



ORIGINAL REPORT

Pelvic congestion syndrome: Outcome after embolization with coils[☆]

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KEYWORDS

Venous congestion;
Pelvis;
Veins;
Ovary;
Therapeutic embolization

Abstract

Objective: To study the clinical manifestations and findings at venography in patients with pelvic congestion syndrome and to evaluate the outcome after percutaneous embolization using coils.

Materials and methods: We studied 34 women referred to the vascular radiology unit from the vascular surgery department for clinical suspicion of pelvic congestion syndrome. All patients underwent venography to assess the competence of the ovarian veins and to detect other varicose pelvic veins. When pelvic varicose veins were detected, they were embolized with coils. Clinical outcomes were recorded after reviewing the clinical history and administering a questionnaire over the phone.

Results: In 22 of the 34 patients, signs of pelvic venous insufficiency were found. The symptoms were mainly the sensation of pelvic and perineal heaviness (20/22) and pelvic pain (18/22). The technical success of venography and embolization was 100%, with three minor complications that did not require hospitalization. The sensation of pelvic heaviness improved in 14 patients (in 13 it was completely eliminated). Pain disappeared in 11 patients and was partially alleviated in another 2.

Conclusion: In patients with pelvic congestion syndrome, the embolization of insufficient pelvic veins brings about clinical improvement with short hospital stays and few complications.

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PALABRAS CLAVE

Congestión venosa;
Pelvis;
Venas;

El síndrome congestivo pélvico. Resultados tras la embolización con espirales

Resumen

Objetivo: Estudiar las manifestaciones clínicas y los hallazgos venográficos en las pacientes con síndrome congestivo pélvico (SCP), y evaluar los resultados después de la embolización percutánea con espirales.

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Ovario;
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Materiales y métodos: Se estudiaron 34 mujeres en la sección de Radiología Vasculardel hospital, todas remitidas con sospecha clínica de SCP desde el servicio de Cirugía Vasculardel hospital. Las pacientes se estudiaron mediante venografía valorando la competencia de las venas ováricas y la existencia de otras venas varicosas pélvicas. En las pacientes en las que se detectaron varices pélvicas se procedió a la embolización percutánea con espirales. Posteriormente se registró el resultado clínico revisando el historial clínico de las pacientes y por medio de un cuestionario telefónico.

Resultados: En 22 de las 34 pacientes se encontraron signos de insuficiencia venosa pélvica. Los síntomas que referían las pacientes eran principalmente la sensación de peso pélvico y perineal (20/22) y el dolor pélvico (18/22). El éxito técnico alcanzado en las distintas venografías y embolizaciones fue del 100%, presentándose en 3 ocasiones complicaciones menores que no requirieron de ingreso hospitalario. La mejoría de la sensación de peso pélvico se constató en 14 pacientes (en 13 fue completa). El dolor desapareció en 11 pacientes y disminuyó de forma parcial en otras 2.

Conclusión: La embolización de las venas insuficientes pélvicas consigue una mejoría clínica en las pacientes con SCP, con cortos periodos de hospitalización y escasas complicaciones.

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Introduction

The chronic pelvic pain (CPP) characterizes by pain in the pelvis and hypogastrium of 6 months duration not associated exclusively with menstrual cycle or sexual relations.^{1,2} Its prevalence in women between 18 and 50 years is around 15% and in 10% is the reason for external consultations in gynecology.³ Back in the 1950s pelvic venous congestion secondary to ovarian and/or hypogastric vein failure was proposed as one of the causes of CPP which in turn coined the term pelvic congestive syndrome (PCS).⁴ Pelvic venous incompetence is due to mechanical (multiparity, anatomical defects in ovarian veins or extrinsic vascular compression like the nutcracker syndrome) and hormonal factors.^{5,6} PCS is common in young multiparous women. The main symptom is unilateral or bilateral pelvic pain usually a dull intermittent pain more acute during premenstrual period presenting with fatigue and bipedalism² and some times accompanied by a sensation of pelvic weight, dysmenorrhea, dyspareunia, pain on ovarian pressure points, vesical irritability, perivulvar varicosities and psychosocial alterations.⁷

During the last three decades different therapies have been proposed with different acceptance and effectiveness. Until the 1980s treatment was symptomatic and in refractory cases doctors would perform hysterectomies with double anexectomy. In time we would see the arrival of progestagens and analogues of GnRH,⁸ and the resection of ovarian veins by retroperitoneal approach through laparoscopy⁹ to interrupt vein flow.¹⁰ In 1993, Edwards et al. described the percutaneous endovascular treatment of PCS¹¹ which today is the preferred therapy due to its effectiveness—greater to surgery according to some studies; short hospital stays; low rate of complications—usually minor; and because it does not need extended use of drugs.¹²

The goal of our work is to study the clinical manifestations and venographic findings in patients with PCS and evaluate the outcomes after the percutaneous embolization with coils.

Materials and methods

We did a retrospective study of a group of 34 female patients who—between January 1999 and January 2009—were referred to the unit of vascular radiology of our hospital from the vascular surgery unit with suspicion of PCS. These patients underwent digital venography without further image studies since this is the benchmark modality for the study of the pelvic venous competence. The endovascular therapy happened in the same act whenever pelvic venous incompetence was confirmed. All patients were briefed upon and signed a written informed consent in less than 24h prior to the proceeding. License from the ethical committee of the hospital was not needed since it was a retrospective study that had nothing to do with the therapeutical attitude towards the patients.

The venographic finding to be able to diagnose pelvic venous incompetence was contrast reflow towards the ovarian and/or hypogastric veins. Other secondary signs are one ovarian vein >5 mm in diameter; the late clearance of contrast from pelvic veins; and the opacification of pelvic veins crossing the medial line and communicating veins with varicose veins in the obturation area.^{13,14}

Both venographies and embolizations were performed by two vascular radiologists with 10+ years of experience using Philips Allura XPer (Best, The Netherlands) digital subtraction angiograph. After the vein puncture procedure (through femoral or brachial approach) using the Seldinger technique and one 5F vascular introducer Terumo (Tokyo, Japan) the left renal vein was characterized with a visceral Cobra 2 type-catheter or 5F vertebral introducer Terumo (Tokyo, Japan). Contrast was injected being the patient relaxed and later using the Valsalva maneuver to see if there was reflow towards the ovarian vein. In presence of an incompetent vein surgeons proceeded to characterize it with the Terumo hydrophilic wire (Tokyo, Japan) to later embolize its lower part with platinum Nest®-type coils from (Cook, Bloomington, Indiana) until complete occlusion (Fig. 1). Similarly both

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