

LETTER TO THE EDITOR

Reminder the PVCS is a Part of the Differential for Pelvic Pain

To the Editor:

The recent article *"Chronic Abdominal Pain: Tips for the Primary Care Provider"* (January/February 2019) provided an excellent overview of the topic. However, I want to remind my colleagues that *Pelvic Venous Congestion Syndrome* is also part of the differential for pelvic pain.

Pelvic Venous Congestion (PVCS) is the process of valve failure of veins or organs in the pelvis, similar to varicose veins in the legs. Those internal varicose veins can cause symptoms similar to those described in the article. Patients will often have visible varicose veins on their upper legs or, sometimes, the labia. The main symptom is pelvic pain that lasts for six months or more. Patients with PVCS report a prolonged deep and dull ache, often associated with movement, posture, and activities that increase abdominal pressure. Like varicose veins in the leg, the achiness that increases with prolonged standing can often be relieved by lying flat or elevating the legs.

PVCS usually affects women who have previously been pregnant, because the ovarian and pelvic veins widened during pregnancy to accommodate the increased blood flow from the uterus. After the pregnancy, some of these veins remain enlarged, causing them to weaken and allow blood to pool or flow in the wrong direction. Similar to varicose veins in the legs, venous congestion in the pelvis often first manifests during or after a pregnancy and worsens with subsequent pregnancies.

Risk factors for PVCS may include a family history of the condition, hormonal influence, pelvic surgery, multiple pregnancies, a retroverted uterus, and a history of varicose veins. African American women and women over 35 years of age have a lower risk of developing this condition.

After an initial exam, a number of non- or minimally-invasive diagnostic tests can be performed to determine whether chronic pelvic pain is a result of pelvic varicose veins. These tests include pelvic ultrasound, pelvic venography, Computed Tomography, and Magnetic Resonance Imaging. For patients with PVCS, interventional radiologists are a critical part of their care team.

There are a number of treatments for those diagnosed with pelvic venous congestion syndrome: medical, surgical, and minimally invasive. According to clinical practice guidelines by the *Society for Vascular Surgery* and the *American Venous Forum*, embolization of refluxing ovarian veins with coils, plugs, or sclerotherapy (usually in combination), has become the standard approach for management of PVCS.

With regard to the *"Chronic Abdominal Pain"* article, I suggest adding a vascular section to *Table 2*, which lists other possible systems. Additionally, *Figure 1* does allude to vascular, though it only reflects arterial dysfunction.

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Response

Dear Dr. Asbjornsen,

We appreciate your feedback to our manuscript, *"Chronic Abdominal Pain: Tips for the Primary Care Provider."* The prevalence of PCVS is 15% in females aged 18 to 50 years in the United States and up to 43.4% worldwide. While this should be listed under pelvic pain, it is not high on the differential diagnosis for chronic abdominal pain. In addition, we have acknowledged your suggestion of adding a vascular section to *Table 2*.

Thank you for your feedback.

Kind regards,
Dr. Gina Charles

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