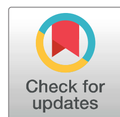

Check for updates

Research Priorities in Pelvic Venous Disorders in Women: Recommendations from a Multidisciplinary Research Consensus Panel

Neil M. Khilnani, MD, Mark H. Meissner, MD, Lee A. Learman, MD, PhD, Kathleen D. Gibson, MD, Jane P. Daniels, PhD, Ronald S. Winokur, MD, Richard P. Marvel, MD, Lindsay Machan, MD, Anthony C. Venbrux, MD, Frank F. Tu, MD, MPH, Waly M. Pabon-Ramos, MD, MPH, Susan M. Nedza, MD, MBA, Sarah B. White, MD, MS, and Mel Rosenblatt, MD

ABSTRACT

Pelvic venous disorders (PeVDs) in women can present with chronic pelvic pain, lower-extremity and vulvar varicosities, lower-extremity swelling and pain, and left-flank pain and hematuria. Multiple evidence gaps exist related to PeVDs with the consequence that nonvascular specialists rarely consider the diagnosis. Recognizing this, the Society of Interventional Radiology Foundation funded a Research Consensus Panel to prioritize a research agenda to address these gaps. This paper presents the proceedings and recommendations from that Panel.

ABBREVIATIONS

CPP = chronic pelvic pain, PeVD = pelvic venous disorder

Pelvic venous disorders (PeVDs) in women can present with a spectrum of interrelated symptoms and signs that include chronic pelvic pain (CPP) as well as lower-extremity and vulvar varicose veins, lower-extremity swelling and pain, and left-flank pain and hematuria. Historically, these different clinical presentations have been independently described as an unrelated group of "syndromes" (pelvic congestion, May-Thurner, and nutcracker) that refer to specific anatomic aberrations but fail to completely account for the underlying pathophysiology and overlapping spectrum of symptoms and signs.

A variety of imaging techniques are used to document pelvic venous reflux; however, variable and poorly validated diagnostic criteria are used (1–3). Although case series and 1 randomized trial suggest that women with CPP caused by ovarian and or internal iliac reflux benefit from embolization, the overall quality of the evidence is low (4–6). In addition, the recent appreciation that venous obstruction can cause PeVD has exposed additional gaps in our understanding of the relative importance of reflux and obstruction and their optimal management (7–9).

Although some gynecologists will consider PeVD in selected situations, skepticism about its relationship to CPP is prevalent (1,10). Consequently, only a minority of potentially affected patients are evaluated for venous disease (1). Treatment exclusions in insurance policies in the United States frequently limit access to reimbursed care in women with documented PeVD. Given the lack of broadly accepted methods to evaluate and diagnose women, the potential that some women are being treated inappropriately with the use of pelvic venous interventions is also concerning.

From the Division of Interventional Radiology (N.M.K., R.S.W.), New York Presbyterian Hospital, Weill Cornell Medical College, 2315 Broadway, Fourth Floor, New York, New York 10128; Division of Vascular Surgery (M.H.M.), University of Washington Medical Center, Seattle, Washington; Department of Obstetrics and Gynecology (L.A.L.), Charles A. Schmidt School of Medicine, Florida Atlantic University, Boca Raton, Florida; Lake Washington Vascular Associates (K.D.G.), Bellevue, Washington; Clinical Trials Unit, University of Nottingham (J.P.D.), Nottingham, United Kingdom; Center for Pelvic Pain at Annapolis (R.P.M.), Annapolis, Maryland; Departments of Radiology and Surgery, University of British Columbia (L.M.), Vancouver, British Columbia, Canada; Division of Interventional Radiology (A.C.V.), George Washington University School of Medicine, Washington, DC; Pritzker School of Medicine (F.F.T.), University of Chicago, Chicago, Illinois; Department of Obstetrics and Gynecology, North Shore University Medical Group (F.F.T.), Skokie, Illinois; Division of Interventional Radiology (W.M.P.-R.), Duke University School of Medicine, Durham, North Carolina; Feinberg School of Medicine (S.M.N.), Northwestern University, Chicago, Illinois; Division of Interventional Radiology, Froedtert Hospital (S.B.W.), Medical College of Wisconsin, Milwaukee, Wisconsin; and Connecticut Image-Guided Surgery (M.R.), Fairfield, Connecticut. Received August 16, 2018; final revision received October 8, 2018; accepted October 11, 2018. **Address correspondence** to N.M.K.; E-mail: nmkhilna@med.cornell.edu

N.M.K. receives personal fees from Medtronic (Minneapolis, MN) and grants from the SIR Foundation. K.G. is a paid speaker for and receives personal fees and grants from Medtronic. L.M. is on the medical advisory board for Boston Scientific (Marlborough, MA). F.T. receives personal fees from Abbvie. S.N. is a paid employee of MPA Healthcare Solutions. S.W. receives research support from and is a paid consultant for Guerbet and Siemens, and is a paid consultant for Cook Medical (Bloomington, IA). None of the other authors have identified a conflict of interest.

© SIR, 2018

J Vasc Interv Radiol 2019; 30:781–789

https://doi.org/10.1016/j.jvir.2018.10.008

Downloaded for Fabio Pacheco (fapsouza@msn.com) at Unimed-Rio Hospital from ClinicalKey.com by Elsevier on January 25, 2021.
For personal use only. No other uses without permission. Copyright ©2021. Elsevier Inc. All rights reserved.