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Gynaecological assessment in the elderly

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Although the changes of ageing can make gynaecological assessment of elderly women more challenging than that of younger women, full investigation and appropriate referral so that patients benefit from up-to-date treatments can be rewarding for women and doctors alike.

Key points

- Many gynaecological problems, both benign and malignant, become more common with age.
- Take a full history, including a sexual history, in women presenting with gynaecological symptoms.
- Do not make assumptions about an older woman's sexuality – talk to the older woman as comfortably as you would to a younger woman.
- Do not assume that elderly women with intercurrent medical conditions that may warrant surgery should not be referred. Modern anaesthesia and surgical techniques have reduced the risks of gynaecological surgery in such patients.

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Over the past 20 years, as the average woman's lifespan has lengthened, an increasing number of elderly women have presented with gynaecological complaints to both GPs and specialists, and this trend is likely to continue. Many gynaecological problems, both benign and malignant, become more common with age. Uterovaginal prolapse is more likely to become symptomatic with age, resulting in presentation to the GP. Older women also account for a high proportion of genitourinary consultations in general practice. Gynaecological cancers, particularly of the endometrium and ovary, increase in frequency with advancing age. Although surgery is still the primary treatment for most forms of gynaecological cancer, there is sometimes reluctance to refer elderly patients, or to offer surgical treatment, both for malignancies and for prolapse. However, advances in anaesthesia, surgical techniques and perioperative care have brought about reductions in rates of morbidity and mortality from major surgical procedures in elderly patients (see case study 1 on page 28).[1-3]

The importance of sexuality for older women is becoming increasingly recognised, both as a predictor of general health and as a contributor to quality of life. Women presenting with gynaecological symptoms may be embarrassed to initiate discussion of sexual matters, but equally GPs may be reluctant to broach the subject. Doctors caring for older women presenting with gynaecological symptoms of all kinds should guard against age bias in both history taking and decisions about referral and treatment.

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CASE STUDY 1

An 88-year-old woman who had undergone hysterectomy for an apparently benign condition at the age of 43 years was referred for specialist management for an 11 cm right ovarian mixed solid and cystic mass, raised CA 125 level and partial obstruction of the right ureter. Six years previously, an ultrasound had shown a mixed solid and cystic mass with a normal CA 125 level and the treating doctor had advised against surgery or further ultrasound.

After investigations were carried out (including a now raised CA 125 level), a bilateral salpingo-oophorectomy, omentectomy and lymphadenectomy were performed with no complications for a stage one serous adenocarcinoma. There was no evidence of spread of disease and she was recommended to have no adjuvant therapy. Now aged almost 90 years she is fit and well with no evidence of recurrence and a normal CA 125 level.

How do we define 'elderly' in the 21st century? For the purposes of this article we have selected 60 years and over. This definition includes many fit and independent women but also a number with major intercurrent medical conditions that will impact on investigations and management. In very frail or demented patients history taking, examination and management may be very limited.

PHYSIOLOGY OF AGEING: NORMAL CHANGES IN THE GENITOURINARY TRACT AND VULVA

The normal physiological processes of ageing in women accelerate after the menopause, particularly in the genital tract as oestrogen levels fall. The vagina and lower third of the urethra are oestrogen-dependent tissues. Lack of oestrogen leads to thinning of the epithelium, loss of vascularity and elasticity in these structures and increased vaginal pH, all of which in turn predispose to vaginal atrophy, vaginal dryness, vaginitis and possible urinary tract infection. The cervix and body of the uterus shrink in size, the cervix becomes flush with the vaginal vault and stenosis of the external cervical os is common. There is thinning of the vulval skin and flattening of the labia majora. Weakening of the pelvic floor musculature and connective tissue, which may already have commenced during pregnancy and childbirth, is accelerated by ageing.

PRESENTATION TO THE GP

Many women may present simply by requesting a well-woman check. Women may also present complaining of postmenopausal bleeding; vaginal discharge, dryness, discomfort or pain associated with vaginitis; symptoms of prolapse (including women with previous hysterectomy or vaginal surgery for prolapse); abdominal pain, swelling or bloating; or bowel or urinary symptoms.

GENERAL HISTORY TAKING

History taking will follow the doctor's normal pattern but should certainly include age at menopause and any past gynaecological surgery. The recall of elderly patients may not be perfect especially many decades after surgery. Some procedures that are now superseded may be unfamiliar to younger practitioners – for example, Manchester repair for prolapse, which involves removal of the cervix and pelvic floor repair but leaves the body of the uterus in situ, has now been replaced by vaginal hysterectomy. Some women may report having had a total hysterectomy when in fact a sub-total, leaving the cervix, was actually performed; others will describe a 'partial hysterectomy' when what they underwent was total abdominal hysterectomy with conservation of both ovaries.

Women with dementia should be accompanied by a relative or carer so that as accurate an account as possible is obtained. This is particularly important if the presenting complaint is vaginal bleeding – how certain is it that the bleeding is actually from the vagina and not the bowel or urethra? When taking a history from a woman with urinary incontinence take the opportunity to ensure that the woman is not becoming dehydrated by trying to restrict her fluid intake – this is not an uncommon scenario in tropical North Queensland practice.

SEXUAL HISTORY TAKING

We encourage GPs to be as comfortable and forthright in their sexual history taking in elderly women as they are with younger women. Establish whether the woman has a partner (treading lightly with new patients as a proportion of these may be recently widowed and still grieving). If she does have a partner then determine whether she is having conventional penetrative sex and, if so, how often. Since the advent of therapies such as sildenafil and tadalafil, we have come across a number of women in their 70s and 80s who are subjected to frequent demands for sex from their male partners and in whom dyspareunia from vaginal atrophy is a major problem. On the other hand, erectile dysfunction or prostate problems in the male partner may mean that sexual activity is more directed to digital, oral and/or vibrator stimulation, which some women may feel embarrassed in discussing; it is important for women to be reassured about the normalcy of such activities.

When asking about dyspareunia be very specific in differentiating superficial and deep dyspareunia, which have quite different causes. In some women who state that they have deep dyspareunia, further questioning reveals that they experience pain with full penetration, but that the pain is at the perineum and fourchette and usually related to atrophic changes. True deep dyspareunia is likely

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to be related to abnormalities of the internal pelvic organs.

EXAMINATION

Careful abdominal examination is essential in elderly women presenting with gynaecological symptoms. Inspection quite often reveals scars of surgery that a woman has forgotten.

Before embarking on a vaginal examination of an elderly woman consider how difficult this may be – it may be appropriate to discuss the procedure in detail with the patient first. In virginal or nulliparous elderly women and in those who have had all their deliveries by caesarean, have had no sexual activity for many years and have not used vaginal oestrogen, vaginal examination even using a paediatric speculum and a single finger for digital examination is likely to be very uncomfortable from the patient's viewpoint and inadequate from the doctor's. Consider whether a short course of vaginal oestrogen may be appropriate before the examination (see text below).

It is important to stress to women with urinary or faecal incontinence that if they are incontinent during the examination, not only is this not a problem (sheets can easily be changed, etc), it is actually helpful to the doctor in gauging the extent of their condition. These women will often ask to go to the toilet after history taking and before the examination (even though they have been just before you called them in). Emptying the bladder at this point makes it harder to assess stress incontinence or subsequently obtain a midstream urine sample. Explanation and reassurance should be offered to these women.

Make sure that your examination couch is easily physically accessible for elderly patients, especially for those with recent hip or knee replacements. Remember that bimanual vaginal examinations and examinations to demonstrate prolapse can, if necessary, be performed with the woman standing with her legs slightly apart on a low stool and the doctor kneeling beside her.

Once all of the above have been considered vaginal examination is the same as for younger women, with a smaller or paediatric-sized speculum, appropriately warmed and lubricated, as indicated. Do not miss the opportunity to check that a woman is able to perform pelvic floor exercises and explain these if necessary; age is no barrier to efforts to improve pelvic floor tone.

In the presence of significant atrophic vaginitis/cervicitis, routine Pap smear taking (to age 70 years in women with no previous history of cytological abnormalities and over 70 years for those with

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CASE STUDY 2

An 85-year-old woman had undergone hysterectomy and removal of both ovaries in her 40s. At age 80 years she underwent anterior and posterior vaginal repair for symptomatic prolapse. Since that surgery she was experiencing worsening stress incontinence, despite use of vaginal oestrogen and pelvic floor exercises, which interfered significantly with the daily activities of a very well preserved and otherwise active 85-year-old woman.

After investigations and discussion, a vaginal sling operation was performed with no complications and immediate good results. Complete cure is still reported 18 months later.

relevant history) may be postponed for up to three months while vaginal oestrogen is prescribed to get a better view and hopefully a normal smear report at a subsequent visit.[4-7]

Vaginal examination should always be preceded by full inspection of the vulva. Lichen sclerosus is more common in elderly women and has a significant association with the development of vulval cancer. In women with an established diagnosis of lichen sclerosus, regular examination (usually annually) should continue for the woman's lifetime (and can be performed by the GP) and a diagrammatic record of findings documented on each occasion.

INVESTIGATIONS IN GENERAL PRACTICE

Although many of the investigations will depend on the individual presentation, ultrasound is a common next step to a gynaecological consultation in elderly women. Although transvaginal scans are preferable, in elderly women in whom vaginal access may be difficult and uncomfortable, transabdominal scans may give the required information.

When a patient presenting with postmenopausal bleeding is referred for an ultrasound, an endometrial thickness of more than 4 mm is an indication for further investigation.[4] This was determined from a retrospective series of symptomatic women with postmenopausal bleeding. The relevance of an incidental finding of endometrial thickness of 6 mm in an asymptomatic woman is therefore not known; however, the GP is unfortunately in a position in which they need to refer the patient for this. Certainly small (1 to 5 cm) simple ovarian cysts are not uncommon on ultrasound in elderly women and can be followed with serial scans. Simple cysts of 1 cm or less are considered within normal limits and no follow up is necessary. An important point to remember is that if one or both ovaries cannot be seen on ultrasound this does not always mean that the ovaries are not present, simply that they are very small and atrophic.

WHEN TO REFER

Thickened endometrium (as described above) or other endometrial abnormalities on ultrasound is an indication for urgent specialist referral of the elderly woman. The earlier the diagnosis and treatment of endometrial cancer, the better the prognosis.

Women with simple ovarian cysts more than 1 cm in size can certainly be referred, not urgently, although the likely specialist management is also follow up with annual ultrasound and, if no change, return to general practice care. Women with any complex ovarian cysts or solid tumours require urgent referral, with CA 125, CA 19-9 and routine blood test results accompanying the patient.

Women with urinary and faecal incontinence should be referred for appropriate investigations and specialist decisions about management. As already noted, surgical options for incontinence and prolapse are becoming more and more appropriate for elderly patients, with better anaesthesia, shorter operating times and minimally invasive techniques (see case study 2 on this page).[1,8]

Women with any suspicious changes in the appearance of lichen sclerosus (or de novo lesions on the vulva) should be referred urgently, as should those with obvious abnormalities on the cervix.

INDICATIONS FOR USE OF VAGINAL OESTROGEN IN ELDERLY WOMEN

- Vaginal irritation and/or itch in the absence of lichen sclerosus (for which corticosteroids are indicated), vulval intraepithelial neoplasia and vulval cancer
- Superficial dyspareunia due to atrophic changes
- Urinary problems including recurrent proven urinary tract infections, cystitis, stress incontinence and unstable bladder symptoms
- First-line management of faecal incontinence when other causes are excluded
- Both conservative and postoperative management of prolapse
- Postmenopausal bleeding where all other causes are excluded and atrophic vaginitis diagnosed
- Abnormal Pap smears (usually atrophic and/or minor changes in reports) with no abnormalities at colposcopy

MANAGEMENT IN GENERAL PRACTICE

Although mild atrophic genital changes occur in most postmenopausal women, 40% of women will develop one or more debilitating symptoms. In this situation, it is important to stress that vaginal oestrogen in most women is safe.[4-7] There is no need to discontinue this therapy after three months and it can be used in the long term. There is no evidence that it exacerbates treated thromboembolic

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disease, treated early stage endometrial cancer or treated cardiovascular disease. In regard to a personal history of breast cancer, if the cancer was hormone-receptor positive then preparations containing oestriol are safe; oestriol cannot bind with a hormone-receptor positive breast cancer cell. It is most important, however, that we tell women that although there is no significant absorption with long-term use, in the early loading dose phase when the vaginal epithelium is thin there may be minor absorption and systemic effects may be felt temporarily. Women should be warned about the possibility of breast tenderness, lower abdominal cramps and headaches and told that once the initial stages of treatment are complete and the skin is thicker there will be no further absorption of significance and these side effects will disappear. Also, women should be warned that a small number of them will develop vaginal candidiasis; this should be treated in the usual way and topical oestrogen continued. The box on page 30 lists the indications for use of vaginal oestrogen in elderly women.

In women with dementia, in nursing homes or other care, oestrogen cream applied to an incontinence pad can provide excellent absorption to allow oestrogenisation of vaginal tissues.

The GP has a major role in the conservative management of prolapse in elderly women, including the management of constipation, chronic cough and obesity. Ring pessaries still play an important part in the treatment of prolapse either short or long term, usually in conjunction with topical oestrogen. Ring pessaries may be regularly changed and the vagina inspected by the GP.

CONCLUSION

The same principles of care and respect in the gynaecological assessment of younger women are equally applicable to the elderly. Treatments are available for elderly women with many different gynaecological conditions meaning that caring for these women can be very rewarding for the doctor as well as beneficial to the patient. MT

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