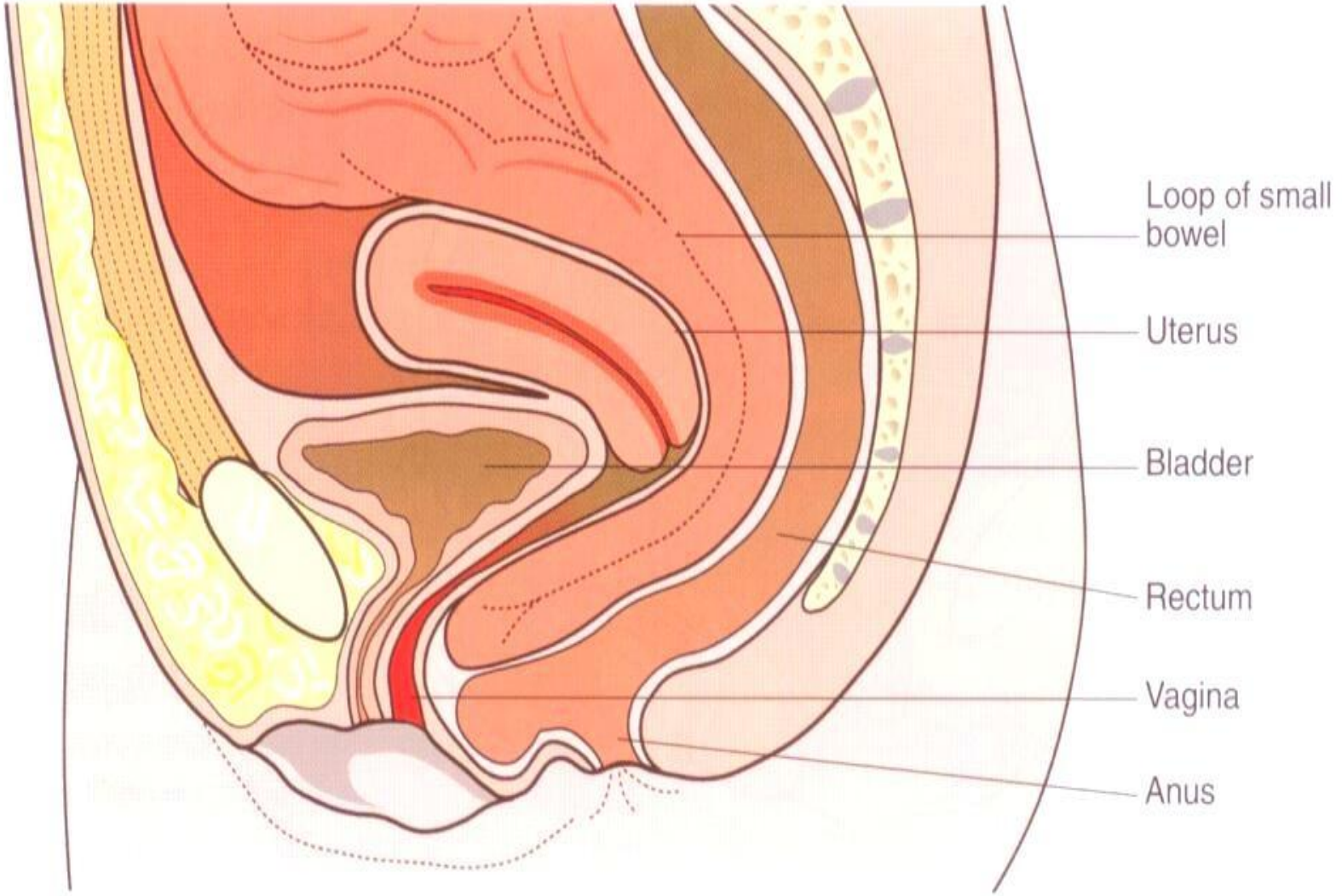


Fig. 19.4 **Enterocele.**

MANAGEMENT:

- Conservative:
- Pelvic floor exercises are not effective when prolaps is well established.
- Do have roll in treatment if associated urinary incontinences.

PESSARIES ARE COMMONLY USED:

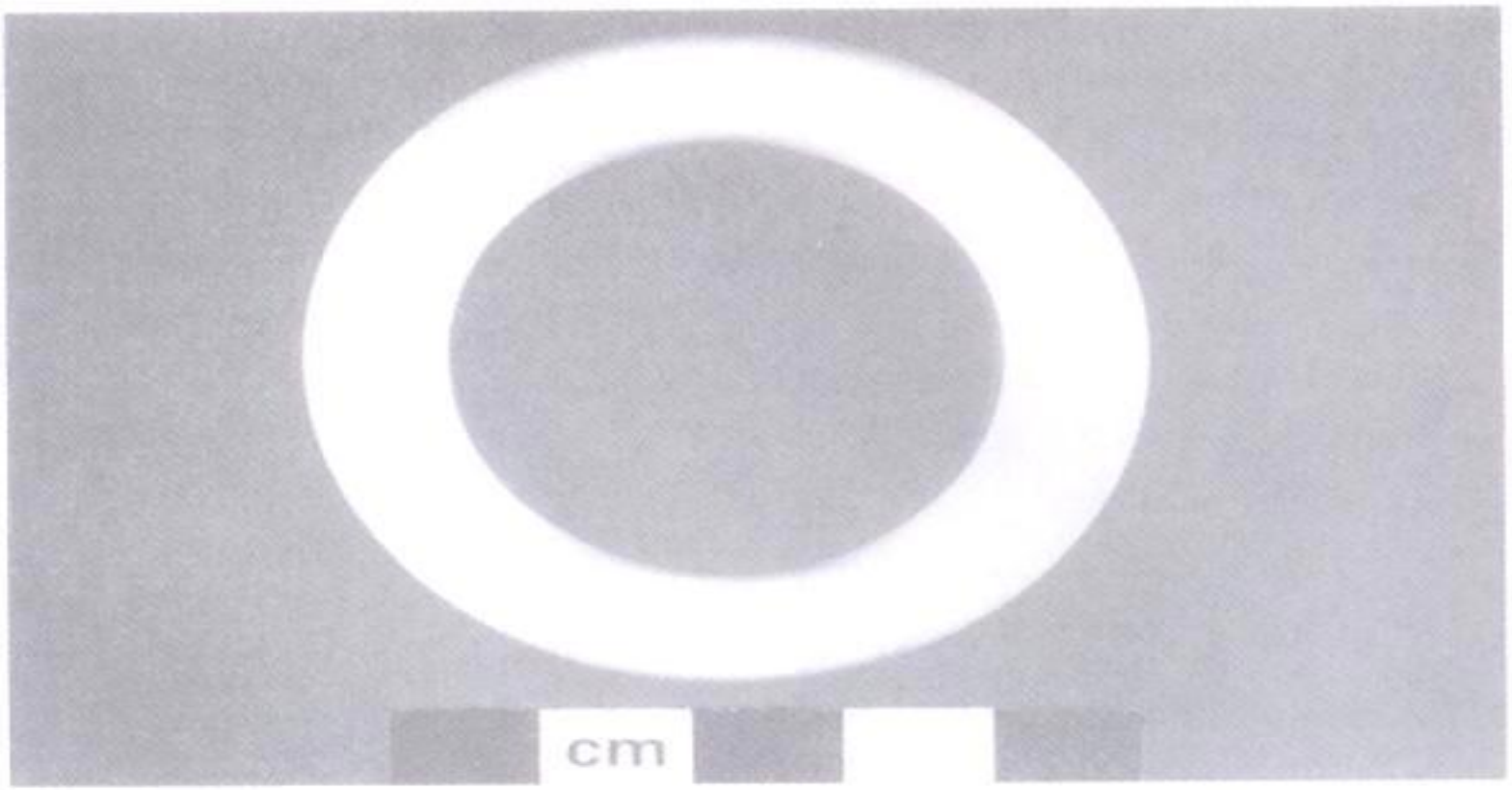


Fig. 19.5 Ring pessary (50 mm diameter).

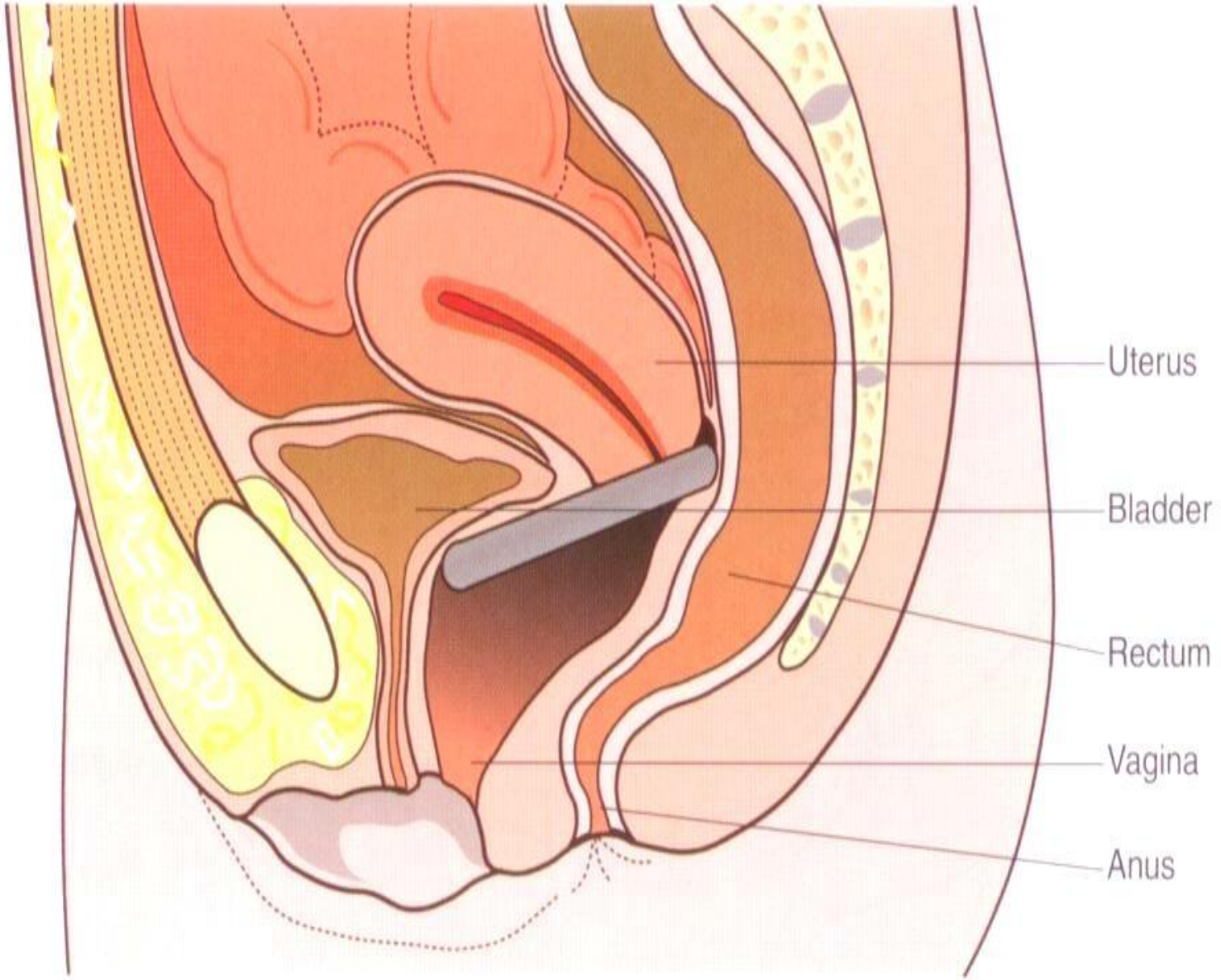


Fig. 19.6 Ring pessary in situ. Note that the anterior vaginal wall is elevated to reduce the cystocele and the uterine prolap
been corrected.

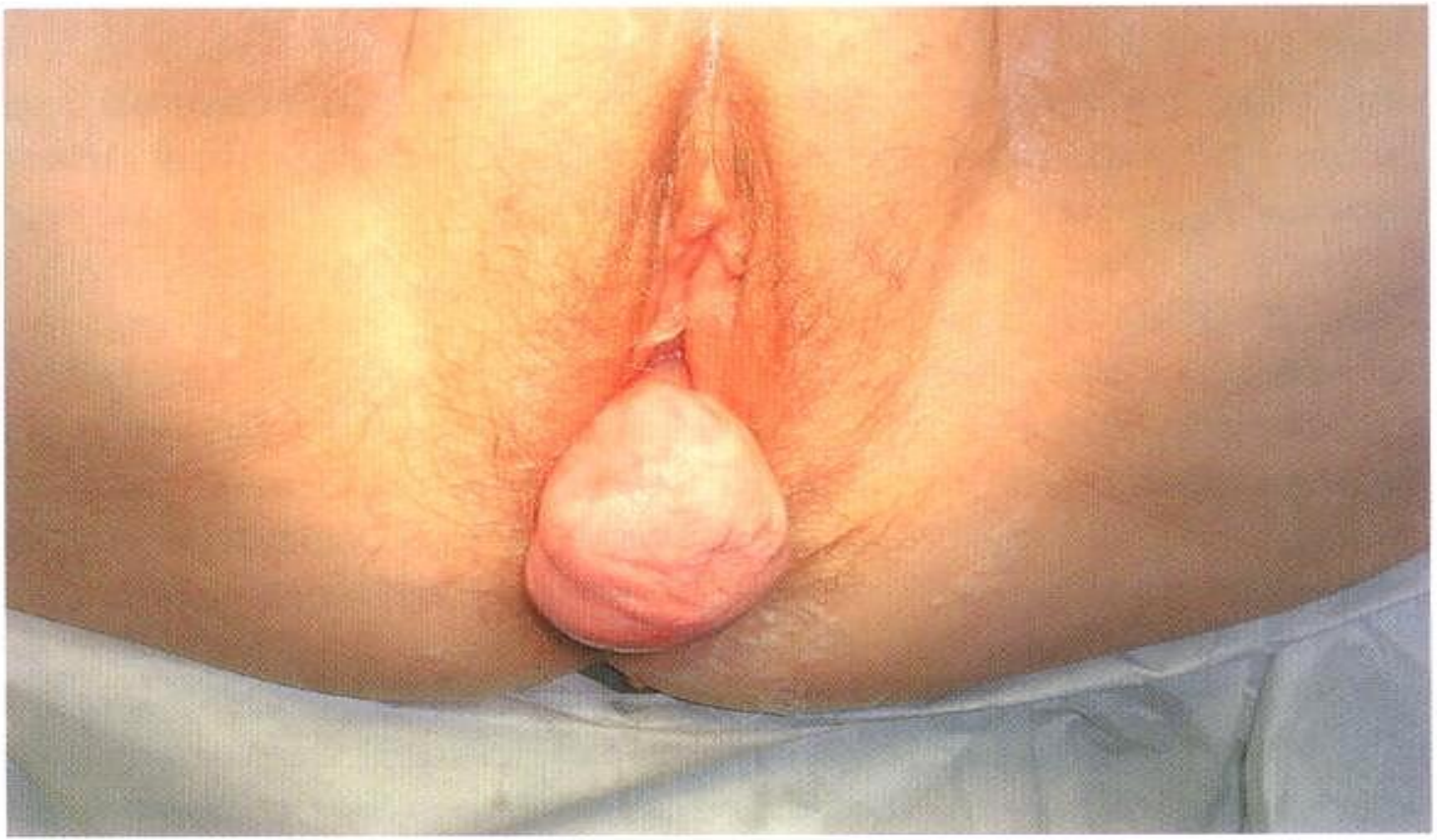


Fig. 19.8 Vault prolapse.

SURGERY:

1. Anterior Colporrhaphy.

2. Posterior Colporrhaphy.

3. Vault prolaps - Abdominal

   - Vaginal approach

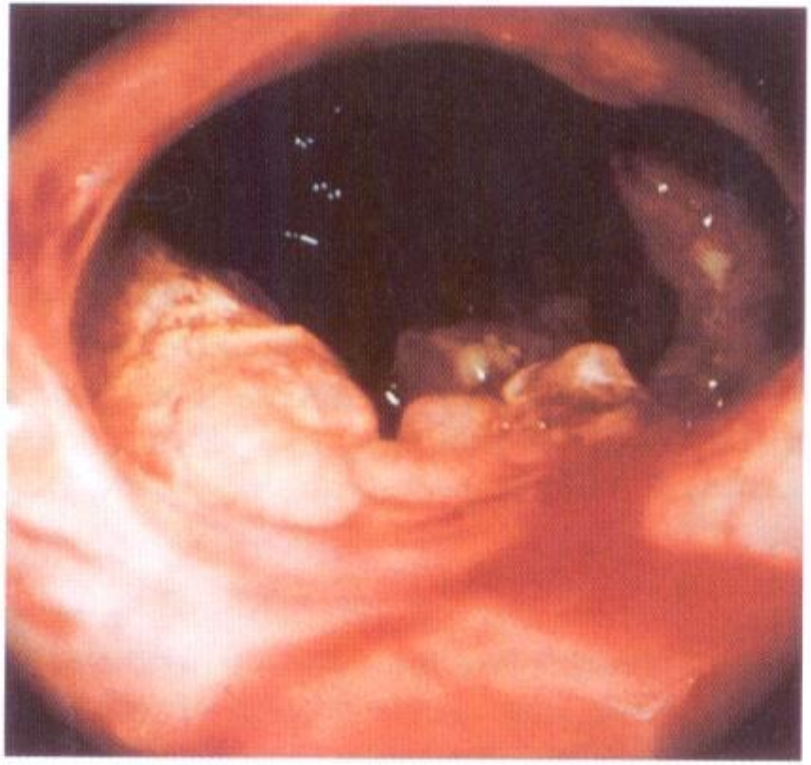
CANCER:

1. <u>ENDOMETRIAL CA:</u>

- Second most common gynae cancer in UK.
- Incidence low < 40 year C<2: 100 000) age 40-55 (44:100000)

CLINICAL FEATURE:

- Post menopausal bleeding.
- 5-10% of PMB will have primary or secondary malignancy
  - (88% endometrial CA).
  - Cervix CA
  - Ovaria CA
- Less common presentation → vaginal discharge.
- Endometrial CA – can also present with abnormal cell on papsmear.



22.1 A hysteroscopic view of an endometrial inoma arising from the posterior uterine wall. (Courtesy rl Storz Endoscopy (UK) Ltd.)

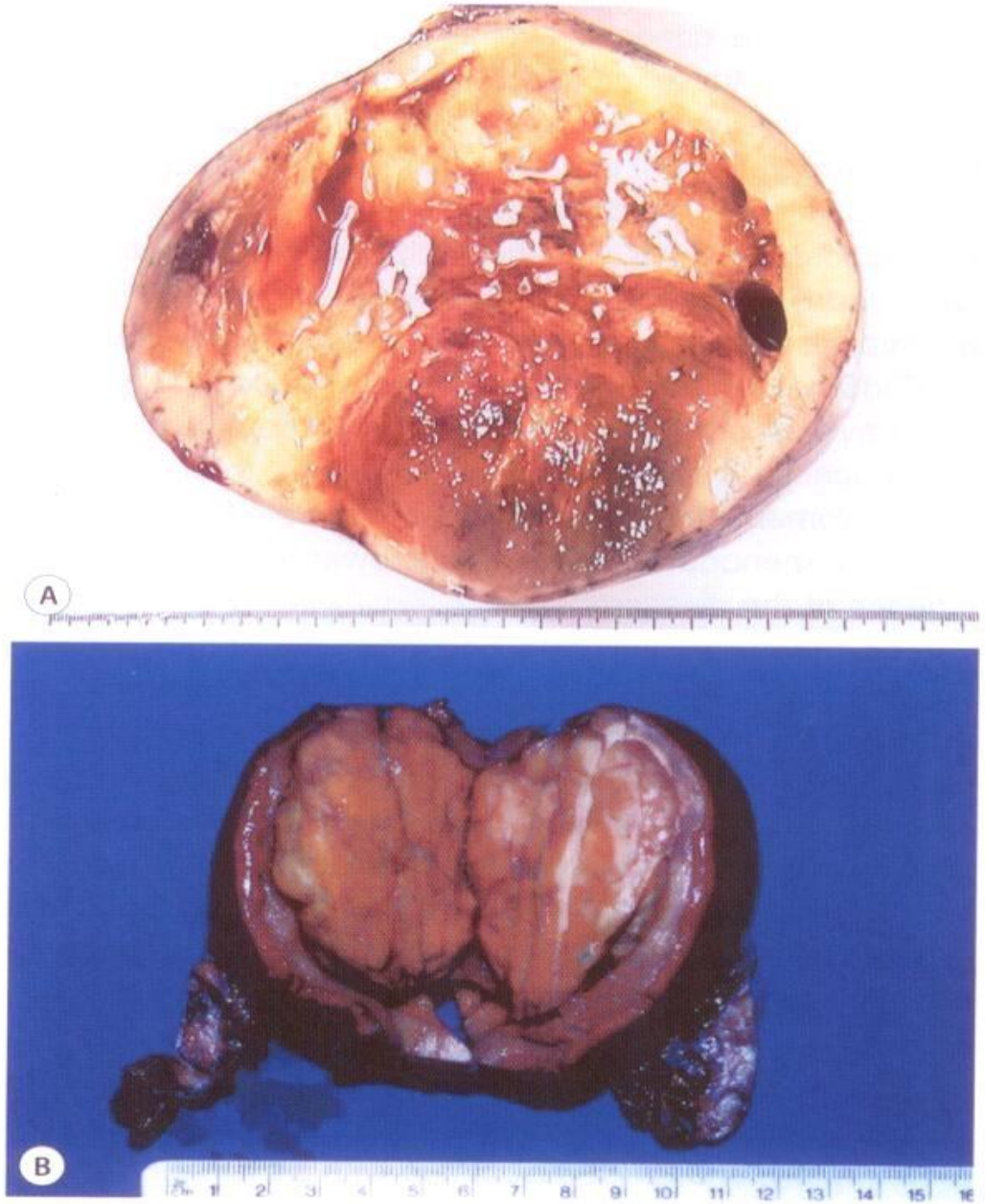


Fig. 22.2 Macroscopic picture of (A) endometrial carcinoma and (B) endometrial sarcoma. (Courtesy of Dr N Wilkinson, Department of Pathology, Leeds.)

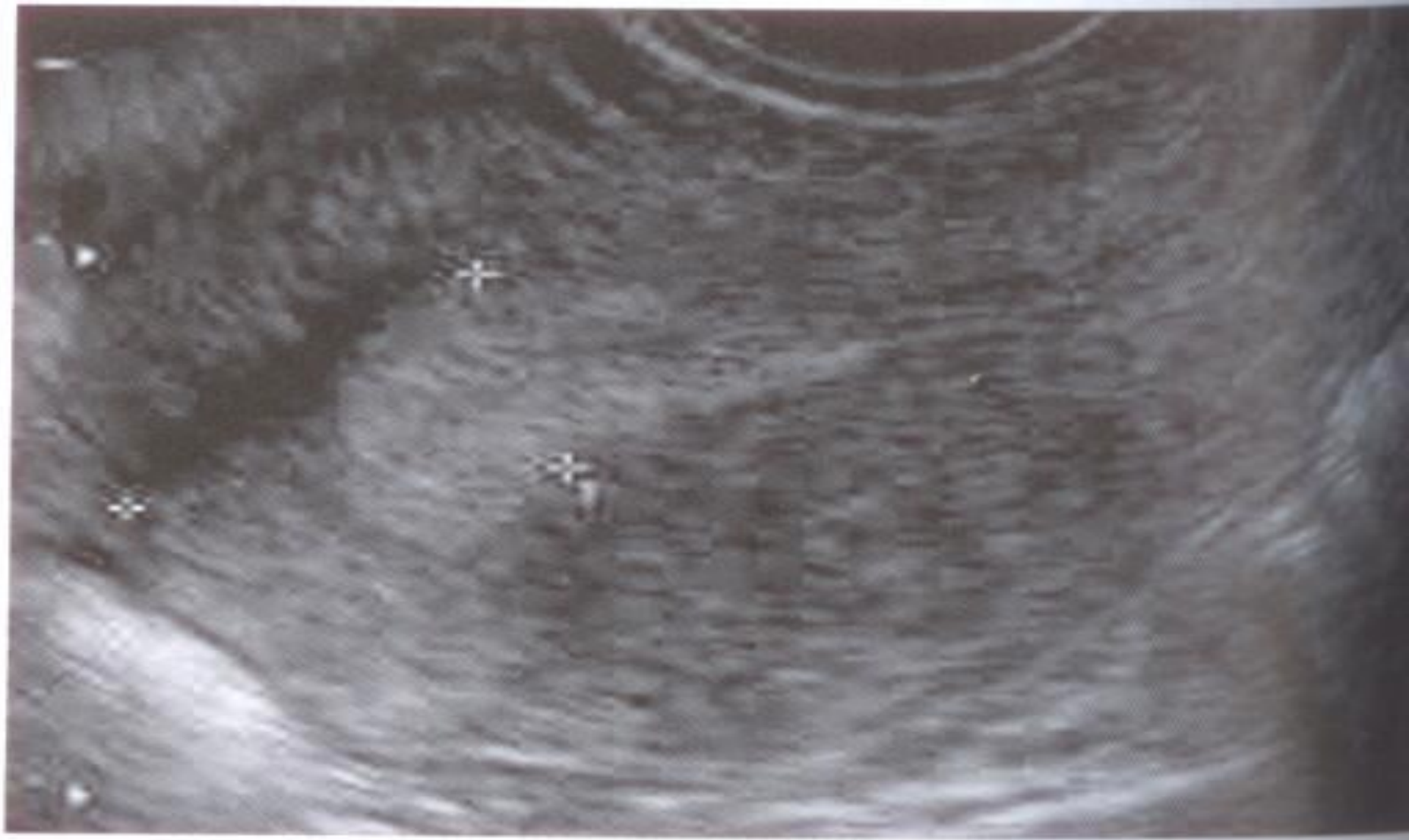
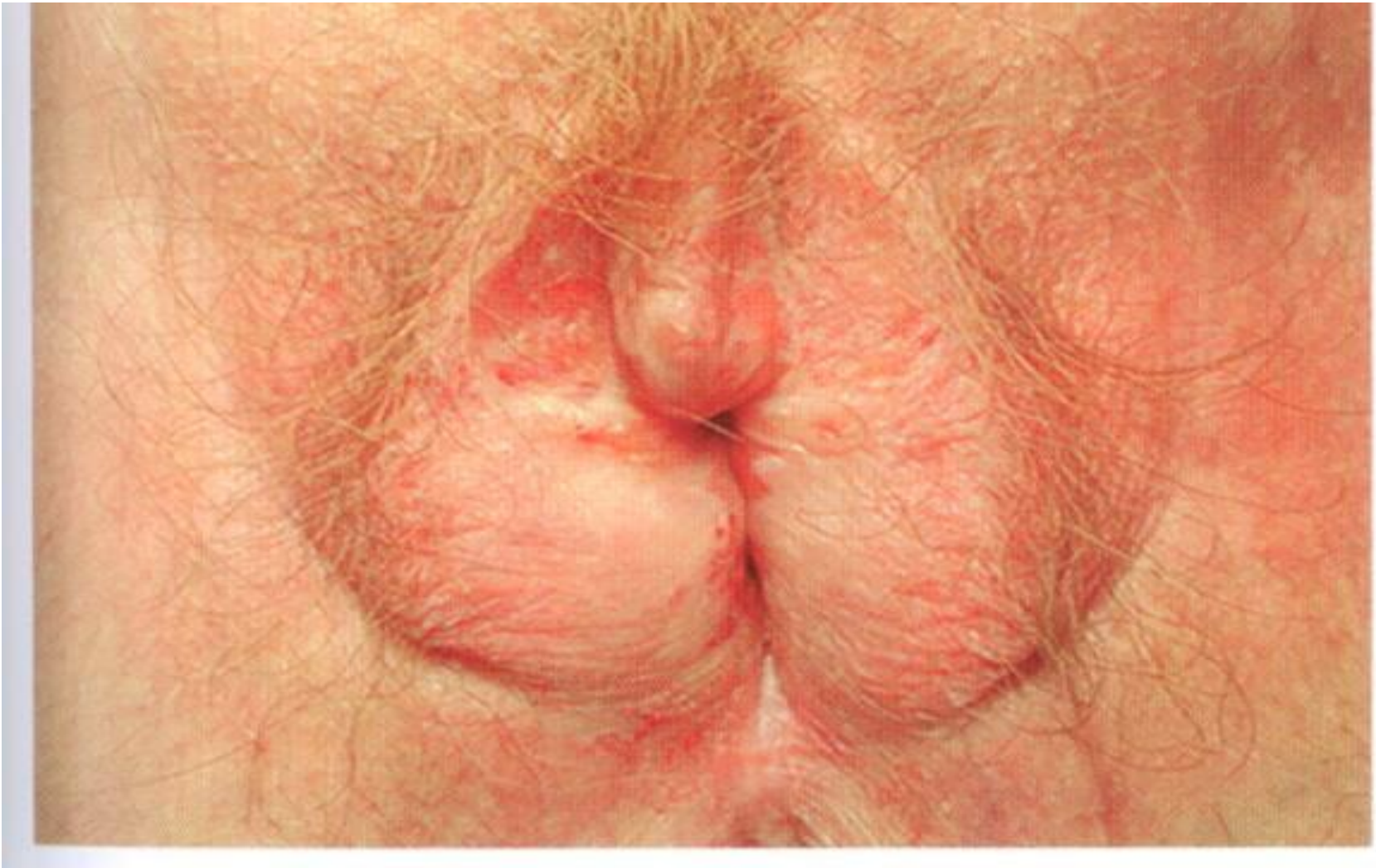


Fig. 22.3 Transvaginal ultrasound image demonstrating thickened endometrium. (Courtesy of Dr C Hardwick, Glasgow.)

LICHEN SCLEROSIS



VIN (VULVAL INTRA EPITHELIAL NEOPLASIA):

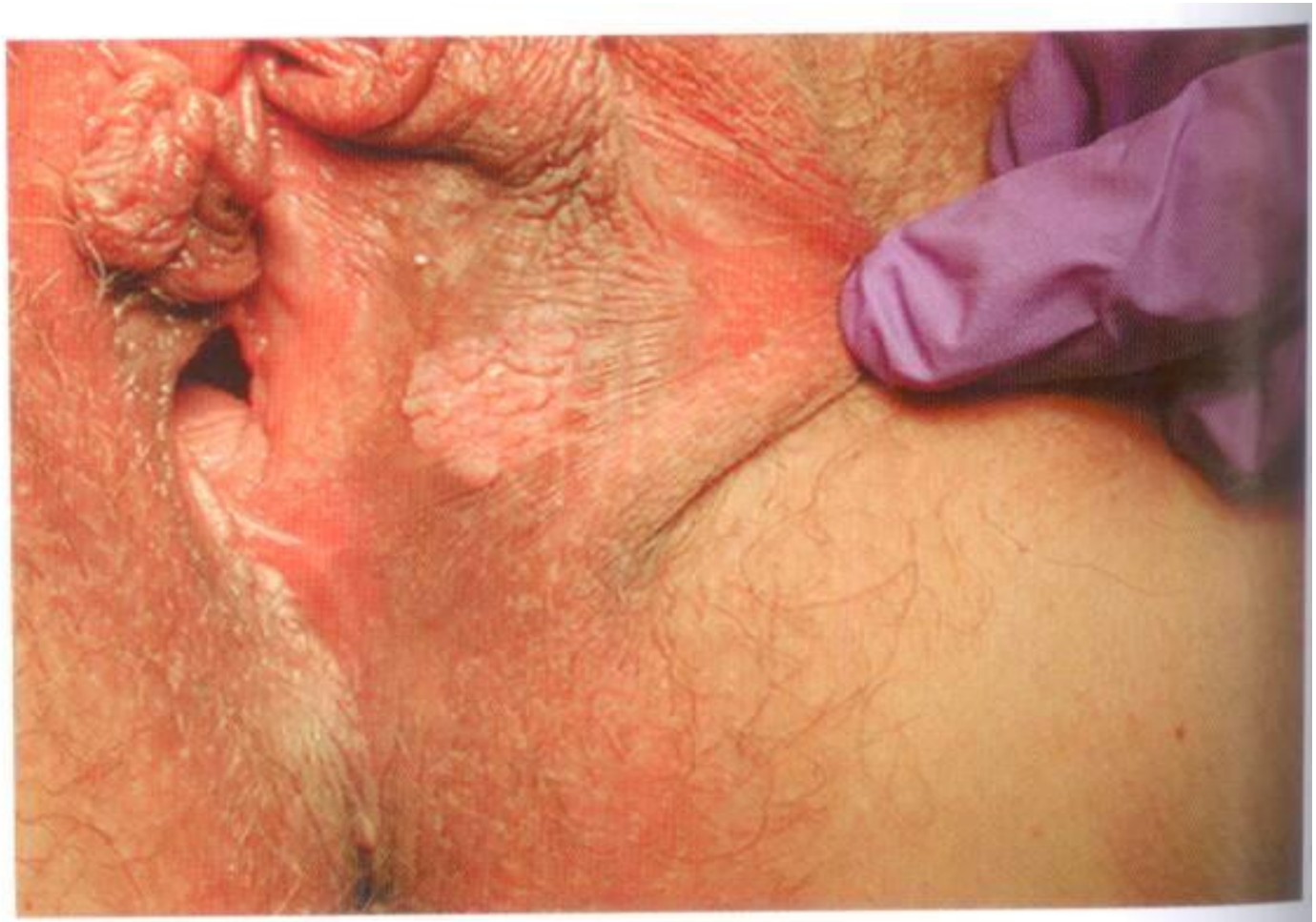
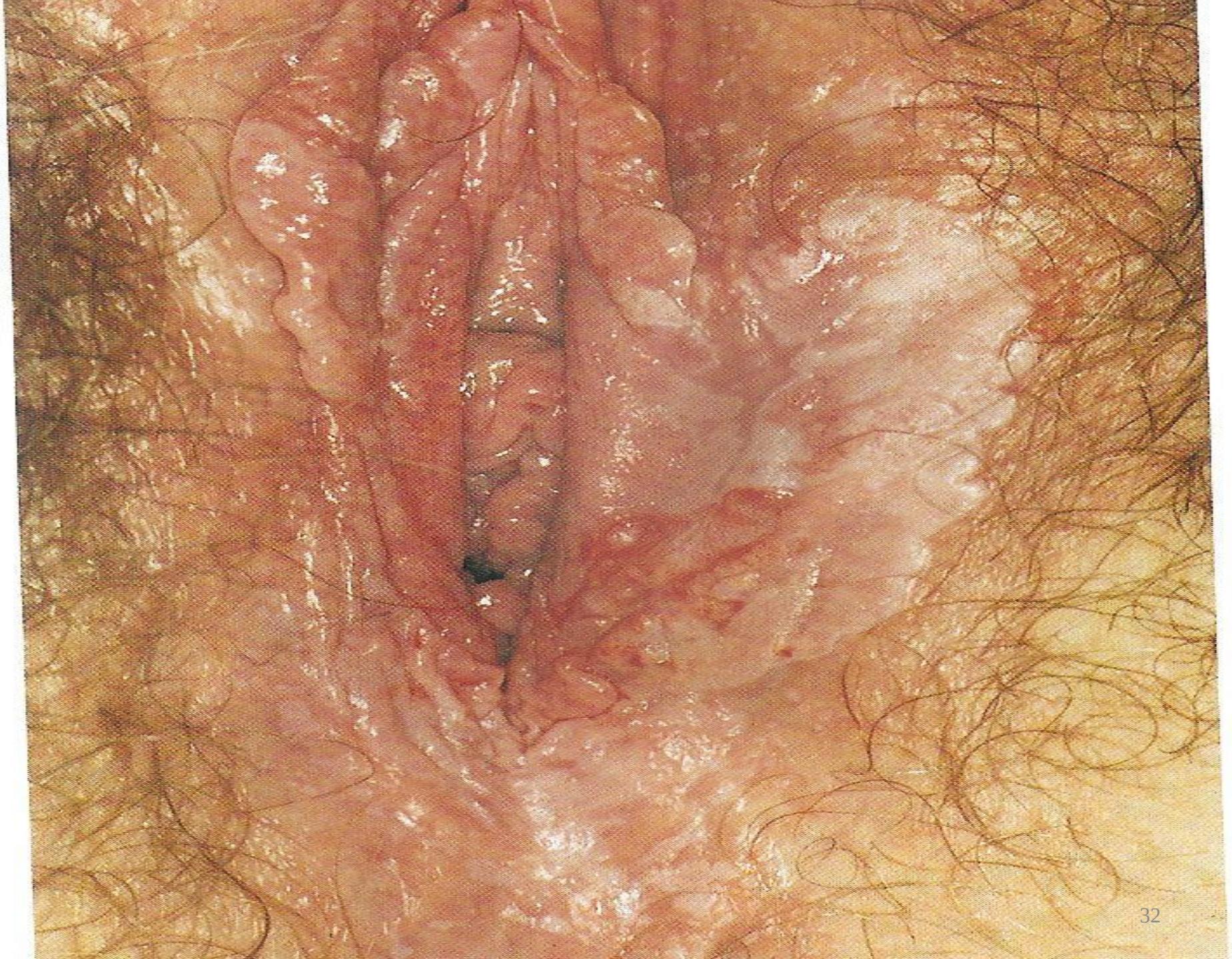
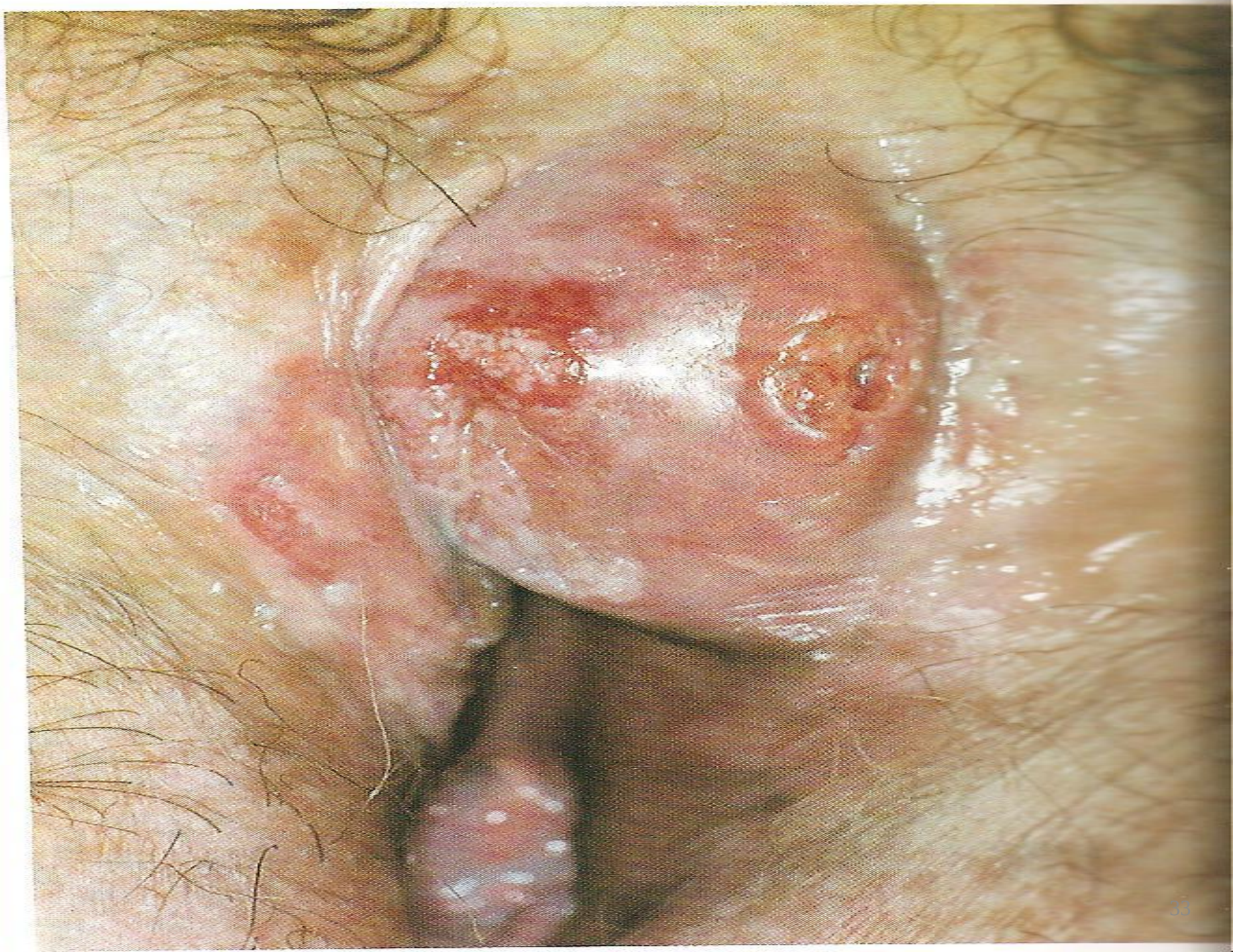


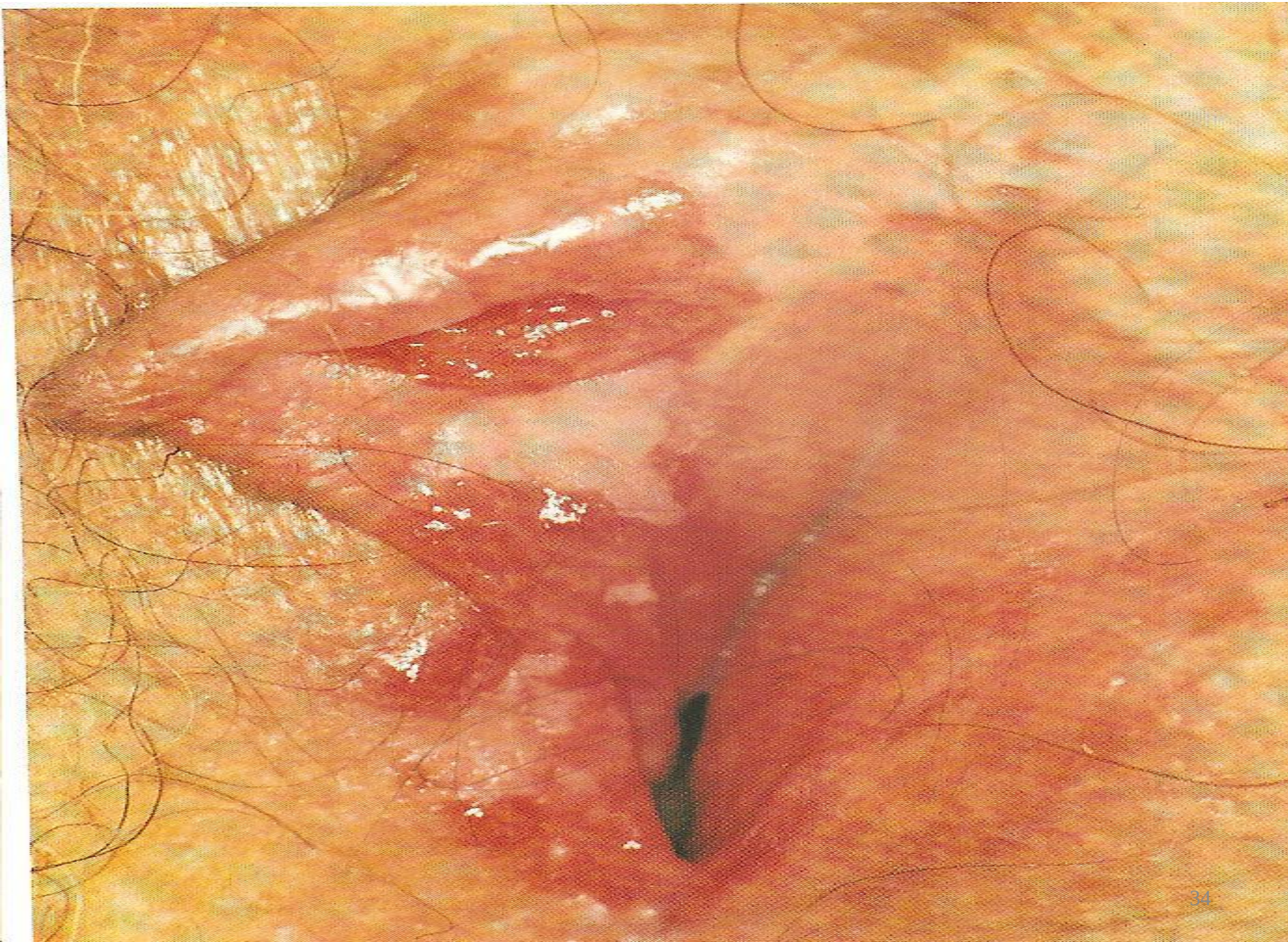
Fig. 23.3 Squamous VIN III of the left labia majora. In this

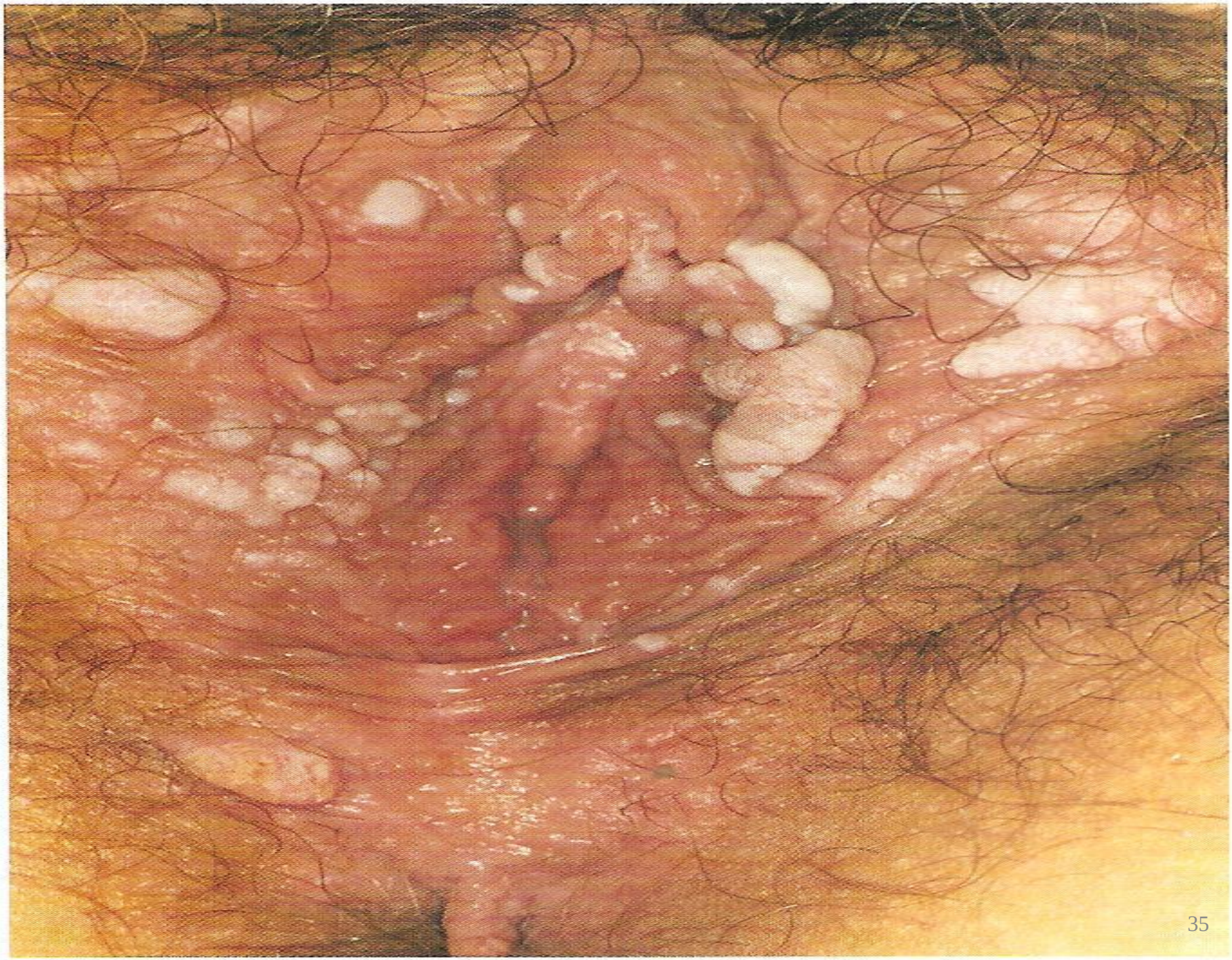
VULVA CARCINOMA:

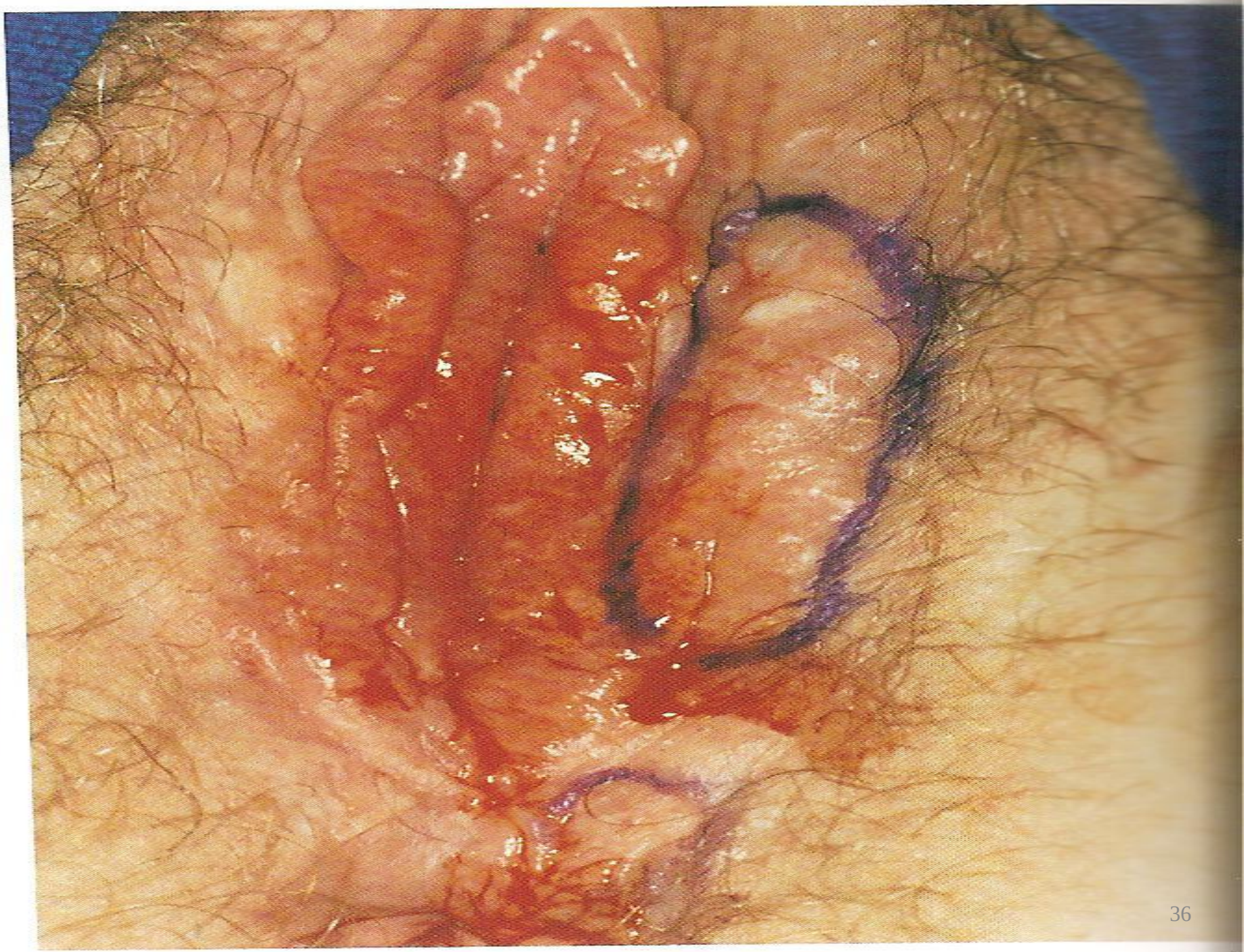
- History of long standing vulval irritation or persists.
- Some previous history of Lichen Sclerosis.
- Lump or ulcer is common.











VULVA CARCINOMA

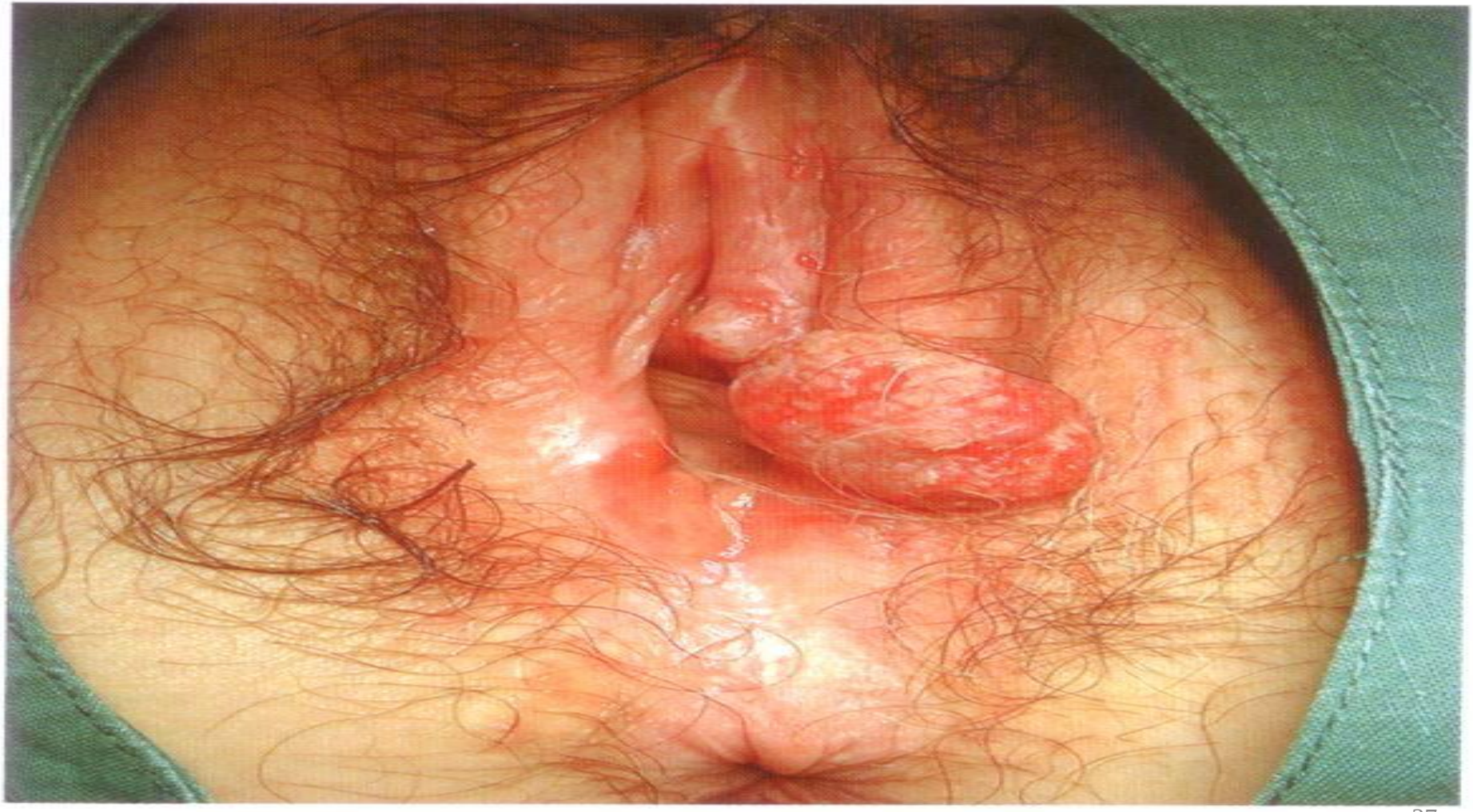


Fig. 23.4 A stage II left-sided squamous vulval carcinoma.