Academy of PHYSICAL MEDICINE

Dysmenorrhoea

with Susanna Unsworth

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TRANSCRIPT

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Steven:

It is great to have you with us, of course. And it's also great to be joined by Dr. Susanna Unsworth, who is a specialist in women's health. Susanna, good afternoon.

Dr. Susanna Unsworth:

Good afternoon. Thanks for inviting me to come and speak to you all today.

Steven:

Oh, it's our pleasure. And I, I know you've got a string of letters after your name. I don't think I could have fitted them on my slide here behind me, but in addition to being a member of the Royal College of GPS, you are also, you also have two diplomas from the Royal College of Obstetricians and Gynaecologists one with the faculty of sexual and reproductive health.

Dr. Susanna Unsworth:

That's right, yeah.

Steven:

Um, you care to explain the difference. I mean, what, what does it mean to have a diploma from the college and then one from their sexual reproductive health faculty?

Dr. Susanna Unsworth:

Yeah, sure. So as a GP, I'm in the training that we did, it's very sort of general hence the name general practice, but a lot of colleagues like to have special interests in certain areas. And so my interest is in women's health. And so during my training and also beyond training as a GP, I did extra qualifications focusing on women's health. So the diploma from the Royal College of Obstetrics and Gynaecology covers lots of different areas of women's health the sexual health and reproductive health focus mainly on areas such as contraception. So it's, they're similar, they're sort of interconnected, but slightly more focused on different areas. And then I've also just recently gained a qualification from the British Menopause Society as well. So that's another area that I'm particularly interested in.

Steven:

Um, what's that qualification?

Dr. Susanna Unsworth:

So that's the Advanced Certificate in Menopause Care. So it allows me to be on their register of menopause specialists as well.

Steven:

Right. So it kind of justifies what it says on your website.

Dr. Susanna Unsworth:

Yeah. Yeah.

Steven:

We've got you on courtesy of your colleague. Hannah Short, she said she, she thought you'd be a good speaker on the topic of dysmenorrhea. And I guess it's probably very timely to talk about things like this, isn't it? Because I think the news yesterday, we're seeing that many women's health problems go untreated because they are regarded as being just a normal part of the menstrual cycle or part of menopause. And perhaps you can help us to distinguish what is unusual in what comes across our treatment tables in our own clinics.

Dr. Susanna Unsworth:

Yeah, sure. I'm hope, hopeful that by the end, you'll be able to definitely think more about that. To me, I think dysmenorrhea particularly women often associate pain with their periods. They think, you know, I've got my period. I can expect to have experienced pain. But actually, for a lot of women, they're experiencing a lot more pain than they should be. Not necessarily because of anything really seriously wrong, but there are things that we can do to help it. And I think from, from my experience, a lot of women don't come to speak, to speak to their doctor about it until they're really, really struggling. And it's such a shame. They don't recognize that they can come sooner because there are things that we can do to help.

Steven:

Yeah. And I think we were on the shows that we've had before with women's health specialists. We recognize the fact that quite often women's health problems can cause pain, which could be mistaken for musculoskeletal things. And so again, it's very important that we're able to do that differential diagnosis in our own clinics and make sure we refer correctly or treat appropriately where we can.

Dr. Susanna Unsworth:

Yeah, sure. I think that is, that is a difficult problem. I think particularly with any sort of abdominal symptom, you know, there's lots of different things going on in your abdomen that can be causing the problem. And sometimes the symptoms do appear quite similar. So it's, it is important to, you know, really talk to someone about what they're experiencing to try and pick out the key factors that can hint towards it being something related to their menstrual cycle, as opposed to if their bladder or bowel, or like you say, your musculoskeletal pains.

Steven:

In the sort of ideas that we shared before this. You said that you, you were to divide this into primary and secondary dysmenorrhea, what do you mean by that?

Dr. Susanna Unsworth:

Sure. So we do this in quite a lot of medical things. Primary dysmenorrhea is kind of a cause of period pain that doesn't really have any sort of physical cause. And this tends to occur in younger women. So maybe sort of late teens and their early twenties, and there isn't actually any physical abnormality that, that you can find, but they experience pain and it can still be quite significant pain, but there isn't a a an actual anatomical problem. And then secondary dysmenorrhea is when there is actually a physical reason, that's abnormal as to why, and that's why they getting pain. And there's a number of different things that can cause that.

Steven:

So in those secondary cases then presumably those are the sorts that would go for surgery. Are they, or for some other medical intervention?

Speaker 2:

Yeah, I mean, not necessarily. So there are different, different levels of treatment that we would offer. I mean, surgery is definitely one of the things that might be considered. But not everyone wants to have surgery. You know, surgery is never without risk. And I I'm sure, I mean, I'm not a surgeon, but I know a lot of my surgical colleagues on the whole try to kind of reserve surgeries a as a kind of, not last resort, but at least try another more conservative things first if, if that's a potential option. But usually if there's, if there's a secondary, cause it, there is usually a treatment that can be provided to hopefully alleviate the symptoms.

Steven:

So then I presume you're dealing, largely with primary causes of dysmenorrhea. Right?

Dr. Susanna Unsworth:

Yeah, I think, I think both really, so as a GP I guess, we're sort of faced with someone just presenting with the pain and then we have to kind of work out, is this a, is this a primary cause of dysmenorrhea, which on the whole would be managed ideally within general practice setting, sometimes you might need to involve some more specialist care if it, if the patient is really struggling. But then yeah, we need to be able to distinguish, is it a primary or a secondary cause, but some secondary causes can be managed quite easily in general practice. It obviously depends on the degree, degree of symptoms they are getting and what the underlying ultimate diagnosis of that is.

Steven:

You mentioned pain, is that the only problem that we get with dysmenorrhea.

Dr. Susanna Unsworth:

So I guess dysmenorrhea by definition sort of means painful periods, but it can be associated with other symptoms. So again, it's a little bit dependent on the underlying cause. So for most women who are just getting what we call the primary dysmenorrhea, they don't tend to get any other sort of significant physical symptoms, but they can be affected by other things such as of emotional symptoms, because often it's an element of, of hormonal. You know, the hormones are involved a little bit and so they can get more emotional type symptoms. However, with secondary cause it is sometimes they can get other symptoms as well, um and it can be due to depending on what the underlying problem is, but there are other things that are close to in the pelvis or the organs within the pelvis that can be affected as well. So it's not just pain. It can be other symptoms too.

Steven:

Is it much of a problem? I mean, I don't know how many women are affected by problems surrounding the period.

Dr. Susanna Unsworth:

Yeah. So it's difficult to say exactly how many women affected, cause if you look at the, the sort of um, the statistics and the data, there's not a huge amount of really detailed studies looking specifically, at least I think that's a common problem with women's health issues actually, but the prevalence sort of ranges from anywhere from 20% to 90%. And I think if you talk to most women, they will experience some sort of pain around the time of their period. And it's, it's quite difficult to define sometimes pain. And like we were saying at the beginning, a lot of women just expect that and they think that that's just normal. So they wouldn't necessarily classify it as a problem, but there is some data to say that probably 50% of women do have an, a degree of pain that affects them in their day to day life. So in younger, in younger girls, who've maybe just started having their periods and in their early teens, they might miss school because of it. And then obviously women, as they get older, it might have an impact, impact on their work life as well. So the actual prevalence of it is actually thought, felt to be very high, even if there may be isn't enough, a lot of evidence to prove that.

Steven:

Does that mean to say then that the, the burden on the NHS is not that great, even though the problem might be quite prevalent?

Dr. Susanna Unsworth:

Yeah. I mean, I think at the moment the burden isn't, isn't a huge and I think the amount of funding put into women's health is, is disproportionately low compared to other, other issues. But the burden on the economy, I think potentially could be a lot higher through sort of missed work days and potentially women and young girls' education as well, um, it can be a significant effect.

Steven:

You kind of made it sound as though there's not much one can do about primary dysmenorrhea.

Dr. Susanna Unsworth:

Well, I mean, there is, there is quite a lot you can do. So obviously when we, when we diagnose that as, as the ultimate problem, in a way that's quite useful to know that we know that there isn't any other underlying physical abnormality, but then there are a lot of things that we can do to help. So the first thing that I would often recommend women try and they can actually do this themselves is just looking at the type of pain relief that they use. So we feel that a lot of primary dysmenorrhea is due to the release of prostaglandins around the time of menstruation and things like anti-inflammatory painkillers, like ibuprofen can actually be really helpful in reducing the amount of prostaglandin release, and that can be really helpful in in managing the pain. So for women who experience pain around the time of their period, I would often recommend that they start using something like ibuprofen in the couple of days, building up to their period and use it during that time. And then obviously the rest of the month, they don't necessarily need to take anything, but that on its own for a lot of women can actually be enough to, to settle it.

Steven:

Yeah. It seems quite surprising that you have to give that advice to me because I would have thought that that would have been a sort of a first port of call for almost everybody with pain.

Dr. Susanna Unsworth:

I think it is, and I think it's, it's tricky. I think a lot of people do use over the counter pain relief, but maybe don't use it quite effectively enough, so they might just take one tablet when they get the pain and then leave it a bit and then maybe take another one. But what would be the best way of doing it is particularly if you've got a regular cycle is to be able to pre-empt your period coming and maybe start using the medication quite regularly for a few days, rather than just taking it as, and when you feel the pain, I think that's often what I, I find women tend to do as opposed to trying to recognize it a little bit in advance.

Steven:

Yeah. That sort of related question there, the the contraceptive pill tends to regularize the cycle. Doesn't it? Does it have any effect on dysmenorrhea?

Dr. Susanna Unsworth:

Yeah. So the pill, the contraceptive pill is kind of the next sort of step of things that I would then talk about with, with women and particularly sort of younger women. So if they've already tried using simple pain relief like ibuprofen, the next thing will be to use some sort of hormonal treatment and the contraceptive pill, there's different types of pill that can be used. The combined pill is probably the most effective cause that tends to lighten the period, which can often have a beneficial effect as well. But yeah, we, you know, we, we often do use other type, types of contraception as well to help. And it's got the added benefit that it's also a contraceptive, if that's what somebody wants. The difficult thing is if somebody obviously is wanting to try for a baby, then they were a bit limited on what we can use from that point of view.

Steven:

Yes, of course. If they're lucky then having a baby, we'll put a stop to the periods for a little while.

Dr. Susanna Unsworth:

Yeah. Yeah. And actually, interestingly, a lot of women do find once they've had a baby, if they, if they have been someone who suffered with primary dysmenorrhea, it does tend to improve after pregnancy. So women who've often suffered in their sort of late teens and twenties, they might find after a baby that actually does seem to be better.

Steven:

Are there any specific risks to women's health who take taking nonsteroidal, anti-inflammatories? I mean, we, we know the standard risks for those drugs.

Dr. Susanna Unsworth:

Yeah. I mean, I guess really the standard risks that we would apply to anybody. So the, this sort of gastric effects that regular anti-inflammatories can have and long-term, they can, can have an effect on your kidney as well. Obviously if, if there's, if you're pregnant, we don't recommend using nonsteroidal anti-inflammatory drugs. So, I guess if there's a chance of pregnancy, it's best to, to avoid those as well. I guess the thing with the primary dysmenorrhea is they're not going to be taking it the whole month. So usually it's just for a few days, each month. So on the whole, most women can tolerate that quite well. Slightly difficulties asthma, so some women who have asthma these sort of drugs can sometimes aggravate that. So then it becomes more difficult to use. But for most women I think for using it for short period of time, she'd be absolutely fine.

Steven:

How about you had a question from somebody in the audience saying, what's the alternative, if you can't take ibuprofen? And I don't know whether she says he or she says nonsteroidals as well as,

Dr. Susanna Unsworth:

Yeah. Yeah. So that's kind of, usually it's a class effect, if you can't take ibuprofen, you probably can't use many of the other similar drugs as well. There are some other drugs which are called Cox two inhibitors, which work in a slightly different way, but they need to be prescribed by your doctor. Paracetamol can be helpful. So obviously if it, if it's pain, that's the main issue then paracetamol is, is another useful option, but it doesn't quite have the same effect on the prostaglandin release, which is what we feel is the underlying cause of most of the pain. But paracetamol is also an option.

Steven:

You mentioned the Cox two inhibitors. They had some very bad press recently, didn't they?

Dr. Susanna Unsworth:

Yeah. I mean, we don't tend to use, I mean, I personally don't prescribe those usually they, they were, they went through quite a phase of using them quite often, I think, because it was felt that they had a better safety profile than the nonsteroidals do. I think it's kind of tipped back the other way a little bit now, but if there's a specific reason that you can't use ibuprofen, sometimes that's a potential option, but usually that would be something that would be sort of discussed with your doctor. Rather than it being something you can do yourself.

Steven:

Sylvie's actually asked again a related question. And what would you advise if you can't take the nonsteroidals, but she's asking specifically about a 15 year old is there a problem with different age groups on these drugs?

Speaker 2:

So I mean, we don't recommend using those in children under 12. I think in a 15 year old they can, they can use ibuprofen. But I mean, in a 15 year old, if she's really, really struggling for me, I'd really be wanting to talk about potentially using the contraceptive pill. I mean, I know sometimes that's a difficult topic for some people to want to, to think about. And, but we often do use hormonal treatment, you know, not as a contraceptive. And I, that's sometimes a difficult barrier for some, some parents particularly to sort of guess, but for younger women, I often do think the pill is the next really good thing to try.

Steven:

In terms of, you know, the sort of patient that comes through our clinics generally they'll be coming to us because they think they've got musculoskeletal pains. Have you got any sort of set questions which are useful for distinguishing menstrually related pain or musculoskeletal?

Dr. Susanna Unsworth:

Yeah, sure. So I think one of the things that I often talk about is the timing of the pain. So I'm sure you often get people to keep a diary of, of when they're getting their pain. And, and with

dysmenorrhea there often does seem to be a strong, obviously a strong association with actually menstruation. So the women who get primary dysmenorrhea, often they get the pain maybe one or two days before their period. And then after sort of three or four days, it tends to settle. And so that's the real soft classical presentation of it really. It can sometimes be associated with a bit of bowel and bladder symptom as well. Then we might be thinking more of it along the, some of the secondary causes but timing of the pain I think is probably one of the classic things to try and work out and if there is a cyclical element to it and then maybe also just asking a little bit about their periods, I know that's not always an easy thing to talk about. Some women don't, don't always like to talk about it. But particularly about the flow as well. So dysmenorrhea and heavy periods often go hand in hand, although not always. But I think the timing and around the cycle is probably the, the key question to ask really,

Steven:

I've been asked by one of our viewers to find out if there's any sort of lifestyle changes that one might make to effect these problems. Usually the medical answer to most things is well, stop smoking, stop drinking and lose weight cause that fixes it.

Dr. Susanna Unsworth:

Yeah, yeah, yeah. Interestingly, I mean, obviously we always, yeah, we always encourage people to lead healthier lifestyles because it has such a positive effect on most elements of, of health. But interestingly, there's not a huge amount of evidence to support any dietary changes with, with periods. I guess if you're somebody who is overweight it can have an effect on your natural cycle. It has an effect on sort of oestrogen production because fat cells produce more, more oestrogen and that can sometimes cause heavier periods. It can sometimes cause problems with irregularity of your cycle as well. But from a, from a kind of dietary exercise point of view, I don't think there's an exact, there's a specific thing that I would say is going to dramatically change the symptoms of dysmenorrhea. I guess exercise in general does release endorphins, which naturally are sort of pain leaving. So we would always encourage people to, to keep active. But there's not any evidence to support anything specific that I'm aware of.

Steven:

And I suspect you're being very precise with your language there because you know, that's the way things are in medicine, but I just want to clarify the fact that there is no evidence probably means that no, one's actually done any research to try and find out.

Dr. Susanna Unsworth:

Yeah. And I think, you know, with any lifestyle thing, if you're leading a healthy lifestyle, if you're active, you're eating healthy, it's going, you know, it is going to have a positive effect on your general health. So I would say that we would always encourage people to think about their lifestyle in relation to anything. But yeah, it's tricky. I think, I guess as a doctor, we tend to try and practice evidence based medicine, but it's difficult if there's never been a study looking at a particular thing. And I think that's often the problem with a lot of, a lot of things.

Steven:

I think Richard, Richard Horton might argue that following evidence based medicine is not necessarily the best course these days.

Dr. Susanna Unsworth:

Yeah, yeah.

Steven:

Then he, but he said that off record. So we shouldn't be quoting. What about natural remedies? Are you aware of any alternatives to artificial hormones or drugs?

Dr. Susanna Unsworth:

So I always get a little bit wary of people using sort of natural hormonal type treatments. Just because again, it's, it's about the safety data. I suppose we began talking about evidence to support things. It's, it's not always necessarily about the evidence to say that something works. It's sometimes it's about the evidence to say how safe something is. I mean, I know in relation to menopause, which is, obviously not necessarily what we're talking about today, but there are lots of kind of herbal options of things that people like to try. And the difficult thing for that is we don't always know how safe they are in relation to other elements and particularly things that maybe have hormonal life effects. I just always a little bit of caution with sort of using things like that. But with, with standards, pain things, there are things like tens machines can be really helpful. I know some women that do use that and then just simple things like applying heat classically when someone's got their periods, they want to have a hot water bottle and hold it on their tummy. And actually that, that has been shown to be helpful. So simple things like that can help as well. So we don't always have to resort to significant medical interventions.

Steven:

Well, that's useful because lots of us prescribe or sell or rent tens machines to patients where you stick the electrodes. So what do you recommend or is that outside your-?

Dr. Susanna Unsworth:

Yeah, I'm afraid. I probably don't know the exact details of that. I know that the nice guidelines do suggest that tens machines can be used. But yeah, I'm afraid I don't know exactly where they do need to be placed. So that would be something you'd have to look into if you, if you're wanting to use that.

Steven:

My own experience of tens machine is backed up by you know, the Tim, Tim Watson, they were the, country's probably leading experts on ultra, ultrasound therapy and so on, is that tens machines are never quite as simple as the manufacturers make you think they are, and the settings are very variable depending on the patient.

Dr. Susanna Unsworth:

Yeah, yeah, yeah, yeah. I think I think, yeah, definitely variable results and I suspect it's, they need to be used correctly in order for them to have their effects. So I think if that's something that you keen to look into probably just need a bit of a bit of research and finding out exactly what you, what you do need to do.

Steven:

I mentioned Richard Horton a minute ago and somebody asked me who the heck is Richard Horton, he's the editor in chief of the Lancet. So, you know, one of the two, probably most important medical journals in the world. And yes, he has his thoughts about evidence-based medicine.

Dr. Susanna Unsworth:

Right yeah.

Steven:

So I've actually, I've asked him if he'll appear on the show, but I haven't had an answer back yet. Specifics of secondary causes of dysmenorrhea. Have you got any advice for people who have fibroids short, hopefully of surgery? They say

Dr. Susanna Unsworth:

Yeah, so fibroids there's something that I used to see a lot in general practice and to be honest, most of the time when we used to diagnose them, they were found incidentally. So somebody might go and have a scan for some other reason, and they happen to note fibroids on there on the scan when they when it's been reported. So for a lot of women, a fibro doesn't mean that you have to do anything fibroids can occur, so fibroids are essentially sort of muscle growths within the, within the wall of the womb and they can cause different symptoms depending on where they are. So if they're inside in that sort of inner side of the womb, they can cause problems with heavy periods. If they're kind of more in the muscle of the, of the wall of the womb, sometimes that can cause pain because a lot of the pain is due to the contraction of the womb and then sometimes they can be on the outside and then that can cause pressure symptoms on other sort of surrounding organs.

Dr. Susanna Unsworth:

So it really depends a little bit about where they are and what symptoms they're causing. So if they're asymptomatic, we just found them incidentally, you don't need to do anything about them. And I think sometimes women get a bit worried when they get a result saying you've got fibroids. For most women, they won't cause any problems, but for some they do and there's different ranges of treatments that we can use. So I know surgery it is an option and there's very different options within us, the surgical umbrella as well, but we can use other things. So hormonal treatments can be really effective. And it depends a little bit about the symptom that you're getting on, what, what kind of hormonal manipulation we might want to do. So it's quite variable, but there's a few different treatment options that we could consider.

Steven:

If you were in that position. Somebody who's concerned about dysmenorrhea, about fibroids or anything else, how would you, how can you find a suitable GP to visit, to get this sort of advice? Because my experience, I don't have fibroids, I don't think, but my experience is that when I go to the GP surgery, I get whoever's available rather than you know, a specialist.

Dr. Susanna Unsworth:

Yeah. I mean, I think with a lot of general practice now, like with myself included, people do seem to have sort of niche, special interests. Obviously my special interest is women's health. And so my surgery they all knew that that was my area of interest. And so they would encourage patients if they

did present and spoke to them on the desk to say, I'd like to speak to a doctor about a particular problem, they could direct them to me. I think it's difficult because sometimes patients don't feel like they want to say what their problem is, but actually for a lot of the time, it is quite helpful to be able to let the people on the reception know what you wanted to talk about so that they can then direct you to the most appropriate doctor. Obviously in the current climate, it's a little bit more difficult, different practices are working in different ways, but actually I think a lot of this can initially be done quite as a remote consultation to talk about the problem that you're getting. And then if you need to then be examined because for a lot of women, we, we probably should examine you, if you're having this sort of problem, um you can then be directed to the most appropriate doctors to do that. So I would never be afraid to ask who would be the best doctor to speak to, because actually as, as GPS, I think we'd much prefer to be seeing the patients who we feel we've got a special knowledge and can help them more than to be seeing, you know, to be seeing-.

Steven:

It's really useful information to be passed onto patients because I've always thought that patients are very unlikely to want to tell the receptionist what they're in, in for. But as you say, if it's, if there's a good reason for it, if we can make it clear that by saying something they might get the doctor whose best suited for their problem.

Dr. Susanna Unsworth:

Yeah, definitely. Cause I think a lot of doctor's surgeries now, when you when the receptionist answers the phone, they often will ask what the problem is and I think initially people feel a little bit nervous about that thinking, well, I don't want to talk to you about what it is, but all, you know, all the staff within us, a GP surgery have confidentiality is, is, you know, one of the upmost things that we have. And it's actually, we're not just, they're not just being nosy, they're actually just trying to find out what will be the best way of us managing your problem.

Steven:

I suspect probably the problem is more apparent when you're standing at the reception desk, the people behind you, listening to what you're saying.

Dr. Susanna Unsworth:

I think that is difficult. And I think maybe with the way everything's going and everything is going to be done probably more remotely now and more over the phone or with video, that might actually be a good move in a positive move from, from that. Cause yeah, I can see how you wouldn't want to start talking about it in the middle of the reception area with a queue of people behind you.

Steven:

Heidi has asked, what about Mittelschmerz pain? And I have no idea what that is, what's that?

Dr. Susanna Unsworth:

Yeah. So Mittelschmerz is the pain that you get in the middle of your cycle and it's to do with ovulation. So most women experience. So if you've got an average sort of 28 day cycle day one is the first day of your period. So people tend to experience that pain around day 14 slightly different from dysmenorrhea, cause this is really relating to menstruation. Um but you can manage it in a similar way with simple analgesia. And if you it's, again, this thing that I was saying is if you're someone who

experiences that every month is to try and pre-empt it and maybe take some pain relief a couple of days before you're expecting it to happen. And that can sometimes relieve it.

Steven:

I have case history for you.

Dr. Susanna Unsworth:

Okay.

Steven:

Um I don't know who sent the question in, but apparently they have a patient who's 45 years old, no pregnancies multi fibroid uterus, largest tumour is 20 centimetres dysmenorrhea, pelvic pressure pain, et cetera, recommended hysterectomy with a above the vertical incision. Patients not keen on this and the GPS refuse gonadotrophin releasing hormone agonist to try and shrink fibroids. The GP said they don't work. Your thoughts.

Dr. Susanna Unsworth:

So, yeah, gonadotrophin gonadotrophin analoges are actually really quite effective in helping to shrink fibroids and they do actually sometimes use them prior to surgery to try and shrink them down beforehand. As a GP, they might feel a little bit uneasy about initiating that, that's the only thing. Usually I would say if someone's got to the point where they're needing that it's usually through one of the gynaecologists, particularly in preparation for surgery you've gotta be yeah, so it might be that the GP is feeling uneasy about initiating it themselves, but I wouldn't have said that that should be a reason for them not to recommend the treatment. And they could definitely, you know, ask the gynaecologist to see them again to consider that because you know, surgery is not for everybody. And fibroids often do shrink, well they shrink at the time of menopause, so what those GnRH analogs do is they sort of mimic a menopause like stage essentially, and they often can shrink the fibroid sometimes enough to then not actually require any surgery. So for me that would sound like a really sensible option to consider, particularly if someone's not keen on having surgery.

Steven:

So does that patient need to go and see a specialist GP then?

Dr. Susanna Unsworth:

So potentially. Yeah. So I think for me that would be something I would be quite happy to, to recommend because obviously I've done extra training in that area. A standard GP may not feel quite happy to do that, but that shouldn't stop them then referring on to someone who can. So that's the thing with general practices. Not all GPS will feel confident in initiating every type of treatment, but they should be able to refer you on to someone who can, so they should never say to you that that's not an option. They should be able to direct you to where you can access that.

Steven:

You're talking about surgery there. It must be a couple of years ago now I interviewed a chap called Rajesh Botchu, who runs a, an MR centre over in Birmingham. And he was talking about MR focused ultrasound surgery. Is that something which is useful for these uterine problems?

Dr. Susanna Unsworth:

I'm not, I'm not a surgeon, so I'm afraid, I don't know much about that particular procedure. I did do as part of my training, um there are some interventional radiology procedures that can sometimes be used to treat fibroids, particularly, in women that are keen to avoid sort of more invasive surgery. And there's a treatment where they, it's called uterine artery embolization, and it's where you, a catheter is passed through the artery down to the uterine artery and then the small arteries that feed the fibroid are embolized. And this can cause a shrinkage of the fibroid and that can sometimes be really effective in women that are not keen to have surgery. The ultrasound treatment you were saying that I don't, I don't know the basis of that, but I guess potentially that may work on a similar sort of process. And I think a lot of places now are looking for sort of minimal intervention type procedures to avoid,

Steven:

To be honest, I'm surprised I haven't heard more about it since we interviewed him because I mean, I'm sure, you know, but for the viewers it's, it's like an ultrasound machine, but the ultrasound is used to focus to, I think different ultrasound devices, which when they concentrate at the target will actually destroy the target area and nothing around it. So there's no incision,

Dr. Susanna Unsworth:

Yeah, yeah.

Steven:

There's nowhere you can cut anywhere.

Dr. Susanna Unsworth:

I can see how that could be abused.

Steven:

Precisely focused because of the, the MRI that's going on.

Dr. Susanna Unsworth:

Yeah. Yeah, yeah.

Steven:

Um somebody has asked whether there was any propensity for fibroids to become cancerous.

Dr. Susanna Unsworth:

So, no there's not re, there's not felt to be any, any risk of that. Fibroids are a definitely a benign condition. The only thing that we would say is if, if a fibroid was rapidly increasing in size so when someone is known to have fibroids, it is always sensible to, to keep a little bit of a an eye on them to see what's happening. If they are, if they, we do find that they are rapidly increasing in size, then that can indicate there, there is actually another pathology going on. But the risk of, of a fibroid becoming cancerous, it's not felt to be any sort of precancerous lesion or anything like that.

Steven:

From what you said earlier on, it sounds to me as though there's a vast number of the female population who've probably got fibroids and don't know it. What would be the first indication that a fibroid was growing in size rapidly? Would it be patient?

Dr. Susanna Unsworth:

Yeah. So I think pain is probably high on the list of symptoms and other pressure related symptoms. So, if you suddenly start noticing that you're getting problems with your bladder, so maybe frequence passing urine more frequently or struggling to control your bladder and then the same with the bowel symptoms as well. So people, if you start getting pressure effects on the, on the back passage, sometimes that can lead to either constipation or, or diarrhoea. So any change in your bowel habit or change in your sort of waterworks then I would definitely say if you, if you're known to have a fibroid, that it would be sensible just to have a chat with your GP about it. Just to, just to see if there's been any change.

Steven:

Yeah. I imagine most of the people watching this would instantly recognize a change in waterworks or bowel habits to be something worth,

Dr. Susanna Unsworth:

Yeah.

Steven:

Going on with.

Dr. Susanna Unsworth:

Checking out. Yeah.

Steven:

Dawn has asked your opinion on the use of the copper coil and whether it flares up acne in young women. She says, she thinks she understands that the copper interferes with zinc metabolism. So aggravates the problem.

Dr. Susanna Unsworth:

I mean the copper coil, I, I'm not aware of it as being a strong trigger for acne problems. So cause there's no, there's no hormones involved in a copper coil, so it can be useful for people who do have sensitivity to hormones. I'm not, I'm not aware of anything to suggest that it can aggravate it, but everyone does react to things differently. And that, I suspect if someone who is very sensitive um, to those sort of changes, I guess potentially it might have an impact, but I'm not aware of it being, being a significant issue. A copper coil is something that I definitely wouldn't consider or want to consider in somebody who's suffered particularly dysmenorrhea. So copper coils can often make your periods more heavy. And that in turn can often make them more painful. And so in someone who has a background of dysmenorrhea, that's probably the one form of contraception that I would dissuade them from using.

Steven:

What's the alternative? Is there an alternative coil?

Dr. Susanna Unsworth:

So yeah, so there's hormone based coils which tend to be, I think, used more, more commonly. So the one that a lot of people might have heard of is called the Marena which has a type of progestogen built into it, which releases into the uterine cavity and into the endometrium. And actually something like the Marena coil can actually be really useful in women who suffer with dysmenorrhea because it often will lighten the flow, which is often part of the problem. So it's one of the options that we might consider in women who are suffering.

Steven:

Out of curiosity, how often do those have to be replaced?

Dr. Susanna Unsworth:

So the Marena coil, the license use for contraception is for five years for HRT, the license is only for four years, but actually the faculty of sexual health recommend that it's used for five, it is used for five years for HRT as well. Recent evidence and obviously with the recent problems with COVID and people accessing services to have their Marena changed, the, the guidance has recently been updated to say that for most women, for contraceptive reasons, they can actually use the Marena for up to six years. So it's for women who are due to have a change in the current situation, they've actually been um, confirmed that they can carry on using it for a further 12 months outside of its license.

Steven:

Given the I personally can't remember what I'm supposed to be doing the day after tomorrow, I mean who keeps women up to date with when these things need to be changed?

Dr. Susanna Unsworth:

Yeah.

Steven:

Does that come from a GP?

Speaker 2:

It does vary. It varies from where you've had it fitted essentially. So where I was working previously and we had a coil clinic, we kept a diary of all the coils that we inserted, when you have it inserted, you get given a little card and it has the date that it needs to be changed on there, which would have been five-year date. But we also have a diary sort of system in our clinical note system that flags up when things are due. So every month we would go um, the administrative staff would go through and find out which women were due to have those changed and we would send out letters. Different practices obviously do work differently, so I'm not sure whether that is always the case. So sometimes I think it is, unfortunately, the responsibility of the patient to remember

Steven:

I mean, is it a problem? Do they forget?

Dr. Susanna Unsworth:

Five years isn't it? It's a long, long time.

Steven:

Yeah. So is it a problem? Do they forget?

Dr. Susanna Unsworth:

Yeah. Yeah. I've definitely met women who it's expired or when I see, I've seen them in my clinic separately and they, they don't know when they had it put in. And it can, that can be quite difficult. So I guess if somebody really doesn't know and there's, there seems to be no way of finding out then, I guess you have to, from a safety point of view, you'd have to assume that it potentially couldn't be, what might be overdue a change and, and suggest that they use, if you use get for contraception than to use alternative contraception, until it can be changed. Most women I guess, would be able to find out. So if they know where they had it fitted they should be able to contact their practice and, you know, and find out, but some people may have had it done in a sexual health clinic. And so, you know, different places might have different systems for informing people.

Steven:

Emily's asked about a patient she has, who has painful breasts for about 10 days before, um her period. Um obviously quite a different pain from abdominal pain. What can you do about that?

Dr. Susanna Unsworth:

Yeah, so, breast pain is really common and in one of my roles, I actually work in the breast clinic at Addenbrooke's, so I see, we see a lot of women in that clinic that have been referred with breast pain. And it is a difficult thing to manage, but it is, it is it's again, this kind of thing that it is normal to experience some element of breast pain. But if it's becoming that it's affecting your quality of life, then there are things that you can do to help. Um breast pain can be caused by different things, so if there is a cyclical pattern to it, then often it is a hormonal trigger. Sometimes again, using different hormones kind of can help, so women who are on the pill might find it does help, but for some women it might make it worse and sometimes it's a bit of a trial and see, see how, how it affects them.

Dr. Susanna Unsworth:

Other lifestyle things that can trigger it, so caffeine is a particular thing that I see a lot of women who, when we actually talk about it more and you know, having a lot of caffeine in their diets and often cutting back on caffeine can have, can have a beneficial effect. And then there are things so evening Primrose oil is something that's classically sort of suggested that you can use. The difficult thing with that is you have to use quite high doses and you have to use it's quite a long time for it to have a benefit. I often find with breast pain that women are often worried about it being a sign of something else. So worried about being assigned with breast cancer breast cancer, very rarely presents breast pain. So actually if you can reassure them that it's not related to that, sometimes that in itself is enough to help them and manage the pain a bit better.

Steven:

Again, that cyclical nature would be an indication, it was less likely to be cancer.

Dr. Susanna Unsworth:

Yeah. Yeah, exactly. Yeah.

Steven:

And Jess has asked about a 20 year old patient, she has, who has terrible PMS and dysmenorrhea, has been diagnosed with borderline personality disorder plus hyper mobility. What bloods would be taken first to look into hormone balance? And she's wondering about her HPA axis.

Dr. Susanna Unsworth:

So blood tests were always a bit difficult when you sort of talking about hormones. So in a natural cycle, the hormone profile changes dramatically throughout the cycle, and this is something classically in, in early life and also in around the time of the menopause, that blood tests do become really difficult. With dysmenorrhea itself, I don't tend to do that much in the way of kind of hormonal blood tests initially. I guess it depends a little bit about what I might be thinking is, is the underlying cause. Things that I might be more concerned about initially is if someone's having very heavy periods, alongside a lot of pain is to be checking things like their blood count, just to make sure they've not developed anaemia because that can often be a problem, particularly in younger women actually. And then checking thyroid function because that can sometimes impact on bleeding patterns.

Dr. Susanna Unsworth:

I suppose then getting into hormonal tests. It depends what we're sort of thinking about. So if we're worried about fertility things, we may be wanting to check things like progesterone at day 21, to see whether or not they're ovulating. But hormones, I always get anxious when people want to check hormone levels because you've got to interpret the results and it can be quite, quite difficult. So I'd always have a bit of caution about just checking hormones standard, as a standard thing. I think they need to be checked for sort of specific reasons, really.

Steven:

When you check hormone levels, presumably they will vary from woman to woman anyway. So you'd need to have a baseline against which to compare them.

Dr. Susanna Unsworth:

Yeah. So I mean, they do, there are, I mean, with all the test, most of the tests there are kind of set standards as what we recognize as being normal, but with hormones, particularly that varies throughout the day and it also varies throughout the cycle. So it's all, it really does require a test to be taken at very specific times. And particularly with, with kind of ones related to menstruation, knowing exactly where they are in their cycle. And so that can be very difficult in women who maybe don't have a regular cycle. So, so it does become quite complex. So I always like I say before, it's, it's difficult to recommend specific tests. It is quite variable from, from situation to situation. And the thing that I often find when I see women in my clinic is that they've had lots of blood tests done.

Dr. Susanna Unsworth:

Cause I think, as a, as a doctor, sometimes we're very quick to do blood tests because it's kind of, we feel like we're doing something. If we're arranging a blood test for somebody, it feels that we're trying, you know, we're trying to sort out what's going on, but actually you can open, it can sort of prevent, present more problems than actually it resolves. And women can often be given the wrong advice because they're told a blood test is normal when actually it may not be normal because they're not in the right part of their cycle for it to be normal, if that makes any sense at all.

Steven:

No, thank you. Nicks asked quite an important question really. Are there things that we, we should recognize as being instant red flags outside the normal musculoskeletal stuff?

Dr. Susanna Unsworth:

Yeah. I mean, I think any, any sort of abdominal pressure symptoms, I would always say that that that really does need to be checked out. So we spoke before about change in bowel habits. So that, that especially is a symptom that I would definitely want people to get checked out. And then, and I guess change in waterwork symptoms, because again, that suggests any, any sort of pressure symptom bleeding patterns are the other thing that I would say is important to ask about. So if someone's having a really regular cycle, that's often quite reassuring, that, that sounds, that seems very normal. The thing that we'd worry about is if they were getting bleeding in between their periods. So that's not normal, people shouldn't really bleed in between their cycles. It doesn't necessarily mean there's something sinister going on, but it needs to be checked out. And the other thing is if they bleed after having sex, that's often another sign that that does need to be assessed. So asking about sort of regularity and bleeding patterns and then symptoms that suggest any sort of pressure within the pelvis would be the sort of two things I'll be thinking.

Steven:

So I think you've actually answered the question from Emilia who says, is it normal to have some bleeding when you're ovulating? I guess you'd need to have that assessed.

Dr. Susanna Unsworth:

Yeah. So it, it can be normal, but it can be a sign of other things. So it's the sort of thing where we have to exclude other things before we can say it's, it's normal. So I think if you are getting bleeding mid cycle I, don't suddenly panic that there's something seriously wrong, but it would be something that I would say does need to be just checked out to make sure there isn't anything cause, anything of concern causing it.

Steven:

A couple of final ones, if I may, because we're now at a time. But I don't know who asked this question, but they have a patient who has been diagnosed with pelvic congestion and they wonder what the hell that is? As do I.

Dr. Susanna Unsworth:

The only thing I can think that that might refer to is um, to do with blockage of kind of the venous system that might be causing sort of a backflow problem. That can be, I think that that's referring to some sort of potential pressure within the pelvis that's affecting the emphatic or the venous system,

Steven:

It was picked up by ultrasound if that helps.

Dr. Susanna Unsworth:

Yeah. So that, that can suggest that there's some sort of pressure type event going on somewhere within the pelvis. So I think that does potentially require further investigation, from that description.

Steven:

Right. And the final question from Lauren is, is there a link between dysmenorrhea and fibromyalgia?

Dr. Susanna Unsworth:

I think fibre, so dysmenorrhea can definitely lead on to more chronic pain problems. So particularly in younger women who have dysmenorrhea, they can develop ongoing chronic pain syndromes. And I think what dysmenorrhea can do is increase people's pain, sensitivity, and then that, unfortunately I think potentially could lead onto other chronic pain problems and fibromyalgia potentially could be one of them, those.

Steven:

Okay, thank you. Susanna, um lots of people wanting you back.

Dr. Susanna Unsworth:

[Laughs] Lovely.

Steven:

I mean, we didn't get on to talking about whether there's a, whether there are things that we can do to help with dysmenorrhea, whether ultras, whether um, acupuncture or asking with your chiropractic can, can help. And there's lots of other things we could have discussed. I've got three pages of notes here and I haven't turned the top page over, but yeah, if you're willing, it will be lovely to get you back on the show again sometime, in the future.

Dr. Susanna Unsworth:

Yeah, definitely. Definitely.

Steven:

Excellent. Well, thank you for that.

Dr. Susanna Unsworth:

No problem. Nice. Thank you for inviting me to come and talk to you.

Steven:

No, it's been, it's been a pleasure. Thank you.