GYNAECOLOGICAL PROBLEMS IN THE ELDERLY
OSTEOPOROOSIS:

• 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 permission from slide set A woman's guide to osteoporosis, produced by the National Osteoporosis Society.)

g. 18.1 Normal (left) and osteoporotic (right) bone.
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 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.

• Denervated 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.
DRUG THERAPY: (OAB)

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

• MEDICAL TREATMENT:

• 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
GENITAL PROLAPS:

Box 19.1

Factors predisposing to genital prolapse

- Childbirth
- Menopause
- Congenital
- Suprapubic surgery for urinary incontinence
- Genetic
<table>
<thead>
<tr>
<th>Original position of organs</th>
<th>Prolapse</th>
<th>Symptoms*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior</td>
<td>Urethrocele and cystocele</td>
<td>Urinary symptoms (stress incontinence, urinary frequency)</td>
</tr>
<tr>
<td>Central</td>
<td>Cervix / uterus</td>
<td>Bleeding and/or discharge from ulceration in association with procidentia</td>
</tr>
<tr>
<td></td>
<td>(1\textsuperscript{st}, 2\textsuperscript{nd}, 3\textsuperscript{rd} degree and procidentia)</td>
<td></td>
</tr>
<tr>
<td>Posterior</td>
<td>Rectocele and enterocele</td>
<td>Bowel symptoms, particularly the feeling of incomplete evacuation and something having to press the posterior wall backwards to pass stool</td>
</tr>
</tbody>
</table>

*In addition to the general symptoms of discomfort, dragging, the feeling of a ‘lump’, and, rarely, coital problems.
Fig. 19.1 Cystocele.

Examination in the left lateral position can also be help...
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. 19.6 Ring pessary in situ. Note that the anterior vaginal wall is elevated to reduce the cystocele and the uterine prolapse has been corrected.
Fig. 19.8 Vault prolapse.
SURGERY:

1. Anterior Colporrhaphy.

2. Posterior Colporrhaphy.

3. Vault prolaps - Abdominal
   - Vaginal approach
CANCER:

1. **ENDOMETRIAL CA:**

   - 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 pap smear.
22.1 A hysteroscopic view of an endometrial inoma arising from the posterior uterine wall. (Courtesy of R 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):
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.