

CLINICAL TIP

Important History Questions in Patients with Endometriosis and Dyspareunia

As a general rule, physiotherapists embarking on a career in pelvic floor dysfunction tend to commence their journey with training in the “relaxation” disorders (ie stress incontinence, pelvic organ prolapse). For many, it is a brand new journey that requires a completely new set of history taking skills including questioning on fluid intake, bladder and bowel function, symptoms of urinary incontinence, pad usage, sexual dysfunction and so forth.

Most introductory courses cover these introductory history taking skills with tips on the types of questions needing to be asked, hints on how to ask them and explanations of what each question is telling the physiotherapist with regards to possible underlying pathophysiology.

Then one day a different type of pelvic floor patient walks through the door.....

Casey is a 26yo female who presents to your clinic with a history of severe dysmenorrhea (painful periods) since menarche at 14yo. She was ultimately diagnosed with endometriosis via a laparoscopy at age 19, and has had 2 subsequent laparoscopic resections of endometriosis at age 21 and 25. She has now been referred to you by her gynaecologist as she has severe dyspareunia (pain with intercourse) and the doctor thinks physiotherapy may be helpful.

WHAT ARE SOME OF THE QUESTIONS I WOULD ASK?

CONSIDERATIONS.....

Whilst nothing is ever definite, it is obviously highly likely there is a link between this lady's history of endometriosis and her dyspareunia. Recurrence of disease or simply persistent dysmenorrhea exacerbating central sensitization mechanisms are all very relevant in determining the underlying cause of her current dyspareunia. It is therefore vital to take a thorough history regarding her menstrual periods (both past and current), current pelvic pain and previous responses to surgery.

FIRST AREA OF QUESTIONING:

Current Medical Management of Menstrual Cycle

It is known that the more menstrual periods a woman has after a surgical resection of endometriosis the more likely it is that she could have a recurrence of disease. As a result, after surgery most women are encouraged to consider either

- being on the Oral Contraceptive Pill *continuously* (ie skipping the sugar pills so as to prevent having periods)
- having a Mirena IUD inserted to stop her periods (or at least reduce them to 'spotting')

OR.....

- in more severe cases, going onto a GnRH agonist temporarily to suppress oestrogen eg Zoladex (note: these can only be used for a very limited time due to severe consequences with long term use eg osteoporosis).

Therefore....

QUESTION SET #1:

1. *"Between each of your laparoscopies and now, were you placed on any type of contraceptive or hormonal treatment to reduce your periods?"*

If she is on the Oral Contraceptive Pill

2. *"Does your doctor get you to skip the sugar pills and try to simply not have a period?"*
3. *If yes, "how long can you be on the OCP before you tend to get a breakthrough bleed?"*
4. *"What is the pain like when you have a breakthrough bleed?"*

If she has a Mirena

2. *"Do you have a period at all with the Mirena?"*
3. *"If yes, what is your pain like when you have a period?"*

If she is on a GnRH agonist (eg Zoladex)

2. *"How long have you been on Zoladex?"*
3. *"How long has your doctor said s/he is happy to keep you on Zoladex?"*
4. *"What is the plan after you stop Zoladex?"*

SECOND AREA OF QUESTIONING:	Effectiveness of Surgeries
------------------------------------	-----------------------------------

As would be expected, with each subsequent surgery there is the potential for increased scar tissue as well as central neural changes that can result in centrally mediated pain (neural sensitisation). As a result, most women typically have their best outcome following their first surgery, with progressively less benefit with each subsequent surgery.

In women who keep having substantial relief following subsequent laparoscopic resections it is likely that their pain has been due to

1. Continual recurrences of disease that needs resection, or
2. Not all of the disease was originally cleared in their first surgery, but was resected in subsequent surgeries.

Either way, in this scenario, the woman's pain appears to have a strong link with actual existence of disease (note: the degree of pain in endometriosis is only ever related to existence of disease, not volume/extent of disease. A small volume of disease can produce just as much pain as a large volume of disease).

In contrast, in women who indicate that they had good relief of pain after their first laparoscopy, but have experienced progressively less benefit with each subsequent surgery, it is highly likely that any current dysmenorrhea or pelvic pain

has either a large central component or is influenced substantially by scar tissue / adhesions / muscular overactivity rather than disease. This central component and/or muscular overactivity obviously needs a different treatment approach to dyspareunia related to current active endometriosis.

Therefore.....

QUESTION SET #2:

A) Questions on Menstrual Periods prior to first Laparoscopy

- *“Before you had any laparoscopies, what were your periods like?”*
 - *On a scale of 0-10 how severe was the pain?*
 - *How many days would you be in pain for?*
 - *How much pain relief did you need to take? Did it actually control your pain?*
 - *Could you get out of bed / go to work when you had period pain?*

B) Menstrual Periods and Pelvic Pain after Primary Laparoscopy

- *“How effective was your first laparoscopy in reducing your period pain”*
 - *What were your periods like after your first surgery?*
 - *How long did you have relief before your pain with periods started to get worse again?*
 - *What was the main symptoms that caused you to consider having a second laparoscopy?*

C) Menstrual Periods and Pelvic Pain after Subsequent Laparoscopies

- *“Were your second and third laparoscopies performed by the same surgeon?”*
 - *Note: If a first or second surgery is not effective in reducing pain some women choose to change surgeons. As different surgeons have differing surgical expertise, sometimes a subsequent surgery is more effective because it is performed by a more skilled surgeon*
- *How effective were your second and third laparoscopies?*
 - *Note: if the patient received benefit from her first laparoscopy, but did not gain any benefit from her most recent laparoscopy (or if it made her worse), it is likely that her current mechanism of pain is unrelated to a recurrence of endometriosis. It could be centrally mediated or related to muscular overactivity.*

THIRD AREA OF QUESTIONING:

Dyspareunia:

- **primary or secondary?**

- **related to the endometriosis or the surgery or neither?**

- How old were you when you first became sexually active?
- Has it always been painful to have intercourse?

- If yes:
 - Does it tend to be better or worse in the first few months after a surgery?
 - Have you ever noticed whether your intercourse pain is worse when your period pain begins getting worse again

Note: women whose dyspareunia is better in the first few months after each surgery and then progressively gets worse are more likely to have a direct endometriosis cause for their dyspareunia. This type of pain is also more typically a deep pain, or a pain that is worse in the hours after intercourse rather than during.

- If no:
 - When did it first start to become painful?
 - Since your last surgery, is it getting progressively worse, better or staying the same?

- *Notes: In women whose dyspareunia has become progressively worse after each surgery, it is more likely to be due to either a central mechanism or a secondary muscular hypertonicity in response to surgery. This is the Grouping physiotherapy is most essential for.*