

SZ IMSCON
2024



POISE

MAGZINE



GENITO URINARY PROBLEMS IN PERI MENOPAUSE

Vijayawada Menopause Society,
Under the aegis of
Indian Menopause Society



Welcome

SZ IMSCON

AUG 31ST

& SEP 1ST

2024



VIJAYAWADA MENOPAUSE SOCIETY

I N D E X

I	Message from President	Dr. Anju Soni
II	Message from Secretary General	Dr. Bipasa Sen
III	Message from Editor	Dr. Shubha Sethia
IV	Message from Co-Editor	Dr. Sailaja Nalluri

Articles

TOPIC	NAME	PAGE
WHAT SHOULD WE KNOW ABOUT GENITAL TRACT IN WOMEN	DR THEJAVATHY G V	8
WHAT IS URINARY TRACT. HOW DOES IT WORK?	DR SHUBHA RAMARAO	9
GENITOURINARY PROBLEMS IN MENOPAUSE	DR HEENA SHENOY T	11
WHY ARE URINARY TRACT INFECTIONS SO COMMON ?	DR SHOBHNA PATTED	12
HOW TO RECOGNISE AND TREAT UTI ?	DR NAGARATHNAMMA	13
RECURRENT UTI	DR SUDHAA SHARMA	14
PERI MENOPAUSAL DYSURIA WITHOUT INFECTION	DR TRIPURA SUNDARI	16
BLOOD AND PROTEIN IN URINE : IS THERE NEED TO WORRY?	DR YAZHINI SELVARAJ	18
RENAL STONES	DR PAYAL BHARGAVA	19
VAGINAL DRYNESS	DR SHUBHA SETHIA	21
ITCHING DOWN THERE : WHAT IS THE CAUSE?	DR ANJU SONI	24
PAINFUL INTERCOURSE	DR SHOBHANA MOHANDAS	26
CHRONIC PELVIC PAIN	DR.SWEETY SONI	27
ATROPHIC VAGINITIS	DR BIPASA SEN	28
PREVENTIVE STRATEGIES FOR GENITOURINARY PROBLEMS	DR AMBUJA MOHAN	30
LEAKAGE OF URINE : A BOTHERSOME PROBLEM	DR MONISHA NAIR A	31
DOES DELIVERY CAUSE URINARY LEAKS ?	DR SUJINDRA ELAMURUGAN	32
PREVENTIVE STRATEGIES FOR URINARY LEAKAGE	DR MAHALINGAM MEENA	33
ARE THERE DRUGS TO CONTROL URINARY LEAKS ?	DR MEERA V V RAGHAVAN	34
IS SURGERY THE ONLY ANSWER TO URINARY LEAKS?	DR T SRIKALA PRASAD	36
WHAT ARE SEXUALLY TRANSMITTED INFECTIONS ?	DR SUMATHI BASKARAN	37
MENOPAUSE AND STIS: DO SAFE SEX RULES STILL APPLY	DR SAMEERA ALLURI	38
VULVOVAGINAL MASSES	DR KONERU GANGADHAR RAO	39
VAGINAL PROLAPSE AND MANAGEMENT	DR. RAGINI AGARWAL	40
PELVIC FLOOR EXERCISES	DR. NAINI TANDON	42
HYSTERECTOMY : GROWING MENACE	DR AMBUJA CHORANUR	44
FOLLOW UP AFTER HYSTERECTOMY	DR PAAPA DASARI	46
ARE GENITOURINARY PROBLEMS MORE IN DIABETICS	DR A V KRISHNA KISHORE	47
VAGINAL INFECTION IN DIFFERENT AGE GROUPS	DR LAKSHMI K S	48
SCREENING FOR OVARIAN CANCER	DR. PADMAJA VEERAMACHANENI	49
SCREENING FOR ENDOMETRIAL CANCER	DR R.S.RAMA DEVI	50
SCREENING FOR CERVICAL CANCER	DR SUSILA PINNAMANENI	52

President message



DR. ANJU SONI

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GOVERNING COUNCIL MEMBER OF ICOG(2023-25)
MEMBER INDIA CCM - 2022-25

We are thrilled to present the second edition of POISE during my tenure—a vital bridge between the Indian Menopause Society (IMS) and women navigating midlife and beyond. POISE is dedicated to empowering women with knowledge, helping them understand and manage menopause-related issues effectively. Armed with the right information, women can dispel fears, overcome myths, and discover the best solutions for their concerns.

This edition of POISE sheds light on the Genitourinary Problems often faced by women in midlife, a topic crucial to their quality of life. We hope you found our last edition on Cardiovascular Diseases, titled "Save Your Heart," both informative and inspiring. If you missed it, it's available on our official website.

I would like to congratulate Dr. Shubha Sethia, Chairperson of Public Awareness and Club 35, for her insightful choice of this significant topic. I also extend my congratulations to the Vijayawada Menopause Society team—President Dr. Padmaja, Secretary Dr. Katru Gayathree and Co-editor Dr. Sailaja Nalluri—for their commendable efforts in bringing this edition to life.

We are delighted to release this edition at the South Zone IMSCON in Vijayawada.

Secretary General message



DR. BIPASA SEN

SECRETARY GENERAL,
INDIAN MENOPAUSE SOCIETY

I am so happy to see the release of the 2nd issue of Poise Magazine of Team 2024-25 at South Zone conference at Vijayawada. The theme being an important topic of "Genitourinary Syndrome of Menopause"- the major and commonest cause of morbidity in elderly women. Hope the articles penned by our experts would help everyone to proceed towards some solution to this irritating and recurrent problem of midlife.

I extend my warm regards to Vijayawada Menopause society for their hard work in publishing the issue and also to Dr Shubha Sethia, Chairperson, Public awareness Committee, IMS, for choosing such a relevant topic.

Heartiest welcome and congratulations on release of this Poise Magazine.

From the Editor's desk



DR. SHUBHA SETHIA

CHAIRPERSON
CLUB 35, PUBLIC AWARENESS
IMS PUBLICATION ,POISE.

Dear Readers

It is a great pleasure to take out this edition of POISE at the South Zone IMSCON, IMS at Vijaywada.

We are dedicating this POISE to “Genitourinary Problems IN Midlife and beyond”

Genitourinary problems affect almost all women at some point in their lives, however women hardly ever discuss it with anyone. Often, these problems are considered to be due to poor hygiene, or a part of natural aging. Only 25% women consult their physician. The issue thus remains underdiagnosed, underreported, and undertreated and our women are forced to suffer in silence. This Poise is an effort on the part of IMS to provide knowledge regarding genitourinary problems to our women, to explain they are not the only ones affected, and to educate them about the treatment options available. This will remove hesitancy and make women more vocal about their problems

I am thankful to all the authors who have contributed to the various articles to make all the issues simple to understand. I thank the office bearers of IMS Dr Anju Soni, Dr Sudhaa Sharma and Dr, Bipasa Sen for having rendered their confidence in us. Last but not the least my special thanks to the team of this Poise from Vijayawada Menopause Society President, Dr Padmaja, Secretary, Dr Katru Gayathree and coeditor of this magazine Dr Sailaja Nalluri.

“ It is heartbreaking that so many suffered in silence both physically and emotionally. It is uplifting that by sharing our stories, more people feel comfortable talking about their own, and ideally we can work together to change the culture in the future.”

Ariela L. Marshall, MD

Co-Editor's



DR. SAILAJA NALLURI

TREASURER SOUTH ZONE IMSCON,
VIJAYAWADA MENOPAUSE SOCIETY

It is indeed my proud privilege to be the co-editor of Poise magazine.

I thank Dr. Anju Soni and the office bearers of IMS for giving me this opportunity.

It was a pleasure working with Dr. Shubha Sethia, editor of Poise magazine. I thank her for her guidance.

It was a wonderful experience going through the articles on the various aspects of Genito urinary syndrome.

The learned authors have given their write ups in simple language, easy for the comprehension of the general public.

Hope the magazine provides adequate and useful information.

WHAT SHOULD WE KNOW ABOUT GENITAL TRACT IN WOMEN

DR. THEJAVATHY G V

MBBS MD DGO FICOG

SECRETARY BANGALORE MENOPAUSE SOCIETY



The female reproductive organs develop in close relation to the urinary system. It consists of

- i) External genital organs
- ii) Internal genital organs

The internal genital organs include:

- a) Ovaries
- b) Fallopian tubes
- c) Uterus with cervix

i) Ovaries: They have a reserve of oocytes (eggs) and release one during each menstrual cycle. Alteration in hormone levels and anatomy of these can cause PCOD, cysts and cancer.

ii) Fallopian tube: These are tube like structures extending from either side of uterus. They pickup egg released from ovary and transport it to the uterus. Fertilisation between sperm and egg occurs here. Any infection can cause swelling of tube leading to Hydrosalpinx and abnormal pregnancy called Ectopic pregnancy most commonly occurs here.

iii) Uterus: A sac like pear shaped structure which bears the pregnancy and nurtures the foetus. It enlarges about 5-6 times its size during pregnancy and regresses in size post menopause. Diseases of uterus include fibroids, endometrial overgrowth, prolapse and cancer.

These organs are under constant influence of female hormones – Estrogen and progesterone throughout the female life. Before puberty, pubic hair is scanty, vagina is narrow and uterus is small in size. The vaginal opening is covered by a membrane like structure called Hymen which has an opening for menstrual flow. With onset of puberty there is increase in height, development of breasts and growth of pubic and axillary hair and puberty concludes with onset of menstruation called Menarche.

As the woman approaches the end of reproductive age, the uterus becomes small, vagina becomes narrow and dry. Few women may also experience hot flushes, mood swings and loss of libido. Reassurance and awareness about these can decrease the anxiety of the women. Calcium and dietary supplements help in relieving the symptoms however, severe cases might need hormonal pills and neurological medications. As cancers are more common in old age, vigilant screening and early visit to the gynaecologists helps in prompt detection and treatment. Health of a woman impacts the health of the family and in turn the health of entire society, hence adequate attention and vigilance is important.

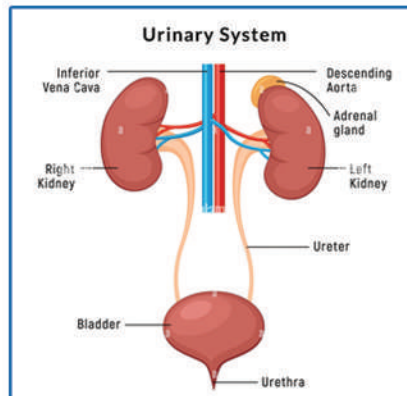
WHAT IS THE URINARY TRACT AND HOW DOES IT WORK?

SHUBHA RAMA RAO

PRESIDENT
BANGALORE MENOPAUSE SOCIETY



Structure of urinary tract.



The urinary tract is a drainage system made up of the organs that make urine and remove it from the body. It is made up of two parts.

1. Upper urinary tract includes 2 kidneys and 2 ureters
2. Lower urinary tract includes bladder urethra

The renal artery carries blood to the kidneys which removes the waste and extra fluid from it to make urine. This flows into the bladder through the ureters, where it is stored and thrown out at intervals through the urethra. All organs have to work together in order to maintain proper health.

KIDNEYS: 2 bean shaped organs, the size of a fist, located on either side of the spine below the rib cage. The kidney does the work of filtration of blood and produces 1-2 litres of urine per day. The amount of urine produced will depend on the fluid intake and loss occurring through sweating, breathing etc.

URETERS: Muscular tubes from kidney to bladder which carry the urine to the bladder. The ureters are about 10 inches in long.

BLADDER: Muscular balloon shaped organ that collects urine. It is in the bony cage (pelvis). It is under your control when to pass urine.

URETHRA: Small tube at the bottom of bladder which allows urine to come out.

There are two sphincters.

Internal sphincter: muscles at bladder neck and urethra which remains closed till the brain sends signal to allow to urinate.

External sphincter: muscles surrounding the internal sphincter which provides more pressure to keep urethra closed.

Sometimes these weaken and cause difficulty in holding urine.

Function of urinary tract.

- The urinary system works to get rid of what your body doesn't need.
- The blood reaches the kidney through the renal artery.
- It throws out extra water, salt, toxins and other waste products. Different parts work in coordination and perform tasks.

1. Filtering blood
2. Separating toxins from the nutrients needed
3. Storing and throwing urine out of the body.

Many conditions can affect the urinary system:

- There can be some developmental problems at birth or can develop later.
- Infections, stones etc can occur.
- Pregnancy, menopause, systemic diseases like diabetes and high blood pressure etc can affect the urinary system.

Care of the urinary system is important to prevent complications:

- Drinking plenty of water, good nutrition, emptying the bladder frequently and completely, hygiene of the genital area, safe sex practices, pelvic floor exercises will help. It is important to see a doctor if you have any problems.

POISE MAGZINE 2024

GENITO - URINARY PROBLEMS IN POSTMENOPAUSAL WOMEN

DR. HEERA SHENOY. T

PROFESSOR, MALABAR MEDICAL COLLEGE HOSPITAL
AND RESEARCH CENTRE ULLIYERI KOZHIKODE, CALLICUT.



Genitourinary syndrome of menopause (GSM) is a term used to define a compilation of signs and symptoms arising from decreased estrogenic stimulation of the vulvovaginal and lower urinary tract. Synonyms-vulvovaginal atrophy, atrophic vaginitis, or urogenital atrophy. It is a chronic, progressive, vulvovaginal, sexual, and lower urinary tract condition characterized by a broad spectrum of signs and symptoms. The hypoestrogenic milieu causes hormonal and anatomical effects in the genitourinary tract, with vaginal dryness, dyspareunia, and reduced lubrication being the most prevalent vaginal symptoms affecting the quality of life (QOL) in sexually active women. This can occur also in hypoestrogenism causing conditions -- chemotherapy, pelvic radiation, progestin-only contraceptives, breastfeeding, or anti-estrogenic medications.

TABLE-1 Major clinical manifestations of GSM

GENITOURINARY SYNDROME OF MENOPAUSE-signs and symptoms	
GENITAL	Dryness of vagina
	Irritation / burning / itching of vagina
	White discharge per vagina
	Thinning /greying pubic hair
	Vaginal /pelvic pain
	Vaginal prolapse
SEXUAL	Dyspareunia
	Reduced lubrication
	Post-coital bleeding
	Decreased arousal, orgasm, desire
	Loss of libido, arousal
	Dys-orgasm
URINARY	Dysuria
	Urgency/Frequency
	Stress/urge incontinence
	Recurrent infection of the urinary tract
	Urethral prolapse
	Ischemia of vesical trigone

TABLE-2 Pathophysiology of GSM

Genitourinary syndrome of menopause- Why?
Loss of labial and vulval thickness
Decreased collagen, elasticity, and blood flow
Reduced vaginal discharge
Reduced pubic hair, subcutaneous fat of labia majora
Reduced labia minora and hymenal remnants
Decreased glycogen in vaginal cells-----vaginal microbiome alteration => increased pH
Decreased pelvic floor strength
Dry and thin epithelium
Short and narrow vagina
Prolapse- vaginal vault, pelvic organ descensus, urethral prolapse
Decreased bladder capacity and sensation
Vaginal hypersensitivity

WHY ARE URINARY TRACT INFECTIONS SO COMMON ?

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Urinary Tract Infection (UTI) is an infection that can occur in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra. Most UTIs occur in the lower urinary tract, specifically the bladder and urethra, though less common, UTIs can also involve the ureters and kidneys, which in some cases can be severe. Most UTIs are caused by bacteria, but some are caused by fungi and, in rare cases, by viruses. UTIs typically occur when bacteria, usually from the digestive tract, enter the urinary tract through the urethra and begin to multiply in the bladder. The urinary system is designed to flush out these bacteria through urination, but sometimes the bacteria can attach to the walls of the urinary tract and cause an infection.

There are several predisposing factors for UTI: Anything that reduces the bladder emptying or irritates the urinary tract can lead to a UTI. Women are more prone to UTIs for several reasons

1. Shorter urethra: Women have a shorter urethra and it is very close to both the vagina and the anus. Hence bacteria that may naturally occur around both the vagina and anus can lead to infection in the urethra and thus increasing the likelihood of developing UTIs.
2. Sexual activity: Pressure on the female urinary tract during penetrative sex can move bacteria from around the anus into the bladder. Oral sex can also introduce bacteria into the urethra, increasing the risk of infection
3. Pregnancy
4. Menopause
5. Spermicide-coated condoms: Non-lubricated latex condoms may increase friction and irritate the skin during sexual intercourse. This may increase the risk of a UTI
6. Spermicides: Spermicides may increase UTI risk because they can disrupt the vaginal microbiome.
7. Urinary tract abnormalities or blockages
8. Weakened immune system
9. Conditions like diabetes or kidney stones
10. Prolonged use of urinary catheters, which may make it easier for bacteria to get into bladder
11. Constipations: Constipation makes it difficult to empty bladder completely, which means trapped bacteria have lots of time to grow and cause infection.
12. Diarrhoea: Diarrhoea also increases risk of getting a UTI, because bacteria from loose stool can easily make their way into the urethra. (A tried-and-true tip: Wipe from front to back after you go to the bathroom.

If you suspect you have a UTI or experience symptoms, it's essential to consult a healthcare provider for proper diagnosis and treatment. Early treatment can help prevent complications and ensure a faster recovery. Treatment for UTIs usually involves antibiotics prescribed by a healthcare provider. Drinking plenty of fluids can also help flush out bacteria from the urinary tract.

Complications: When treated promptly and properly, lower urinary tract infections rarely lead to complications. But left untreated, UTIs can cause serious health problems like

1. Repeated infections, which means having two or more UTIs within six months or three or more within a year.
2. Permanent kidney damage from a kidney infection due to an untreated UTI.
3. Delivering a low birth weight or premature infant when a UTI occurs during pregnancy.
4. Sepsis, a potentially life-threatening complication of an infection. This is a risk especially if the infection travels up the urinary tract to the kidneys.

HOW TO RECOGNIZE AND TREAT URINARY TRACT INFECTION

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About 1/3rd of women are diagnosed with UTI before 24 years and half develop at least 1 episode by 35 years. Up to 70% of women suffer from UTI during their lifetime, of those, 30% will have recurrent UTIs (rUTIs). It is common in women in their 40s and 50s.

Bladder infection is called cystitis
A urethral infection is called urethritis

Lower urinary tract infection (bladder and urethra),
Common symptoms of UTI

- Burning/pain/discomfort during urination (dysuria)
- Urgency (desire to pass urine which cannot be averted)
- Frequency (>8 times during day / >2times at night)
- Urinary incontinence (involuntary passage of urine)
- Blood in urine (Haematuria)
- Cloudy urine
- Pain during coitus
- lower abdominal / pelvic pain

Upper urinary tract infection (kidneys)

- Pain and tenderness in upper back and sides
- Fever with chills
- Nausea, vomiting

TREATMENT OF UTI

ACUTE UNCOMPLICATED UTI— nitrofurantoin, trimethoprim-sulfamethoxazole (TMP-SMX), fosfomycin for 3–5 days is usually sufficient. If no response, Cephalexin / Ceftriaxone may be used

COMPLICATED UTI-aminoglycosides, fluoroquinolones, ceftazidime, carbapenems, piperacillin/tazobactam for 10-14 days. Antibiotics changed according to cultures if no response within 48-72hours

OTHER TREATMENT OPTIONS (for rUTI)

Intravesical-COLISTIN, Vaccine-(Uro-Vaxom/OM-89), Vaginal estrogen (postmenopause), Methenamine-with vitamin C, D-mannose supplements, Cranberry juice, Lactobacillus probiotics
Preventive methods for UTI-Hydration, Proper hygiene- Wipe from front to back after using toilet, Rinsing urethral area after sexual act

RECURRENT UTI

DR. SUDHA SHARMA

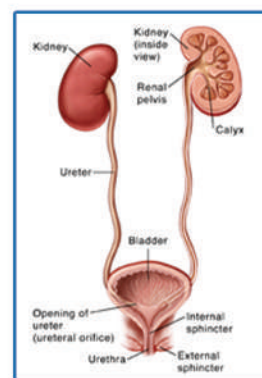
VICE PRESIDENT, IMS



Recurrent Urinary Tract infections are 2 episodes of acute bacterial cystitis, associated symptoms with in last 6 months, or 3 episodes with in the previous year. Its more common in women than men. UTIs may occur more often after Menopause, usually caused by the drop in the oestrogens. oestrogen loss causes thinning of the tissues, decreased vascularity, decreased elasticity in the Genitourinary Tract causing dryness, irritation, itching and setting the stage for UTIs.

Risk Factors for Recurrent UTIs

Any spermicide use, primarily with a diaphragm, Atrophic vaginitis (Menopause), Diabetes, Cystocele, Chronic Diarrhoea, First UTI before age 16, A higher frequency of sexual intercourse (more than 2 times a week) triples the risk of UTI, previous history of 5 or more UTIs, inadequate fluid intake, H/o frequent UTIs in mother or sister, new or multiple sexual partners, urethral diverticula, use of spermicide coated condoms.



Personal hygiene factors also play a role

History and Physical Examination

Acute cystitis can present with urinary frequency, urgency, dysuria and suprapubic pain. The presence of fever, chills, rigors, marked fatigue or malaise suggests that the infection has extended beyond the bladder. Women with recurrent UTIs should undergo a pelvic examination to check for cystocele, vaginitis, vaginal atrophy or prolapse (UV). A recurrence is termed reinfection if the interval between 2 episodes is > 2 weeks, if a different uropathogenic strain is documented or if a sterile culture (with the patient off antibiotic) is documented between 2 UTI episodes.

If the interval between the 2 episodes is less than 2 weeks, this is a relapse.

Evaluation

However, the diagnosis of recurrent cystitis is clinical. The typical patient with recurrent UTIs does not require cystoscopy or urological imaging. In women with a H/o recurrent UTIs with typical symptoms, no further urological evaluation is necessary other than a urine culture and sensitivity.

The American Urological Association guidelines on recurrent UTIs in women, recommend obtaining a urine analysis and urine culture with each episode of acute cystitis.

Treatment for recurrent UTIs

Recommended treatments, for recurrent UTIs include personal hygiene factors, avoiding spermicides, wiping the genitalia correctly, increasing fluid intake, using vaginal oestrogens if appropriate.



Commonly recommended initial non antibiotic therapies

- Cranberry products
- D-mannose
- Methenamine Prophylaxis
- Oestrogen vaginal cream
- Vaccines for preventing recurring UTIs. These are still mostly under development. one oral vaccine, **MV140** has shown good efficacy in several studies.

Antibiotics Prophylaxis

- Post coital prophylaxis
- Self-directed short course of antibiotics at the 1st sign / symptom, only if patient is sufficiently educated.
- Long term low dose antibiotic prophylaxis is the gold standard, indicated in the most intractable cases. This regimen requires highest level of patient compliance, has a long duration of therapy (at least 6 months) & risk of increasing antibiotic resistance.

Recurrent UTIs require management from an inter professional healthcare team who co-ordinates their efforts & share case information to achieve optimal outcomes with fewest adverse events.

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PERI MENOPAUSAL DYSURIA WITHOUT INFECTION

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Dysuria, painful urination, in women is often caused by urinary tract infections.

Dysuria, due to non-infectious causes. Could be –

**Hormonal Imbalance,
Vaginal Atrophy,
Urinary Tract Changes,
Pelvic Floor Dysfunction,
Interstitial Cystitis.
Psychological Factors,
Sexually transmitted infections,
Genital herpes,
Bladder and kidney stones
soaps, perfumes, and other personal care products that irritate locally.**

To determine the exact cause a thorough evaluation including a pelvic examination, urine analysis, and other specific tests are needed.

The management depends on the underlying cause

Avoid Irritants.

Local Estrogen Therapy for vaginal atrophy.

Behavioural and Lifestyle Changes-

Hydration,

Bladder Training,

Limiting intake of caffeine, alcohol, and acidic foods that can irritate the bladder.

Medications-

Pain Management

Anticholinergics.

NSAIDs

Antibiotics if indicated.

Physical Therapy: Pelvic floor exercises.

Psychological Support: stress or anxiety.

Persistent dysuria has Impact on Sexual Health: Vaginal atrophy and associated dysuria can lead to discomfort during sexual intercourse (dyspareunia), which may affect sexual health and intimacy. It can disrupt daily activities, sleep patterns, and overall quality of life.

Regular Medical Check-ups

Prompt Treatment of Symptoms will help.

By incorporating these preventive measures into daily life, perimenopausal women can help reduce the likelihood of developing dysuria and maintain optimal urinary tract health during this transitional phase.

Stay Hydrated.

Practice Good Genital Hygiene.

Consider Vaginal Moisturizers/Lubricants.

Avoid Irritants.

Pelvic Floor Exercises,

Use Medications as Directed.

Seek Prompt Medical Attention.

Manage Stress.

Follow-Up Care.

Educate Yourself:

Remember, every woman's experience with perimenopause and dysuria can be different, so it's important to tailor a management plan that addresses your specific needs and concerns. By taking proactive steps and seeking appropriate medical care, you can improve your comfort and quality of life during this transitional phase.



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BLOOD AND PROTEIN IN URINE: IS THERE NEED TO WORRY ?

DR. YAZHINI SELVARAJ

Managing Director &
Chief Consultant Ponni Fertility &
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Urine output is an essential indicator of overall health and can provide valuable insights into the functioning of various organ systems in the body. Changes in urine output can be indicative of underlying diseases that may require further investigation and treatment.

Blood and proteins are not normal components of urine. Excretion of >150 milligrams of protein in urine per day, called as proteinuria and >5 RBCs in urine per high-power field of microscope is called as hematuria. These symptoms should not be ignored. You ought to consult the doctor.

Systematically, kidneys are responsible for filtering waste and excess substances from the blood, including proteins. When the kidneys are not functioning properly, they may allow proteins to leak into the urine, which may be a sign of kidney disease, diabetes, high blood pressure, or other conditions.

Common causes of blood in the urine include urinary tract infections (UTI), kidney stones, bladder or kidney infections, trauma or injury to the urinary tract, certain medications, and strenuous exercise. It can also be a sign of more serious conditions such as kidney disease, prostate problems, or even cancer.

Both blood and protein in urine can be detected through a simple urine test. Treatment for this will depend on the underlying cause. If UTI is causing blood in the urine, antibiotics will be prescribed to control it. If kidney disease is the cause of protein in the urine, treatment involves medication to control blood pressure and manage symptoms. Lifestyle changes are recommended to help manage blood and protein in urine. This includes drinking plenty of water, avoiding foods that can irritate the urinary tract, and maintaining a healthy diet and exercise routine. Avoid UTI by reducing the residual urine to <50ml. triple voiding of urine will help to prevent recurrent UTI due to increased residual urine.

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URINARY STONES

DR. PAYAL BHARGAVA

TREASURER,
HYDERABAD MENOPAUSE SOCIETY



Symptoms like a burning sensation while urinating and pain in the pelvic region make women assume that they have a urine infection. While this is true in most cases, it could be due to Renal Stone (Kidney Stone) formation. Every 1 in 10 individuals has a urinary stone in their lifetime.

Symptoms of Renal Stones are:

- Severe pain in the back, side, or below the ribs
- Pain that travels to the lower abdomen or groin area
- Pain when urinating
- Pink, red, brown coloured, cloudy, or bad-smelling urine
- Nausea and vomiting
- Fever and chills
- Persistent feeling of needing to urinate
- Urinating often
- Urinating in small amounts
- Blood in the urine

What are Renal or Kidney Stones:

The kidneys help remove waste products from the body, maintain balanced electrolyte levels, and regulate blood pressure.

A kidney stone is a solid mass made up of tiny crystals. It can develop in one or both kidneys or in the ureter, the tube that connects the kidneys to the urinary bladder. Stones form when urine is concentrated allowing minerals to crystallise and form stones

Any person having the symptoms of Kidney Stone should contact a healthcare provider.

The uptick in cases is attributed to an increase in obesity rates, high-salt intake, high-sugar intake, and diabetes. Once an individual develops a kidney stone, they are at a 50 percent risk of developing another in the next five to seven years.

Types of Renal Stones

Calcium stones (80%): usually oxalate or phosphate

People who have oxalate stones should avoid oxalate rich foods like spinach, almonds. Too much salt also increases calcium excretion in the urine leading to calcium stones Calcium rich food or calcium supplementation is not contraindicated, rather calcium combines with dietary oxalate and decreases the absorption of oxalate in the body

Uric acid stones (5-10%)

People who take high protein diet or have diabetes or metabolic syndrome have greater likelihood of uric acid stones Striate and cysteine stones are rare.



Prevention and Treatment

Kidney stones that are small most often pass through your system on their own.

- Drink plenty of fluids orally to produce enough urine.
- Make changes to your diet for some types of stones.
- Follow the prescription of your doctor that may include an antibiotic depending on your urine culture and sensitivity report, a pain killer etc.

Surgery is needed if:

- The stone is too large to pass on its own or is growing or is blocking urine flow and causing an infection or kidney damage.
- A kidney stone may be treated with shortwave lithotripsy, percutaneous nephrolithotomy or nephrolithotripsy.

Tests and Scans that can be done

Physical examination of the abdomen or back.

- Complete Blood Picture
- Complete urine examination
- Kidney function tests
- Abdominal ultrasound
- Kidney X-ray
- Retrograde pyelogram

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VAGINAL DRYNESS

DR. SHUBHA SETHIA

CHAIRPERSON
CLUB 35, PUBLIC AWARENESS
IMS PUBLICATION ,POISE



Vaginal dryness affects about a third of females in their lifetime. It has associated problems like itching, irritation, burning, stinging, heaviness, and fissures. There are associated sexual issues like painful intercourse, lack of interest, libido, and orgasm which may culminate into marital disharmony, loss of self-esteem, and depression.

Although common with a significant impact on a woman's quality of life, only 25% of females discuss it with their physician and keep suffering in silence.

Causes of vaginal dryness

- 1) Menopause With declining estrogen at menopause, mucosal thinning, decreased blood supply, atrophy, and scanty glandular secretions, lead to vaginal dryness. It is estimated that 50% of menopausal women suffer from vaginal dryness, and 17-45 % have their sex life affected.
- 2) Apart from natural menopause, surgical menopause, iatrogenic menopause (due to radiotherapy or chemotherapy)
- 3) Lack of estrogen during breastfeeding also lead to vaginal dryness.
- 4) Decrease frequency of sexual activity, lack of foreplay, lack of arousal, desire, and orgasm can also be a causal agent for vaginal dryness
- 5) Damage to the vulvovaginal tissue with strong soaps, bubble baths, perfumed vaginal products, synthetic undergarments, and vaginal douching are other implicating agents for vaginal dryness.
- 6) Smoking and excessive alcohol also cause vaginal dryness.
- 7) Drugs like antihistamines, anticholinergics, antidepressants, antipsychotics, tamoxifen, danazol, progestins, aromatase inhibitors, and GnRHa also lead to vaginal dryness.



Treatment of Vaginal Dryness

Simple measures can give relief in 85 % of women with only 15% requiring drug therapy. These include

- 1) Avoid the implicating irritants like irritant or strong soaps ,smoking and alcohol

2) Regular sexual activity, vaginal dilatation with fingers or dilators, pelvic floor exercises



3) Home-based products like Cold creams, Vaseline or Coconut oil should be avoided as they are different in osmolality and pH from normal vaginal secretions



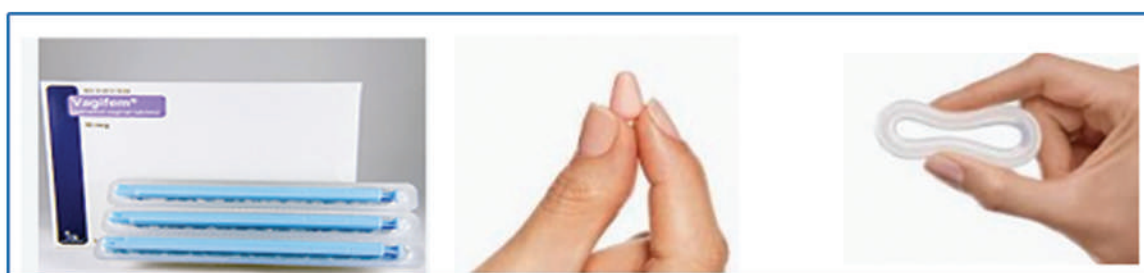
4) Vaginal lubricants May be used by both males and females just before intercourse. They ease penetration, provide lubrication, and avoid pain. There are several types available in the market like water, oil, and silicone-based lubricants. Water based are good for sensitive skin. Oil-based lubricants provide maximum benefit, but they may lead to infection and irritation and may also damage the condoms. Silicone-based are best, although more expensive. There are several lubricant in the market, but use products which are isoosmolar and isosmotic to vaginal secretions



5) Vaginal Moisturizers They are made of bio-adhesive products that stick to the vaginal mucosa forming a layer that lasts for 2-3 days and are thus better in people whose dryness and irritation are experienced throughout the day.



6) Vaginal Estrogen: Since lack of estrogen is the underlying cause and locally applied estrogen leads to favorable effects with minimal absorption in the body, so vaginal creams, tablets, inserts, and rings are being used for relief of vaginal dryness. In the Indian market at present only vaginal creams are available. However, they must be used on the advice of doctors as they are contraindicated in breast cancer survivors, hormone-induced cancers, or those at risk of thromboembolism



7) Systemic MHT: People who do not respond to local vaginal estrogen can use systemic menopause hormone therapy either oral, subcutaneous, intradermal, or vaginal on the advice of doctors after ruling out any contraindications.

8) Other Newer drug are also available in some countries like Vaginal DHEA, Oral SERMS which may be used in hormone-dependent cancer survivors.

POISE
MAGZINE
2024

ITCHING DOWN THERE : WHAT IS THE CAUSE?

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About 1 in 10 women suffer from an itchy vulva at some stage of their life. It may be due to allergy, infection, or inflammation. Vulvar itching may be short-lived or persistent causing severe distress, affecting sleep and markedly impairing a woman's quality of life. The vulva is moist and warm and

vulnerable to infections. The most common cause of vulvar thinning is fungal infection followed by allergens or irritants. However, dermatological conditions,

autoimmune disorders, and premalignant and malignant conditions also lead to vulval itching. Systemic diseases like liver or renal diseases, diabetes or drug allergies may also lead to vulval itching. Thus, women should always consult their gynecologist who will take a thorough history and do a complete examination to come to an etiological conclusion and initiate adequate management.



ALLERGIC/IRRITANT VULVITIS

Strong soaps, laundry detergents, fabric softeners, dyed or perfumed toilet papers, bubble baths, perfume sprays, synthetic undergarments, bathing in chlorinated swimming pools, spermicides, condoms, panty liners, urinary or fecal incontinence, local creams or ointments. Skin patch testing may be needed to look for an allergen. Treatment is to avoid the implicating irritant or allergen, use cotton undergarments, avoid wearing tight-fitting clothes to allow aeration, using a soap substitute moisturizer. Do not wear the underwear till the vulva is completely dry.

FUNGAL INFECTION/THRUSH

The commonest cause of itching vulva is fungal infection. It is associated with a thick curdy/cheesy white discharge. Fungal infection can be readily treated with antifungal pessaries or creams. However, despite treatment, frequent recurrences may occur especially in diabetics, patients on steroids, or prolonged antibiotics. Regular treatment under your physician's guidance can help you out.

Sexually transmitted infections like trichomoniasis and pubic lice, genital warts, gonorrhoea and herpes can also give rise to vaginal itching.

SCABIES

causes widespread itching in the whole body including the vulva.



SEBORRHOEIC DERMATITIS

presents with salmon pink, poorly defined patches, sometimes with mild exfoliation.

PSORIASIS

It is an autoimmune condition that can affect the vulva in 30-40% of cases. It is of two types, classical with erythema and silvery white scales and inverse which occurs on the genitocrural folds with only redness and itching and no scales. Psoriasis on other body areas leads to suspicion of genital psoriasis though in 2-5% cases it may be limited to genital areas.



Lichen simplex

it is an inflammatory disorder found in around 12% of women that occurs secondary to a chronic itch-scratch cycle. There is an uncontrolled intense itch that disturbs the sleep. it is aggravated by stress. Skin becomes dry, scaly, thick, with accentuated skin markings, sparse hair, and leathery plaques. Breaking the itch-scratch cycle with sedative antiallergics, local steroids, and antidepressants helps.



Lichen sclerosis

It is a chronic inflammatory, autoimmune disorder that begins as redness, swelling, and itching around the clitoris, inter-labial sulcus, perineum, and perianal region (figure of eight distribution). There is thinning of skin, and the appearance of white shiny wax or porcelain-like spots which coalesce to form large white patches with intense itching. Local high-intensity steroids and immunomodulators are advised. If not treated in time it may lead to scarring and distortion of vulvar architecture and sexual problems. Role of newer methods of treatment like Laser, phototherapy, and PRP is now emerging. Untreated conversion to malignancy has been found in 2-5% of cases.



Lichen planus

This is another inflammatory autoimmune vulvar disorder that affects the vulva, vagina, and extragenital sites like oral mucosa, skin, hair, and nails. There are red/purple patches with white lacy borders. Pain burning and soreness are more than itching. Treatment is again with local steroids and immunomodulators, but systemic steroids are frequently used to treat extragenital lesions.



Menopausal atrophic vulvovaginitis

Menopause with declining estrogen leads to thinning, dryness, and itching in the vulvar skin. Local vaginal estrogens help to relieve symptoms.

Pagets disease

Accounts for 1-2% of vulvar cancers. Itchy, eczematoid red velvety patches with raised edges, white icy scaling, associated oozing or ulcers. Any eczematoid vulvar lesion should raise suspicion of cancer.

Vulvar cancer or Precancer

5% of gynecological cancers are vulvar cancers. Uncontrolled vaginal itching not responding to usual treatment should raise suspicion of vulvar cancer and a biopsy is done.

Take home message

Always consult a gynecologist if itching doesn't go in 7 days or if there is an ulcer, blister, swelling, redness, eczema, bleeding, or unusual discharge.



PAINFUL INTERCOURSE AROUND MENOPAUSE

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Menopause or the final cessation of menstruation happens due to the fluctuations and finally a fall in level of estrogen, the feminine hormone responsible for many feminine attributes in the woman.

One of the less talked about, but generally widely prevalent change is lack of libido and decrease in the frequency of intercourse, which also becomes painful in many women. This may lead to frustration, and rifts in interpersonal relationship in the couple, however well-adjusted they are socially and otherwise.

Common causes and remedial measures are mentioned below;

Menopausal women :

1. Estrogen therapy: In post-menopausal women, there is decrease in the hormone called estrogen, which causes thinning and dryness in vagina. The thin vagina breaks in between, causing small ulcers or breaks. Intercourse becomes painful in these women. Local estrogen creams will rejuvenate the vagina and the pain decreases. Estrogen creams are generally applied deep in the vagina using applicators, but many women like to insert it with their fingers also. Some women who have pain at the entry point, may apply it on the vestibule or entry point also.
2. Moisturisers: Dry vagina in menopausal women may, if left untreated, may later lead to pain. So it is best to treat dry vagina from the beginning. It can be managed with lubricants, which are natural, like coconut oil, olive oil or hydrating gels available in tubes, which will keep the vagina moist.
3. Pelvic exercises: Pelvic exercises as well as increased frequency of intercourse can improve blood supply to the vagina and help.
4. Laser therapy: Laser therapy is available in many parts of India, which can rejuvenate the vagina and treat and prevent painful intercourse.

Menstruating women

Infections : Infections in the vagina or pelvis also may cause pain and should be looked for and treated.

CHRONIC PELVIC PAIN: UNDERSTANDING AND MANAGING A COMMON CONDITION

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Nearly one out of six women experiences chronic pelvic pain (CPP) at some point in their lives. This debilitating condition affects millions worldwide, yet it often goes undiagnosed and misunderstood. CPP is defined as pain in the lower abdomen or pelvis lasting six months or longer, severely impacting daily life, relationships and mental well-being. The pain often results from a combination of physical, psychological and social factors influencing how it is perceived.

The causes of CPP are varied and complex, making it a challenging condition to manage. Common causes include Endometriosis, where tissue similar to the uterine lining grows outside the uterus; Pelvic Inflammatory Disease (PID) an infection of the female reproductive organs; Irritable Bowel Syndrome (IBS) and musculoskeletal issues involving the pelvis. CPP can also stem from problems in the urinary tract, uterine fibroids or abdominal adhesions. In many cases, no specific cause is identifiable, which can be frustrating for both the woman and her doctor.

Symptoms of CPP can vary widely. Common symptoms include persistent pain in the lower abdomen or pelvis, pain during intercourse, urination or bowel movements, severe menstrual pain and pain radiating to the lower back, hips, or thighs. Keeping a Pain Diary to track when pain occurs, its severity, duration and factors that aggravate or relieve it can help diagnose the cause and plan effective management. Other aspects of daily life such as sleep, appetite, bladder and bowel patterns, moods and general well-being, also play an important role. Any history of physical or sexual abuse is significant and should be communicated to the healthcare provider.

Diagnosing CPP is challenging due to its many potential causes. Doctors typically start with a detailed medical history and physical examination, including a vaginal exam. Further investigations may include an Ultrasound Scan to check for abnormalities in the pelvic organs, MRI or CT scans for detailed pelvic images and blood or urine tests to detect infections. Laparoscopy, a procedure to look inside the abdomen using a telescope, may help identify conditions like adhesions, endometriosis, cysts, hydrosalpinx etc. However, this procedure can be normal in about one-third to half of women with CPP.

Managing CPP often requires a multi-faceted approach. Treatment options may include medications such as pain relievers, hormonal treatments or antibiotics if an infection is present. Physiotherapy and postural education can help address musculoskeletal issues, while surgery may be necessary when a specific cause, like endometriosis or adhesions, is identified. Counselling and psychological support are crucial, as chronic pain can lead to anxiety and depression and vice-versa. Some women find relief with complementary or alternative therapies such as Acupressure, Acupuncture, Homeopathy, Ayurveda, Yoga with Pranayama and meditation or dietary & lifestyle changes.

Living with CPP can be debilitating, but it is important to remember that help is available. Seeking medical advice early, exploring different treatment options and connecting with support groups can make a significant difference in managing this challenging condition.

ATROPHIC VAGINITIS

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Vulvovaginal Atrophy (VVA) is a common and underreported condition associated with effect of declined estrogen level on vaginal tissue. The hypoestrogenic state results in vaginal dryness, irritation, soreness, dyspareunia, and mild bleeding due to tear of friable thin vaginal epithelial mucosa. There is also urinary symptoms like frequency, urge incontinence, mixed incontinence. Although the prevalence is almost 45 – 54% in postmenopausal and 15% in premenopausal age group, it can occur earlier in life also due to various reasons like pan hysterectomy, oophorectomy, radiotherapy or chemotherapy for malignancy treatment, stress, diabetes, obesity, excessive smoking, alcohol consumption, increased prolactin level (as in lactation), alkaline soap, local deodorant, perfume, detergents, synthetic undergarments, decreased coital activity, immune disorders or due to certain medications like Tamoxifen, Diazole, methotrexate, GnRH agonist, Aromatase inhibitor, antipsychotic, antidepressants and anticholinergics. Decline from normal circulating estradiol level (40-400 pg./ml) to almost 20 pg./ml causes vaginal dryness not only at coitus but in daily life that the woman can't sit, walk, urinate, defaecate or even sleep comfortably. Thus it significantly affects the Quality of Life. The International Society for Study of Women's Sexual Health and North American Menopause Society together, in a consensus in 2014, coined the term "Genitourinary syndrome of Menopause (GSM)" for vulvovaginal and urogenital symptoms occurring at or around Menopause. Its ICD 10 CM Code is N95.2.

Clinical Features: Vulvovaginal mucosa becomes pale, dry along with petechiae. There is atrophy of labia majora and vaginal introitus, labia minora may recede, vaginal rugae disappear and cervix becomes flush with vaginal wall. Vaginal pH becomes 4.6 or more.

Pathophysiology: Normal vaginal epithelium is stratified squamous epithelium which is moist and thick with rugae. As epithelial cells exfoliate and die, they release glycogen – which is hydrolyzed to glucose – which in turn, is broken down to lactic acid by Doderlain's lactobacillus – a normal vaginal commensal organism. With declining estrogen levels this cascade is disrupted – vaginal pH rises – resulting in loss of lactobacilli and overgrowth of other bacteria like streptococci, staphylococci, coliform etc. Also, due to decreased estrogen level, there is reduced vaginal blood flow and reduced lubrication. The elasticity of vagina is also reduced. The effects of endogenous estrogen on urogenital organs is mediated through receptors ER α and ER β located at vagina, vulva, labia, urethra and trigone of bladder.

How to diagnose VVA:

1. Thorough history taking (lifestyle, disease, drug intake).
2. Pelvic examination including visual inspections.
3. Vaginal pH ≥ 4.6
4. Altered Vaginal Maturation index (VMI)
Normal preponderance of superficial cells (15%) is replaced by low superficial cells (< 5%) and comparative increases in ratio of parabasal cells.
5. Altered Vaginal Health Index (VHI)
 - (i) decreased elasticity
 - (ii) less secretion
 - (iii) raised pH
 - (iv) Friable mucosa
 - (v) less vaginal hydration



Management:

1. Lifestyle modification – Avoid excess smoking, alcohol
 - reduce stress, obesity
 - avoid drugs causing vaginal dryness
2. Moisturizers for VVA – these are water based gel, liquid or ovule that are bio adhesives and absorbed through mucosa and helps vaginal wall retain water. These may be used on long term basis for chronic maintenance of vaginal epithelial health.
3. Lubricants for dyspareunia – these are water or silicone based, applied to introitus for short and instantaneous action.
4. Hormonal – Low dose vaginal estrogen cream –
 - i) Conjugated Equine Estrogen cream 0.3 mg daily for 2 wks., then twice a wk. for 2 – 3 months. They have best rating.
 - ii) Estradiol cream: 8 – 10 Mg/day for 2 wks., then twice a wk. Absorption rate is less than CEE and so less rise of plasma estrogen.
 - iii) Estriol cream weak, but no effect on serum estrogen, hence safest.

None of the local estrogen have known safety data beyond 1 yr.

Contraindicated in unexplained vaginal bleeding and hormone dependent tumor or cancer.

5. Local DHEA – As precursor of androgen and estrogen, it improves libido and affects all 3 layers of vaginal wall – increasing modification of epithelium, thickness of muscularis and collagen fiber compactness in lamina propria. It improves VMI and reduces pH in 7 days without increasing circulating level of estrogen.

6. SERM – Ospemifene (approved by USFDA in 2013 for treatment of severe dyspareunia).

- Oral dose of 30/60 mg per day significantly improves VMI, vaginal pH without affecting other estrogen dependent organs. It increases the ratio of type I and type III collagen at vaginal and vestibular level, so, improves elasticity.
- contraindicated in hot flush, past h/o thromboembolic events, endometrial hyperplasia and unexplained vaginal bleeding.

7. Tissue Selective Estrogen Complex –

Bazedoxifene (20 mg) + CEE (0.625 mg/0.3 mg).

8. Laser - Erbium doped yttrium aluminum garnet laser (Er : YAG) or micro ablative Co2 laser therapy or High Intensity Focused Ultrasound (HIFU) can restore the vaginal epithelium, increase lactobacillus flora, improve VHI and subjective symptoms of GSM.

Conclusion: Several studies like SWAN, or by Wilbur, Crandall, and Williams at USA have cited VVA as a prominent health issue with high prevalence in postmenopausal women. As per latest guidelines of International Menopause Society, VVA is one of the only two absolute indications of MHT. Still the complaint is grossly underreported due to stigma/lack of awareness/ poor access to medical facility on the part of women. Physician's approach too differ because menopause management is not consistently included in training curriculum of general practicing doctors except in USA, Canada, Australia and New Zealand.

PREVENTIVE STRATEGIES IN UROGYNÆCOLOGICAL DISORDERS

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Urogynaecological disorders including urinary and anal incontinence, recurrent UTI, pelvic organ prolapse and fistulas have a negative impact on the quality of life of women. Prevention should be the primary goal. Pelvic floor disorders have a long latency, and may go through periods of remission making diagnosis difficult. The risk factors may be demographics, genetics, obstetrics, previous pelvis surgeries, life style factors or multifactorial.

The prevalence of **pelvic organ prolapse** varies between 30% and 40%. Selective modification of obstetric events or other risk factors and planned caesarean section plays a central role in the prevention. Elevator any trauma could be used as a surrogate marker and missing link between childbirth and for the prevention of pelvic floor dysfunction. McCall culdoplasty and use of a vaginal apical support procedure with mesh at the time of surgery might reduce the long-term risk of recurrence of prolapse urogenital atrophy and prolapse can be prevented with local estrogen.

Genitourinary and anal fistulas prevention need better quality of medical care, timely caesarean section, good surgical techniques, proper evaluation and selection of special cases like endometriosis and cancer involving multidisciplinary team. Standard training of post- graduates program need to be addressed properly for preventing both obstetric and iatrogenic fistula.

Healthy life style and behavioral changes helps prevention of urinary incontinence like healthy food, exercise , managing weight ,avoidance smoking, alcohol and constipation, treating UTI promptly, **timed voiding and urgency suppression Medications and Nerve damage** which precipitate incontinence must be evaluated

Prevention of urogynaecological disorders can be achieved by raising awareness of pelvic floor dysfunction for women of all ages by providing information within primary and intermediate care services, as part of general and comprehensive geriatric health programmers.

LEAKAGE OF URINE: BOTHERSOME PROBLEM

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CALICUT.



Leakage of urine is seen in 25-50% women .It causes significant impairment in quality of life which may limit women from physical, social or sexual activities and can even destroy their self-confidence. Symptoms are often neglected because of the fear of judging or thinking it as a common scenario.

Type of urinary incontinence includes

- 1. STRESS URINARY INCONTINENCE:** Loss of urine occurs at the time of activities like sneezing, coughing or exercise. It is due to increase in pressure or stress on the bladder.
- 2. URGE INCONTINENCE:** There is a sudden and intense urge to urinate, sometimes followed by leaking on the way to bathroom or while pulling down the clothes.
- 3. OVERFLOW INCONTINENCE:** Leakage occurs due to incomplete emptying of urine.
- 4. TOTAL INCONTINENCE:** Inability to store urine
- 5. FUNCTIONAL INCONTINENCE:** Urine escapes because a person cannot reach the bathroom in time, possibly due to mobility issue
- 6. MIXED INCONTINENCE:** A combination of types

RISK FACTORS: Chronic cough, constipation, obesity, smoking, extreme weight lifting, multiple vaginal deliveries, prolonged and difficult birth, increasing age , urine infection, bladder stones,diabetes.Genetics also plays a role

COMMON TESTS DONE FOR EVALUATION include bladder diary, physical examination of vagina and pelvic floor muscles, urinalysis, blood tests, post void residual urine measurement, ultrasound, stress test, urodynamic test, cystogram and cystoscopy

MANAGEMENT must include proper understanding of severity of condition through a detailed evaluation. Patient should be counseled regarding bladder training, avoidance of risk factors and pelvic floor exercises.The ultimate goal of treatment is psychological and physical well being of the patient, which can be achieved through medical and surgical methods

SMILE...REASSURANCE ...AND GUIDANCE IS THE CORNERSTONE OF ANY TREATMENT

DOES DELIVERY CAUSE URINARY LEAKS?

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Yes!!

It can be common to have leakage of urine after delivery. Every third woman can have urinary symptoms of leaking due to hormones that stretch the muscles and tissues that support the bladder, the bowel and the uterus, called pelvic floor muscles. Weakened pelvic floor muscles can cause accidental leak of urine.

Stress urinary incontinence (SUI) is the most common type of urinary incontinence associated with pregnancy. This might be the common statement among friends and family: "After you have a baby, you won't be able to cough, sneeze, or exercise without peeing a little."

Most women who leak urine after delivery get relieved in the first few weeks, as the stretched muscles and tissues recover. Some may take months while others find that their pelvic floor never recovers fully. But it's not that one needs to live a life with urinary incontinence.

Dealing with this issue early can reduce the risk of a life-long problem. Following birth, the pelvic floor should be given time to recover like icing the perineal area and plenty of rest. Later pelvic floor exercises are required to strengthen the muscles called Kegel exercises. Lifestyle changes such as losing the pregnancy weight gain, eating more fiber, drinking more water and lifting less will help.

Doing Kegel exercises regularly is key to strengthening the pelvic floor. So, where are the pelvic floor muscles? If you lie on your back, imagine the top of the opening of your vagina is 12 o'clock and the bottom of the opening is 6 o'clock. The pelvic floor muscles are easily palpated at 5 o'clock and 7 o'clock positions.

These are the same muscles that contract when you try to stop the flow of urine midstream. These are the muscles that need to be contracted during Kegels exercises. These pelvic floor muscle exercises were named after Dr. Arnold Kegel, who described them in the 1940s to help patients strengthen their pelvic floor muscles to treat urinary incontinence. Women are recommended to do 10 repetitions, holding each squeeze for 5 to 10 seconds, three times each day. The exercise is best learnt by making the patient to do the exercise when a health worker confirms the muscle contractions. Let's learn, perform and stop the Tik Toks!!

PREVENTIVE STRATEGIES FOR URINARY LEAKAGE

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Preventive strategies for leakage of urine:

- Intake of fluid up to 2 liters per day
- Consuming High fiber diet
- Pelvic Floor exercise
- Bladder training
- Training for good toilet habits
- Quitting Smoking
- Passing urine for at least 4-6 times per day, not to exceed 8 times per day and once (or not at all) during the night.
- Urine that is dark yellow or brown urine may indicate that the intake of fluid is not enough (dehydration).
- Water is the best fluid for preventing dehydration, but other hydrating fluids may include fresh fruit juices, tender coconut water, buttermilk, milk, soup. Limit the daily intake of carbonated drinks, tea, coffee, alcohol, because they can cause bladder irritation.

High fiber diet helps to prevent leakage of Urine:

- Dietary fiber is not digested, so it adds bulk to the stools which is important to avoid constipation.
- It is important to eat plenty of whole grain cereals (such as porridge, brown rice, whole meal pasta, whole meal bread or pulses such as lentils and beans) rather than highly processed or refined food.
- Eat fruits (at least two pieces) and vegetables (at least five parts) every day.
- Aim for 25-30 grams of fiber every day. As a rough guide, a bowl of muesli contains about 8 grams of fiber and an apple (with skin) has just over 3 grams.

Physical Activity:

- Exercise helps to maintain a healthy body weight, which in turn reduces the pressure on the pelvic floor (the sling of the muscle directly responsible for bladder & bowel control).
- Pelvic floor exercises helps to strengthen the pelvic floor muscles.

Good Toilet habits:

- Take time on the toilet to allow urine to flow at its own speed.
- Use correct posture on the toilet.
- Do not smoke (chronic cough because of smoking weakens the pelvic floor and contributes to leakage of Urine.) If you smoke, do quit your smoking.

ARE THERE DRUGS TO CONTROL URINARY LEAKS ?

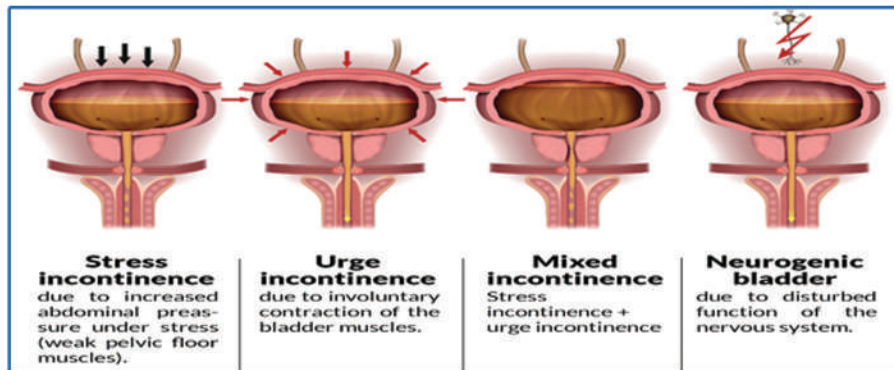
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The involuntary lack of bladder control that results in uncontrollably leaking pee is known as urinary incontinence. Talking to a doctor about it is advised as it can range from small instances to intense cravings that are hard to control.

Types of female Urinary Incontinence

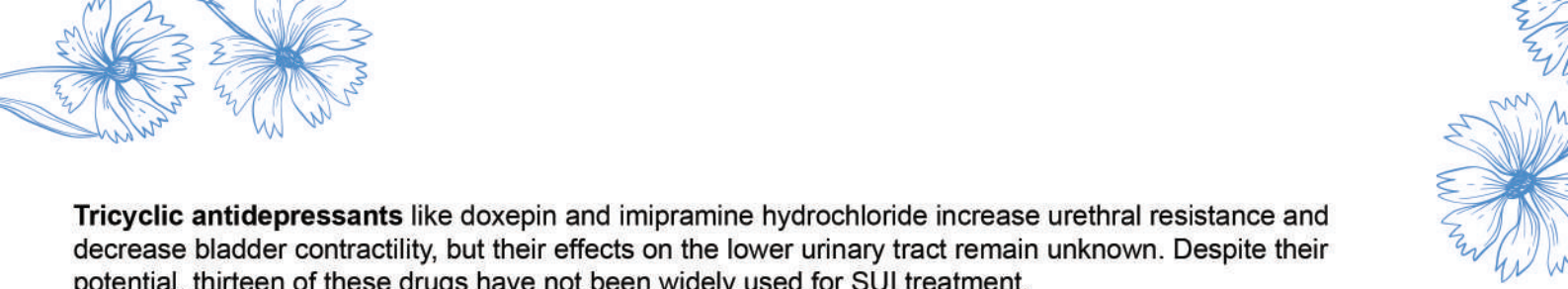


Anticholinergics Agent - Anticholinergic medications like transdermal oxybutynin (36 mg patch applied twice weekly), oxybutynin IR (2.5-5 mg b.i.d or t.i.d), oxybutynin gel (1g Sachet), tolterodine (1-2 mg b.i.d), tropism chloride (20 mg b.i.d), darifenacin (7.5-15 mg q. d), solifenacin (5-10 mg q.d), and ER fesoterodine (4-8 mg q. d) are commonly used in clinical practice for treating urge incontinence of urine in individuals who have not responded well to conservative nonpharmacological therapies.

Anticholinergics should not be combined with acetylcholinesterase inhibitors for dementia prevention. Nonpharmacological treatments are recommended for urge incontinence of urine, with modest doses and patient education. Patient education should emphasize healthy diet, exercise, and avoiding alcohol consumption to minimize constipation and dry mouth.

Mirabegron- This drug, a derivative of anilides, is used to treat adults with overactive bladder syndrome and incontinence. It can be taken alone or in combination with solifenacin, with recommended dosages ranging from 25-50 mg daily. It may cause allergic reactions, side effects such as swelling, breathing difficulties, hives, unpleasant urination, increased blood pressure, headache, constipation, headache, and quick heartbeat or dry mouth when combined with solifenacin and should not be taken by patients with certain conditions or those on CYP3A4 inhibitors.

Torfaen XR is a medication for overactive bladder. It relieves symptoms related to increased urine and difficulty controlling urination, requiring 20 mg twice daily orally. It's best taken without food, with typical side effects including dry mouth, constipation, diarrhoea, and headaches. Before beginning treatment, patients with renal or liver illness should speak with a physician.



Tricyclic antidepressants like doxepin and imipramine hydrochloride increase urethral resistance and decrease bladder contractility, but their effects on the lower urinary tract remain unknown. Despite their potential, thirteen of these drugs have not been widely used for SUI treatment.

Drug (TCAs)	Starting Dose (mg/d)	Dose Range (mg/d)
Imipramine	25-75	150-300
Trimipramine	50-70	100-200
Amitriptyline	25-75	150-300
Nortriptyline	25-50	75-150
Desipramine	50-75	100-200
Protriptyline	15-30	30-60
Doxepin	50-70	75-150
Clomipramine	25	100-250

TCAs block cholinergic receptors, causing adverse effects like constipation, vertigo, xerostomia, tachycardia, and blurred vision. They can cause cardiovascular issues, epileptic seizures, and are rarely linked to severe hepatitis.

Desmopressin is a medication that reduces urine production by the kidney, improving frequency and urgency symptoms but does not cure incontinence. It comes in the form of tablets, nasal sprays, or melt-in-the-mouth tablets and is taken before sleep. It is effective for 4 hours but can cause drop in sodium levels. Common side effects include headache, nausea, diarrhoea, abdominal pain, and stuffed noses.

Duloxetine helps moderate-to-severe urine incontinence by reducing unconscious nerve impulses and strengthening the sphincter muscle, increasing bladder pressure resistance. However, it has temporary effects like nausea, vomiting, constipation, exhaustion, and trouble sleeping.

Botulinum A toxin- novel therapeutic agent used in various medical specializations, particularly in patients resistant to anticholinergic medications requiring the recommend dose of 200 U of Botox® for treating NDO. Its injections into the detrusor muscle are well-tolerated and have low side effects. Future research should focus on standardized injection techniques and randomized controlled trials to determine optimal use.

Conclusion:

Urinary incontinence often requires collaboration among healthcare professionals, including nurses, pharmacists, and primary care physicians, for effective treatment and improved patient outcomes through thorough examinations and drug education.

IS SURGERY THE ONLY ANSWER TO URINARY LEAKS ?

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1) Leakage of urine from birth itself because of conditions like ectopic ureter and bladder exstrophy require appropriate corrective surgeries to restore normal anatomy.

2) Stress urinary incontinence is a condition where there is involuntary leakage of urine associated with coughing, laughing and sneezing. If patients have no relief from urinary leakage, despite conservative measures like weight reduction and pelvic floor exercises, they can undergo surgical treatment.

- Pubo vaginal sling surgery utilises the patient's own tissue like rectus fascia and an open abdominal-vaginal surgery is done to support the urethra and help correct urinary leakage.
- Minimally invasive surgeries using synthetic sling (mesh) can also be done.
- Burch colposuspension is a procedure where the bladder neck is lifted and attached to the iliopectineal ligaments. This can be done by open, laparoscopic, or robotic methods.
- Urethral bulking agents injected into the tissues surrounding the urethra help to close the urethra and reduce the leakage. The cost and need for repeated procedures are worrying.

3) Urge urinary incontinence is usually treated with tablets. Other modalities are tried if it becomes intractable.

- When the bladder becomes small and contracted because of advanced TB of the bladder, the patient can have severe frequency, urgency and urge incontinence. Augmentation cystoplasty is a surgery where a portion of the intestine is taken and attached to the bladder thereby increasing its capacity.
- Botox instillation into the bladder also helps in intractable urgency incontinence.
- Sacral neuromodulation is another procedure where a device implanted in the body helps bladder control.

4) Urinary Fistula Repair Surgery

- An abnormal connection can occur between the bladder and the vagina because of prolonged labour, difficult hysterectomy, malignancy or radiation, that causes continuous urinary leakage. They need to be evaluated and necessary corrective surgeries can be done by vaginal, abdominal, laparoscopic or robotic methods.

WHAT ARE SEXUALLY TRANSMITTED INFECTIONS ?

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INTRODUCTION

Midlife women are increasingly at risk of Sexually transmitted infection although the overall rate remains low. Symptoms are often non-specific or absent and may be interpreted as being due to menopause. Both the woman and the clinician may not be aware of their infection risk, leading to delayed or missed diagnosis. Risk assessment and referral for screening of infection should be carried out appropriately.

Sexually Transmitted Infection

Gonorrhoea, Syphilis, Chlamydia, Genital Herpes, Genital Warts, HPV, Hepatitis B, Trichomoniasis are sexually transmitted infections and sexually active mid-life women are at risk of contracting them.

Presenting symptoms

No symptom or pelvic pain, pain with urination, pain with intercourse, urethral discharge, post-coital bleeding may be there.

Protective mechanism

Healthy vaginal microbiota primarily composed of Lactobacillus species maintains acidic pH 3.5-4.5 owing to lactic acid production inhibiting the growth of urogenital pathogens.

Why post-menopausal women are at risk?

Vaginal epithelium in post-menopausal women is likely to be inflamed from coital function and offering a receptive environment for transmission of STI's. Advancing age leads to decreased humoral and cellular immunity as well as T-cell activity and immunoglobulin production.

Chlamydia infection is often identified on screening asymptomatic women. Herpes is common among women 50-80 years of age. Genital Herpes presents with Vulval ulceration, soreness and dryness. HIV infection may exacerbate menopausal symptom which appears earlier with great intensity and also display an increased prevalence of low bone mineral density. Sexually active post-menopausal woman continues to be at the risk of acquiring Bacterial vaginosis, further they are risk of STI, recurrence is also common with prevalence of 17%. Vaginal microbiota environment plays a role in persistent HPV infection. Women known to be HPV positive need regular pap smear testing beyond 70years also.

SCREENING

One STI serves as a marker for the presence of other STI's and should be appropriately screened, should be counselled to undergo therapy for her partner.

PREVENTION

Protection against STI should be stepped up in menopause.

- Awareness of risk of STI to be programmed.
- Use of latex condom to be encouraged.

CONCLUSION

- Mid-life women / post-menopausal women have risk factors that may lead to STI acquisition.
- They do experience vaginal symptoms which is erroneously attributed to menopause.
- Evidence based screening is recommended. Treatment is guided by centre for disease control and prevention of Sexually transmitted infection.
- Misconception, lack of HPV Vaccination and high infection risk are tied to STI growth in mid-life women.
- Obstetrician and gynaecologist should ask all patients about sexual history to test for and prevent Sexually transmitted infection.

MENOPAUSE AND STIS: DO SAFE SEX RULES STILL APPLY

DR. SAMEERA ALURI

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While menopause eliminates pregnancy risk, STI risk remains high. Women during the menopausal transition and post menopause should allay false sense of security and need to understand that they are not safe and should take all precautions to prevent sexually transmitted infections.

Common STIs include:

- Bacterial: Syphilis, Gonorrhoea, Chlamydia, Trichomoniasis
- Viral: Genital Herpes, Hepatitis B, HIV/AIDS, HPV

Transmission:

Oral, anal, or vaginal sex, and genital contact

Symptoms

- Asymptomatic initially
- Vulvovaginal symptoms: Vaginal discharge, itching, Burning, sores, bumps, and pain during urination and intercourse. Post coital bleeding, pelvic pain
- Do not confuse your symptoms with menopause
- Systemic symptoms include fever, headache, sore throat, rashes, fatigue.

Consequences of Untreated STIs

- Increased risk of other STI
- Organ damage
- Cervical Cancer

Prevention

- Male/Female Condom Use
- Limit Sexual Partners: Reduces risk.
- Regular Annual screening for those with multiple partners.: Tests for both partners and treatment if necessary. Screening includes Blood tests for HIV and syphilis, swabs, and urine tests for chlamydia and gonorrhoea.
- Doxycycline 200mg, Single dose within 24-72 hours post-unprotected sex prevents bacterial STIs.
- Vaccination for Hepatitis B and HPV.

Remember

Bacterial STIs are curable. Viral STIs are manageable but incurable. Hence prevention, timely diagnosis, and treatment are needed to prevent complications.

VULVOVAGINAL MASSES

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A vaginal mass refers to an abnormal growth or lump in or around the vagina. This can be caused by various conditions, ranging from non-cancerous to cancerous and may or may not be painful.

They may include:

1. Cysts:

- Bartholin's cyst: Blockage of the Bartholin's glands near the vaginal opening can lead to a fluid-filled cyst.
- Gartner's duct cyst: A benign cyst that can develop from remnants of embryonic ducts.

2. Polyps: Non-cancerous growths that can appear in the vagina or below the vagina and arising either from cervix or endometrium or may be a fibroid polyp.

3. Tumours:

- **Benign tumours:** Such as fibromas or leiomyomas.
- **Malignant tumours:** Vaginal cancer is rare but possible, often associated with human papillomavirus (HPV).

4. Infections:

- **Abscesses:** Infected, pus-filled masses that can form due to bacterial infection usually due to hair follicle infection.
- **Genital warts:** Caused by HPV, they can appear as a mass in or around the vagina.

5. Prolapse: In cases of pelvic organ prolapse, cervix and uterus descend down from their original position due to laxity of ligaments and muscles.

6. Vault prolapse may occur sometimes in post hysterectomised women and can cause dragging feeling in the vagina

7. Endometriosis: Sometimes, endometrial tissue can grow outside the uterus, including in the vaginal area, forming a mass.

Symptoms

- A noticeable lump or bulge in or near the vagina.
- Pain or discomfort, especially during sexual intercourse.
- Unusual discharge or bleeding.
- Difficulty urinating or bowel movements if the mass is pressing on nearby organs.
- Dragging sensation in the vagina

Diagnosis is by

- Primarily Physical examination.
- Imaging tests: Ultrasound, MRI, or CT scans.
- Biopsy: To determine if the mass is benign or malignant.

Treatment

Treatment depends on the cause:

- Cysts and benign tumours: May require surgical removal or drainage.
- Infections: Treated with antibiotics or drainage.
- Malignant tumours: May need surgery, radiation, or chemotherapy.

It's important to seek medical evaluation for an accurate diagnosis and appropriate management.

VAGINAL PROLAPSE AND MANAGEMENT

DR. RAGINI AGRAWAL

MS, FICOG, FICMCH,
GURGAON.



Vaginal prolapse is a common condition where the bladder, uterus and or bowel protrudes into the vagina. This can cause symptoms such as a sensation of a vaginal lump, constipation, difficulty emptying the bowel or bladder or problems with sexual intercourse. Treatment is only recommended when the prolapse is symptomatic. The biggest cause of prolapse is pregnancy and birth, though a number of other factors such as family history, lifestyle and certain medical conditions can also cause prolapse. Treatment can vary from simple lifestyle changes to surgery

You are also more likely to have a vaginal prolapse if:

- Someone in your family has also had a prolapse
- You have been through menopause and you have low levels of the hormone oestrogen
- You are overweight
- You cough a lot or strongly (because you smoke, have bad bronchitis or asthma)
- You often have constipation and need to push hard or strain to go to the toilet
- You regularly lift heavy things (like furniture, older children etc.)
- You have fibroids or a pelvic tumor
- You have had surgery in the past to treat a vaginal prolapse

What are the signs of prolapse?

Many women don't notice a prolapse when it first happens or if the organ has not moved far. If your prolapse has moved further down (and is a higher stage) you may:

- Sense that your vagina is different. It may feel heavy or like it is dragging. This may be more noticeable when you sneeze or cough, have been standing for a long time, have done something very physical such as running or at the end of the day.
- See or feel a lump. This can be inside your vagina or poking out of it.
- Have achy pain in your pelvic region or back.
- Have difficulty going to the toilet. You may need to urinate a lot, have trouble emptying your bladder or bowel, or urinate accidentally.
- Have a urinary tract infection (UTI) that often comes back again.

Some women also say they have discomfort, pain or less sensation during sex.

How is prolapse diagnosed?

Your doctor can diagnose a prolapse. They will most likely:

- Ask you questions about the history of your health
- Examine your body
- Look into your vagina or inside your bottom (rectum)
- Ask you to cough, push down or tighten with your pelvic muscles.

Many prolapses are discovered during regular cervical screening tests.



How is prolapse treated?

The kind of treatment you have will depend on:

- Which organ has moved (prolapse type) and how far (prolapse stage)
- your age, health and medical history
- Whether you want to have (more) children.

Your doctor may refer you to a women's physiotherapist or a doctor who specialises in women's pelvic floor problems (called a urogynaecologist). They may recommend one or more of these treatment options:

Lifestyle changes to stop doing the things that may cause the prolapse or make it worse. This can include losing weight, quitting smoking, eating and drinking differently, and lifting less. These changes aim to fix prolapses.

Physiotherapy to strengthen the pelvic floor that supports your organs. A physiotherapist can design a special pelvic exercise program for you. Physiotherapy aims to fix prolapses.

A pessary (a small plastic or silicon support) that is placed inside your vagina to hold up the prolapsed organ. Pessaries don't fix prolapses but they can reduce or lessen the symptoms of prolapse and help you live more comfortably.

Surgery to repair the torn or stretched pelvic floor. There are several types of prolapse surgery but all of them try to fix the prolapse and prevent it from happening again. Some surgeries will mean you can no longer have children.

Treatment is not always successful and sometimes a prolapse will come back.

PELVIC FLOOR EXERCISES

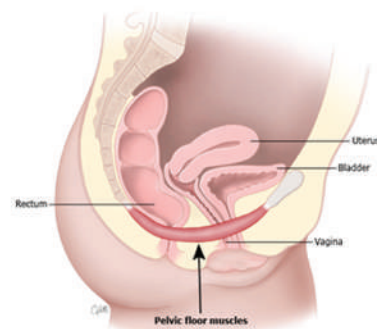
DR. NAINI TANDON

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What is the pelvic floor?

The "pelvic floor" is the name for the muscles that support the organs in the pelvis. These organs include the bladder, uterus, cervix, vagina and rectum.



What happens when the pelvic floor becomes weak ?

Factors such as pregnancy, childbirth, aging, and being overweight often weaken the pelvic muscles resulting in the following problems-

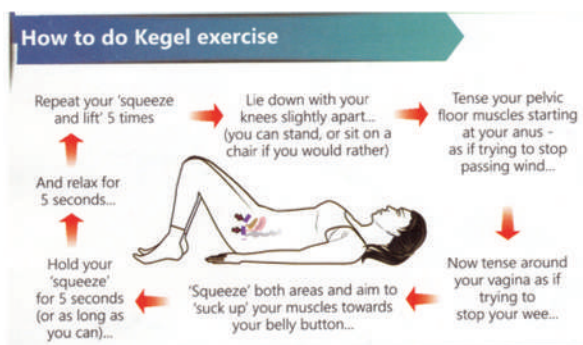
- Urinary incontinence – This is leakage of a few drops of urine when there is increased pressure in the abdomen (for example, during coughing, sneezing, or straining) or there is a strong, sudden uncontrollable desire to urinate that is difficult to delay and the whole urine leaks.
- Anal incontinence – This refers to the involuntary loss of stool or gas.
- Pelvic organ prolapse – This is when the bladder, rectum, or uterus may drop down and bulge into the vagina.

What are pelvic floor muscle exercises?

Pelvic floor exercises, also known as Kegel exercises, are done to strengthen the pelvic floor by repeatedly contracting and relaxing the muscles that form part of the pelvic floor.

Identify the pelvic floor muscles - learning the proper technique-

1. Put a clean finger inside your vagina and squeeze the muscles around your finger. Or you can imagine that you are sitting on a marble and have to pick it up using your vagina.
2. Squeeze the muscles that control the flow of urine.- try to stop the flow of urine while emptying your bladder. If you can do it for a second or two, you are using the correct muscles. Do not do this repeatedly.
3. Squeeze the muscles around the anus as to avoid passing gas.



Performing pelvic floor exercises

1. Begin by emptying your bladder.
2. Tighten the pelvic floor muscles and hold for a count of 10.
3. Relax the muscles completely for a count of 10.
4. Do 10 repetitions, 3 to 5 times a day (morning, afternoon, and night).

You can do these exercises at any time and place and in any posture-sitting, lying down or standing. Breathe deeply and relax your body during these exercises.

Make sure you are not tightening your stomach, thigh, buttock, or chest muscles.

Different methods and steps to do kegel exercise



Benefits of Pelvic Floor Exercises

When done the right way, pelvic floor muscle exercises have been shown to be very effective in controlling urinary leakage, reducing or preventing the leakage of stool or gas and in relieving symptoms of pelvic organ prolapse. Some improvement is often noticed after 4 to 6 weeks but it may take as long as 3 months to see a major change.

HYSTERECTOMY GROWING MENACE

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One might have decided to get hysterectomy done before the age of natural menopause for various reasons, with or without removal of ovaries. But the consequences are distressing. Women age early even when ovaries are retained at hysterectomy. Menopausal symptoms and sequel follow at a very early age.

- Salient characteristics are
- Sudden onset,
- more intense,
- increased morbidity due to NCDs.

Having a hysterectomy at an early age can present several potential challenges and considerations

1. Emotional and Psychological Impact: For many individuals, the loss of reproductive capability can be emotionally challenging, especially if the surgery was unexpected or if there were hopes of having children in the future. Women with children also felt a sense of sadness and loss. Many women consider menstruation and pregnancy as symbols of femininity. The feeling of loss of femininity and self-esteem can be distressing. Depression and anxiety are likely exacerbation of underlying stress.

2. Hormonal Changes: Symptoms of menopause occur leading to premature ovarian insufficiency. It is because of decreased estrogen and other steroid hormones. Even if ovaries are retained at hysterectomy, premature ovarian failure follows within 2 to 5 yrs. .

Following hysterectomy with bilateral salpingo - oophorectomy at early age, there is abrupt fall in estrogen levels within 24 hrs.; 80% below mean follicular phase. Plasma testosterone falls by 30% of premenopausal age.

In contrast oophorectomy in post menopausal women does not alter the estrogen level but there is significant fall in testosterone level. Post menopausal ovary contributes 50% of testosterone and 30% of androstenedione in circulation.

Estrogen receptors expressions are found in reproductive organs and other cells like cardiovascular system liver, pituitary, bone, and central nervous system. **Deficiency leads to short term and long term adverse effects**

Short term consequences	long term consequences
Hot flashes/ flushes	Obesity – visceral mainly
Night sweats	Increased risk of cardio vascular disease
Disturbed sleep, head ache, fatigue	Metabolic syndrome
Mood swings / anxiety / depression	Type 2 Diabetes. Hypertension
Genitor urinary syndrome of menopause – GSM	Osteosarcopenia
Vaginal dryness, irritation, itching,	GSM stress and urge incontinence
Muscular skeletal pain	Increased risk of cancers – breast, colon. & endometrial
Dry skin, brittle nails	Dementia, Alzheimer's
Impaired verbal memory	All-cause mortality

Vasomotor symptoms are temporary, last for 2 to 5 yrs and are highly responsive to estrogen therapy. Genito urinary syndrome is progressive, needs prolonged treatment. Local estrogen, DHEA and testosterone creams are highly effective.



3. Sexual function and Quality of life

The International Journal of Gynaecology & Obstetrics 2023; Michael Geary Studied by 5D – five dimensional scale. Parameters are desire, arousal, lubrication, orgasm and satisfaction. When hysterectomy done for benign conditions no change in the activity was found, vaginal mucosa is supplied with more blood during sexual stimulation, controlled by autonomic nervous system. Transudate that comes ensures lubrication during intercourse.

Majority of studies demonstrate improved sexuality after hysterectomy for benign diseases. Oophorectomy may lead to vaginal dryness and dyspareunia, in long run.

Some individuals may experience changes in sexual function, including decreased libido or discomfort during intercourse, especially if the surgery involved removal of the cervix or part of the vagina.

4. Long-Term Health Considerations: There is evidence suggesting that early hysterectomy, especially before natural menopause, may slightly increase the risk of certain health conditions later in life, such as cardiovascular disease and osteoporosis and there is increased morbidity due to chronic non communicable diseases.

Evidence

Hysterectomy < 35 yrs

- Congestive heart failure – 4.6 fold ↑
- Coronary artery disease – 2.5 fold ↑

Hysterectomy at early age leads to subclinical atherosclerosis, Carotid Intima media thickening, surrogate marker for atherosclerosis is increased

BMJ Open 7(11):e018861

5. Estrogen deficiency leads to telomere shortening

- short telomeres contribute to metabolic disturbances through mitochondrial dysfunction, early beta-cell senescence, dementia and cancers

Conclusion

It's essential for individuals considering or recovering from hysterectomy, especially at a young age, to discuss these concerns with their healthcare provider. They can provide guidance on managing physical symptoms, hormone replacement therapy if needed, and emotional support.

FOLLOW UP AFTER HYSTERECTOMY

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One should not be of the opinion after hysterectomy that no more health checkups are needed as one may develop complications due to surgery or due to the disease for which hysterectomy was undertaken. Need to have a first check up as per your doctor's advice when you were discharged as early after a day care hysterectomy or after 48 hours . Take timely medication for chronic diseases like diabetes, hypertension and hypothyroidism as per the dosage schedule given to you. Avoid heavy work and coitus for the first 6 weeks. If you have undergone hysterectomy prior to menopause, you may require to take Hormone replacement therapy to prevent acute onset of postmenopausal symptoms like hot flashes and night sweats, insomnia etc. If you have undergone hysterectomy for non-cancerous condition and did not suffer from vaginal discharge , bleeding, fever, difficulty in passing urine you can have your first follow up at 6 weeks of your surgery and subsequent follow-ups 3 to 6 months during the first 2 years and once in 6 to12 months next 3 years and need to follow healthy diet and exercise. If you have undergone hysterectomy for a cancerous condition or cancer was diagnosed in the hysterectomy specimen you will require further investigations and more specific follow up check ups. These would differ from person to person depending on the stage of the disease and hence these follow ups are personalized during which you would be adviced to take additional treatments like chemotherapeutic drugs and radiation if the stage of the cancer is advanced. Hence do not compare your follow up visits with other women who underwent hysterectomy and neglect yourself.

ARE GENITOURINARY PROBLEMS MORE IN DIABETICS

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Diabetes, a term which is infamous for many reasons and almost heard on a daily basis. We all are aware of what diabetes is and how it affects the patients. It is essentially a medical condition in which the blood glucose levels are extremely high. From timely medications to insulin injections and many more, the management and control of diabetes has propelled in many leaps and bounds over the last few years. But what about the cases when this diabetes is not under control or is unable to be brought under control despite many measures. The plethora of complications associated with uncontrolled diabetes are way too many to be bound into a single article. From nervous disorders to brain strokes and heart attacks, from kidney troubles to infections, the list goes on.

One of the lesser known complications of uncontrolled diabetes is its effect on the urinary system or the genitourinary tract, the infections caused are more severe and recurrent. In the female system, the genitourinary tract consists of the reproductive organs, genitals and urinary tract. Genitourinary syndrome of menopause (GSM) is another well-known result of uncontrolled diabetes. Other than the usual menopause symptoms, women affected by GSM might experience the presence of vaginal dryness, painful intercourse and frequent urge to urinate. In severe situations, this condition could sometimes even cause discomfort to sit or stand.

Identifying GSM:

- Burning sensation while urinating
- Recurrent urine infections
- Severe vaginal dryness
- Painful intercourse
- Genital itching
- Chances of light bleeding after intercourse
- Frequent urination
- Incontinence

It is imperative that women understand that menopause does not entail all of these signs and in case they do suffer with these symptoms, immediate attention by medical professionals is necessary to help manage the condition safely and effectively.

VAGINAL INFECTIONS IN DIFFERENT AGE GROUPS

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Introduction

Vaginal infections are prevalent health issue among women, varying significantly across different age groups. These infections include bacterial vaginosis, fungal infections, and sexually transmitted infections. Each age group presents unique risk factors, symptoms, and treatment challenges.

Prepubescent Girls

Prepubescent girls have a lower incidence of vaginal infections compared to older age groups. Non-specific vulvovaginitis is common, often resulting from poor hygiene, foreign bodies, or irritants such as soaps and tight clothing. Symptoms include itching, redness, and discharge. Management focuses on educating about proper hygiene, removing irritants, and sometimes using topical antibiotics and pH balanced lotions. Parental guidance is crucial to ensure adherence to hygiene practices.

Adolescents

Adolescents experience a higher incidence of bacterial and fungal infections. The onset of sexual activity, and hormonal changes can predispose them to bacterial infections. Management involves comprehensive sexual education, promoting safe sex practices, barrier contraceptive use, and appropriate antimicrobial therapy.

Adults

Women in their reproductive years face the highest rates of vaginal infection. Contributing factors include hormonal fluctuations, sexual activity, contraceptive use, and antibiotic usage. Treatment is tailored to the specific infection and may include antifungals, antibiotics, probiotics, and lifestyle modifications. Education on preventative measures and prompt treatment is crucial for maintaining reproductive health.

Postmenopausal Women

Postmenopausal women are at increased risk for atrophic vaginitis, recurrent bacterial and fungal infection due to decreased estrogen levels, leading to vaginal atrophy and altered microbiota. Symptoms include dryness, itching, discomfort, and recurrent infections. Management strategies include hormone replacement therapy, pH balanced lotions or vaginal moisturizers, and antifungal treatments. Regular gynaecological care helps manage symptoms and prevent recurrent infections.

Conclusion

Vaginal infections affect women differently across their lifespan. Tailored approaches considering age-specific risk factors and symptoms are essential for effective prevention, diagnosis, and treatment, ultimately improving women's health outcomes.

OVARIAN CANCER SCREENING:

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President Vijayawada Menopause society. Ovaries are the paired organs of the reproductive system that produce eggs, the hormones that go along with the eggs, so that pregnancy can occur and grow inside the woman's womb to give birth to a child. That is the way human life continues on earth. As with all organs ovarian cancer can occur, and the lifetime risk of ovarian cancer is 1.4%, i.e. about 14 women in 1000 women can have cancer.

Most frequently, in about 70% of women with ovarian cancer, the diagnosis is in later stage - Stage III. Unfortunately none of the screening programs are good enough to pick up ovarian cancer in early stages accurately enough to be used for all women.

There are some high risk groups like having a close family member with ovarian cancer (mother, sister, or daughter),

Personal history of breast cancer <40 years of age

Personal history of breast cancer <50 years of age and one or more close relative with breast or ovary cancer at any age;

two or more close relative with breast cancer <50 years of age or ovarian cancer at any age.

The women should be on a regular check up program.

In these women screening for BRCA mutation carrier status might be helpful.

Ovarian cancer occurs more frequently in women 50 yrs or older, who have never had children, women with obesity. Being health aware and having persistent unexplained complaints like such as bloating, fatigue, weight loss, and abdominal distention can be a warning.

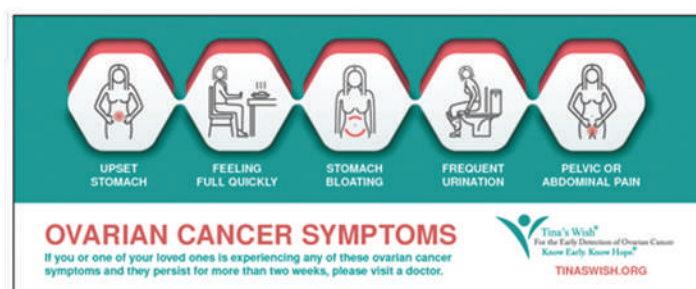
Other symptoms like increased frequency of micturition, back ache, lower-leg discomfort, lack of urge for food, undernourished look, uncommon bleeding also need to have a check up with the doctor.

For screening having a heightened awareness of the symptoms of early ovarian cancers on the parts of the patients and practitioners may help reduce the delay in diagnosis and hopefully result in an improvement in the outcome.

For general population, annual pelvic examination, PAP smear, and Transvaginal sonography are recommended as a part of postmenopausal surveillance.

Work is being done on development of a panel of biomarkers for ovarian screening in the form of getting a simple blood test.

To conclude being health aware, regularly exercising, maintaining a healthy body weight, if not well having a doctor's check up and having annual health check ups are till now the best way to screen for ovarian cancer.



SCREENING FOR ENDOMETRIAL CANCER

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Endometrial cancer, also known as uterine cancer, is the most common gynaecologic cancer in developed countries. It primarily affects the lining of the uterus, called the endometrium. Screening for endometrial cancer is less straightforward than for cervical cancer, as there is no standard screening test for the general population. However, several methods and strategies are used to detect this cancer, especially in high-risk women.

Risk Factors

- Age: Most common in postmenopausal women.
- Obesity: Higher body fat can increase estrogen levels, raising cancer risk.
- Hormone Therapy: Estrogen-only hormone replacement therapy increases risk.
- Genetic Factors: Lynch syndrome and other hereditary conditions.
- Diabetes and Hypertension: These conditions are associated with higher risk.

Symptoms Leading to Screening

Endometrial cancer often presents with symptoms that prompt further investigation:

- Abnormal Uterine Bleeding is the most common symptom.
- Pelvic Pain: Less common but can be a sign of advanced disease.
- Unusual Vaginal Discharge: Sometimes observed.

Screening Methods

1. Transvaginal Ultrasound (TVUS):

Procedure: An ultrasound probe is inserted into the vagina to obtain images of the uterus.

Purpose: Measures the thickness of the endometrium. Thickened endometrium in postmenopausal women can be a sign of cancer.

Use: Commonly used in women with abnormal bleeding.

2. Endometrial Biopsy:

Procedure: A small sample of the endometrial tissue is obtained using a thin, flexible tube inserted through the cervix.

Purpose: The tissue is examined under a microscope for cancerous cells.

Use: Often performed in women with abnormal uterine bleeding or those at high risk.

3. Hysteroscopy:

Procedure: A thin, lighted tube (hysteroscope) is inserted through the cervix to visualize the inside of the uterus and take tissue samples if necessary.

Purpose: Allows direct inspection of the endometrium and targeted biopsy.

Use: Used for further evaluation if initial tests are inconclusive.

High-Risk Population Screening

For women at high risk, such as those with Lynch syndrome:

- Regular Screening: Annual endometrial biopsies are often recommended starting at a young age (typically 35) or earlier if symptomatic.
- Genetic Counseling: Recommended for women with a family history of Lynch syndrome or other hereditary cancer syndromes.



Limitations and Challenges

- **No Standard Screening Test:** Unlike cervical cancer, there is no routine screening test for endometrial cancer in asymptomatic women.
- **False Positives/Negatives:** Screening methods can yield false results, leading to unnecessary anxiety or missed diagnoses.
- **Resource-Intensive:** Some methods like hysteroscopy require specialized equipment and trained personnel.

Prevention

- **Lifestyle Modifications:** Maintaining a healthy weight, managing diabetes, and avoiding unopposed estrogen therapy can reduce risk.
- **Prophylactic Surgery:** In high-risk women, prophylactic hysterectomy (removal of the uterus) may be considered.

In conclusion, while there is no standard screening test for endometrial cancer in the general population, various methods are used for early detection, particularly in symptomatic women and those at high risk. Early detection through appropriate screening and diagnostic methods can lead to timely treatment and better outcomes.

SCREENING FOR CERVICAL CANCER

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Cervical cancer starts in the cells lining the cervix - the lower part of the uterus. The best way to find cervical cancer early is to have regular screening tests. Early detection greatly improves the chances of successful treatment and can save lives. Being alert to any signs and symptoms of cervical cancer can also help avoid unnecessary delays in diagnosis.

The tests for cervical cancer screening are

Pap test & HPV test

The Pap test or Pap smear, involves collecting cells from the cervix. These cells are then examined under a microscope to look for abnormalities that may indicate pre-cancerous or cancerous conditions

Procedure

- 1. Preparation:** The patient lies on an examination table, usually with her feet placed in stirrups.
- 2. Speculum Insertion:** A speculum is inserted into the vagina to hold it open and provide a clear view of the cervix.
- 3. Cell Collection:** Using a small brush or spatula, the healthcare provider gently scrapes cells from the cervix.
- 4. Preservation:** The collected cells are placed in a solution or smeared on a glass slide for laboratory analysis.

HPV DNA testing is a method used in cervical cancer screening to detect the presence of high-risk types of human papillomavirus (HPV) that are most likely to cause cervical cancer. HPV is a group of viruses, some of which are sexually transmitted and can infect the genital areas.

Procedure

- 5. Sample Collection:** Similar to the Pap test, a healthcare provider collects cells from the cervix using a brush or spatula during a pelvic exam.
- 6. Laboratory Analysis:** The collected sample is sent to a laboratory where it is tested for the DNA of high-risk HPV types. This can be done using various molecular techniques, such as polymerase chain reaction (PCR) or hybrid capture technology

Frequency

- **Routine Screening:** The recommended frequency of screening test varies based on age and health history. It is advised for women to start screening at age 21 and continue every three years for Pap test & every 5 yrs for HPV DNA Testing till 65 yrs of age.
- **Follow-Up:** Abnormal results often require follow-up procedures, such as a colposcopy or biopsy, for further investigation.

In summary, Screening for cervical cancer with Pap test is a crucial tool in women's health, playing a vital role in the early detection and prevention of cervical cancer. Regular screening, along with follow-up care, can greatly reduce the incidence and mortality associated with cervical cancer.

