Pelvic Congestion Syndrome Is Underdiagnosed and Undertreated

Hello, and welcome to the February 2020 issue of Vascular Disease Management. There are multiple interesting articles in this issue, but I have chosen to comment on the article “Current Clinical Management of Pelvic Congestion Syndrome,” authored by Greuner and DeMarco.

I have decided to comment on this excellent article as pelvic congestion syndrome is a highly prevalent and profoundly underdiagnosed and undertreated cause of pelvic pain in women. It can result in devastating symptoms such as profound dyspareunia, chronic fatigue, vaginal and peri-vulvar varicosities, and chronic abdominal and lower back pain. The authors have not only described the causes, both primary and secondary, but have created a suggested algorithm for improving identification and treatment of this disorder.

Chronic pelvic pain has many potential etiologies, including pelvic inflammatory disease, endometriosis, interstitial cystitis, adhesions, malignancy, adenomyosis, irritable bowel syndrome, uterine fibroids, and pelvic congestion syndrome. One of the key clinical tipoffs is pain that is worsened with changes in body positions.

The initial diagnostic test of choice is a carefully performed pelvic duplex ultrasound using Valsalva maneuver to accentuate venous reflux and to engorge and measure vessels. A highly skilled ultrasound technician is crucial, as this disease process can easily be missed. Ultrasound findings in the diagnosis include incompetent pelvic veins measuring greater than 5 mm, dilated arcuate veins crossing the myometrium and communicating with bilateral pelvic varicosities, and slow blood flow less than 3 cm/second.

Definitive diagnosis is established with venography coupled with intravascular ultrasound (IVUS) to evaluate for obstructive lesions in the iliac veins, such as webs or venous compression (May-Thurner syndrome), and compression of the left renal vein (Nutcracker syndrome). Findings include engorgement of the ovarian plexus, venous reflux in the ovarian veins, filling of veins across the midline, and filling of vulvar or thigh varicosities. Invasive evaluation should include visualization of the internal and external iliac veins, bilateral ovarian veins, and left renal vein.

The interventional therapy of pelvic congestion syndrome includes occluding the incompetent veins with embolization or sclerotherapy and relieving obstructive lesions with stenting. Interventional therapy has been reported to have excellent clinical outcomes, with more than 80% of patients noting improvement in chronic pain and dyspareunia.

Like most other vascular disorders, pelvic congestion syndrome can only be diagnosed and treated if there is a high index of suspicion in the diagnosis made. This is a chronic, debilitating disorder that results in physical pain as well as psycho-social and relationship consequences. I strongly suspect that this disease process is usually misdiagnosed and undertreated, or mistreated, with anxiolytic or anti-depressant drugs.

Many physicians are unaware of the existence of pelvic congestion syndrome. If we are to improve the treatment of all vascular disorders, we must educate ourselves and our peers about this disorder and the potential excellent treatment outcomes.