GYNECOLOGICAL PROBLEMS OF OLDER WOMEN

Kathleen McIntyre-Seltman, MD
University of Pittsburgh
Magee Womens Hospital
Objectives

As a result of this presentation, the participant will be able to:

• List common gynecologic concerns in older women
• Perform basic evaluation of common gynecologic concerns
• Know when to refer older women with gynecologic problems
GYNECOLOGIC PROBLEMS OF OLDER WOMEN

- Urogenital prolapse
- Incontinence
- Vaginal atrophy
- Vulvar disorders
- Post menopausal bleeding
- Cancer screening in older women
CASE 1

A 75 year old woman comes in because of something protruding from her vagina and difficulty voiding.

What else do we need to know about her to make a management recommendation?
Epidemiology

• Symptomatic pelvic floor disorders are common
• Lifetime risk of surgery approx 12%
  • 200,000 surgeries per year in US
  • prevalence increases as women age
  • affects 37% women in population, 65% of older women
How Common are Symptomatic Pelvic Floor Problems?

<table>
<thead>
<tr>
<th>AGE</th>
<th>INCONT ONLY</th>
<th>PROLAPSE ONLY</th>
<th>BOTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-39</td>
<td>6.9</td>
<td>1.6</td>
<td>9.7</td>
</tr>
<tr>
<td>40-59</td>
<td>17.2</td>
<td>3.8</td>
<td>26.5</td>
</tr>
<tr>
<td>60-79</td>
<td>23.3</td>
<td>3.6</td>
<td>36.8</td>
</tr>
<tr>
<td>&gt;80</td>
<td>31.7</td>
<td>4.1</td>
<td>49.7</td>
</tr>
</tbody>
</table>

**NHANES data**

_Nygaard et al JAMA 300:1311 2008_
UROGENITAL PROLAPSE - SYMPTOMS

- pelvic pressure, bearing down sensation
- sacral backache
- groin pain
- dyspareunia
- bulging past introitus
- bladder or bowel difficulties
- symptoms worse in evening, better in morning
How do symptoms impact on daily life?

Population based sample of 2000 older women, 118 had pelvic floor sx
*Rortveit et al ObGyn109:1396 2007*

<table>
<thead>
<tr>
<th>Limits daily activities</th>
<th>31%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits social interaction</td>
<td>9%</td>
</tr>
<tr>
<td>Limits sexual function</td>
<td>10%</td>
</tr>
</tbody>
</table>
UROGENITAL PROLAPSE - MANAGEMENT

general measures

- estrogen replacement - topical
- correct underlying factors
  - obesity
  - chronic cough
  - Ascites
- Kegel’s exercises – pelvic floor physical therapy
  - Even frail older women can benefit
  - Significant improvement in sx
Management Options: Pessaries

• 70% of women can be fitted successfully
• If successfully fitted:
  • 2/3 still using at 1 year
  • 1/2 still using at 3 years
Management Options: Pessaries

ADVANTAGES
• Non surgical
• Can temporize
• Independence – pt may be able to manage herself
• Flexible – may use only when needed

DISADVANTAGES
• 70% fitted successfully
  • If successfully fitted:
    • 2/3 still using at 1 year
    • 1/2 still using at 3 years
• Takes practice to fit
• Upkeep
• Discharge, bleeding
• May unmask SUI
• RARE: erosion, incarceration, perforation, fistula
UROGENITAL PROLAPSE - MANAGEMENT

surgical management

❖ many options – more or less invasive
❖ conserve sexual function or not, as indicated
❖ some procedures amenable to local anesthesia
❖ Some procedure well tolerated by frail elderly
❖ can combine with transvaginal taping procedures for incontinence
❖ Can be minimally invasive
Incontinence

• Stress incontinence:
  • associated with increased intraabdominal pressure
  • Responds less well to medications
  • Responds to physical therapy, pessary, surgery
  • Wt loss of 10 -15% improves sx

• Urge incontinence:
  • Associated with atrophy, aging, medications, neurological dysfunction
  • Responds to behavioral therapy, medications
  • May worsen with surgery
  • Beware anticholinergics in older population

• Mixed

• Overflow
  • Rare in women
  • May see with severe prolapse, prior surgeries
# Management Options:
## Success Rates

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Outcome</th>
<th># improved/1000 women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic floor PT</td>
<td>Improved sx and continence</td>
<td>490 for SUI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>167 for urge</td>
</tr>
<tr>
<td>Bladder training</td>
<td>Improved sx and continence</td>
<td>54</td>
</tr>
<tr>
<td>Pelvic floor PT and biofeedback</td>
<td>Improved but not resolved</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual therapy better than group education</td>
<td></td>
</tr>
<tr>
<td>Electrical stimulation</td>
<td>Same as biofeedback – e stim added no benefit</td>
<td></td>
</tr>
</tbody>
</table>
CASE 2

A 72 year old woman expresses concerns about difficulty with intercourse. In spite of lubricant use, she is dry. She has pain with insertion and some spotting afterward. She had a hysterectomy in her 40’s, and she was treated for Stage 1 breast cancer at age 60.
VAGINAL ATROPHY SYMPTOMS

- dryness
- dyspareunia
- vaginal spotting
- increased pelvic relaxation
- urinary symptoms: urgency, frequency, SUI
VAGINAL ATROPHY MANAGEMENT

- Topical lubricants / moisturizers
- Local estrogen
  - topical creams – some systemic absorption
  - Vaginal tablets – NO systemic absorption
  - estrogen containing silastic ring – NO systemic estrogen absorption
  - Non cream options safe in women with hx breast cancer
- Systemic estrogen – only if other indications
CASE 3

You are consulted to evaluate an 83 year old woman in a nursing home because of constant vulvar scratching.

What is your differential diagnosis?
How will you evaluate her?
VULVAR DISORDERS SYMPTOMS

- itching
- burning
- pain, dyspareunia
- mass / lump
- bleeding
EVALUATION

- inspection - magnification helpful
- KOH prep
- biopsy often indicated
VULVAR DISEASE

1. *non-neoplastic epithelial disorders* (vulvar dystrophies)
   - squamous cell hyperplasia (formerly hyperplastic dystrophy)
   - lichen sclerosus

2. *vulvar intraepithelial neoplasia (VIN)*

3. *neoplastic disorders*
   - squamous cell cancer
   - Paget’s disease
   - other
VULVAR DISEASE

4. Infections
   • Fungal
   • Bacterial

5. Other skin conditions
   • Excema
   • Psoriasis
   • Bullous disorders – increased incidence in elders

6. Vulvar pain syndromes
SQUAMOUS HYPERPLASIA MANAGEMENT

- rule out atypia
- decrease local irritation – sitz baths, hygiene
- high potency topical steroids for 6-8 weeks
- taper steroids rapidly
- maintenance
  - hygiene
  - skin lubricants, protectants
- intermittent low potency steroids only if needed
LICHEN SCLEROSUS MANAGEMENT

- LS is autoimmune disorder - evaluate for other associated autoimmune disorders as needed
- decrease local irritation
  - Sitz baths
  - Hygiene
  - Skin emollients
- topical clobetasol
- topical tacrolimus
- may take months for regression
- most women require long term maintenance therapy Q 1 – 2 x per week
VIN

- Approximately half is HPV related
- Less likely to be HPV related in geriatric population
- Requires Bx
  - Premalignant
  - Up to 20% have cancer at time VIN dx’ed
- Refer for management
CASE 4

A 72 year old woman is brought in by her daughter because of blood staining on the underwear for the last week. She went through menopause uneventfully 20 years ago, and she has used no hormone therapy.
POST MENOPAUSAL BLEEDING

- ANY bleeding or spotting > 1 yr after menopause
  - consider work up if > 6 months
- In women on HT:
  - unscheduled bleeding on sequential HT
  - continued bleeding > 1 yr on continuous HT
  - recurrence of bleeding after amenorrhea on HT
POST MENOPAUSAL BLEEDING: differential diagnosis

❖ Non-genital
  ❖ hemorrhoids
  ❖ hematuria
  ❖ coagulopathy
  ❖ systemic disease
  ❖ ovarian pathology

❖ Vulvo-vaginal
  ❖ vulvar lesions
  ❖ atrophy
  ❖ infection
  ❖ trauma

❖ Cervical
  ❖ polyp
  ❖ cancer (5 - 10% all PMB)
  ❖ infection
POST MENOPAUSAL BLEEDING: differential diagnosis

UTERINE

- atrophy: 30 - 50%
- polyps: 5 - 10%
- hyperplasia: 5 - 20%
- cancer: 10 - 15%
POST MENOPAUSAL BLEEDING: evaluation

history and physical exam
Evaluate endometrium

**Endometrial biopsy**
- Office / bedside
- Disposable suction cannula device
- > 95% sensitive for cancer
- 90% + sensitive for hyperplasia

**Ultrasound**
- Transvaginal, NOT abdominal
- Endometrium ≤4 mm: benign
- >4 mm: biopsy
- > 95% sensitive for cancer

If non diagnostic – D & C, hysteroscopy
Case 5

A 65 year old woman asks you whether she still needs Pap tests.

What information do you need in order to counsel her regarding the risks and benefits of her request?
PAP SCREENING IN OLDER WOMEN

ACS recommendation: stop at age 65

❖ problem: 25% invasive cervical cancers diagnosed after age 65
❖ low risk women: stop screening
❖ Pap + HPV neg x2 in prior 10 years – low risk
PAP SCREENING IN OLDER WOMEN

- high risk women: continue to screen
  - prior CIN 2/3 or cancer – screen at least 20 years
  - Immunocompromised
  - Previously underscreened

- prior hysterectomy
  - if hx CIN 3 /cancer, continue screening
  - Endometrial cancer - continue screening
PAP MANAGEMENT

- **unsatisfactory** - manage as if no Pap had been done (repeat)
- **atrophy** - no treatment indicated
- **absent endocervical cells** - No need to repeat
- **benign cellular changes, inflammation** - no treatment needed

**ASCUS**
- HPV negative – routine screening
- HPV +: colposcopy

**CIN or VAIN** – colposcopy

**AGUS**
- Not the same as ASCUS
- Colposcopy, ECC, endometrial Bx

**Endometrial cells** – endometrial assessment (u/s and/or bx)
Summary

• GYN symptoms common in older women
• Many gyn issues can be treated effectively even in frail elderly
• Refer patients to us!

Thank you for your attention