GYNAECOLOGY DEPARTMENTS

Adult Referral Evaluation and Management Guidelines

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EVALUATION AND MANAGEMENT GUIDELINES

For Emergency Referrals: Phone on call Gynaecology Registrar via:

Royal Brisbane & Women's Hospital switch - (07) 3646 8111

Redcliffe Hospital switch – (07) 3883 7777

Caboolture Hospital switch – (07) 5433 8888

And send patient to the Department of Emergency Medicine (DEM) at their nearest hospital.

Category 1

i. Appointment within thirty (30) days is desirable; AND

ii. Condition has the potential to require more complex or emergent care if assessment is delayed; AND

iii. Condition has the potential to have significant impact on quality of life if care is delayed beyond thirty (30) days.

Category 2

i. Appointment within ninety (90) days is desirable; AND

ii. Condition is unlikely to require more complex care if assessment is delayed; AND

iii. Condition has the potential to have some impact on quality of life if care is delayed beyond ninety (90) days.

Category 3

i. Appointment is not required within ninety (90) days; AND

ii. Condition is unlikely to deteriorate quickly; AND

iii. Condition is unlikely to require more complex care if assessment is delayed beyond 365 days.

The Gynaecology Department provides a high standard of complex patient care. Our Outpatient waiting times are available on the http://www.health.qld.gov.au/hospitalperformance website.

All urgent cases must be discussed with the on call Gynaecology Registrar. Contact through RBWH switch (07) 3646 8111, Redcliffe (07) 3883 7777 or Caboolture (07) 5433 8888 to obtain appropriate prioritisation and treatment. Urgent cases accepted via phone must be accompanied with a written referral and a copy faxed immediately to the Central Patient Intake Unit: 1300 364 952.

When possible all non–metropolitan patients referred must include travel, accommodation, and escort arrangements. An inpatient bed may not be possible or relevant once the patient has been assessed by the Gynaecology department.

Referrals containing insufficient information or that are illegible will be returned to the referral centre. This may result in delayed appointment/treatment for your patient.

GYNAECOLOGY DEPARTMENT CLINIC LOCATIONS

Royal Brisbane and Women's Hospital (RBWH)

Ground floor, Ned Hanlon Building

Redcliffe Hospital

Level 1, Specialist Outpatient Department, Main Building

Caboolture Hospital

Specialist Outpatient Department, Main Building

IN-SCOPE FOR GYNAECOLOGY OUTPATIENT SERVICES

Please note this is not an exhaustive list of all conditions for Gynaecology outpatient services and does not exclude consideration for referral unless specifically stipulated in the out-of-scope section.

• Abnormal Cervical Screening / Cervical Dysplasia/Abnormal Cervix • Cervical Polyp • Dyspareunia (deep or superficial) • Fibroids • Heavy Menstrual Bleeding (HMB) • Infertility/Recurrent Pregnancy Loss (RPL)/Polycystic Ovarian Syndrome (PCOS) • Intermenstrual Bleeding • Known or Suspected Endometriosis • Mirena®/Progesterone Releasing IUD Insertion or Removal for Heavy Menstrual Bleeding (HMB) or Hormone Replacement Therapy (HRT)	• Ovarian Cyst / Pelvic Mass • Pelvic Floor Dysfunction (e.g. prolapse and/or incontinence) • Pelvic Pain / Dysmenorrhea/ Premenstrual Syndrome (PMS) • Post-Coital Bleeding • Post-Menopausal bleeding (vaginal bleeding more than 12 months following last menstrual period) • Primary/secondary amenorrhoea • Vulva Lesion / Lump / Genital Warts / Boil / Swelling / Abscess / Ulcer / Bartholin's Cyst

OUT-OF-SCOPE FOR GYNAECOLOGY OUTPATIENT SERVICES

Not all services are funded in the Queensland public health system. The following are not routinely provided in a public Gynaecology service.

- Elective Cosmetic Surgery e.g. labiaplasty

  NB: Labial hypertrophy in paediatric and adolescent patients: refer to Statewide Paediatric and Adolescent Gynaecology Services (SPAG) at LCCH/RBWH.
- Elective tubal ligation is not accepted at RBWH, however will be accepted as a category 3 at Redcliffe and Caboolture, if:
  - patient cannot use/trialled other contraceptive methods

    - patient does not want to pass on any genetic disorders or disabilities
    - indicated for women suffering from medical or obstetric conditions that would contraindicate future pregnancy
- Contraception e.g. Implanon
    - Routine Mirena®/Progesterone-releasing IUD insertion for **contraception**
- Primary menopausal care
- Cervical screening
- Postnatal check up

  NB: where available recommend referral to *True* – relationships and reproductive health (formally known as Family Planning Queensland) or Women's Health speciality primary care provider/service
- Elective termination of pregnancy
- IVF services
- Reversal of tubal ligation

EMERGENCY

If any of the following are present or suspected arrange immediate transfer to the emergency department.

- Ectopic pregnancy
- Ruptured haemorrhagic ovarian cyst
- Torsion of uterine appendages
- Acute/severe pelvic pain
- Significant or uncontrolled vaginal bleeding
- Severe infection
- Abscess intra pelvis or PID
- Bartholin's abscess/acute painful enlargement of Bartholin's gland/cyst
- Acute trauma including vulva/vaginal lacerations, haematoma and/or penetrating injuries
- Post-operative complications within 6 weeks including wound infection, wound breakdown, vaginal bleeding/discharge, retained products of conception post-op, abdominal pain
- Urinary retention
- Molar pregnancy
- Inevitable and/or incomplete abortion
- Hyperemesis gravidarum
- Ascites, secondary to known underlying gynaecological oncology

METRO NORTH CENTRAL PATIENT INTAKE (CPI) UNIT

https://www.health.qld.gov.au/metronorth/refer/

GENERAL REFERRAL INFORMATION

Patient's Demographic Details • Full name (including aliases) • Date of birth • Residential and postal address • Telephone contact number/s – home, mobile and alternative • Medicare number (where eligible) • Name of the parent or caregiver (if appropriate) • Preferred language and interpreter requirements • Identifies as Aboriginal and/or Torres Strait Islander	**Relevant Clinical Information about the Condition** • Presenting symptoms (evolution and duration) • Physical findings • Details of previous treatment (including systemic and topical medications prescribed) including the course and outcome of the treatment • Body mass index (BMI) • Details of any associated medical conditions which may affect the condition or its treatment (e.g. diabetes), noting these must be stable and controlled prior to referral • Current medications and dosages • Drug allergies • Alcohol, tobacco and other drugs use
Referring Practitioner Details • Full name • Full address • Contact details – telephone, fax, email • Provider number • Date of referral • Signature	**Reason for Request** • To establish a diagnosis • For treatment or intervention • For advice and management • For specialist to take over management • Reassurance for GP/second opinion • For a specified test/investigation the GP can't order, or the patient can't afford or access • Reassurance for the patient/family • For other reason (e.g. rapidly accelerating disease progression) • Clinical judgement indicates a referral for specialist review is necessary
Clinical Modifiers • Impact on employment • Impact on education • Impact on home • Impact on activities of daily living • Impact on ability to care for others • Impact on personal frailty or safety • Identifies as Aboriginal and/or Torres Strait Islander	**Other Relevant Information** • Willingness to have surgery (where surgery is a likely intervention) • Choice to be treated as a public or private patient • Compensable status (e.g. DVA, Work Cover, Motor Vehicle Insurance, etc.)

GYNAECOLOGY CONDITIONS

Abnormal Cervical Screening / Cervical Dysplasia/ Abnormal Cervix

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Positive HPV 16/18, LBC prediction of pHSIL/HSIL, possible high grade glandular lesion, AIS, or invasive cancer • SCC cervix • Pregnant women with invasive disease. For optimum care, patient should be seen within two weeks
Category 2 (appointment within 90 days is desirable)	• Suspicious or abnormal cervix with normal cervical screening - LBC for atypical glandular/endocervical cells of undetermined significance immune deficiency • History of diethyistilboestrol exposure regardless of HPV status or LB • Persistent abnormal bleeding, even with a normal cervical screen result
Category 3 (appointment within 365 days is desirable)	• No category 3 criteria

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of
    - any abnormal bleeding (i.e. post-coital and intermenstrual) or abnormal discharge
    - previous abnormal cervical screening
    - immunosuppressive therapy
- Medical management to date
- Current cervical screening (LBC should be performed on any sample with positive oncogenic HPV)

Additional Referral Information (Useful for processing the referral)

- HPV vaccination history
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- History of smoking

Other Useful information for referring practitioners (Not an exhaustive list)

- Women who are in follow-up for pLSIL/LSIL cytology in the previous program (pre-renewal NCSP) should have a HPV test at their next scheduled follow-up appointment.
    - If oncogenic HPV is not detected, the women can return to 5 yearly screening.
- A single Cervical Screening Test may be considered for women between the ages of 20 and 24 years who experienced their first sexual activity at a young age (e.g., before 14 years), who had not received the HPV vaccine before sexual activity commenced.
- Adolescent patients with abnormal HPV should follow the same pathway as adult patients. Patients <25 years old should also have screening for STI as they ae a high-risk group.

- Adolescent patients with abnormal HPV should follow the same pathway as adult patients. Patients <25 years old should also have screening for STI as they are a high-risk group.
- Consider using oestrogen cream +/- liquid cytology in post-menopausal patients.
- Patients with positive non-16/18 but normal or LSIL on LBC would not need referral and on a repeat CST in 12 months.
- Recall women in 6-12 weeks if they have an unsatisfactory screening report.
- Specific efforts should be made to provide screening for Aboriginal and Torres Strait Islander women. They should be invited and encouraged to participate in the NCSP and have a 5-yearly HPV test, as recommended for all Australian women.
- Routine colposcopic examination is NOT routinely required following treatment for CIN II/III. These patients would need a speculum inspection of the cervix and a co-test (i.e. HPV and LBC as 12 months post-treatment). They do not routinely need referral to a specialist.

Cervical Polyp

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Cervical polyp with positive oncogenic HPV and/or HSIL on LBC
Category 2 (appointment within 90 days is desirable)	• Cervical polyps in post-menopausal women with normal cervical screening
Category 3 (appointment within 365 days is desirable)	• Cervical polyps in pre-menopausal women

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Findings of speculum examination
- Current cervical screening
- Pelvic USS (TVS preferable)

Other Useful information for referring practitioners (Not an exhaustive list)

- Small endocervical polyps (<2cm) in pre-menopausal women with a normal cervical screening can be avulsed and sent for histology
- Cervical polyps in post-menopausal women have a higher risk of malignancy

Dyspareunia (deep or superficial)

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• No category 1 criteria
Category 2 (appointment within 90 days is desirable)	• Severe pelvic pain associated with dyspareunia
Category 3 (appointment within 365 days is desirable)	• Vulvodynia/vulvar vestibulitis syndrome • Other dyspareunia

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - nature of the pain – location, intermittent or persistent
  - general body muscle tensing and general or focal pelvic floor muscle tension before and during attempts at penetration
  - medical, surgical and obstetric history
- Pelvic USS results (TVS preferable)

Additional Referral Information (Useful for processing the referral)

- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- HVS M/C/S and viral PCR result

Other Useful information for referring practitioners (Not an exhaustive list)

- Advise using lubricant and adequate foreplay prior to intercourse
- For superficial dyspareunia (consider referral to women's health physiotherapist):
  - breast feeding women – consider topical oestrogen
  - consider vaginismus and referral to a sexual medicine service
  - consider psychosocial issues and referral for counselling

Fibroids

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Suspicion of degeneration or malignancy • Urinary obstruction, renal impairment e.g. hydronephrosis, history of urinary retention • Heavy Menstrual Bleeding (HMB) with anaemia (Hb<85) or requiring transfusion • Fibroid prolapse through cervix
Category 2 (appointment within 90 days is desirable)	• Pressure symptoms (such as ureteric impingement) • HMB with anaemia (Hb>85) • Abdominal discomfort
Category 3 (appointment within 365 days is desirable)	• HMB without anaemia not responding to maximal medical management • Fibroids and reproductive issues

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - HMB, brief description of periods, medical management to date
  - dragging sensation
  - urinary frequency
- Current cervical screening
- FBC iron studies results
- Pelvic USS (TVS preferable)

Other Useful information for referring practitioners (Not an exhaustive list)

- If asymptomatic with normal menstrual pattern and normal Hb, there is no need for referral

Heavy Menstrual Bleeding (HMB)

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Suspicion of malignancy • HMB with anaemia (Hb<85) or requiring transfusion
Category 2 (appointment within 90 days is desirable)	• HMB with anaemia (Hb>85)
Category 3 (appointment within 365 days is desirable)	• HMB without anaemia not responding to medical management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Brief description of periods
- Medical management to date
- Current cervical screening
- FBC iron studies results
- Pelvis USS (TVS preferable)
- Adolescent patient- Coag profile including von Willebrand's disease (vWD)

Additional Referral Information (Useful for processing the referral)

- TSH if symptomatic of thyroid disease
- Previous management modalities, iron utilisation if deficient

Other Useful information for referring practitioners (Not an exhaustive list)

- Medical management
    - OCP
    - NSAIDS
    - Tranexamic acid
    - Progesterone releasing IUD
    - Oral progestogens
    - Consider increased risk of hyperplasia or malignancy if:
        - Endometrial thickness greater than 12mm (transvaginal USS ideally day 4-7)
        - Irregular endometrium or focal lesion
        - Weight >90kg
        - PCOS / diabetes / unopposed oestrogen
        - Age >45years
        - Intermenstrual or post-coital bleeding

Infertility/Recurrent Pregnancy Loss (RPL)/Polycystic Ovarian Syndrome (PCOS)

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Imminent chemotherapy required • All other category 1 referral for infertility not accepted, refer to a private specialist to avoid delay
Category 2 (appointment within 90 days is desirable)	• Category 2 referral for infertility not accepted, refer to a private specialist to avoid delay
Category 3 (appointment within 365 days is desirable)	• All referrals for infertility NB: Infertility is the failure to achieve pregnancy after 12 months or more of unprotected intercourse

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - previous pregnancies, STIs and PID, surgery, endometriosis
  - other medical conditions
- Include the following information about partner
  - age and health, reproductive history, testicular conditions
- Weight / BMI
- FBC group and antibodies rubella IgG varicella IgG, syphilis serology, HBV/HCV/HIV serology results
- Day 21 serum progesterone level (7 days before the next expected period)
- FSH, LH (Day 2-5), prolactin, TSH if cycle prolonged and/or irregular
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- Partner seminal analysis result
- Pelvic USS (TVS preferable)

Additional Referral Information (Useful for processing the referral)

- History of marijuana use (including partner)
- Fasting blood glucose level, testosterone and free androgen index test for those likely to have PCOS
- Hysterosalpingography (HSG) or saline infusion USS (sonohysterography)

Other Useful information for referring practitioners (Not an exhaustive list)

- IVF not available in public hospitals
- To assess tubal patency, consider Hysterosalpingography (HSG) or saline infusion USS (sonohysterography) if history suggestive of blocked fallopian tubes
- Seminal analysis of partner (≥4 days of abstinence). Repeat in 4-6 weeks if abnormal
- Lifestyle modification (increased activity, dietary, weight, smoking, alcohol)
- Achieve optimal weight BMI 20 – 30
- Folic acid 0.5mg/day

Intermenstrual Bleeding (IMB)

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Oncogenic HPV, LBC prediction of pHSIL/HSIL, possible high-grade glandular lesion, AIS, or invasive cancer – cervical or endometrial • Focal endometrial lesion
Category 2 (appointment within 90 days is desirable)	• IMB not due to hormonal contraception • Abnormal cervical screening (other than for Cat 1) • Endometrium >12mm / irregular on pelvic USS (TVS ideally day 4-7) • Persistent and/or unexplained IMB
Category 3 (appointment within 365 days is desirable)	• IMB bleeding related to hormonal contraception that is not responding to medical management e.g. contraception manipulation

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of abnormal bleeding / hormonal contraceptive use
- Current cervical screening
- HVS result
- BHCG result
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- Pelvic USS (TVS preferable)

Other Useful information for referring practitioners (Not an exhaustive list)

- Reference material - RANZCOG, Investigation of intermenstrual and post coital bleeding

Known or Suspected Endometriosis

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• No category 1 criteria
Category 2 (appointment within 90 days is desirable)	• Endometriomas on USS • Endometriosis/ chronic pain not responding to maximal medical management • Associated bowel or bladder disturbance
Category 3 (appointment within 365 days is desirable)	• Endometriosis and reproductive issues

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Medical management to date/surgical history
- History of pain and menstrual diary
- Symptoms
    - dysmenorrhoea
    - deep dyspareunia
    - dyschezia
    - history of sub-fertility
- Pelvic USS results (TVS preferable)

Other Useful information for referring practitioners (Not an exhaustive list)

Medical Management

- suppression of menstrual cycle with oral contraceptive pill / Implanon® / Depo-Provera® / Mirena®. 6-month trial appropriate prior to referral
- NSAIDs for pain
- NICE Guideline currently under development. Nice Guideline: Endometriosis: diagnosis and management (anticipated publication date: September 2017)

Mirena®/Progesterone Releasing IUD Insertion or Removal for Heavy Menstrual Bleeding (HMB) or Hormone Replacement Therapy (HRT)

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• HMB with anaemia (Hb<85) or requiring transfusion
Category 2 (appointment within 90 days is desirable)	• HMB with anaemia (Hb>85)
Category 3 (appointment within 365 days is desirable)	• HMB without anaemia not responding to maximal medical management • HRT • Replacement Mirena®/progesterone releasing IUD • Mirena®/progesterone releasing IUD insertion or removal

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - including relevant family
  - menstrual
  - obstetric
  - contraceptive
  - sexual history
- Current cervical screening
- FBC iron studies results (if referring for HMB)

Additional Referral Information (Useful for processing the referral)

- Mirena® prescription – the referring GP is to give a prescription for the device to the patient who must bring the device with her to the clinic
- Pelvic USS if lost strings, HMB or other clinical indication
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA

Other Useful information for referring practitioners (Not an exhaustive list)

- Mirena® prescription to be supplied by referring GP. Patient must bring the device with her to the clinic
- For paediatric and adolescent gynaecology patients please refer to statewide paediatric and adolescent gynaecology (SPAG) services at LCCH/RBWH
- Where available for the routine removal or insertion of Mirena®/progesterone releasing IUD please consider referral to *True* – relationships and reproductive health (formerly known as Family Planning Queensland) or a Women's Health specialty primary care provider who may be able to provide this service in their own clinic.

Ovarian Cyst / Pelvic Mass

Minimum Referral Criteria	

Category 1
(appointment within 30 days is desirable)
	• Suspicious of malignancy or high risk features:
	  ○ USS finding such as solid areas, papillary projections, septations, abnormal blood flow, bilaterally or ascites
	  ○ ovarian cyst >12cm
	  ○ elevated CA125 and cyst >5cm in pre-menopausal patients or any size cyst in post- menopausal patients
	• Consider if significant pain and/or due to risk of torsion
	• Pre-pubertal patient

Category 2 (appointment within 90 days is desirable)	• Persistent ovarian cyst >5cm on 2 pelvic USS 6 weeks apart • Complex cyst (haemorrhagic, endometriotic, or dermoid) • Persistent pelvic pain
Category 3 (appointment within 365 days is desirable)	• Hydrosalpinx

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History including pain and other symptoms
- CA125 results
- Pelvic USS (TVS preferable)

Additional Referral Information (Useful for processing the referral)

- Family history of breast and ovarian cancer
- HE4, CA 19.9, CEA for complex ovarian cysts suspicious for malignancy (Cat 1 referrals)
- AFP, LDH, BHCG .if suspected germ cell tumour (particularly paediatric and adolescent patients)

Other Useful information for referring practitioners (Not an exhaustive list)

- If cyst simple or haemorrhagic corpus luteal cyst and <5cm repeat scan in 6 – 12 weeks
- If recurrent cysts, consider COCP or Implanon®
- If suspected torsion of uterine appendages, refer to emerge

Pelvic Floor Dysfunction (e.g. prolapse and/or incontinence)

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Uterine procidentia • Urinary obstruction
Category 2 (appointment within 90 days is desirable)	• Difficulty voiding +/- significant residuals on bladder screening • Recurrent UTIs • Genital fistulae
Category 3 (appointment within 365 days is desirable)	• Any other prolapse or incontinence • Obstructive defecation • Previous failed or complicated prolapse surgery (e.g. sling erosion)

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Obstetric and gynaecological history
- History of:
    - prolapse symptoms
    - protruding lump
    - dragging sensation
    - difficulty with defecation (requiring manual evacuation)/micturition including incontinence
- MSU M/C/S results

Additional Referral Information (Useful for processing the referral)

- Pelvic USS (TVS preferable) if available
- Bladder diary
- Renal USS if major uterine procidentia

Other Useful information for referring practitioners (Not an exhaustive list)

Medical Management

- Consider trial of anticholinergics
- Treat constipation
- Consider topical oestrogen in post-menopausal women
- Lifestyle modification (increased activity, dietary, weight, smoking, alcohol)
- Consider referral to women's health physiotherapist for the following:
    - prolapse – consider pessary
    - stress incontinence – physiotherapist for pelvic floor exercises and bladder retraining for 3 months prior to referral
    - urinary urgency – exclude infection

Pelvic Pain/Dysmenorrhea/Premenstrual Syndrome (PMS)

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Suspicion of malignancy
Category 2 (appointment within 90 days is desirable)	• Pelvic pain and significant USS findings e.g. presence of endometriomas / fixed retroverted uterus
Category 3 (appointment within 365 days is desirable)	• Chronic pain not responding to maximal medical management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - pain
  - severity and duration
  - cyclical nature
  - dysmenorrhoea
  - differentiation from GI pain
  - previous sexual abuse
  - PID
- Current cervical screening
- HVS result
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- MSU M/C/S results
- Pelvic USS (TVS preferable)

Other Useful information for referring practitioners (Not an exhaustive list)

Medical Management

- Important to exclude cyclical bladder, bowel symptoms
- Treat infection if present
- Simple analgesia
- Suppress menstrual cycle with oral contraceptive pill / Implanon® / Depo-provera / Mirena®
- Treat dysmenorrhoea with NSAIDs or COCP

Post-Coital Bleeding

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Suspected malignancy • SCC, HSIL, glandular lesion on pap smear
Category 2 (appointment within 90 days is desirable)	• Post-coital bleeding with LSIL or normal pap smear result
Category 3 (appointment within 365 days is desirable)	• No category 3 criteria

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Findings of speculum examination
- Current cervical screening
- HVS result
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA

Additional Referral Information (Useful for processing the referral)

- Pelvic USS (TVS preferable)

Other Useful information for referring practitioners (Not an exhaustive list)

- Reference material - RANZCOG, Investigation of intermenstrual and postcoital bleeding

Post-Menopausal Bleeding (vaginal bleeding more than 12 months following last menstrual period)

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Endometrial thickness >4mm • Cervical polyps • Suspicion of malignancy • Focal endometrial lesion
Category 2 (appointment within 90 days is desirable	• Endometrial thickness ≤4 mm
Category 3 (appointment within 365 days is desirable)	• No category 3 criteria

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of HRT use
- Current cervical screening
- Pelvic USS (TVS preferable)

Other Useful information for referring practitioners (Not an exhaustive list)

- Post-menopausal women with an incidental finding on pelvic ultrasound of a regular endometrial thickness of less than 11mm and having no episodes of postmenopausal bleeding would only need a repeat ultrasound and referral if developing vaginal bleeding

Primary / Secondary Amenorrhoea

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• No category 1 criteria
Category 2 (appointment within 90 days is desirable)	• Primary amenorrhoea
Category 3 (appointment within 365 days is desirable)	• Secondary amenorrhoea

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Duration of amenorrhoea (i.e. >6 months)
- Weight / BMI
- BHCG results
- FSH LH prolactin oestradiol TSH results
- Pelvic USS (TVS preferable)

Additional Referral Information (Useful for processing the referral)

- Renal USS

Other Useful information for referring practitioners (Not an exhaustive list)

- Primary amenorrhoea – is defined as the absence of menses at age 16 years in the presence of normal growth and secondary sexual characteristics and 14 in the absence of secondary sexual characteristics
- Secondary amenorrhoea – absence of menses for more than six months after the onset of menses
- TAS-TVS USS may not be appropriate in non-sexually active females, therefore important to seek early advice from statewide paediatric and adolescent gynaecology (SPAG) services
- Refer to statewide paediatric and adolescent gynaecology (SPAG) services at LCCH/RBWH
- Address excessive exercise or dieting
- If BMI is greater than 30, manage weight loss
- Address any significant stress or anxiety
- Review medications if relevant (e.g. antipsychotics, metoclopramide)

Vulva Lesion / Lump / Genital Warts / Boil / Swelling / Abscess / Ulcer / Bartholin's Cyst

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Vulval disease with suspicion of malignancy • Unexplained vulval lump, ulceration or bleeding • Postmenopausal women with abnormal vulval lesions • Pregnant or immunosuppressed

Category 2
(appointment within 90 days is desirable)
	• Suspected vulval dystrophy
	• Bartholin's cysts or other vulval cysts in patients >40 years old
	• Vulval warts where:
	  ○ the patient is immunocompromised (e.g. HIV positive, immunosuppressant medications)
	  ○ the diagnosis is unclear
	  ○ atypical genital wards (including pigmented lesions)
	  ○ there are positive results from the screen for other STIs

Category 3
(appointment within 365 days is desirable**)**
	• Vulval lesions where:
	  ○ there is treatment failure or where treatment cannot be tolerated due to side-effects
	  ○ there are problematic recurrences
	• Vulval rashes
	• Vulval warts
	• Bartholin's cyst/labial cysts

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - pain
  - swelling
  - pruritus
  - dyspareunia
  - localised lesions (pigmented or non-pigmented lesions)
  - STIs or other vaginal infections
  - local trauma
- Elicit onset, duration and course of presenting symptoms
- Date of last menstrual period
- Medical management to date
- Cervical screening if the referral is for genital warts

Additional Referral Information (Useful for processing the referral)

- Vulva ulcers – swab M/C/S and viral PCR result
- Vulval rashes – scraping, swabs or biopsy (as appropriate)
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA (as appropriate)
- Syphilis HIV serology (as appropriate)

Other Useful information for referring practitioners (Not an exhaustive list)

- For paediatric and adolescent gynaecology patients, please refer to statewide paediatric and adolescent gynaecology (SPAG) services at LCCH/RBWH
- Antibiotic treatment of Bartholin's cyst is of no value
- In women where a vulval cancer is strongly suspected on examination, urgent referral should not await biopsy
- Vulval cancers may present as unexplained lumps, bleeding from ulceration or pain
- Vulval cancer may also present with pruritus or pain. For a patient who presents with these symptoms and where cancer is not immediately suspected, it is reasonable to use a period of 'treat, watch and wait' as a method of management. However, this should include active follow-up until symptoms resolve or a diagnosis is confirmed. If symptoms persist, the referral may be urgent or non-urgent, depending on the symptoms and the degree of concern about cancer.
- For optimum care, the patient with vulval disease with a suspicion of malignancy and/or unexplained vulval lump, ulceration or bleeding, should be seen by a specialist within two weeks.