

THE SIGNS AND SYMPTOMS OF GYNECOLOGICAL DISEASES

SYMPTOMY CHOROÓB GINEKOLOGICZNYCH

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ABSTRACT

In gynecology, especially in operating gynecology prevention aspects are important, which are closely linked to the knowledge of the patient's symptoms of gynecological diseases. Moreover, proper health education for women is important, taking into account the spread of knowledge about these symptoms.

Keywords: gynecological diseases, symptoms, education, women.

STRESZCZENIE

W ginekologii, a szczególnie w ginekologii operacyjnej istotne są aspekty profilaktyki, które ściśle wiążą się ze znajomością przez pacjentki objawów chorób ginekologicznych. Ponadto ważna jest właściwa edukacja prozdrowotna kobiet, uwzględniająca szerzenie wiedzy na temat objawów tych chorób.

Słowa kluczowe: choroby ginekologiczne, symptomy, edukacja, kobiety.

Very important information for patients is recognizing symptoms early and seeing a physician right away increases the likelihood of successful treatment [1–3].

Recognize gynecological signs and symptoms – information for patients

Gynecological signs and symptoms that may require medical attention:

- Vaginal bleeding and discharge are a normal part of your menstrual cycle prior to menopause. However, if you notice anything different or unusual, consult your physician before attempting to treat the problem yourself.
- Symptoms may result from mild infections that are easy to treat. But, if they are not treated properly, they can lead to more serious conditions, including infertility or kidney damage. Vaginal symptoms may also be a sign of more serious problems, from sexually transmitted diseases (STDs) to cancers of the reproductive tract.

Consult your physician if you have any of the following symptoms:

- bleeding between periods,
- frequent and urgent need to urinate, or a burning sensation during urination,
- abnormal vaginal bleeding, particularly during or after intercourse,

- pain or pressure in your pelvis that differs from menstrual cramps,
- itching, burning, swelling, redness, or soreness in the vaginal area,
- sores or lumps in your genital area,
- vaginal discharge with an unpleasant or unusual odor, or of an unusual color,
- increased vaginal discharge,
- pain or discomfort during intercourse,
- hirsutism.

Sexual dysfunction as signs of gynecologic problems

A sexual history should be included as a routine part of a woman's periodic health assessment. A history of childhood sexual abuse or adult sexual assault should be routinely sought because these experiences are common and often have a lasting and profound effect on a woman's sexuality and general well-being. Concerns about sexuality and sexual dysfunction are common in the general population. Almost two thirds of the women questioned have concerns about their sexuality. One third of the women lacked interest in sex, 20% said sex was not pleasurable, 15% experienced pain with intercourse, 18–48% experienced difficulty becoming aroused, 46% noted difficulty reaching orgasm, and 15–24% were not orgasmic.

The sexual dysfunctions include:

- sexual desire disorders (e.g., hypoactive or inhibited sexual desire and sexual aversion),
- sexual arousal disorders,
- orgasmic disorders,
- sexual pain disorders (e.g., vaginismus and dyspareunia), and sexual disorders due to general medical conditions and substance abuse.

Sexuology/gynecology

Each disorder can be further classified as lifelong or acquired (i.e., after a period of normal sexual functioning), generalized (i.e., not limited to a specific partner or situation), or situational.

In evaluating patients with sexual dysfunction, it is important to obtain the following information:

- a specific description of the dysfunction and an analysis of current sexual functioning,
- when the dysfunction began and how it has progressed over time,
- any precipitating factors,
- the patient's theory about what caused the dysfunction,
- what effect the dysfunction has had on her relationship,
- past treatment and outcome,
- the patient's expectations and goals for treatment.

Dyspareunia

Dyspareunia is described as a painful sexual intercourse with absent vaginal obstruction or constriction. This should be differentiated from vaginismus, which prevents from penile penetration.

Dyspareunia is one of common sexual disorders in women. One of dyspareunia causes is endometriosis.

Discerning diagnosis of dyspareunia, after rejecting other causes of the disease, should lead to peritoneal endometriosis seeking. The association between peritoneal endometriosis and dyspareunia suggests that an intercourse pain could stem from inflammatory mediators or adhesions connected with peritoneal endometriosis.

Endometriosis

Endometriosis affects about 7% of all women. It is found in 25–50% of all women with infertility. It can often begin during adolescence and so it is important for us to keep that in mind as we see patients who are 16, 18, with severe cramps. Delay in the diagnosis of endometriosis can be as much as six years before the diagnosis is made.

The symptoms are, obviously, pelvic pain, dyspareunia, dyschesia, dysuria, back ache, dysmenorrhea. But the

most important thing is that the extent of the symptoms does not correlate with the extent of the disease and therefore the patients with sometimes minimal disease may have the worst pain [1, 3–5].

Menstrual disorders as signs of gynecology problems

- The median age of menarche is 12.8 years, and the normal menstrual cycle is 21 to 35 days in length.
- Bleeding normally lasts for 3 to 7 days and consists of 30 to 40 mL of blood.
- Cycles are abnormal if they are longer than 8 to 10 days or if more than 80 mL of blood loss occurs.
- Soaking more than 25 pads or 30 tampons during a menstrual period is abnormal.

Terminology of abnormal vaginal bleeding

- Ovulatory.
- Menorrhagia/hypermenorrhea – heavy flow (> 80 mL), longer flow (> 7 days), or both.
- Intermenstrual bleeding – bleeding between otherwise-normal menses.
- Midcycle bleeding – bleeding at time of expected ovulation.
- Premenstrual spotting – light bleeding preceding regular menses.
- Polymenorrhea – periods too close together (< 21 days).
- Anovulatory metrorrhagia – irregular bleeding at frequent intervals.
- Menometrorrhagia – irregular heavy bleeding.
- Oligomenorrhea – bleeding at intervals of > 40 days.
- Amenorrhea – no bleeding for at least 90 days.

Differential diagnosis of abnormal bleeding

- Pregnancy.
- Ectopic pregnancy.
- Trophoblastic disease.
- Abnormal intrauterine pregnancy.
- Anovulatory.
- Transient anovulation.
- Polycystic ovary syndrome.
- Androgen disorder.
- Ovarian tumor.
- Adrenal tumor.
- Thyroid disorder.
- Ovulatory.
- Menorrhagia.
- Idiopathic.

Differential diagnosis of abnormal bleeding

- Endometrial polyp.
- Submucous leiomyoma.
- Coagulopathy (von Willebrand's disease, iatrogenic cause, hematologic malignancies).
- Intrauterine device.
- Ovulatory: not cycle related.
- Injury.
- Intravaginal foreign body.
- Endometritis.
- Cervicitis.
- Cancers of endometrium, cervix, vagina, or vulva/trogenic secondary to sex steroid use (e.g., oral contraceptive).
- Nongenital tract: bladder, kidney, colon, or rectum.

Urinary incontinence as signs of gynecology problems (can be connected with prolapsus or descensus genitalium)

Urinary incontinence affects an estimated 8 million women. Urinary incontinence is not a normal part of aging (more than 75% of women older than age 80 years are continent).

Etiology

Urinary incontinence is a symptom for which the underlying etiology should be sought. The two most common forms of urinary incontinence in ambulatory women are genuine stress incontinence and detrusor overactivity.

Detection of incontinence

Obstetrician-gynecologists can facilitate the reporting of urinary incontinence by regularly inquiring about it. The fact that approximately one of five women who experience urinary incontinence do so after a single vaginal delivery suggests that this group should be questioned as part of routine postpartum assessment. Additionally, open-ended questions during annual examinations should facilitate reporting of bowel and bladder control disorders. Comments such as, „Let me know if you experience leakage of urine when you cough“ or „Let me know if your urine begins to come out before you reach the toilet“ can be followed with an explanation that such experiences are not normal and can be evaluated and treated.

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Genital tract-infection-symptoms „itching“, „discharge“, „odor“, „pelvic pain“

- Vaginitis is the most common gynecologic problem encountered by primary care physicians. It may result from bacterial infections, fungal infection, protozoan infection, contact dermatitis, atrophic vaginitis, or allergic reaction.
- Pathophysiology.
- Vaginitis results from alterations in the vaginal ecosystem, either by the introduction of an organism or by a disturbance that allows normally present pathogens to proliferate.
- Antibiotics may cause the overgrowth of yeast. Douching may alter the pH level or selectively suppress the growth of endogenous bacteria.
- Clinical evaluation of vaginal symptoms.
- The type and extent of symptoms, such as itching, discharge, odor, or pelvic pain should be determined.
- A change in sexual partners or sexual activity, changes in contraception method, medications (antibiotics), and history of prior genital infections should be sought.

Physical examination

- Evaluation of the vagina begins with close inspection of the external genitalia for excoriations, ulcerations, blisters, papillary structures, erythema, edema, mucosal thinning, or mucosal pallor.
- The color, texture, and odor of vaginal or cervical discharge should be noted.

Vaginitis – examination

- Vaginal fluid pH. The pH level can be determined by placing pH paper on the lateral vaginal wall or immersing the pH paper in the vaginal discharge. A pH level greater than 4.5 often indicates the presence of bacterial vaginosis. It may also indicate the presence of *Trichomonas vaginalis*.
- Saline wet mount.

- One swab should be used to obtain a sample from the posterior vaginal fornix, obtaining a “clump” of discharge. Place the sample on a slide, add one drop of normal saline, and apply a coverslip.
- Coccoid bacteria and clue cells (bacteria-coated, stippled, epithelial cells) are characteristic of bacterial vaginosis.
- Trichomoniasis is confirmed by identification of trichomonads – mobile, oval flagellates. White blood cells are prevalent.
- Potassium hydroxide (KOH) preparation.
- Place a second sample on a slide, apply one drop of 10% potassium hydroxide (KOH) and a coverslip. A pungent, fishy odor upon addition of KOH – a positive whiff test – strongly indicates bacterial vaginosis.
- The KOH prep may reveal *Candida* in the form of thread-like hyphae and budding yeast.
- Screening for STDs. Testing for gonorrhea and chlamydial infection should be completed for women with a new sexual partner, purulent cervical discharge, or cervical motion tenderness.
- Differential diagnosis.
- The most common cause of vaginitis is bacterial vaginosis, followed by *Candida albicans*. The prevalence of trichomoniasis has declined in recent years.

Risk of diseases and infections

It is important to recognize that women are more vulnerable to diseases of the genital tract than men. The lining of the vagina is a mucous membrane and more permeable than the outside of the penis, and women have more surface area through which infection can occur. Lack of lubrication during intercourse, changes in the cervix during the menstrual cycle, and asymptomatic infections facilitate more efficient transmission of infection to women.

Prepubertal girls and adolescents are particularly vulnerable, because their vaginal and cervical tissues may be less mature and more readily penetrated by organisms (e.g., chlamydia and gonococcus). Postmenopausal women are more likely than younger women to get small abrasions in

the vagina during sexual activity as a result of thinning of the tissue and dryness.

Women who already have an infection (particularly one that causes genital lesions) are more likely to get or transmit another STI, including HIV. Other biological risks include the use of vaginal douches, which increase the risk of pelvic inflammatory disease, and the influence of hormonal contraceptives on acquiring or transmitting an STI (e.g., increased risk of chlamydial infection with use of oral contraceptives), though this is not fully understood.

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