**Dilated Pelvic Veins**

September 19, 2006  
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OBGYN.net Conference Coverage From IPPS - Simsbury, Connecticut - April/May, 1999

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**Dr. Carter:** "Hello, I'm Dr. Jim Carter, and I'm here in Connecticut at the International Pelvic Pain Society meeting. With me I have R. William Stones, physician from England, specifically University of Southampton, who has been very busy working in this area of pelvic pain for many years and has a number of insights into how we should approach women with chronic pelvic pain. Welcome to Connecticut, it was a long trip, and I'm sure happy you're here."

"Thank you very much Jim, it's a pleasure to be here. It's particularly interesting to get the American angle on pelvic pain and see how it compares to the way that things happen in Britain and Europe. I think that some of our perspectives have been somewhat different over the years, and it's very interesting to exchange views with colleagues."

"Let's start with the views from England and the area that you are in; approaching women with chronic pelvic pain - would you describe some of your work?"

"Yes, I think, probably in common with practice in the U.S., most women probably have a laparoscopy looking for specific pathology at an early, early stage in their investigation. But one of the problems arises when we don't find specific pathology, and I'm sure that's your experience as well. The question then arises - how do we explain the condition in women who have pain but don't have specific obvious laparoscopic pathology? I think one of the answers may well be that we haven't looked hard enough, that we haven't done a laparoscopic evaluation that hasn't been systematic as it should have been. But I think on the other hand, there are people even when we do our laparoscopy very carefully that clearly don't have specific pathology. The condition that we've really focused on quite a lot over the last few years, and particularly under the influence of my own teacher, Richard Beard, has been pelvic congestion syndrome - i.e. pain related to congestion of veins in the uterus and the ovarian circulation."

"Could you describe what you might find on a physical examination, a radiologic study, and a laparoscopy for your patients with pelvic pain and congestion?"

"Sure, I think the classic clinical features that Richard Beard has highlighted are really a variable nature of the pain, that symptoms are typically not confined to one specific location, they may well shift. There's the posture effect, particularly, that the patient's symptoms will be exacerbated by their standing for a long time, perhaps relief by rest. I know that Richard describes the classic occupation of the patient with pelvic congestion as a hairdresser whose occupation makes her stand all day attending to her clients."

"So one first thing to look for is in the history. A real important feature is the occupation; a person that's standing a long time can develop this type of pelvic congestion, kind of a venous stasis-type picture."

"Absolutely. I suspect it's probably not the primary cause but in somebody who has that predisposition, it's certainly an acerbating factor."
"And then physical exam..."

"Just finishing on the symptom thing. I think the other very interesting symptom which we don't always get unless we inquire for it specifically, is in women who have pain with intercourse, there's pain going on after post-coital aching. Those are symptoms that women may not volunteer during their consultation unless we ask them specifically about it. I think that seems to be a particular feature with pelvic congestion."

"So those women who have pain afterward...."

"Going on after intercourse."

"That's a common complaint that we'll hear and that may be related to this issue of pelvic congestion."

"Absolutely. Going on to the physical exam, I think, perhaps tenderness typically related to the ovaries rather than the uterus or uterine - I call ligament tenderness, but adnexal palpation by manual palpation of the ovaries, perhaps exquisitely tender."

"So on the deep palpation, the physical exam, the ovarian tenderness..."

"Yes, the tenderness seems to be more prominent and related to the ovaries than the uterus itself."

"And then your radiologic studies, could you describe those?"

"Yes, the technique of venography to demonstrate pelvic venous congestion is an old technique, it's been around, I think, since the 1940's, that recently has been used more systematically, perhaps, to try to evaluate that pelvic congestion. The technique is actually surprisingly simple for those who are familiar with doing hysterosalpingograms. It's really not too much more troublesome for the patient than a hysterosalpingogram. But the trans-myogram where a needle is inserted - just penetrating a couple of millimeters into the myometrium, and then contrast medium injected under fluoroscopic screening into the myometrium with some vigor. Then we can see on the imaging the contrast medium dispersing into the pelvic veins, and get that impression not only of the venous diameters but also of the clearance - the venous clearance - which I think is one of the key features of pelvic congestion - that it's dilated veins that would reduce the rate of clearance from the pelvic veins."

"You inject the dye just a couple of millimeters deep into the myometrium, the veins are dilated but they clear very slowly."

"That's right, you get pools of contrast medium sitting there for several minutes, even up to ten minutes. One really wonders why those veins don't clot, the contrast just seems to be sitting there. I think it's obviously desirable not to be minimizing one's use of radiation, even diagnostic radiation, in women in their reproductive years. Of course, we're talking about a condition which is a relative feature of reproductive years, and obviously it would be better if we could primarily rely on ultrasound."

"Are there ultrasound findings that can help you with this diagnosis?"
Dr. Stones: “Yes, we can certainly identify dilated pelvic veins, particularly, I think the transvaginal ultrasound. I think the possible problem with transabdominal scanning is that the full bladder that we use for our artistic window may possibly contract some of the pelvic veins and alter their appearance, so transvaginal is probably the ideal modality. One can easily assess diameters using transvaginal but unfortunately it's less easy to really assess venous clearance or venous flow because, I think, the Doppler possibilities are really still under evaluation. So the venous flow rates tend to be rather low, and it's difficult to get a decent Doppler shift in order to get meaningful data.”

Dr. Carter: “Then your findings of laparoscopy, are there any specific pearls that we could give to the laparoscopist on what to evaluate?”

Dr. Stones: “Anyone who undertakes laparoscopy certainly will have seen very dilated pelvic veins, and in the appropriate context that could be very useful. I think the practical problem for diagnostic laparoscopy as the modality for diagnosing pelvic congestion is, of course, we have the patient in the head-down-tilt, and we've also distended the abdomen with gas for the procedure which in both procedures will tend to collapse pelvic veins. I think as some people have advocated, carrying out laparoscopy with some degree of head-up-tilt and perhaps using a minimum of gas. But I think the bottom line is - it's probably unrealistic to rely entirely on laparoscopy for the diagnosis of pelvic congestion. I think we'd probably be better off with ultrasound.”

Dr. Carter: “So if a physician sees pelvic congestion at laparoscopy, they can pretty well say, “That's pelvic congestion.” But then if they don't see it, it still could be a significant factor. They need to look at their history of a standing position with occupation, with the complaint of pain after intercourse, the discomfort after intercourse, and also the physical examination findings of tenderness in the ovarian focil area rather than on the ovaries. Then they do the laparoscopy, if they've done the procedure to look for the dilated veins or even at ultrasound if they see the dilated veins, perhaps, they should simply be ready to treat.”

Dr. Stones: “Absolutely.”

Dr. Carter: “What treatment approaches are you using?”

Dr. Stones: “I think if we're going up the scale of invasive treatments, one would start obviously with simply discussing the diagnosis with the patients. I tend to discuss the diagnosis very much as one might with the diagnosis of cerebral migraine. In other words, this is a pain of vascular origin, which as in the case of cerebral migraine isn't associated with any ongoing or serious progressive pathology but it does, of course, cause pain. Thinking in terms of a migraine-like condition, I think that's a conceptual model that patients find very useful, and that type of explanation sometimes lead women to say, "Thank you very much, now I've got an explanation for my pain." It helps remove the anxiety, and they perhaps don't necessarily need specific treatments. Moving up the scale then, of course, to people who do need specific treatment. I think the women fully evaluated in our practice are certainly under the leadership of Richard Beard, our treatments with ovarian suppression. One that we know most about is using a high dose of medroxyprogesterone with a dose for endometriosis of around 30 milligrams daily taken continuously. That seems to be effective in reducing pain symptoms.”

Dr. Carter: “I've also seen good reports on norethindrone of 20 milligrams, a similar approach.”

Dr. Stones: “I suspect there isn't any one specific route of the choice of ovarian suppression, and similarly, the analogues will obviously will be potentially useful.”

Dr. Carter: “The GNRH analogues are appropriate ?.”
“Of course, they'll be limited by each individual's side effects and the use of addback which will obviate side effects. Then the limiting factor, of course, becomes practicality and costs.”

“Yes, the addback meaning the addback of .3 milligrams, say of an estradiol agent?”

“Yes, and that doesn't seem to render the ovarian suppression less effective in terms of pain relief.”

“Then if you go into a surgical modality for treatment - what approaches are you using?”

“Again the extreme, of course, would be hysterectomy and oophorectomy. I think in women with this condition, if they have reached the end of the line, if they are in extreme pain, and other treatments haven't been successful, it does seem to me that treatment by hysterectomy with ovarian conservation is not a good idea. Removing the ovaries and then continuing long-term estrogen replacement is probably much more appropriate. If one does a hysterectomy and conserves the ovaries, that is likely to be associated with unknown symptoms. Of course, we are talking about young women with this condition, and therefore, early recourse to that kind of mutilating treatment is clearly inappropriate. This is really reserved for those with very extreme symptoms where other treatments have failed.”

“I've had physicians report to me that uterine suspension or uterine positioning procedures have also been performed in those patients who are preserving fertility and gives them a relief for a period of time until their pregnancy. Then of course, if this condition recurs and becomes a terribly severe condition, I know Dr. Beard demonstrated an 80% success with the extirpation procedure, which of course you want to reserve, but it does have to be considered in some of the worst cases. Do you have any pearls on the diagnostic area for this rather underdiagnosed condition, because when we're looking at laparoscopy we don't see the dilated veins generally. So we probably missed this at our laparoscopy, our "gold standard" of laparoscopy somewhat fails us because the positions people are in. Could you give a pearl to the physicians who are watching that will help alert them to being a little more open to this?”

“The key thing is to be aware of that diagnostic possibility from the outset. The clinical evaluation is the diagnosis that perhaps should be formed early on in the process of diagnosis rather than at the end when all the investigations have proved to be negative. If we're considering if we're asking the right questions, I think, the pearl really is to focus on the history and the physical exam, and in a way we're half expecting our negative laparoscopy or our observation of dilated pelvic veins.”

“So truly, this is a place where history and physical examination, and one additional small pearl would be as I picked up from your discussion - ask if you send your patients to a radiologist or to an ultrasound center, and you're not doing your ultrasound yourself, ask them to measure the caliber of the veins. How often do we actually get a report back where they've told us the caliber of the veins - I think very rarely.”

“Jim, I think that's a very important point, and it's something that when one is carrying out ultrasound scans one would assume somebody has mentioned the possibility of looking for a vein but suddenly become obvious and sonographers then sometimes say, "I've never seen them." Then one says, "Well, just go and look for them." And then having pointed them out - it's obvious. But as you say, if we don't ask about information from our sonographers, then we won't get it.”

“Is there a particular diameter of these veins, just to comment that they should be looking at when they do this caliber measurement?”
"Yes, I think the variables to look at, perhaps, are the number of veins. I think in some individuals would be one or two quite large veins, perhaps, more than a centimeter in diameter but others will have very large numbers of smaller vessels in say, the 3-5 millimeter range but they'll be very widely distributed around both adnexa. It's really the number of vessels and their caliber."

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"So you're looking at ovarian veins, and you're looking at caliber, and if it's greater than a centimeter you should be concerned. If there's one or two that are greater than a centimeter or if you see this plexus of ovarian veins, that's just a mass of 3-4 millimeter veins that are all distributed - that would give you a very good hint."

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"Yes, exactly. I think it's important to bear in mind the limitations of ultrasound compared to venography in that it is more difficult to evaluate venous flow and venous clearance - ultrasound can't do that. If we really want the gold standard and that still remains transvaginal sonography."

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"I am very thankful that you've taken the time to travel from England to the States to give us a perspective. By the way, I'd like you to tell the audience the opportunity they have to come to London to England to your conference. Do you want to give us some information on that?"

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"Certainly do, Jim, thank you. On Saturday, May the 13th in the year 2000, we're having the millennial meeting of the International Pelvic Pain Society in London in England. That's going to be a meeting held the day before the start of the World Congress of Endometriosis. Maybe many who are planning to come to that World Congress which starts on Sunday, the 14th of May, might like to add that to their schedule, perhaps come a day or two earlier and can join in. We've got a very pleasant venue for the meeting in Central London at the Royal Society of Medicine, and I'm sure that's going to be very exciting meeting."

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"I'd like to add - we're working out the details of this program. Dr. Stone, I'd be very appreciative myself if you would run a work shop prior to that on your work on the venography and the techniques that are used. Also, we're hopeful that he's going to put together a very nice party the night before for all of you, and a little plenary lecture, and perhaps, a reception. So come in early, don't just plan to come in for the 13th, we're going to have him give us a little party in London. So the 12th would be a good day to plan for it. Thank you very much."

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"Thank you very much, Jim."

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"Thank you."

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