GP BULLETIN – A NEWSLETTER FOR GPs BY HEALTHWAY MEDICAL

FIBROIDS & ENDOMETRIOSIS: FOCUS ON FIBROIDS

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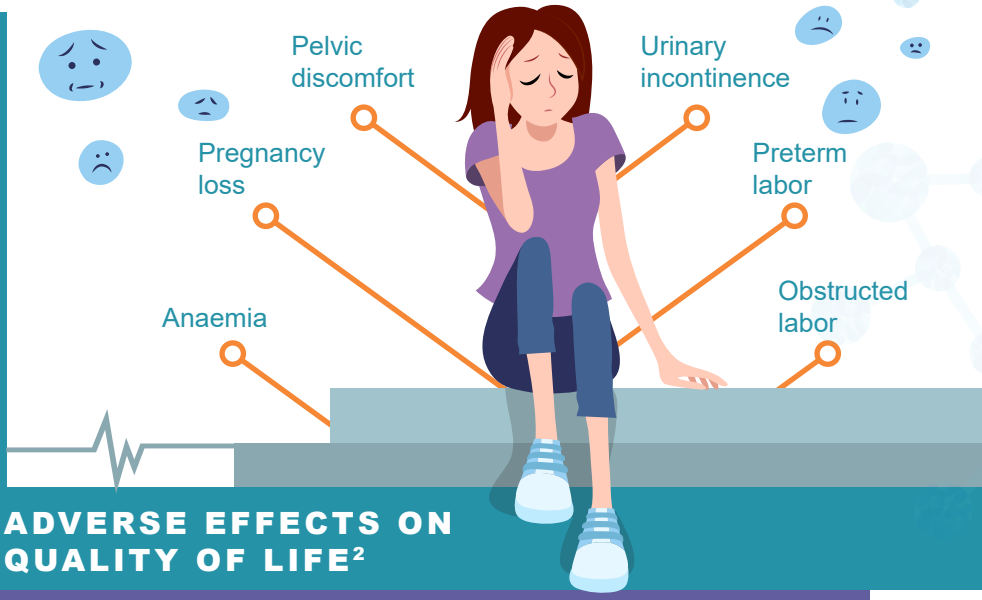
Uterine fibroids are the most common benign tumours in women being clinically apparent in up to 25% of women.[1, 2]

- The mainstay of treatment is conservative approach (eg observe or simple medicines). However, surgery may be applicable in a small group of patients.[1]
- Fibroids are responsible for disruption of uterine functions, excessive uterine bleeding and may mimic or mask malignant tumours.[2]



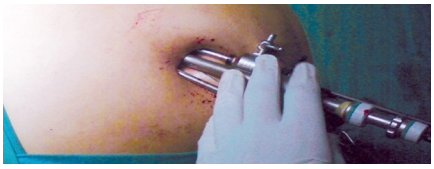
ADVERSE EFFECTS ON QUALITY OF LIFE[2]

ADVANCES IN GYNECOLOGY HAVE IMPROVED HEALTH AND QUALITY OF LIFE OF WOMEN WITH FIBROIDS

FIGO International Federation of Gynecology and Obstetrics
the Global Voice for Women's Health

PALM-COEIN

- FIGO approved classification of abnormal uterine bleeding based on causation.[3]



Single incision laparoscopic surgery (SILS)

- SILS is the recent value added surgery for fibroid with excellent outcomes[4]
- Maximises cosmetic benefits of laparoscopic surgery[4]
- Minimizes morbidities associated with multiple incisions[4]
- Incision size:15-20 m[4]

Key messages:

- The PALM-COEIN classification emphasises on causation of abnormal uterine bleeding.[3]
- New surgical modalities such as SILS enable better cosmesis with good clinical outcomes.[4]

References

1.Stewart EA. Uterine fibroids. Lancet. 2001 Jan 27;357(9252):293-8; 2. Bulun SE. Uterine fibroids. NEJM. 2013 Oct 3;369(14):1344-55; 3. Munro MG, Critchley HO, Broder MS, Fraser IS, FIGO Working Group on Menstrual Disorders. FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nongravid women of reproductive age. Int J Gynecol Obstet. 2011 Apr 1;113(1):3-13; 4. Chern BS, Lakhotia S, Khoo CK, Siow AY. Single incision laparoscopic surgery in gynecology: evolution, current trends, and future perspectives. GMIT. 2012 Nov 1;1(1):9-18.

Strictly for health care professionals only. Full prescribing information is available upon request.

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OVERCOMING URINARY INCONTINENCE

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More than 200 million people suffer from urinary incontinence worldwide. Incontinence usually occurs from middle age onwards and is associated with reduced quality of life.[1]

Nearly 50% women suffer from urinary incontinence. However, only 25% seek care, with less than half of those receiving treatment.[2]

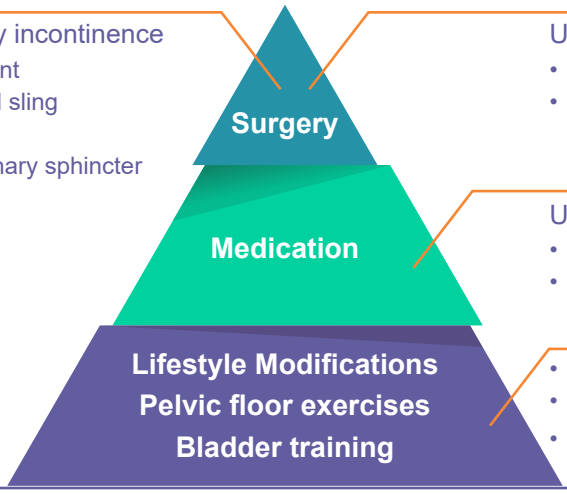
Based on the history, urinary incontinence can be subtyped as[3]:

- Stress urinary incontinence (SUI)
- Urge urinary incontinence (UUI)
- Mixed urinary incontinence (MUI)

Red flags for urgent specialist referrals include[3]:

- Associated pain
- Haematuria
- Recurrent urinary tract infections
- H/o pelvic surgery/radiotherapy
- Constant leaking
- Voiding difficulties

GUIDELINES ON MANAGEMENT OF URINARY INCONTINENCE[3]



Stress urinary incontinence

- Bulking agent
- Mid-urethral sling
- Male sling
- Artificial urinary sphincter

Urge urinary incontinence

- Neuromodulation
- Intravesical botulinum toxin injection

Urge urinary incontinence

- Anticholinergics
- Beta-3 adrenoceptor agonists

- Weight loss
- Smoking cessation
- Reduce caffeinated drinks

Key messages:

- Increased awareness and access to continence services significantly improves quality of life in patients with urinary incontinence.[2]
- Urodynamic studies help in diagnosing urinary incontinence subtypes.[2]
- Refer to specialist when conservative methods are ineffective.[2]

References

1.Norton P, Brubaker L. Urinary incontinence in women. Lancet. 2006 Jan 7;367(9504):57-67; 2. Lukacz ES, Santiago-Lastra Y, Albo ME, Brubaker L. Urinary incontinence in women: a review. JAMA. 2017 Oct 24;318(16):1592-604; 3. Burkhard FC, Bosch JL, Cruz F, Lemack GE, Nambiar AK, Thiruchelvam N, et al. EAU guidelines on urinary incontinence. Arnhem, The Netherlands: European Association of Urology. 2016:88.

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