Plenary 7: Pelvic Pain

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Professional Education Information

Target Audience
This educational activity is developed to meet the needs of surgical gynecologists in practice and in training, as well as other healthcare professionals in the field of gynecology.

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AAGL is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

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Chronic pelvic pain is a common symptom for which women seek gynecologic care and continues to be a challenging entity to treat. This session will provide an update on surgical modalities for evaluating and treating pelvic pain, highlight the multimodal etiology, and identify possible risk factors that may influence postoperative pain in benign gynecologic surgery.

**Learning Objectives:** *At the conclusion of this course, the participant will be able to:* 1) Identify anatomical landmarks for performing laparoscopic surgical interventions for chronic pelvic pain; 2) discuss the role of genetic mutation, interstitial cystitis, and occult hernia in chronic pelvic pain; and 3) consider the role of pre-operative risk factors on postoperative pain.

**Course Outline**

2:15  
**Catechol-O-Methyltransferase (COMT) Genetic Polymorphisms in Women with Vulvodynia**  
I. Patanwala

2:21  
**Discussant**  
B.D. Skinner

2:25  
**Diagnosis of Occult Hernia in Women with Unexplained Chronic Pelvic Pain**  
J. Aoun

2:31  
**Discussant**  
J.F. Steege

2:35  
**Pre-Operative Risk Factors for Increased Postoperative Pain after Benign Hysterectomy**  
N.M. Abualnadi

2:41  
**Discussant**  
N.R. Patel

2:45  
**Correlation between Frequency of Urinary Symptoms and Clinical and Image-Based Indexes of Interstitial Cystitis in a Prospective Cohort of Patients with and without Interstitial Cystitis**  
G. Vazirabadi

2:51  
**Discussant**  
D.I. Eisenstein

2:55  
**Video: Laparoscopic Ovarian Vein Ligation for Treatment of Pelvic Congestion Syndrome**  
S. Vilasagar

3:01  
**Discussant**  
S. As-Sanie

3:05  
**Video: Presacral Neurectomy: Relevant Anatomy and Strategies for Success**  
M.A. Stuparich

3:11  
**Discussant**  
M. Hibner

3:15  
**Adjourn**
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).
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Consultant: Olympus
Erica Dun*
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FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
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Bethany D. Skinner*
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Mallory A. Stuparich*
Golnar Vazirabadi*
Smitha Vilasagar*
Content Reviewer has no relationships.

Asterisk (*) denotes no financial relationships to disclose.
Catechol-O-Methyltransferase Genetic Polymorphisms in Women with Vulvodynia

Insiyyah Patanwala, MD, Fellow
Advanced and Minimally Invasive Gynecology
Florida Hospital, Orlando
November 17th, 2016

I have no financial relationships to disclose.

Audience Objectives

- Explain how vulvodynia is diagnosed and classified
- Describe the function of catechol-O-methyltransferase (COMT) and how it may affect pain sensitivity
- Discover whether a specific COMT genetic polymorphism is more common among women with vulvodynia

Background

- Vulvodynia is defined as vaginal or vulvar stabbing or burning pain of at least three months duration that can be spontaneous or provoked, that has no other discernible cause (i.e. infection, injury, etc.)
- The etiology of vulvodynia is unclear and thought to be multi-factorial
- Catechol-O-methyltransferase (COMT) is an enzyme that metabolizes neurotransmitters involved in transmission of pain signals
- A single nucleotide polymorphism in the COMT gene at position 158 in exon 3 results in the substitution of methionine for valine in the final protein which leads to reduction in enzyme function
- This polymorphism has been associated with increased pain sensitivity, therefore the objective of this investigation was to determine if this COMT polymorphism is associated with vulvodynia

Methods

- Women with and without vulvodynia were recruited from five clinical centers across the country
- Participants completed study questionnaire and underwent a gynecologic examination
- Buccal swab was then collected for genetic testing and shipped to Weill Cornell Medicine for analysis

Analysis

- Genetic comparison is considered more accurate among participants of the same race
- Given that >70% of our cases were Caucasian, we only completed final data analysis for controls and cases that were Caucasian for more accurate results
- The numbers of subjects in each minority group were too low to complete an accurate analysis, therefore they are not included in the following tables/graphs
Results

**COMT genotypes and allele frequencies in women with vulvodynia and controls**

<table>
<thead>
<tr>
<th>Genotype</th>
<th>Vulvodynia</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>H,H</td>
<td>55 (32.9%)</td>
<td>23 (21.5%)</td>
</tr>
<tr>
<td>H,L</td>
<td>81 (48.5%)</td>
<td>57 (53.2%)</td>
</tr>
<tr>
<td>L,L</td>
<td>31 (18.6%)</td>
<td>27 (25.2%)</td>
</tr>
</tbody>
</table>

**H** 191 (57.2%) 103 (48.1%)

**L** 143 (42.8%) 111 (51.9%)

\[P = 0.0543, \text{Odds ratio (OR)} = 1.793, 95\% \text{confidence interval (CI)} 1.021, 3.149\]

\[P = 0.0435, \text{OR} = 1.439, 95\% \text{CI} 1.020, 2.030\]

**Results**

**Influence of COMT gene polymorphism on pain perception vulvodynia**

<table>
<thead>
<tr>
<th>Genotype</th>
<th>Allele</th>
<th>Vulvar Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>1-2x/week</td>
<td>&lt;1 week</td>
</tr>
<tr>
<td>N = 78</td>
<td>N = 3</td>
<td>N = 22</td>
</tr>
<tr>
<td>H,H</td>
<td>23 (29.5%)</td>
<td>1 (33.3%)</td>
</tr>
<tr>
<td>H,L</td>
<td>35 (44.9%)</td>
<td>2 (66.7%)</td>
</tr>
<tr>
<td>L,L</td>
<td>20 (25.6%)</td>
<td>0</td>
</tr>
<tr>
<td>H</td>
<td>81 (51.9%)</td>
<td>4 (66.7%)</td>
</tr>
<tr>
<td>L</td>
<td>75 (48.1%)</td>
<td>2 (33.3%)</td>
</tr>
</tbody>
</table>

\[P = 0.0090 \text{vs. none, OR} = 2.499, 95\% \text{CI} 1.267, 4.930\]

\[P = 0.0153 \text{vs. none, OR} = 0.3065, 95\% \text{CI} 0.1189, 0.7903\]

\[P = 0.0017 \text{vs. none, OR} = 2.057, 95\% \text{CI} 1.308, 3.236\]

**Conclusions**

- Contrary to our hypothesis, women with vulvodynia do not have a higher prevalence of the L allele compared to women without vulvodynia, therefore low enzyme activity due to the SNP at position 158 (rs4680) is not implicated in the pathophysiology of vulvodynia.
- Surprisingly, certain sub-groups of women with vulvodynia actually have a higher prevalence of the high enzyme activity genotype and the reason for this is unclear.
- A major limitation of our study is that we could not recruit many minorities despite diverse clinic locations, likely reflecting a disparity in health care. Thus our conclusions can only be applied to Caucasian women.

**Future Directions**

- Measurement of COMT enzyme levels in women with vulvodynia may more accurately reflect COMT function.
- Determining the prevalence of other COMT genetic polymorphisms, such as its 3 major haplotypes, among women with vulvodynia, would provide a more comprehensive genetic analysis.
- More research in minority populations is imperative.

**References**


**Acknowledgements**

Georgine Lamvu, MD, MPH
Jessica Feranec, MD

Department of Surgery
Orlando VA Medical Center
Orlando, Florida
Thank you for listening!
Questions?
Diagnosis of Occult Hernia in Women with Unexplained Chronic Pelvic Pain

Presenter: Joelle Aoun, MD, MIGS
Henry Ford Hospital
Department of Minimally Invasive Gynecologic Surgery

I have no financial relationships to disclose

“In Women, Hernias May Be Hidden Agony”

“Laura Sweet was an active 42-year-old saleswoman [...] when the agony first started — debilitating, flaring pains in her pelvis that lasted for days and recurred periodically [resulting] in many visits to the emergency room, referrals to various specialists, wrong diagnoses and a daily cocktail of painkillers.”

OBJECTIVES
At the conclusion of this activity, the participant will be better able to:

- Evaluate women with unexplained chronic pelvic pain and focal inguinal tenderness for the presence of occult hernia
- Identify the role and accuracy of ultrasound imaging in the diagnosis of occult hernia

CHRONIC PELVIC PAIN

- Affects 15% of women during their reproductive years with significant impact on quality of life, work productivity and healthcare utilization (ref 10-13).
- Accounts for 10% of outpatient gynecological consultations and 40% of laparoscopies in the United States (ref 10)

HERNIAS

- Have been shown to cause chronic pelvic pain (ref 3)
- Typically non-palpable and clinically occult in women, and thus more difficult to diagnose as compared to men. (ref 3)
- Further investigation with imaging may be indicated in women with high levels of suspicion for occult hernia prior to proceeding to surgery or additional management (ref 5)
IMAGING

- The most reliable and cost-effective diagnostic modality in the evaluation of suspected occult hernia in women is not standardized.

- Limited recent literature examined the role of ultrasound and other imaging tools in the diagnosis of occult hernia; results are conflicting and very few studies included a female-only cohort (ref 4 to 6, 15 to 16).

RELEVANCE

As Gynecologists we are likely to see those patients before other specialties due to the pelvic location of their pain.

Recognizing women with a high clinical suspicion for occult hernia and offering the proper evaluation is of significant importance in order to prevent delays in diagnosis and prolonged sufferings of women with chronic pelvic pain.

METHODS

- **Design:**
  Retrospective chart review. Approved by the IRB.

- **Setting:**
  Pelvic Pain Clinic at a university-affiliated tertiary medical center in Southeast Michigan. This clinic is multidisciplinary and consists of an Obstetrician and Gynecologist, a pain psychologist, and physical therapists trained in pelvic floor physiology.

- **Study population:**
  All women seen between Jan 2005-Jul 2012 at the Pelvic Pain clinic for unexplained chronic pelvic pain with ALL the following inclusion criteria:
  1. History that points to an inguinal source of pain
  2. Physical examination demonstrating focal inguinal tenderness on standing and supine abdominal exam and/or on retro-inguinal palpation during bimanual exam
  3. No evidence of hernia or bulge on physical examination
  4. Documentation of a musculoskeletal ultrasound to evaluate for the presence of a hernia.

- **Intervention:**
  All musculoskeletal ultrasounds were performed by a single sonographer. A standard imaging protocol was used to assess the inguinal and upper thigh soft tissue anatomy at rest and with provocative maneuvers. Hernia was diagnosed when fat or visceral tissue was visualized protruding into the inguinal anatomy from within a visceral source.

RESULTS

- 96 women met the inclusion criteria and were included.
- All 96 women had a standardized musculoskeletal ultrasound to evaluate for the presence of an occult hernia.
- The ultrasound was suggestive of a hernia diagnosis in 53% of women (51/96).
Patients with an ultrasound diagnosis of hernia were significantly older than patients with a negative ultrasound (41±13 years vs 34±11 years, respectively, p = 0.005).

They were also more likely to have a history of arthritis compared to patients with no evidence of hernia on ultrasound (p = 0.02).

All 51 patients with positive ultrasound findings were referred to general surgery.

69% (35/51) underwent surgical evaluation.

Patients who underwent surgical evaluation had higher pain metrics on their Brief Pain Inventory as compared to patients who did not have the surgery.

Of those, 97% (34 patients) had a confirmed diagnosis of hernia at the time of surgery.

SUMMARY

In this retrospective analysis of a female clinic population with unexplained chronic pelvic pain and focal inguinal tenderness, we found evidence to support that:

- The diagnosis of occult hernia on soft tissue ultrasound was found in around half of the cases.
- The ultrasound results were highly correlated with surgical findings (PPV of 97%).

TAKE HOME MESSAGE

Women with chronic pelvic pain and a physical examination pointing to focal inguinal pain, in the absence of other clear etiologies, warrant an evaluation to rule out the presence of an occult hernia.

While no clear guidelines exist in the literature, we believe that imaging should be an essential part of this evaluation before proceeding to surgery.

We believe that a musculoskeletal ultrasound is a valuable initial imaging modality due to its high predictive value, low cost and noninvasiveness. In patients with negative results on ultrasounds, in the absence of clear etiology, and a highly suggestive physical examination, an MRI might aid in diagnosis.

REFERENCES


ACKNOWLEDGEMENTS

Jonathan Shaw, BS
Wayne State University, Detroit, Michigan

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Department of Minimally Invasive Gynecologic Surgery
Henry Ford Hospital, West Bloomfield, Michigan

Ziv Tsafrir, MD
Department of Gynecology Oncology
Sourasky Medical Center, Tel Aviv, Israel
THANK YOU
Pre-Operative Risk Factors for Increased Postoperative Pain After Benign Hysterectomy

Presenter: Noor M. Abualnadi, MD
University of Michigan-Ann Arbor

DISCLOSURES:
I have no financial relationships to disclose.

OBJECTIVES:
- Identify patient characteristics associated with increased post-operative pain
- Recognize pre-operative management can impact post-operative pain
- Describe how post-operative pain can impact post-operative course

Value in Healthcare:
- Importance of VAS scores
  - Goal < 7
- Joint Commission on Accreditation of Healthcare Organizations Pain Management Program

What do we know?
- Female
- Duration of surgery
- Non-minimally invasive technique
- Chronic pain
- Younger age

METHODS:
- Statewide collaborative of 52 teaching and community hospitals
- All payers
- Standardized data collection methodology
- 30 day postoperative outcomes
- Funded by Blue Cross/Blue Shield of Michigan
RESULTS:

Hysterectomy routes in MSQC database

- Abdominal: 2,605 (23.8%)
- Vaginal: 7,020 (64.2%)
- Laparoscopic: 1,312 (12.0%)

Total Hysterectomies: 10,937

RESULTS:

<table>
<thead>
<tr>
<th>Route</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal</td>
<td>2,605</td>
</tr>
<tr>
<td>Vaginal</td>
<td>7,020</td>
</tr>
<tr>
<td>Laparoscopic</td>
<td>1,312</td>
</tr>
</tbody>
</table>

RESULTS:

<table>
<thead>
<tr>
<th>Route</th>
<th>Mean VAS score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal</td>
<td>4.18</td>
</tr>
<tr>
<td>Vaginal</td>
<td>3.58</td>
</tr>
<tr>
<td>Laparoscopic</td>
<td>3.87</td>
</tr>
</tbody>
</table>

RESULTS:

<table>
<thead>
<tr>
<th>Route</th>
<th>Mean POD3 VAS scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic pelvic pain</td>
<td>3.89/3.34 (.002)</td>
</tr>
<tr>
<td>Prior pelvic surgery</td>
<td>3.62/3.2 (.001)</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>3.74/3.44 (.002)</td>
</tr>
</tbody>
</table>

RESULTS:

<table>
<thead>
<tr>
<th>Tobacco use</th>
<th>Yes</th>
<th>No</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>smokers</td>
<td>21%</td>
<td>26%</td>
<td>.001</td>
</tr>
<tr>
<td>non-smokers</td>
<td>12%</td>
<td>74%</td>
<td></td>
</tr>
</tbody>
</table>

RESULTS:

<table>
<thead>
<tr>
<th>Race</th>
<th>White (%)</th>
<th>Non-white (%)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>21%</td>
<td>13%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RESULTS:

<table>
<thead>
<tr>
<th>Age</th>
<th>≤50</th>
<th>&gt;50</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>74%</td>
<td>26%</td>
<td></td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

RESULTS:

<table>
<thead>
<tr>
<th>Surgical time</th>
<th>≤2 hours (%)</th>
<th>≥2 hours (%)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>41%</td>
<td>26%</td>
<td></td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

RESULTS:

<table>
<thead>
<tr>
<th>Post-operative complications</th>
<th>Yes</th>
<th>No</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation to ED within 30 days</td>
<td>948 (8.7%)</td>
<td>9,662 (88%)</td>
<td>.001</td>
</tr>
<tr>
<td>Mean VAS score</td>
<td>4.24</td>
<td>3.46</td>
<td></td>
</tr>
</tbody>
</table>

RESULTS:

<table>
<thead>
<tr>
<th>Re-admission within 30 days</th>
<th>Yes</th>
<th>No</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>364 (3.3%)</td>
<td>10,229 (93.5%)</td>
<td></td>
<td>.001</td>
</tr>
<tr>
<td>Mean VAS score</td>
<td>4.31</td>
<td>3.5</td>
<td></td>
</tr>
</tbody>
</table>

CONCLUSION:

- Elevated post-hysterectomy VAS scores are associated with certain patient characteristics.
- These patients may be at higher risk for post-operative complications.
REFERENCES:


ACKNOWLEDGEMENTS:

Erika L. Mowers, MD, Neil S. Kamdar, Daniel Morgan, MD, and Sawsan As-Sanie, MD, MPH
University of Michigan-Ann Arbor
Objectives

- By the end of this lecture, the listener should be able to:
  - Describe the correlation between frequency of symptoms of Interstitial Cystitis (IC) and clinical and procedure-based indexes of IC
  - Explain the role of cystoscopy with hydrodistention in the diagnosis
  - Contextualize the results of this study within the framework of previous literature

Interstitial Cystitis: An Overview

- Persistent or recurrent chronic pelvic pain, pressure or discomfort perceived to be related to the urinary bladder accompanied by at least one other urinary symptom such as an urgent need to void or urinary frequency (Doggweiler RICS 2016).
- IC is difficult to study as there are no objective tools that have been validated for diagnosis (Davis 2014).
- Recently the role of cystoscopy with hydrodistension for diagnosis of IC has been called into question (Wennevik GE 2016, Messing 1997, Erickson AUA 2011)

Study Design

- **Design:** Prospective interventional cohort study with blinded image review
- **Setting:** Participants were recruited from an academic urogynecologic and minimally invasive gynecologic practice
- **Participants:**
  - patients scheduled to have routine gynecologic and urogynecologic procedures involving cystoscopy or cystoscopy with hydrodistention (CwHD).
  - 224 of the 269 women initially enrolled had complete data sets and are included in this analysis.
- **Interventions:**
  - Participants completed questionnaires including the IC Symptom Index (ICSI)
  - Physicians performing cystoscopy with hydrodistention were asked pre-operatively to rate likelihood of patients having IC and post-operatively to assign a final (Yes/No) diagnosis of IC.
  - All patients initially underwent cystoscopy with hydrodistension
  - A panel of three urogynecologists evaluated de-identified batched picture sets.

Questionnaires and Indexes of Interstitial Cystitis

- **Interstitial Cystitis Symptom Index (O’Leary MP 1997)**
  - Frequency of 4 key IC symptoms
  - Frequency, Urgency, Nocturia, Burning/Pain/Discomfort
- **Clinical Indexes**
  - Initially scheduled procedure
  - Physician expectancy
- **Procedure Based Indexes**
  - Composite diagnosis by physician performing CwHD
  - Diagnosis based on blinded image review

Disclosures

- I have no financial relationships to disclose.
**Composite ICSI Score by Clinical and Procedural Based Indexes of Interstitial Cysts**

<table>
<thead>
<tr>
<th>Clinical Index</th>
<th>Scheduled Procedure</th>
<th>Procedural Index</th>
<th>Prognostic Index</th>
<th>$P$ Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>Interstitial</td>
<td>Pain/Discomfort</td>
<td></td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>IC P Symptons</td>
<td>0.02</td>
<td>0.2</td>
<td></td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

- Average composite ICSI score and range of scores.

**Discussion**

- Cystoscopic findings correlate poorly with individual symptoms and with ICSI score
- Reliance on cystoscopic findings might lead to under-diagnosis of IC
- While ICSI components do correlate with clinical indexes of IC, ICSI overall appears to be a poor diagnostic tool for IC
- Our related study found a significant relationship between severity of burning/pain/discomfort and all four clinical and procedure-based indexes of IC

Bogart 2007, Clemens 2015, Lai 2012

**Thank You**

Gardner J, PhD, Rockefeller N, MD, Nieto R, BS, BA, Marcu L, MD, Miller C, MSW, Yeung P, MD, Holloran-Schwartz MB, MD, Steele A, MD, Leong FC, MD, McLeans MT, MD and Campian EC, MD, PhD

Dept of Obstetrics, Gynecology and Women’s Health
St. Louis University
Laparoscopic Ovarian Vein Ligation for treatment of Pelvic Congestion Syndrome

Presenter: Smitha Vilasagar, MD
Carolinas HealthCare System, Charlotte, North Carolina

Objective: To demonstrate pelvic congestion syndrome using transcervical pelvic venography followed by laparoscopic ovarian vein ligation for surgical treatment.

Design: Stepwise demonstration of the techniques with narrated video footage.

Setting: Pelvic congestion syndrome is characterized by cyclic chronic pelvic discomfort exacerbated by prolonged standing and intercourse. Pelvic venography is the diagnostic study of choice; it provides dynamic images of the utero-ovarian venous varicosities. This video illustrates a patient who was diagnosed with right sided pelvic congestion syndrome with persistent aching discomfort that started during pregnancy. After confirmation on venography, she underwent laparoscopic right ovarian vein ligation.

Interventions: Transcervical pelvic venography followed by laparoscopic ovarian vein ligation for surgical management of pelvic congestion syndrome, with consideration of the following key points:

1. Transcervical pelvic venography with fluoroscopy can be performed in the operating room, and diagnosis of pelvic congestion syndrome can be made using an objective scoring system.
2. Retroperitoneal dissection of the infundibulopelvic ligament to isolate the two ovarian vasculature is carried out parallel to the course of the vessels to avoid injuries.
3. The external iliac vessels and ureter are identified and kept in view during exposure of the ovarian vessels.

Conclusion: With careful surgical technique, laparoscopic ovarian vein ligation is a safe fertility-sparing treatment with reports of pain improvement in up to 75% of women following surgery.
Presacral Neurectomy: Relevant Anatomy and Strategies for Success

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**Objective:** To highlight important anatomic landmarks in the performance of presacral neurectomy, review patient selection criteria that will increase the procedure’s chance for success, and provide evidence of the procedure’s effectiveness in improving endometriosis-related pain.

**Design:** Stepwise demonstration of the technique with narrated video footage.

**Setting:** Presacral neurectomy is a surgical procedure that transects the nerve fibers carrying afferent pain sensation from the upper vagina, cervix, uterus, broad ligament, and proximal 1/3 of the fallopian tube. Candidates for the procedure should have midline pelvic pain, failed medical therapy, and desire conservative surgery. Presacral neurectomy has an excellent published success rate when performed concomitantly with laparoscopic excision of endometriosis.

**Interventions:** Laparoscopic presacral neurectomy with particular attention directed to:

1. Identification of key anatomic structures overlying the sacral promontory, most importantly the left common iliac vein and the middle sacral artery.
2. Delineation of the borders of dissection for presacral neurectomy, including the aortic bifurcation, inferior mesenteric artery, right common iliac artery, and sacral promontory.
3. Meticulous surgical technique to minimize the risk of injury to surrounding anatomic and vascular structures.
4. Maintenance of hemostasis to preserve a clean operative field.

**Conclusion:** Presacral neurectomy is a conservative surgical procedure for endometriosis-related pelvic pain that has an excellent published success rate. In our video, we demonstrate important concepts for safe performance of the procedure, appropriate patient selection, and effectiveness of the procedure.
CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California's physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL's obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at [http://www.imq.org](http://www.imq.org).

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 [http://www.usdoj.gov/crt/cor/pubs.htm](http://www.usdoj.gov/crt/cor/pubs.htm).

Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency", signed by the President on August 11, 2000 [http://www.usdoj.gov/crt/cor/13166.htm](http://www.usdoj.gov/crt/cor/13166.htm) was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. [http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538](http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538).