GP Liaison Officer Program

GYNAECOLOGY WORKSHOP SATURDAY 4 June 2022

Case Studies

- 15 minutes to discuss the case
- In each group, GPs elect a spokesperson to present the case

Prolapse

- Helen is a healthy 43 year old - BMI 35 kg/m^2
- G2P2
  - 4200g forceps, episiotomy, 2nd degree tear
  - 3800g vaginal birth, episiotomy
- "Feels like something is bulging out"
- Feeling of heaviness, dragging
- Constipation
- Feeling of incomplete emptying bladder & bowel
- Outline your approach

AUSTRALIAN PELVIC FLOOR QUESTIONNAIRE

Patient's Name: _____

Date of Birth: _____

Date completed: _____

Please circle your most applicable answer. Consider your experience during the last month.

BLADDER FUNCTION (___/ 45)

Q1. How many times do you pass urine in a day?
0 Up to 7
1 Between 8-10
2 Between 11-15
3 More than 15

Q2. How many times do you get up at night to pass urine?
0 0-1
1 2
2 3
3 More than 3 times

Q3. Do you wet the bed before you wake up at night?
0 Never
1 Occasionally - less than once per week
2 Frequently - once or more per week
3 Always - every night

Q4. Do you need to rush/hurry to pass urine when you get the urge?
0 Can hold on
1 Occasionally have to rush – less than once/week
2 Frequently have to rush – once or more/week
3 Daily

Q5. Does urine leak when you rush or hurry to the toilet or can't you make it in time?
0 Not at all
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q6. Do you leak with coughing, sneezing, laughing or exercising?
0 Not at all
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q7. Is your urinary stream (urine flow) weak, prolonged or slow?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q8. Do you have a feeling of incomplete bladder emptying?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q9. Do you need to strain to empty your bladder?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q10. Do you have to wear pads because of urinary leakage?
0 None - Never
1 As a precaution
2 When exercising / during a cold
3 Daily

Q11. Do you limit your fluid intake to decrease urinary leakage?
0 Never
1 Before going out
2 Moderately
3 Always

Q12. Do you have frequent bladder infections?
0 No
1 1-3 per year
2 4-12 per year
3 More than one per month

Q13. Do you have pain in your bladder or urethra when you empty your bladder?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q14. Does urine leakage affect your routine activities like recreation, socializing, sleeping, shopping etc?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Q15. How much does your bladder problem bother you?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Other symptoms (haematuria, pain etc.)

_____

_____

BOWEL FUNCTION (____/ 34)

Q16. How often do you usually open your bowels?
0 Ever other day or daily
1 Less than every 3 days
2 Less than once a week
0 More than once per day

Q17. How is the consistency of your usual stool?
0 Soft
0 Firm
0 Hard (pebbles)
1 Variable
2 Watery

Q18. Do you have to strain to empty your bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q19. Do you use laxatives to empty your bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q20. Do you feel constipated?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q21. When you get wind or flatus, can you control it, or does wind leak?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

AUSTRALIAN PELVIC FLOOR QUESTIONNAIRE

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AUSTRALIAN PELVIC FLOOR QUESTIONNAIRE

Patient's Name: _____

Date of Birth: _____

Date completed: _____

Q22. Do you get an overwhelming sense of urgency to empty bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q23. Do you leak watery stool when you don't mean to?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q24. Do you leak normal stool when you don't mean to?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q25. Do you have a feeling of incomplete bowel emptying?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q26. Do you use finger pressure to help empty your bowel?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q27. How much does your bowel problem bother you?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

PROLAPSE SYMPTOMS (____/15)

Q28. Do you have a sensation of tissue protrusion/lump/bulging in your vagina?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q29. Do you experience vaginal pressure or heaviness or a dragging sensation?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q30. Do you have to push back your prolapse in order to void?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q31. Do you have to push back your prolapse to empty your bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q32. How much does your prolapse bother you?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Other Symptoms: (problems: walking / sitting, pain, vaginal bleeding)

_____

_____

_____

SEXUAL FUNCTION (____/21)

Q33. Are you sexually active?
□ No
□ Less than once per week
□ Once or more per week
□ Daily or most days

If you are not sexually active, please continue to answer questions 34 & 42.

Q34. If you are not sexually active, please tell us why?
□ Do not have a partner
□ I am not interested
□ My partner is unable
□ Vaginal dryness
□ Too painful
□ Embarrassment due to the prolapse/incontinence
□ Other reasons: _____

Q35. Do you have sufficient vaginal lubrication during intercourse?
0 Yes
1 No

Q36. During intercourse vaginal sensation is:
0 Normal / pleasant
1 Minimal
1 Painful
3 None

Q37. Do you feel that your vagina is too loose or lax?
0 Never
1 Occasionally
2 Frequently
3 Always

Q38. Do you feel that your vagina is too tight?
0 Never
1 Occasionally
2 Frequently
3 Always

Q39. Do you experience pain with sexual intercourse?
0 Never
1 Occasionally
2 Frequently
3 Always

Q40. Where does the pain during intercourse occur?
0 Not applicable, I do not have pain
1 At the entrance to the vagina
1 Deep inside, in the pelvis
2 Both at the entrance & in the pelvis

Q41. Do you leak urine during sexual intercourse?
0 Never
1 Occasionally
2 Frequently
3 Always

Q42. How much do these sexual issues bother you?
□ Not applicable
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Q43. Other symptoms?
(faecal incontinence, vaginismus etc)

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https://urogynaecology.com.au/wp-content/uploads/2018/08/australian-pelvic-floor-questionnaire-V2018.pdf

https://www.mypelvicfloor.com/

Prolapse

- Grading of prolapse
  - POP-Q
  - Baden-Walker
  - Other
- MSU M/C/S
- Pelvic/transvaginal USS

Prolapse

- Weight loss – diet and exercise
- Smoking cessation
- Treat constipation
- Pelvic floor muscle training (PFMT)
- Bladder & bowel retraining
- Topical oestrogen in post menopausal women
- Pessaries
- Surgery

Useful Resources

- Australian Family Physician – pelvic organ prolapse

  https://www.racgp.org.au/afp/2015/july/pelvic-organ-prolapse-—-a-review/

- Joint Report on the Terminology for Female Pelvic Organ Prolapse (POP)

  https://urogynaecology.com.au/wp-content/uploads/2018/02/international_joint_statement_of_prolapse_terminology.pdf

Useful Resources

- RACGP Handbook of Non-Drug Interventions

  https://www.racgp.org.au/clinical-resources/clinical-guidelines/handi

Useful Resources

- Pathway for the surgical treatment of pelvic organ prolapse

https://urogynaecology.com.au/ici-2017-pathway-prolapse-surgery/

- Assess your pelvic floor

https://www.mypelvicfloor.com/

- UroGynaecological Society of Australasia – Patient Information

https://www.ugsa.com.au/home-2/patient-resources/

Welcome To My Pelvic Floor

This page is dedicated to the assessment of female pelvic floor dysfunction which affects more than 50% of women who have had children and includes:

Bladder problems: urinary leakage or retention
Bowel problems: faecal urgency/leakage or incomplete evacuation
Vaginal prolapse or bulge
Sexual problems: vaginal laxity or painful sex

The Australian Pelvic Floor Questionnaire (APFQ) is a validated multi-lingual self-completed questionnaire that evaluates and scores all four areas of female pelvic floor dysfunction.

Once completed the results from the questionnaire are utilised to predict a pelvic floor diagnosis such as vaginal prolapse or urinary incontinence and will also compare your results with those of women without pelvic floor dysfunction in the community.

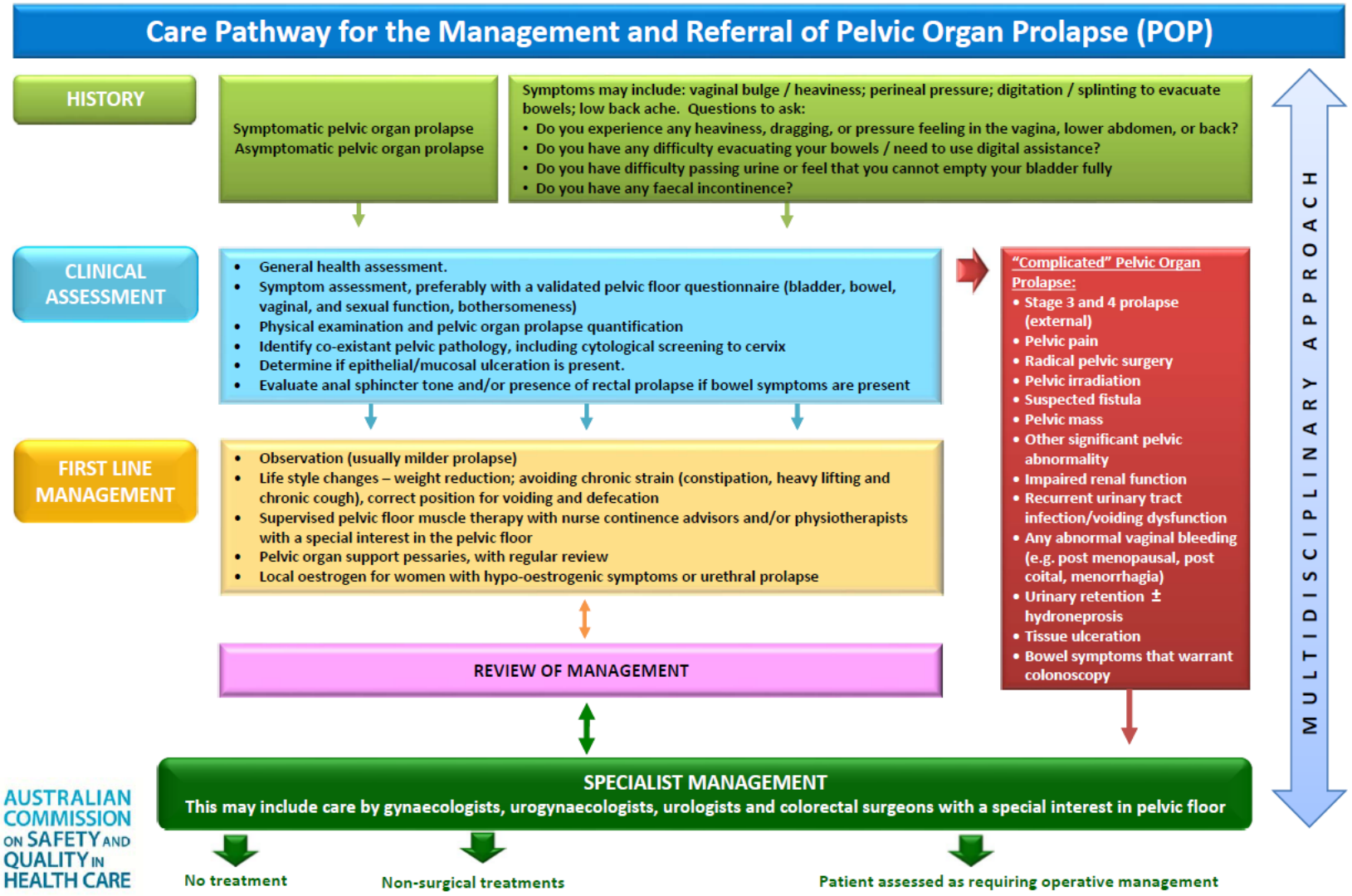
Begin Your Survey ›

Patient Resources

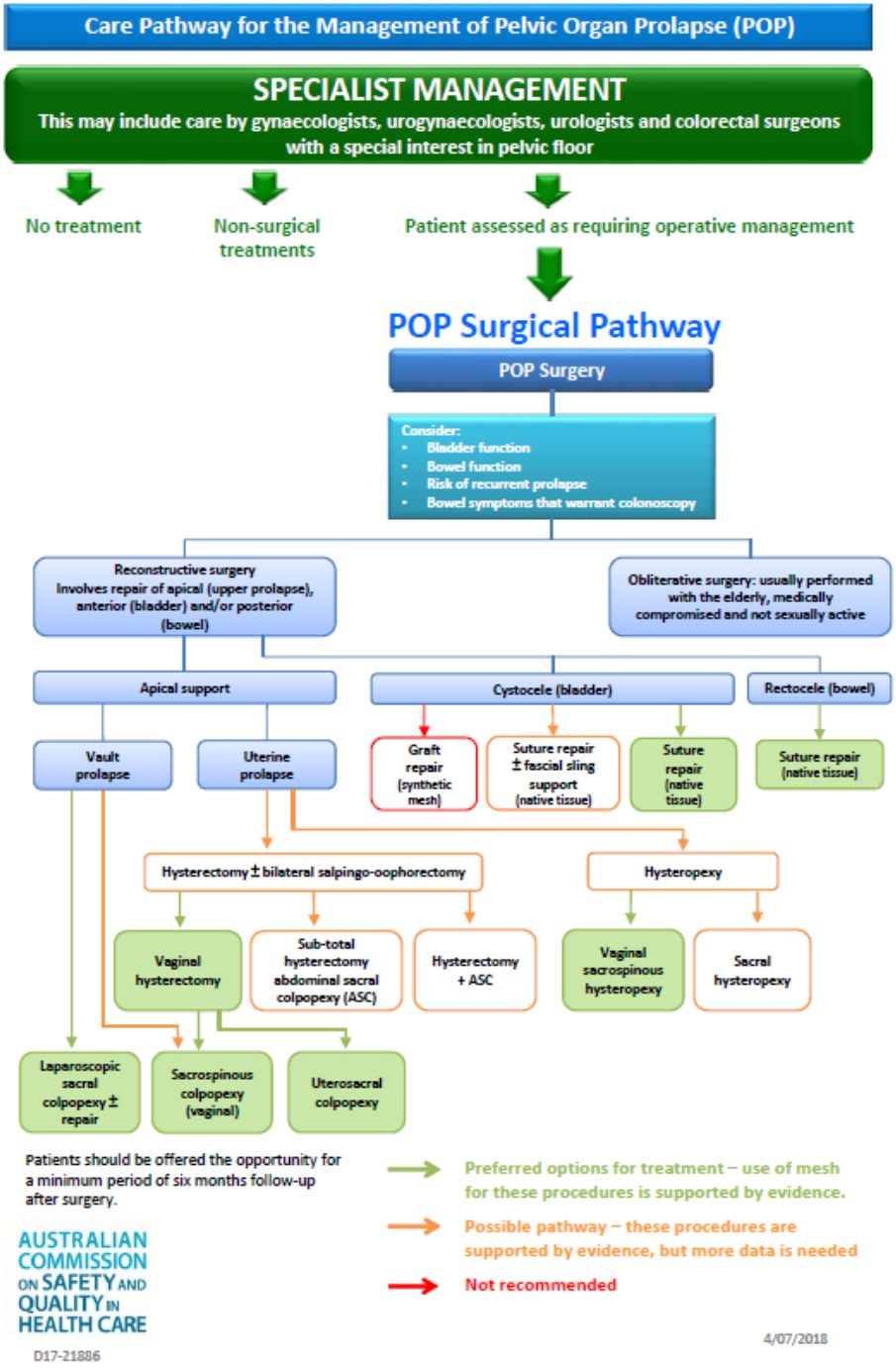
UGSA Patient Resources

UGSA has developed a series of patient resources intended to be used as a guide of general nature, regarding general circumstances.

Each Patient Resource Information Sheets' content was accurate at the time of its preparation, but its currency should be determined in consultation with other available information. UGSA disclaims all liability to users for the information provided.



https://www.safetyandquality.gov.au/sites/default/files/migrated/TV-mesh-care-pathway-for-GPs-pelvic-organ-prolapse.pdf



https://www.safetyandquality.gov.au/sites/default/files/migrated/TV-Mesh-surgical-care-pathway-POP-portrait.pdf

Care Pathway for the Management and Referral of Transvaginal Mesh Complications

Synthetic transvaginal mesh has been used to manage pelvic organ prolapse (POP) and stress urinary incontinence (SUI) in Australian women for over 15 years. In November 2017 the Therapeutic Goods Administration removed transvaginal mesh products where the sole use is the treatment of POP. Transvaginal mesh is a recommended treatment for SUI in women. Some women experience significant complications associated with transvaginal mesh following treatment for POP and SUI. This care pathway assists general practitioners to assess and manage women who may be experiencing transvaginal mesh complications.

HISTORY

Recent mesh insertion e.g. ≤ 6 weeks since transvaginal mesh procedure performed

Women experiencing significant pain in the pelvis / vagina / lower back / thigh, bleeding from the vagina / bladder / bowel, infection, extrusion or erosion of the mesh through the vagina, urinary tract symptoms such as retention, urinary infection and incontinence

CLINICAL ASSESSMENT

Clinical assessment as required

MANAGEMENT

Urgent referral to treating specialist for management of complications

Mesh not inserted recently, or a history of mesh is not documented

Does the woman report any of the following since their operation?

- Pain in the pelvis / lower back / thigh
- Awareness of the mesh during intercourse or pain during intercourse for the patient or their partner (dyspareunia)
- A prickling feeling or pain in the vagina
- Vaginal bleeding
- Mesh palpable in the vagina
- Recurrent urinary or vaginal infection
- Other urinary tract symptoms such as incontinence, voiding difficulties, retention

If YES:

- Describe and document all symptoms reported by the woman
- Record impacts the woman reports of symptoms on quality of life, relationships, social and occupational function
- Take a comprehensive gynaecological history and consider all potential causes of the woman's symptoms (continence, prolapse, sexual function, abnormal cervical cytology) and obstetric
- Take a comprehensive mesh operative history:
  - Initial procedure, any subsequent procedures, when and where procedures were performed
  - Treatments woman has received for mesh complications (medications, physical therapies, any other treatments)
- Mental health history
- Where possible, obtain a copy of the woman's operation records to confirm what transvaginal mesh procedures were performed

If NO symptoms to date:

- Reassurance only required

- Clinical health assessment
- Abdominal, pelvic and vaginal examination
  - Signs of mesh complications on examination may include: tenderness on palpation, visible mesh in the vagina, vaginal adhesions and / or scarring
- Comprehensive investigation for causes of the woman's symptoms as indicated clinically

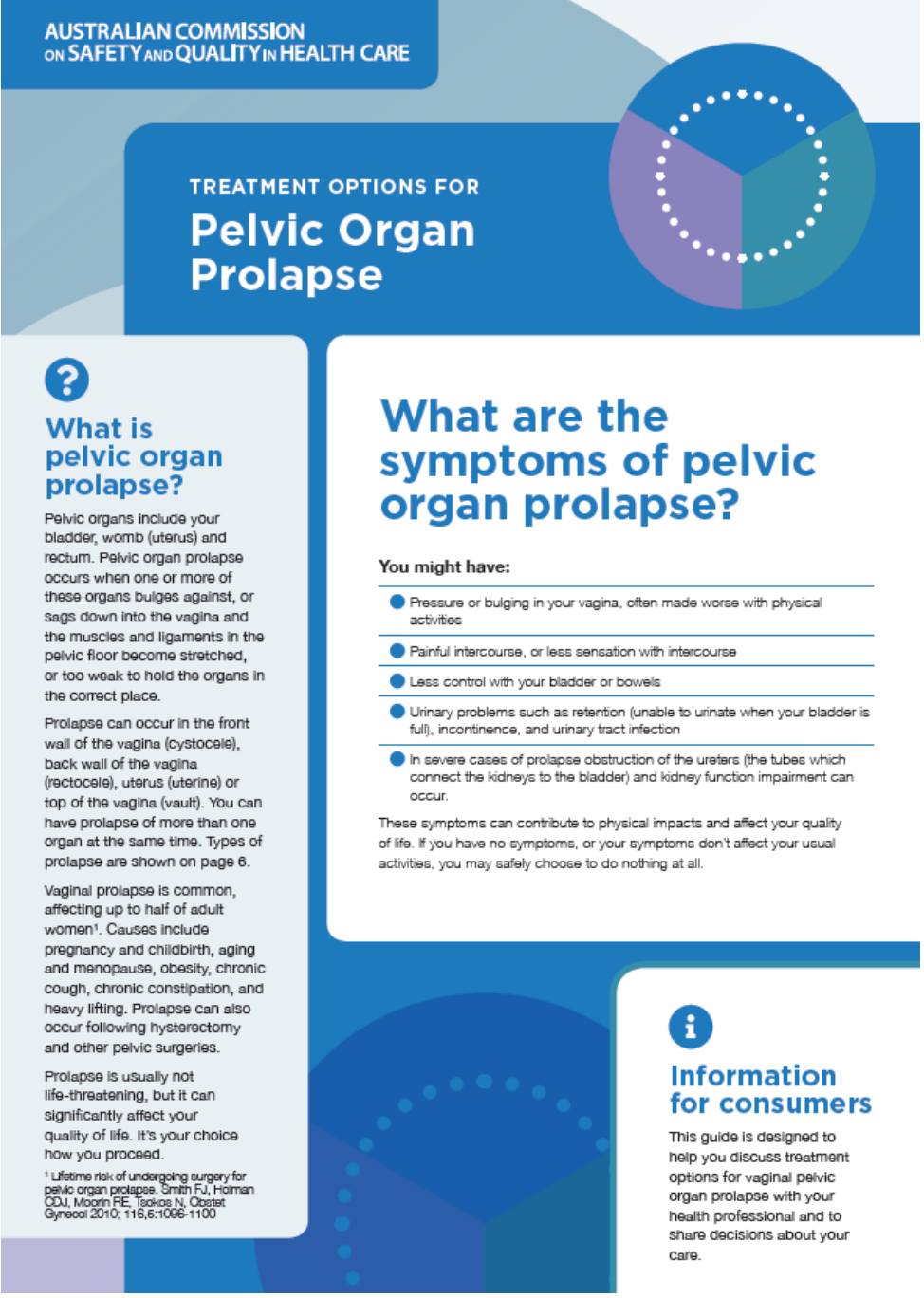
If mesh complications are suspected, offer the woman referral to a relevant specialist or to a multidisciplinary clinical service that specialises in the treatment of women with transvaginal mesh complications. Women with uncomplicated mesh erosion or exposure may opt for treatment by a gynaecology, urology or urogynaecology service

NOTES:

- Although mesh erosion may be asymptomatic patients still require further specialist review
- An examination of the vagina may not be possible due to patient discomfort. Examination under anaesthesia by specialist may be indicated

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

https://www.safetyandquality.gov.au/sites/default/files/migrated/TV-Mesh-care-pathway-for-GPs-complications.pdf



https://www.safetyandquality.gov.au/sites/default/files/2020-01/treatment_options_for_pelvic_organ_prolapse_pop_-_transvaginal_tv_mesh_-_information_for_consumers_patient_resource.pdf

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

TREATMENT OPTIONS FOR

Complications of transvaginal mesh (including options for mesh removal)

What is Transvaginal Mesh?

Transvaginal mesh is a manufactured, net-like product that has been used to treat pelvic organ prolapse and stress urinary incontinence in women. The mesh is intended to provide extra support to weakened tissues in the pelvis. It has been used worldwide for many years and in Australia for over 15 years.

Transvaginal mesh is intended to be permanent once placed in the body. This affects your options for removal in the event of complications.

Transvaginal mesh products are no longer used in Australia where the intended purpose is solely for the treatment of pelvic organ prolapse. This is due to concerns about its safety in this procedure.

A range of surgical and non surgical treatment options are available for stress urinary incontinence in women.

What are complications of transvaginal mesh?

Women have experienced a range of outcomes after treatment using transvaginal mesh.

Some women have experienced complications and others have not.

If you have mesh implanted and are not experiencing any troublesome symptoms, there is no need to be concerned.

Complications can occur immediately after your operation or even some years later.

For women who have experienced complications, the symptoms range from mild to debilitating, and have significantly affected their quality of life.

If you experience symptoms that may be related to your mesh implant, it is important that you have a comprehensive assessment by a team of highly-skilled, specialised clinicians. Most health departments in Australia have or will soon have, a specialised service to assist you.

There are a variety of treatments available to treat complications, depending on outcomes of your assessment. Your treatment team will discuss the options with you to help make an informed decision about the best treatment for you.

Information for consumers

This guide is designed to help you discuss the treatment options for complications or removal of transvaginal mesh with your health professional, and to share decisions about your care.

https://www.safetyandquality.gov.au/sites/default/files/2020-11/treatment_options_for_complications_and_removal_of_transvaginal_tv_mesh_-_consumer_information_patient_resource.pdf

Incontinence

- Donna is 52 years old. G0P0 - BMI 40 kg/m^2
- Smoker
- Hypertension, COPD, anxiety/depression, chronic back pain
- Urinary incontinence
  - Has to “rush to the bathroom”
  - “Leakage with coughing”
- No fever, no dysuria, no haematuria, no pelvic pain
- Outline your approach

AUSTRALIAN PELVIC FLOOR QUESTIONNAIRE

Patient's Name: _____

Date of Birth: _____

Date completed: _____

Please circle your most applicable answer. Consider your experience during the last month.

BLADDER FUNCTION (___/ 45)

Q1. How many times do you pass urine in a day?
0 Up to 7
1 Between 8-10
2 Between 11-15
3 More than 15

Q2. How many times do you get up at night to pass urine?
0 0-1
1 2
2 3
3 More than 3 times

Q3. Do you wet the bed before you wake up at night?
0 Never
1 Occasionally - less than once per week
2 Frequently - once or more per week
3 Always - every night

Q4. Do you need to rush/hurry to pass urine when you get the urge?
0 Can hold on
1 Occasionally have to rush – less than once/week
2 Frequently have to rush – once or more/week
3 Daily

Q5. Does urine leak when you rush or hurry to the toilet or can't you make it in time?
0 Not at all
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q6. Do you leak with coughing, sneezing, laughing or exercising?
0 Not at all
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q7. Is your urinary stream (urine flow) weak, prolonged or slow?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q8. Do you have a feeling of incomplete bladder emptying?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q9. Do you need to strain to empty your bladder?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q10. Do you have to wear pads because of urinary leakage?
0 None - Never
1 As a precaution
2 When exercising / during a cold
3 Daily

Q11. Do you limit your fluid intake to decrease urinary leakage?
0 Never
1 Before going out
2 Moderately
3 Always

Q12. Do you have frequent bladder infections?
0 No
1 1-3 per year
2 4-12 per year
3 More than one per month

Q13. Do you have pain in your bladder or urethra when you empty your bladder?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q14. Does urine leakage affect your routine activities like recreation, socializing, sleeping, shopping etc?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Q15. How much does your bladder problem bother you?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Other symptoms (haematuria, pain etc.)

_____

_____

BOWEL FUNCTION (____/ 34)

Q16. How often do you usually open your bowels?
0 Ever other day or daily
1 Less than every 3 days
2 Less than once a week
0 More than once per day

Q17. How is the consistency of your usual stool?
0 Soft
0 Firm
0 Hard (pebbles)
1 Variable
2 Watery

Q18. Do you have to strain to empty your bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q19. Do you use laxatives to empty your bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q20. Do you feel constipated?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q21. When you get wind or flatus, can you control it, or does wind leak?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

AUSTRALIAN PELVIC FLOOR QUESTIONNAIRE

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AUSTRALIAN PELVIC FLOOR QUESTIONNAIRE

Patient's Name: _____

Date of Birth: _____

Date completed: _____

Q22. Do you get an overwhelming sense of urgency to empty bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q23. Do you leak watery stool when you don't mean to?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q24. Do you leak normal stool when you don't mean to?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q25. Do you have a feeling of incomplete bowel emptying?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q26. Do you use finger pressure to help empty your bowel?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q27. How much does your bowel problem bother you?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

PROLAPSE SYMPTOMS (____/15)

Q28. Do you have a sensation of tissue protrusion/lump/bulging in your vagina?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q29. Do you experience vaginal pressure or heaviness or a dragging sensation?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q30. Do you have to push back your prolapse in order to void?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q31. Do you have to push back your prolapse to empty your bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q32. How much does your prolapse bother you?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Other Symptoms: (problems: walking / sitting, pain, vaginal bleeding)

_____

_____

_____

SEXUAL FUNCTION (____/21)

Q33. Are you sexually active?
□ No
□ Less than once per week
□ Once or more per week
□ Daily or most days

If you are not sexually active, please continue to answer questions 34 & 42.

Q34. If you are not sexually active, please tell us why?
□ Do not have a partner
□ I am not interested
□ My partner is unable
□ Vaginal dryness
□ Too painful
□ Embarrassment due to the prolapse/incontinence
□ Other reasons: _____

Q35. Do you have sufficient vaginal lubrication during intercourse?
0 Yes
1 No

Q36. During intercourse vaginal sensation is:
0 Normal / pleasant
1 Minimal
1 Painful
3 None

Q37. Do you feel that your vagina is too loose or lax?
0 Never
1 Occasionally
2 Frequently
3 Always

Q38. Do you feel that your vagina is too tight?
0 Never
1 Occasionally
2 Frequently
3 Always

Q39. Do you experience pain with sexual intercourse?
0 Never
1 Occasionally
2 Frequently
3 Always

Q40. Where does the pain during intercourse occur?
0 Not applicable, I do not have pain
1 At the entrance to the vagina
1 Deep inside, in the pelvis
2 Both at the entrance & in the pelvis

Q41. Do you leak urine during sexual intercourse?
0 Never
1 Occasionally
2 Frequently
3 Always

Q42. How much do these sexual issues bother you?
□ Not applicable
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Q43. Other symptoms?
(faecal incontinence, vaginismus etc)

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https://urogynaecology.com.au/wp-content/uploads/2018/08/australian-pelvic-floor-questionnaire-V2018.pdf

https://www.mypelvicfloor.com/

Welcome To My Pelvic Floor

This page is dedicated to the assessment of female pelvic floor dysfunction which affects more than 50% of women who have had children and includes:

Bladder problems: urinary leakage or retention
Bowel problems: faecal urgency/leakage or incomplete evacuation
Vaginal prolapse or bulge
Sexual problems: vaginal laxity or painful sex

The Australian Pelvic Floor Questionnaire (APFQ) is a validated multi-lingual self-completed questionnaire that evaluates and scores all four areas of female pelvic floor dysfunction.

Once completed the results from the questionnaire are utilised to predict a pelvic floor diagnosis such as vaginal prolapse or urinary incontinence and will also compare your results with those of women without pelvic floor dysfunction in the community.

Begin Your Survey ›

Appendix 13A. The 3 Incontinence Questions (3IQ)

1. During the last three months, have you leaked urine (even a small amount)?

   ☐ Yes ☐ No → Questionnaire completed.

2. During the last three months, did you leak urine (check all that apply):

   a. ☐ When you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?

   b. ☐ When you had the urge or feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?

   c. ☐ Without physical activity and without a sense of urgency?

3. During the last three months, did you leak urine most often (check only one):

   a. ☐ When you are performing some physical activities, such as coughing, sneezing, lifting, or exercise?

   b. ☐ When you had the urge or feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?

   c. ☐ Without physical activity or a sense of urgency?

   d. ☐ About equally as often with physical activities as with a sense of urgency?

Definitions of the type of urinary incontinence are based on responses to Question 3

Response to question 3	Type of incontinence
a. Most often with physical activity	Stress only or stress predominant
b. Most often with the urge to empty the bladder	Urge only or urge predominant
c. Without physical activity or sense of urgency	Other cause only or other cause predominant
d. About equally with physical activity and sense of urgency	Mixed

Reproduced with permission from Brown JS, Bradley CS, Subak LL, et al. The sensitivity and specificity of a simple test to distinguish between urge and stress incontinence. Ann Intern Med 2006;144(10):715–23.

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr/preamble/introduction

Incontinence

- MSU M/C/S
- USS kidneys, ureters, bladder, including post void residual
- ELFTs
- Bladder diary
- Bowel diary

Incontinence

- Medical conditions – COPD, screen for diabetes
- Medications
- Caffeine, alcohol, carbonated beverage avoidance
- Smoking cessation
- Weight loss – diet and exercise

Incontinence

- Pelvic floor muscle training (PFMT)
- Bladder & bowel retraining
- Treat constipation
- Topical oestrogen in post menopausal women
- Urge incontinence/overactive bladder
  - Anti-cholinergics (oxybutynin, solifenacin)
  - Beta 3 agonist (mirabegron)
  - Intravesical Botulinum toxin A
  - Sacral Nerve Stimulator
- Surgery

Incontinence – Bladder chart

s

Metro North Hospital and Health Service *Putting people first*

Royal Brisbane and Women's Hospital \ Continence Advisory Service \ Women's and Newborn Services

Bladder Chart

Why keep a Bladder Chart?

The reason we keep a Bladder Chart is to know: -

1. How much your bladder can hold:
   - You do this by measuring the amount of urine you pass in a jug
   - You measure every time you pass urine over a 24-hour period including night-time
2. How many times you are passing urine each day and night
3. How much fluid you drink in a 24-hour period and the type of fluid
4. To see how many times you are incontinent, and
5. If you use a catheter to empty your bladder, record the volume that is drained by the catheter.

How to do this:

Write in the Fluid Intake column the amount of fluid you drink e.g. 100mls or 200mls.

In the next column, record the Type of Fluids e.g. tea, coffee, water, orange juice or alcohol.

Each time you pass urine you must collect the urine in a container. The easiest way to do this is to place a container into the toilet bowl i.e. bucket or old ice cream container – lift the toilet seat up and place the container into the toilet bowl then replace the seat. Once you have emptied your bladder, measure the volume with a measuring jug then write the amount of urine passed in the Volume Passed column. Remember to then wash these containers ready for the next time.

The Comments column is where you write down any leakage episodes and what you were doing when you leaked. For example; sneezing, laughing, coughing, straining, movement (sitting to standing) or if you are catheterising yourself, the drainage amount. You can place any other comment you want to make note of for example, pain before passing urine or blood noted in urine.

National Standard 2. Partnering with Consumers
Consumers and/or carers provided feedback on this publication

V6 Effective: August 2020 Review: August 2023

Queensland Government

Date	Time	Fluid Intake	Type of Fluid	Volume of Urine Passed Naturally	Comments Leakage, Catheter Total
For example 1/1/2017	6.30am	250mls	Coffee	300mls	Rushed to toilet and wet pants

Incontinence – Bowel chart

Metro North Hospital and Health Service *Putting people first*

Royal Brisbane and Women's Hospital \ Continence Advisory Service \ Women's and Newborn Services

Bowel Chart

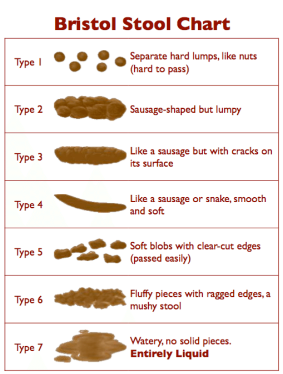
Why keep a Bowel Chart?

The reason we keep a Bowel Chart is to know: -

1. The frequency of your bowel movements
2. The consistency of your bowel motion compared to the Bristol Stool Form (see below)
3. The size of the motion you have passed
4. Sensations to pass a bowel motion
5. Record how many times you are incontinent or soil, and
6. Any medications you use to help make your bowel movements regular.

How to do this:

Use the following pictures from the Bristol Stool Form Scale to compare your bowel motion



The Bristol Stool Form Scale; Movicol ® - product of Norgine Pty Ltd (NZ)

Quantity (size of bowel motion): S = Small M = Medium L = Large

Write the information in the chart under the column headings.

National Standard 2. Partnering with Consumers
Consumers and/or carers provided feedback on this publication

Queensland Government

Date/Time	Bristol Stool Form Scale Type (note number)	Quantity	Did you feel the sensation to go? Yes/No	Incontinent or soiling?	Comments (Laxatives used, flatulence, urgency etc)
For example 01/01/2017 7am	4	M	Yes	No	Pear Juice this morning

Bladder Diary

Keep this diary accurately each day, for at least 3 days (If you can, make these 3 consecutive days)
If you have not already spoken to your doctor or continence nurse about a bladder control problem, it could be helpful to take this diary with you to an appointment

Name

Day and times passed urine, or times of any **leakage episodes**	**Amount of urine passed**	**Did you feel the urge to go?** Yes/No Urgency 1-10 (10 is severe urge)	**Leakage episodes** Small, Medium or Large) and record **times** in left hand column	**Fluid intake** Note types of drinks & amounts (record total of drinks over 24 hrs)	**Bowel function check** Record day/times when bowel motion passed	**Notes** about when you urinate or leakage happened (eg "when I arrived home and put the key in the door", "when I was out walking ...", "didn't feel like I emptied", or "leaked before I got to the toilet", and similar. You could also list any drinks or foods you suspect might be irritating the bladder, and include comments about your diet or digestion, etc.)

* In the toilet, wee into a large plastic container, then tip into a measuring jug. Record the amount before flushing urine.

https://www.continence.org.au/resource/bladder-diary-instructions

Bowel Diary

Keep this diary accurately each day, for about 7 days
Use with **Bristol Stool Form Chart**
(available on the Continence Foundation website www.continence.org.au

Name

Date Week beginning ...

Day/Time of every bowel movement	**Stool description** (Refer to Bristol Stool Chart Type 1-7)	**Did you feel the urge to go?** (Yes/No)	**Accident/soiling?** Record time in left hand column and note description of leakage in this column	**Fluid check** (all drinks taken during the 24 hrs - types and quantities)	**Laxatives, aperients, fibre supplements, etc** (what taken and when)	**Comments** (include when bowel movement or leakage happened, eg "half hour after breakfast", "11 am, soiling when I was out walking")

If you have not already spoken to your doctor or continence nurse about a bowel problem, it could be helpful to take this diary with you to an appointment.

https://www.continence.org.au/resource/bowel-diary-instructions

TPCH Physiotherapy Continence Clinic

PROMOTING HEALTHY BLADDER AND BOWEL FUNCTION

Bladder control problems are common but not normal.

The Physiotherapy Continence Clinic specialises in the area of women's and men's pelvic floor health:

- Continence Management and pelvic floor muscle exercise program based on the patient's abilities and needs
- Empowering women and men to regain their confidence and improve their quality of life
- Lifestyle advice and education regarding good bladder habits, fluid intake and bladder retraining
- Lifestyle advice and education regarding healthy bowel habits and lifestyle factors
- Improve bowel control and emptying
- Treatment of pelvic pain conditions including obstetric related pelvic girdle pain, endometriosis, proctalgia fugax
- MASS and/or CAPs funding applications

Evidence shows that you can successfully treat bladder control problems through a personalised pelvic health program designed and managed by a specially trained Physiotherapist.

When

Monday and Thursdays 8am - 4pm

Where

TPCH Physiotherapy Outpatient Clinic, Ground Floor, Main Hospital Building

Who can refer

Specialist Medical Officers or local GP

Referral via: Metro North HHS Central Patient Intake. Fax 1300 364 952

Clinic Contact Details

- Telephone 3139 4443
- Fax 3139 4082
- Email TPCH-Allied-Health-Admin@health.qld.gov.au

V4 Effective: Aug 2021 Review: Aug 2023

Metro North Health | Queensland Government

Useful Resources

- Veterans' MATES – Urinary incontinence therapeutic brief

https://www.veteransmates.net.au/topic-26

- Surgical Treatment Female Stress Urinary Incontinence

https://urogynaecology.com.au/ugsa-surgical-treatment-of-sui-pathway-2016/

Useful Resources

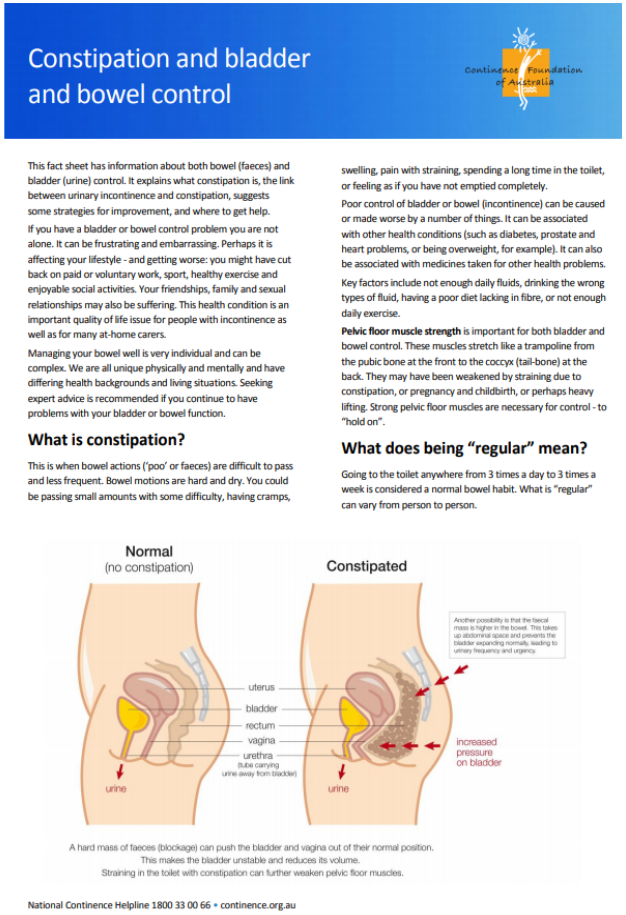
- Overactive bladder

https://www1.racgp.org.au/ajgp/2020/september/overactive-bladder-syndrome

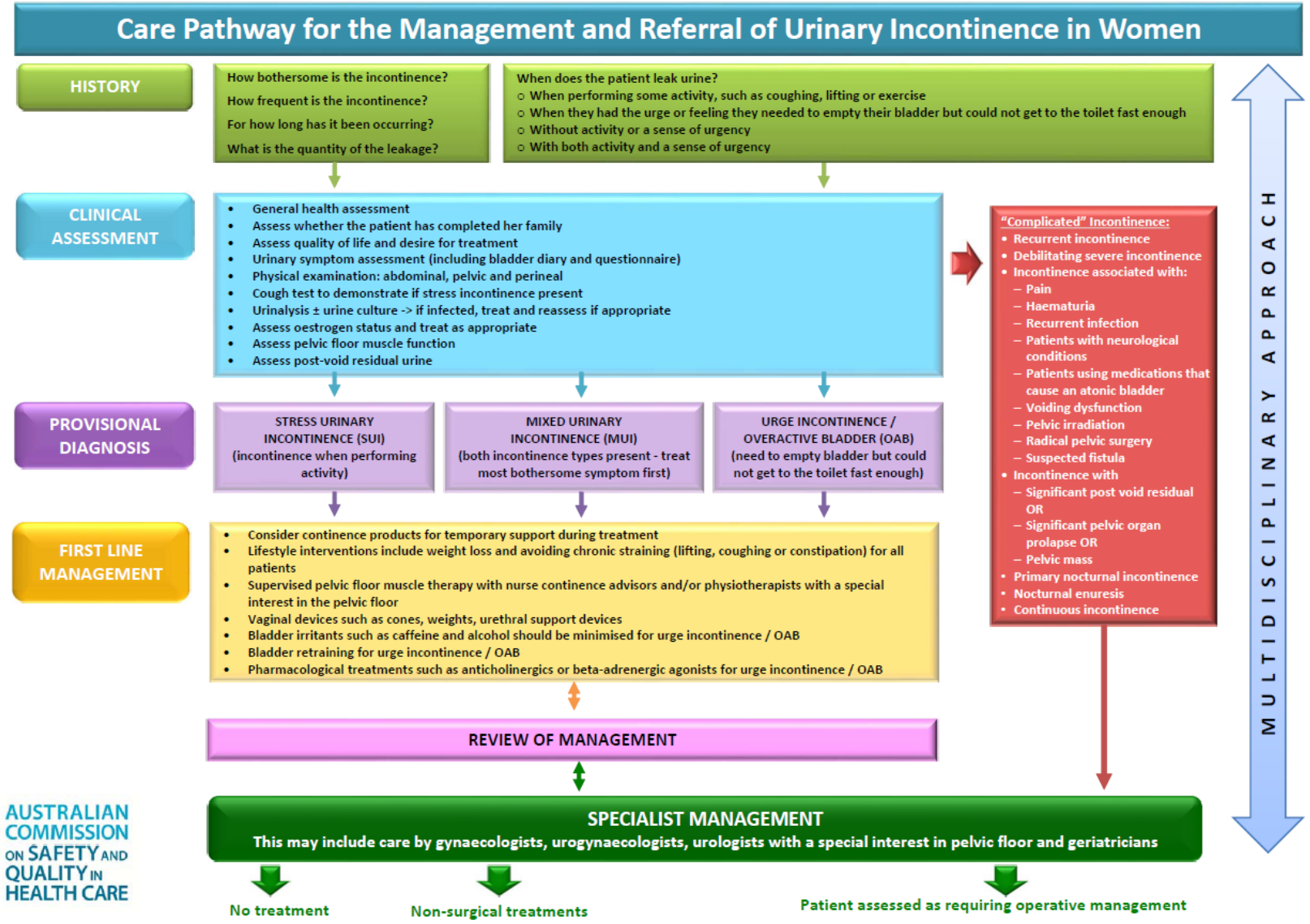
- Overactive bladder

https://urogynaecology.com.au/overactive-bladder/

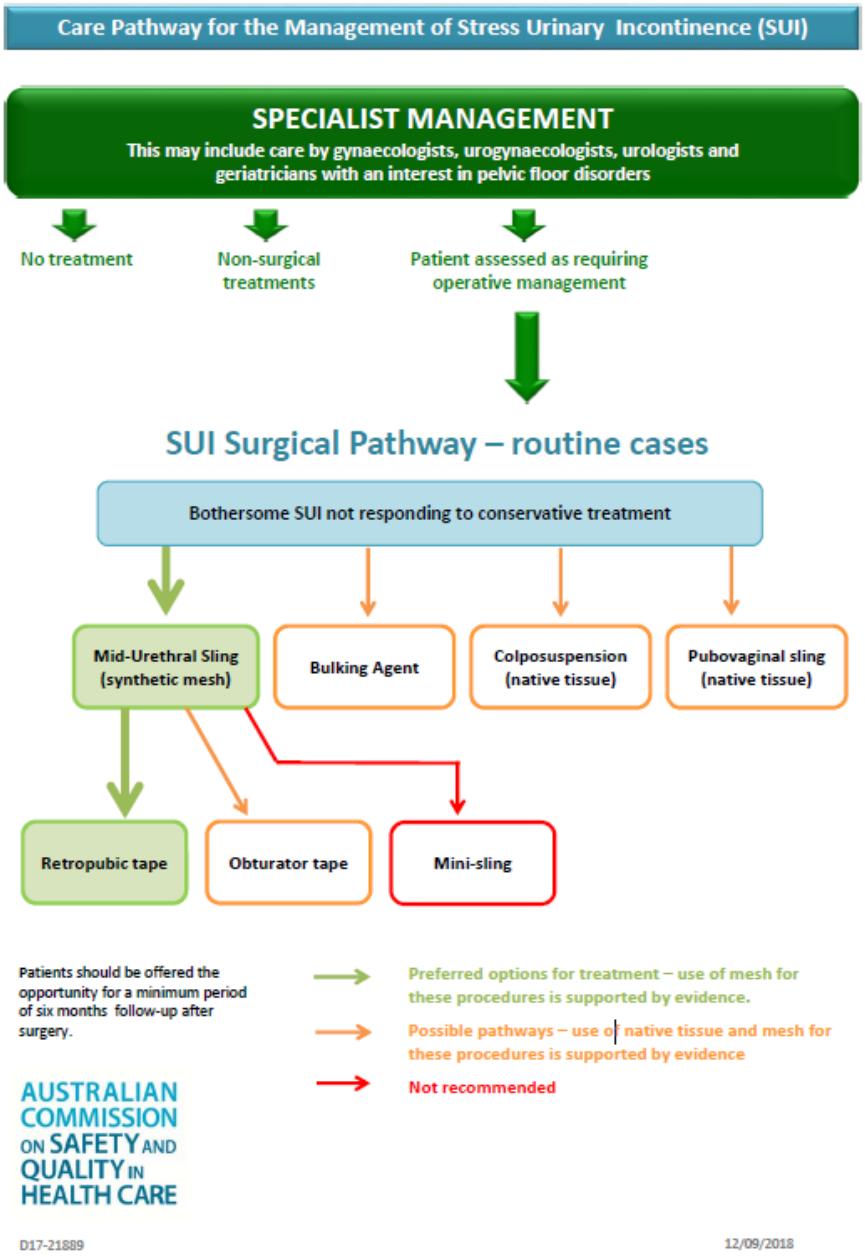
Continence Foundation of Australia



https://www.continence.org.au/get-support/resources



https://www.safetyandquality.gov.au/wp-content/uploads/2018/02/TV-Mesh-Care-pathway-for-GP-SUI-landscape.pdf



https://www.safetyandquality.gov.au/wp-content/uploads/2018/02/TV-mesh-Surgical-Care-Pathway-SUI-portrait.pdf

Care Pathway for the Management and Referral of Transvaginal Mesh Complications

Synthetic transvaginal mesh has been used to manage pelvic organ prolapse (POP) and stress urinary incontinence (SUI) in Australian women for over 15 years. In November 2017 the Therapeutic Goods Administration removed transvaginal mesh products where the sole use is the treatment of POP. Transvaginal mesh is a recommended treatment for SUI in women. Some women experience significant complications associated with transvaginal mesh following treatment for POP and SUI. This care pathway assists general practitioners to assess and manage women who may be experiencing transvaginal mesh complications.

HISTORY

Recent mesh insertion e.g. ≤ 6 weeks since transvaginal mesh procedure performed

Women experiencing significant pain in the pelvis / vagina / lower back / thigh, bleeding from the vagina / bladder / bowel, infection, extrusion or erosion of the mesh through the vagina, urinary tract symptoms such as retention, urinary infection and incontinence

CLINICAL ASSESSMENT

Clinical assessment as required

MANAGEMENT

Urgent referral to treating specialist for management of complications

Mesh not inserted recently, or a history of mesh is not documented

Does the woman report any of the following since their operation?

- Pain in the pelvis / lower back / thigh
- Awareness of the mesh during intercourse or pain during intercourse for the patient or their partner (dyspareunia)
- A prickling feeling or pain in the vagina
- Vaginal bleeding
- Mesh palpable in the vagina
- Recurrent urinary or vaginal infection
- Other urinary tract symptoms such as incontinence, voiding difficulties, retention

If YES:

- Describe and document all symptoms reported by the woman
- Record impacts the woman reports of symptoms on quality of life, relationships, social and occupational function
- Take a comprehensive gynaecological history and consider all potential causes of the woman's symptoms (continence, prolapse, sexual function, abnormal cervical cytology) and obstetric
- Take a comprehensive mesh operative history:
  - Initial procedure, any subsequent procedures, when and where procedures were performed
  - Treatments woman has received for mesh complications (medications, physical therapies, any other treatments)
- Mental health history
- Where possible, obtain a copy of the woman's operation records to confirm what transvaginal mesh procedures were performed

If NO symptoms to date:

- Reassurance only required

- Clinical health assessment
- Abdominal, pelvic and vaginal examination
  - Signs of mesh complications on examination may include: tenderness on palpation, visible mesh in the vagina, vaginal adhesions and / or scarring
- Comprehensive investigation for causes of the woman's symptoms as indicated clinically

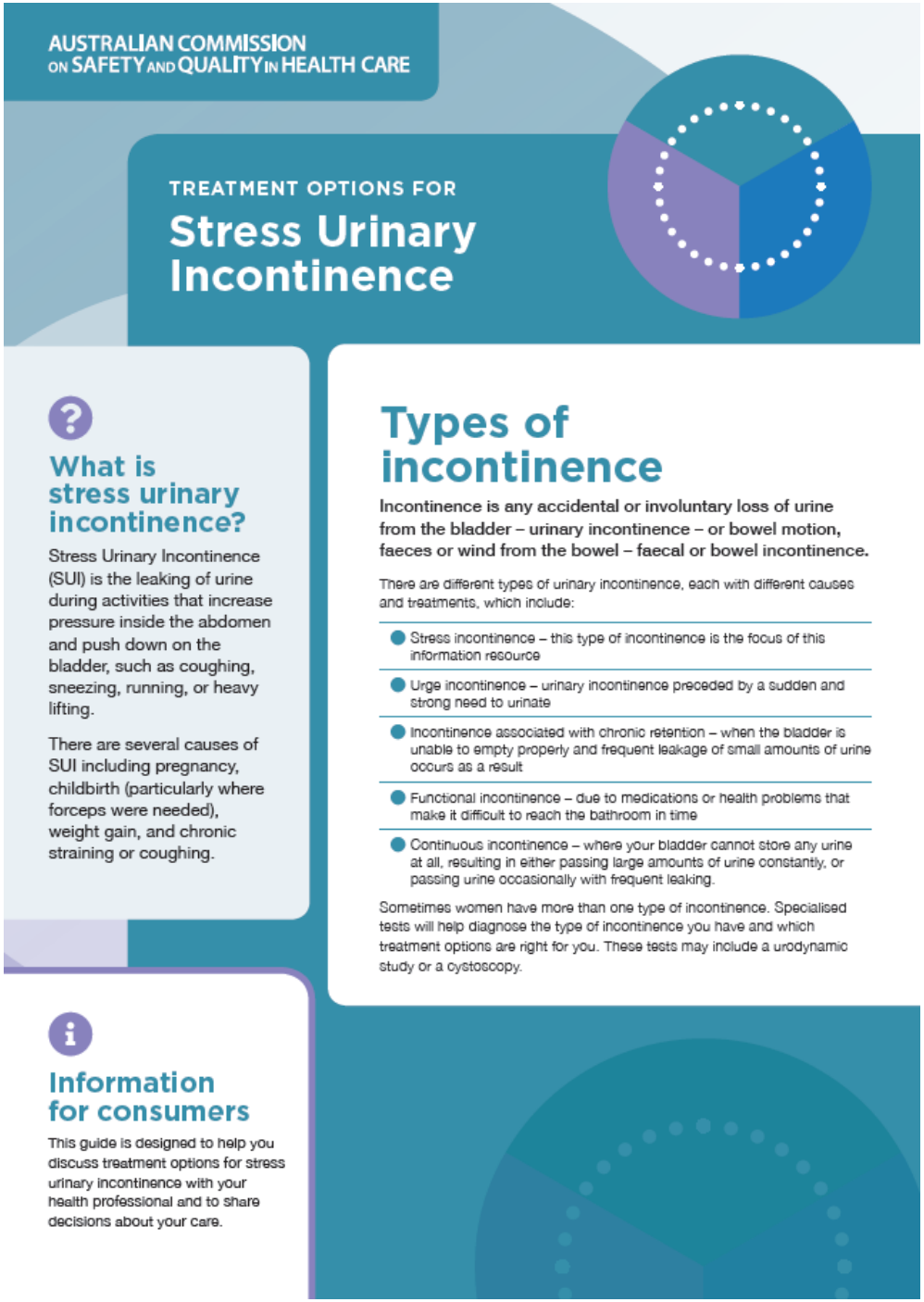
If mesh complications are suspected, offer the woman referral to a relevant specialist or to a multidisciplinary clinical service that specialises in the treatment of women with transvaginal mesh complications. Women with uncomplicated mesh erosion or exposure may opt for treatment by a gynaecology, urology or urogynaecology service

NOTES:

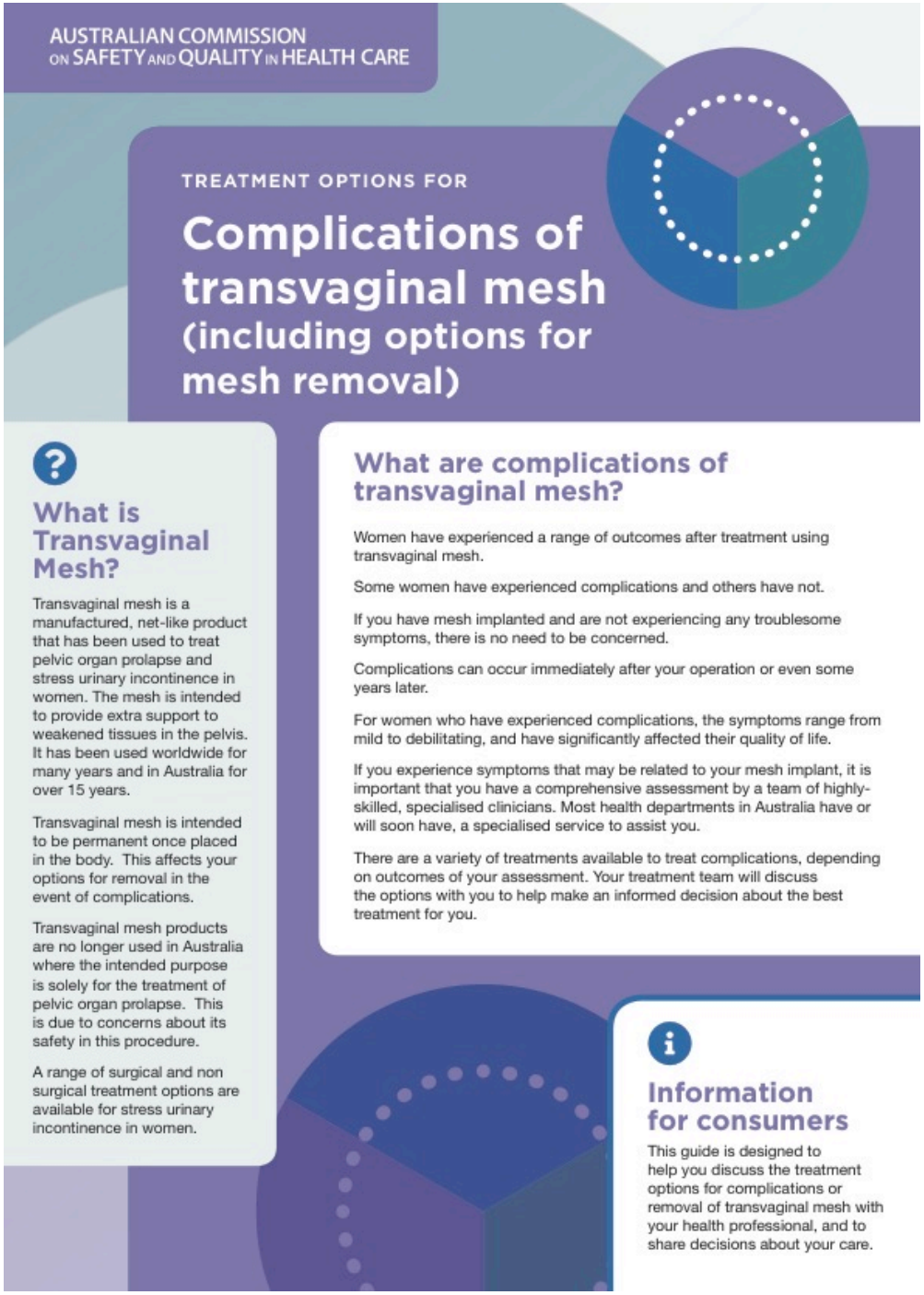
- Although mesh erosion may be asymptomatic patients still require further specialist review
- An examination of the vagina may not be possible due to patient discomfort. Examination under anaesthesia by specialist may be indicated

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

https://www.safetyandquality.gov.au/sites/default/files/migrated/TV-Mesh-care-pathway-for-GPs-complications.pdf



https://www.safetyandquality.gov.au/sites/default/files/migrated/Treatment-Options-SUI-Consumer-Info.pdf



https://www.safetyandquality.gov.au/sites/default/files/migrated/Treatment-Options-Complications-Consumer-Info.pdf

Pelvic Pain

- Kate is 28 years old, G0P0, BMI 30 kg/m^2
- Chronic abdominal pain & bloating
- Laparoscopy - mild endometriosis
- Upper GI endoscopy & colonoscopy NAD
- Focal nodular hyperplasia liver – nodule resected laparoscopically
- Taking Naproxen, Esomeprazole, Oxycodone, LNG-IUS in situ
- Pelvic USS – LNG-IUS in situ, “pelvic congestion syndrome”
- Outline your approach

Pelvic Pain

- Hx of pain, cyclical nature, dysmenorrhea, dyspareunia, fertility, bladder & bowel symptoms, mental health, Hx of sexual abuse
- Examination – abdo/pelvis/PV/PR
- Cervical Screening Test, MSU M/C/S, HVS M/C/S, cervical swab or urine PCR for Chlamydia/Gonorrhoea
- Pelvic/transvaginal USS
- Laparoscopy – histology

Pelvic Pain

Red Flags

- Abnormal vaginal bleeding
- PR Bleeding
- Change in bowel habit in > 40yo
- New onset of pain after menopause
- Pelvic mass
- Weight loss
- Suicidal ideation

Pelvic Pain

- Focal nodular hyperplasia liver & COCP
- “Pelvic congestion syndrome”
- Irritable Bowel Syndrome
- Pelvic Inflammatory Disease
- Adhesions
- Role for repeat laparoscopy
- Management of chronic pain – multidisciplinary pain clinic

Pelvic Pain - endometriosis

- Paracetamol/NSAIDS
- COCP, progestogens, LNG-IUS
- GnRH analogues
- Opioids, amitriptyline, gabapentin
- Surgery – ablation, excision, cystectomy for endometrioma, hysterectomy

PELVIC PAIN 2019

an introduction to pelvic pain for girls women men and families

Introduction to Pelvic Pain

DR SUSAN EVANS

Pelvic Pain Foundation OF AUSTRALIA

https://www.pelvicpain.org.au

Royal College of
Obstetricians and Gynaecologists

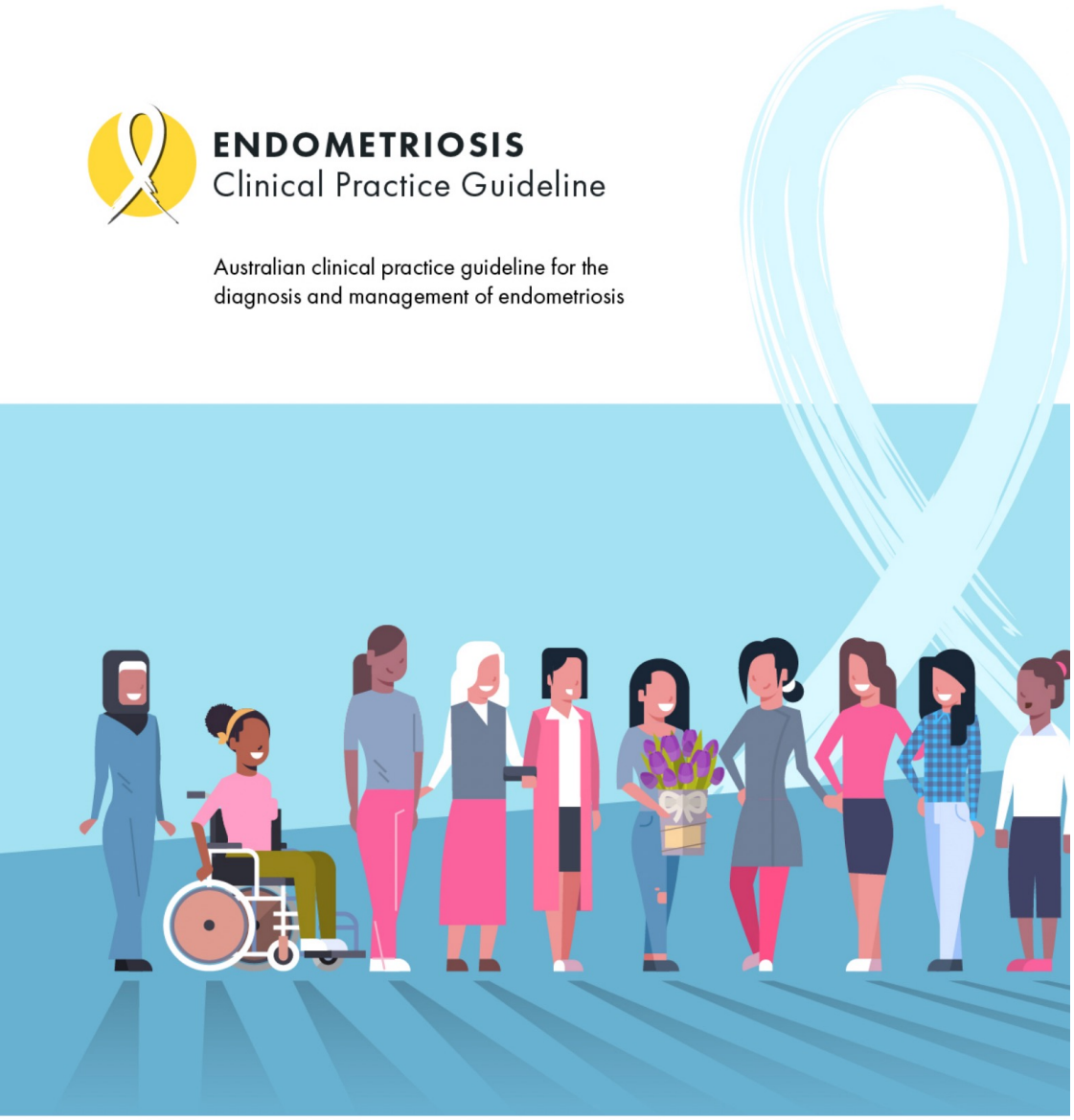
Bringing to life the best in women's health care

Green-top Guideline No. 41

May 2012

The Initial Management of Chronic Pelvic Pain

https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf



THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

RANZCOG™ Excellence in Women's Health

https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Endometriosis-clinical-practice-guideline.pdf?ext=.pdf

Acquire

Dashboard / Site pages / Endometriosis

The RANZCOG Endometriosis eLearning Module provides comprehensive coverage of endometriosis symptoms, management, and the 'whole-person' patient care pathway.

With more than 700,000 Australians estimated to be living with endometriosis, and a delay from onset to diagnosis of 7 to 12 years, this free self-directed online module aims to improve time to diagnosis and effective management for better patient outcomes.

https://acquire.ranzcog.edu.au/

Raising Awareness Tool for Endometriosis (RATE)

The Raising Awareness Tool for Endometriosis (RATE) is a quick-to-use electronic resource for health professionals and their patients to help identify and assess endometriosis – and endometriosis-associated symptoms – to reach a faster diagnosis and achieve more effective management of symptoms.

The RATE was developed by a team of experts including gynaecologists, general practitioners, pain medicine specialists, fertility specialists, emergency physicians, and nurses, working with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). If you are a medical professional, explore our Endometriosis online resources.

https://ranzcog.edu.au/womens-health/patient-information-guides

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Human Reproduction, Vol.0, No.0 pp. 1–13, 2014
doi:10.1093/humrep/det457

human reproduction ORIGINAL ARTICLE *ESHRE pages*

ESHRE guideline: management of women with endometriosis†

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Submitted on October 14, 2013; resubmitted on October 14, 2013; accepted on November 18, 2013

STUDY QUESTION: What is the optimal management of women with endometriosis based on the best available evidence in the literature?

SUMMARY ANSWER: Using the structured methodology of the *Manual for ESHRE Guideline Development*, 83 recommendations were formulated that answered the 22 key questions on optimal management of women with endometriosis.

WHAT IS KNOWN ALREADY: The European Society of Human Reproduction and Embryology (ESHRE) guideline for the diagnosis and treatment of endometriosis (2005) has been a reference point for best clinical care in endometriosis for years, but this guideline was in need of updating.

STUDY DESIGN, SIZE, DURATION: This guideline was produced by a group of experts in the field using the methodology of the *Manual for ESHRE Guideline Development*, including a thorough systematic search of the literature, quality assessment of the included papers up to January 2012 and consensus within the guideline group on all recommendations. To ensure input from women with endometriosis, a patient representative was part of the guideline development group. In addition, patient and additional clinical input was collected during the scoping and review phase of the guideline.

PARTICIPANTS/MATERIALS, SETTING, METHODS: NA.

MAIN RESULTS AND THE ROLE OF CHANCE: The guideline provides 83 recommendations on diagnosis of endometriosis and on the treatment of endometriosis-associated pain and infertility, on the management of women in whom the disease is found incidentally (without pain or infertility), on prevention of recurrence of disease and/or painful symptoms, on treatment of menopausal symptoms in patients with a history of endometriosis and on the possible association of endometriosis and malignancy.

LIMITATIONS, REASONS FOR CAUTION: We identified several areas in care of women with endometriosis for which robust evidence is lacking. These areas were addressed by formulating good practice points (GPP), based on the expert opinion of the guideline group members.

WIDER IMPLICATIONS OF THE FINDINGS: Since 32 out of the 83 recommendations for the management of women with endometriosis could not be based on high level evidence and therefore were GPP, the guideline group formulated research recommendations to guide future research with the aim of increasing the body of evidence.

† ESHRE pages content are not externally peer reviewed. This manuscript has been approved by the Executive Committee of ESHRE.

https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/ESHRE-Management-of-Women-with-Endometriosis.pdf?ext=.pdf

Heavy Menstrual Bleeding

- Marlene is 45 yo Aboriginal woman G4P4, all SVD, BMI 30kg/m^2
- Heavy irregular periods, iron deficiency
- Previous failed “in rooms” LNG-IUS insertion
- Pelvic/transvaginal USS day 7 - endometrium 6mm
- Fearful of hospitals
- No reliable transport or child care

- Outline your approach

Heavy Menstrual Bleeding

- Hx of bleeding, dysmenorrhoea, dyspareunia, impact on quality of life, comorbidity, symptoms suggestive of structural or histological abnormality, desire for more pregnancies
- PALM-COEIN - FIGO Classification (Polyp, Adenomyosis, Leiomyoma, Malignancy and Hyperplasia, Coagulopathy, Ovulatory dysfunction, Endometrial, Iatrogenic, Not yet classified)

International Journal of Gynecology and Obstetrics 113 (2011) 3-13

Heavy Menstrual Bleeding

- Risk Factors for Endometrial Cancer
  - Chronic anovulation
  - PCOS
  - Exposure to unopposed oestrogen or tamoxifen
  - Family history endometrial or colon cancer
  - Obesity, hypertension, diabetes
  - Nulliparity
  - Endometrium - premenopausal > 12mm, perimenopausal 5mm or greater, postmenopausal, > 4mm

Heavy Menstrual Bleeding

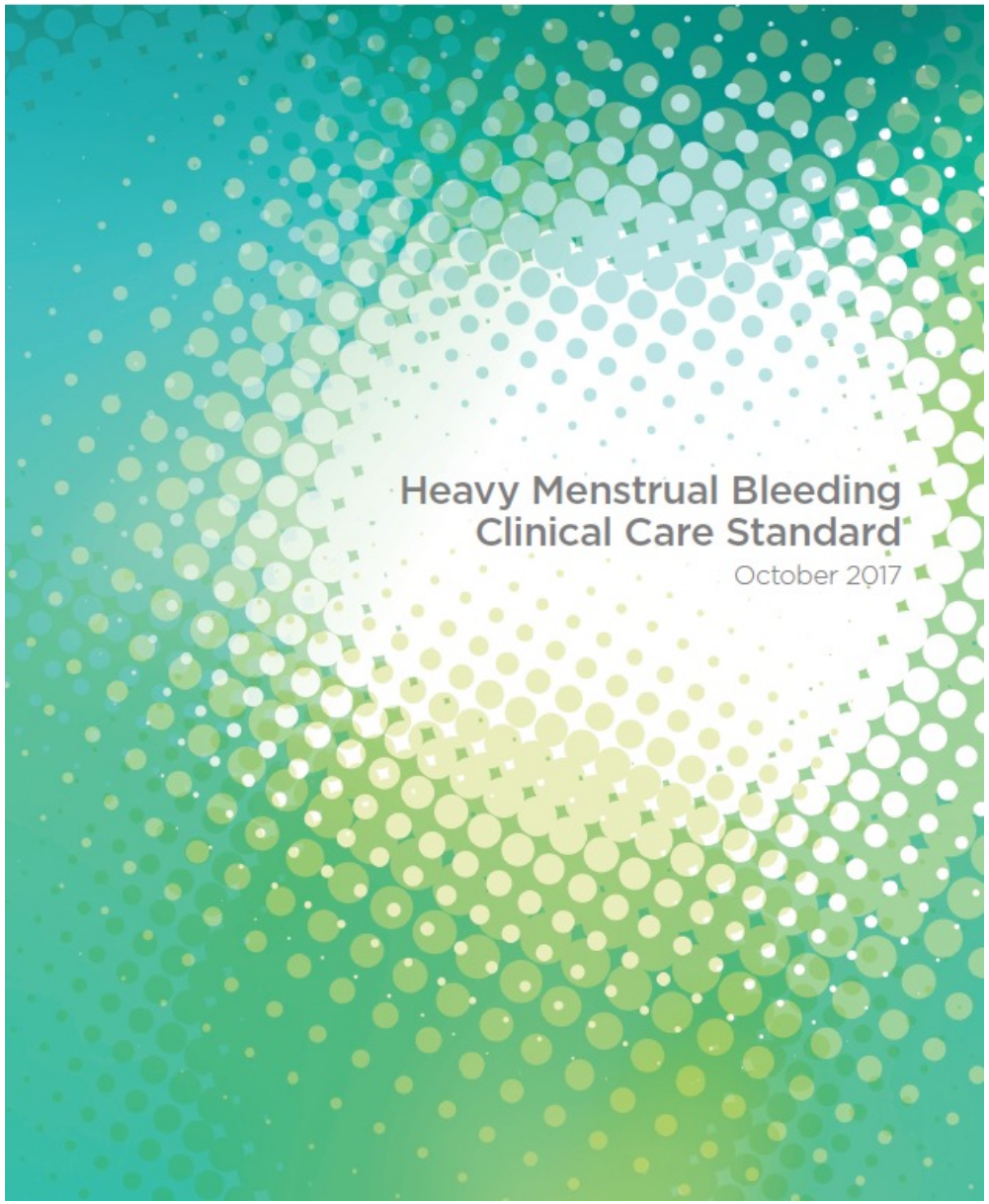
- Cervical co-test (HPV + LBC)
- FBC, iron studies, TSH
- Coagulation profile
- FSH
- Pelvic/transvaginal USS (day 4-7)
- Role for endometrial sampling?
- Role for D&C, hysteroscopy?

Heavy Menstrual Bleeding

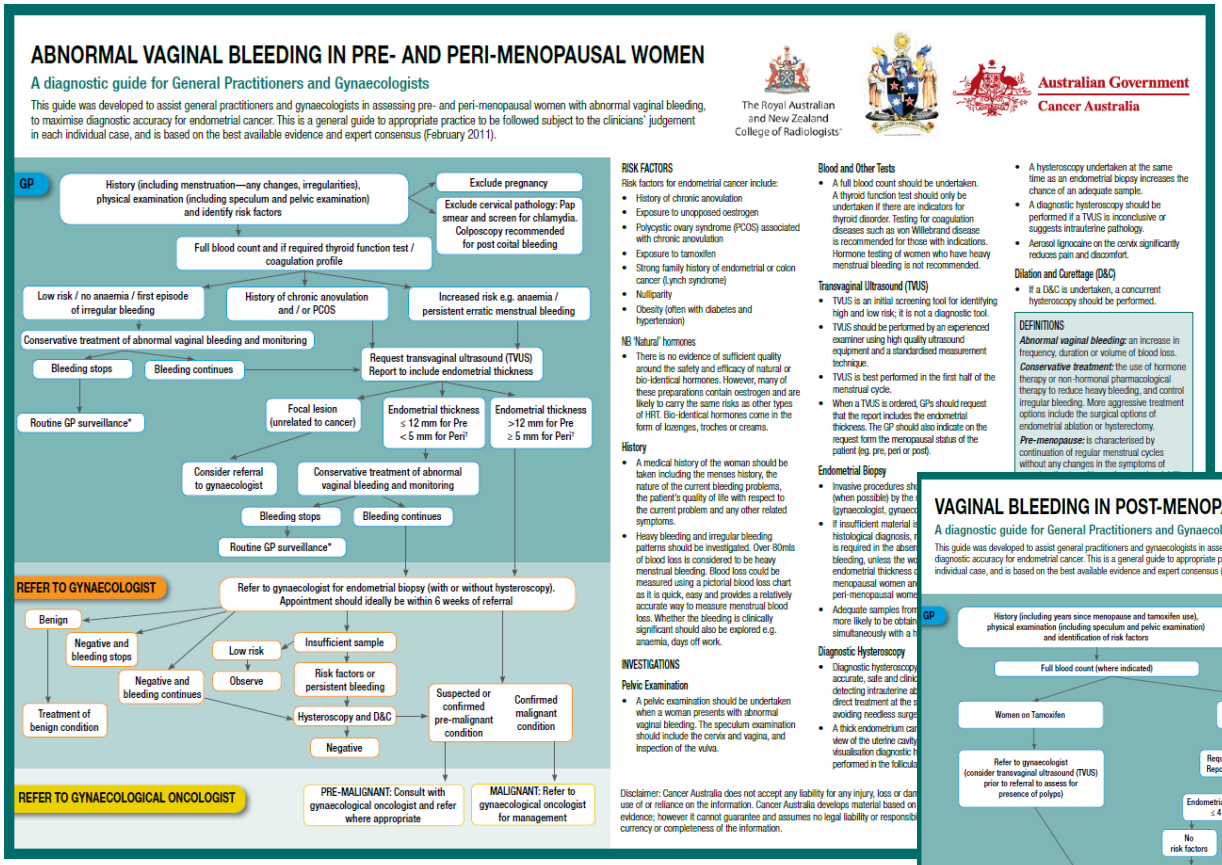
- Rx - Pharmacological – correct iron deficiency, tranexamic acid, NSAIDs, COCP, cyclical oral progesterone , DMPA, LNG-IUS, ulipristal acetate or GnRH analogues if fibroids
- Rx - Surgical - endometrial ablation, hysteroscopic removal of polyps/fibroids, myomectomy, uterine artery embolisation, hysterectomy

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards



https://www.safetyandquality.gov.au/wp-content/uploads/2017/10/Heavy-Menstrual-Bleeding-Clinical-Care-Standard.pdf



ABNORMAL VAGINAL BLEEDING IN PRE- AND PERI-MENOPAUSAL WOMEN

A diagnostic guide for General Practitioners and Gynaecologists

This guide was developed to assist general practitioners and gynaecologists in assessing pre- and peri-menopausal women with abnormal vaginal bleeding, to maximise diagnostic accuracy for endometrial cancer. This is a general guide to appropriate practice to be followed subject to the clinicians' judgement in each individual case, and is based on the best available evidence and expert consensus (February 2011).

The Royal Australian and New Zealand College of Radiologists

Australian Government Cancer Australia

GP

History (including menstruation—any changes, irregularities), physical examination (including speculum and pelvic examination) and identify risk factors

Exclude pregnancy

Exclude cervical pathology: Pap smear and screen for chlamydia. Colposcopy recommended for post coital bleeding

Full blood count and if required thyroid function test / coagulation profile

Low risk / no anaemia / first episode of irregular bleeding

History of chronic anovulation and / or PCOS

Increased risk e.g. anaemia / persistent erratic menstrual bleeding

Conservative treatment of abnormal vaginal bleeding and monitoring

Bleeding stops

Bleeding continues

Request transvaginal ultrasound (TVUS) Report to include endometrial thickness

Routine GP surveillance*

Focal lesion (unrelated to cancer)

Endometrial thickness ≤ 12 mm for Pre < 5 mm for Peri†

Endometrial thickness >12 mm for Pre ≥ 5 mm for Peri†

Consider referral to gynaecologist

Conservative treatment of abnormal vaginal bleeding and monitoring

Bleeding stops

Bleeding continues

Routine GP surveillance*

REFER TO GYNAECOLOGIST

Refer to gynaecologist for endometrial biopsy (with or without hysteroscopy). Appointment should ideally be within 6 weeks of referral

Benign

Negative and bleeding stops

Treatment of benign condition

Low risk

Observe

Insufficient sample

Risk factors or persistent bleeding

Negative and bleeding continues

Hysteroscopy and D&C

Negative

Suspected or confirmed pre-malignant condition

Confirmed malignant condition

REFER TO GYNAECOLOGICAL ONCOLOGIST

PRE-MALIGNANT: Consult with gynaecological oncologist and refer where appropriate

MALIGNANT: Refer to gynaecological oncologist for management

RISK FACTORS

Risk factors for endometrial cancer include:

- History of chronic anovulation
- Exposure to unopposed oestrogen
- Polycystic ovary syndrome (PCOS) associated with chronic anovulation
- Exposure to tamoxifen
- Strong family history of endometrial or colon cancer (Lynch syndrome)
- Nulliparity
- Obesity (often with diabetes and hypertension)

NB 'Natural' hormones

- There is no evidence of sufficient quality around the safety and efficacy of natural or bio-identical hormones. However, many of these preparations contain oestrogen and are likely to carry the same risks as other types of HRT. Bio-identical hormones come in the form of lozenges, troches or creams.

History

- A medical history of the woman should be taken including the menses history, the nature of the current bleeding problems, the patient's quality of life with respect to the current problem and any other related symptoms.
- Heavy bleeding and irregular bleeding patterns should be investigated. Over 80mls of blood loss is considered to be heavy menstrual bleeding. Blood loss could be measured using a pictorial blood loss chart as it is quick, easy and provides a relatively accurate way to measure menstrual blood loss. Whether the bleeding is clinically significant should also be explored e.g. anaemia, days off work.

INVESTIGATIONS

Pelvic Examination

- A pelvic examination should be undertaken when a woman presents with abnormal vaginal bleeding. The speculum examination should include the cervix and vagina, and inspection of the vulva.

Blood and Other Tests

- A full blood count should be undertaken. A thyroid function test should only be undertaken if there are indicators for thyroid disorder. Testing for coagulation diseases such as von Willebrand disease is recommended for those with indications. Hormone testing of women who have heavy menstrual bleeding is not recommended.

Transvaginal Ultrasound (TVUS)

- TVUS is an initial screening tool for identifying high and low risk; it is not a diagnostic tool.
- TVUS should be performed by an experienced examiner using high quality ultrasound equipment and a standardised measurement technique.
- TVUS is best performed in the first half of the menstrual cycle.
- When a TVUS is ordered, GPs should request that the report includes the endometrial thickness. The GP should also indicate on the request form the menopausal status of the patient (eg. pre, peri or post).

Endometrial Biopsy

- Invasive procedures sh… (when possible) by the … (gynaecologist, gynaeco…
- If insufficient material i… histological diagnosis, … is required in the absen… bleeding, unless the wo… endometrial thickness … menopausal women an… peri-menopausal wome…
- Adequate samples from … more likely to be obtain… simultaneously with a h…

Diagnostic Hysteroscopy

- Diagnostic hysteroscopy … accurate, safe and clinic… detecting intrauterine ab… direct treatment at the s… avoiding needless surge…
- A thick endometrium car… view of the uterine cavity … visualisation diagnostic h… performed in the follicul…

- A hysteroscopy undertaken at the same time as an endometrial biopsy increases the chance of an adequate sample.
- A diagnostic hysteroscopy should be performed if a TVUS is inconclusive or suggests intrauterine pathology.
- Aerosol lignocaine on the cervix significantly reduces pain and discomfort.

Dilation and Curettage (D&C)

- If a D&C is undertaken, a concurrent hysteroscopy should be performed.

DEFINITIONS

Abnormal vaginal bleeding: an increase in frequency, duration or volume of blood loss.

Conservative treatment: the use of hormone therapy or non-hormonal pharmacological therapy to reduce heavy bleeding, and control irregular bleeding. More aggressive treatment options include the surgical options of endometrial ablation or hysterectomy.

Pre-menopause: is characterised by continuation of regular menstrual cycles without any changes in the symptoms of

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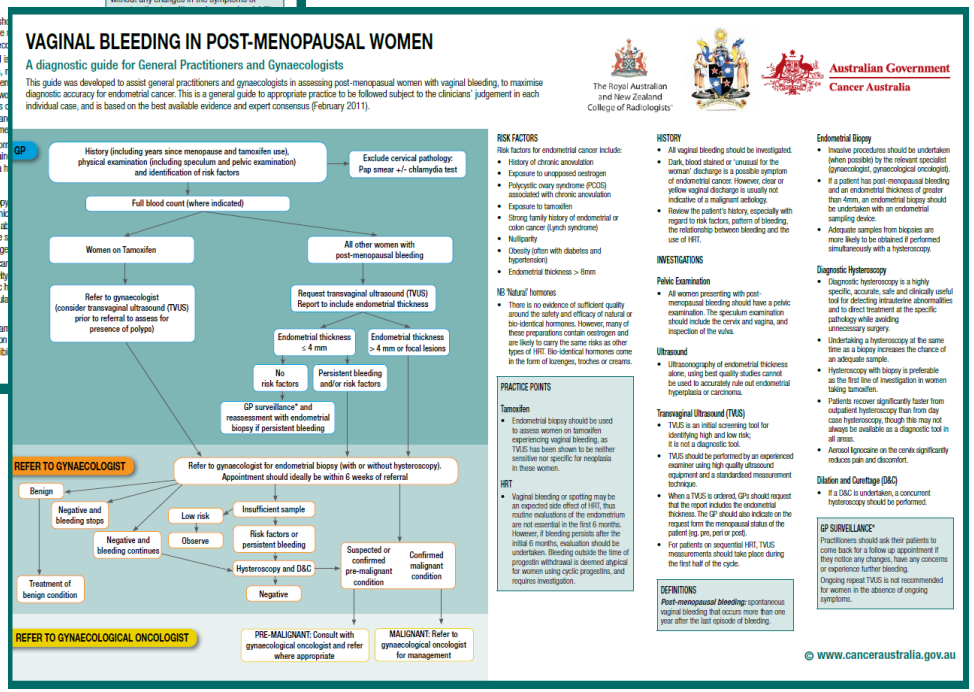

VAGINAL BLEEDING IN POST-MENOPAUSAL WOMEN

A diagnostic guide for General Practitioners and Gynaecologists

This guide was developed to assist general practitioners and gynaecologists in assessing post-menopausal women with vaginal bleeding, to maximise diagnostic accuracy for endometrial cancer. This is a general guide to appropriate practice to be followed subject to the clinicians' judgement in each individual case, and is based on the best available evidence and expert consensus (February 2011).

The Royal Australian and New Zealand College of Radiologists

Australian Government Cancer Australia

GP

History (including years since menopause and tamoxifen use), physical examination (including speculum and pelvic examination) and identification of risk factors

Exclude cervical pathology: Pap smear +/- chlamydia test

Full blood count (where indicated)

Women on Tamoxifen

All other women with post-menopausal bleeding

Refer to gynaecologist (consider transvaginal ultrasound (TVUS) prior to referral to assess for presence of polyps)

Request transvaginal ultrasound (TVUS) Report to include endometrial thickness

Endometrial thickness ≤ 4 mm

Endometrial thickness > 4 mm or focal lesions

No risk factors

Persistent bleeding and/or risk factors

GP surveillance* and reassessment with endometrial biopsy if persistent bleeding

REFER TO GYNAECOLOGIST

Refer to gynaecologist for endometrial biopsy (with or without hysteroscopy). Appointment should ideally be within 6 weeks of referral

Benign

Negative and bleeding stops

Treatment of benign condition

Low risk

Observe

Insufficient sample

Risk factors or persistent bleeding

Negative and bleeding continues

Hysteroscopy and D&C

Negative

Suspected or confirmed pre-malignant condition

Confirmed malignant condition

REFER TO GYNAECOLOGICAL ONCOLOGIST

PRE-MALIGNANT: Consult with gynaecological oncologist and refer where appropriate

MALIGNANT: Refer to gynaecological oncologist for management

RISK FACTORS

Risk factors for endometrial cancer include:

- History of chronic anovulation
- Exposure to unopposed oestrogen
- Polycystic ovary syndrome (PCOS) associated with chronic anovulation
- Exposure to tamoxifen
- Strong family history of endometrial or colon cancer (Lynch syndrome)
- Nulliparity
- Obesity (often with diabetes and hypertension)
- Endometrial thickness > 8mm

NB 'Natural' hormones

- There is no evidence of sufficient quality around the safety and efficacy of natural or bio-identical hormones. However, many of these preparations contain oestrogen and are likely to carry the same risks as other types of HRT. Bio-identical hormones come in the form of lozenges, troches or creams.

PRACTICE POINTS

Tamoxifen

- Endometrial biopsy should be used to assess women on tamoxifen experiencing vaginal bleeding, as TVUS has been shown to be neither sensitive nor specific for neoplasia in these women.

HRT

- Vaginal bleeding or spotting may be an expected side effect of HRT, thus routine evaluations of the endometrium are not essential in the first 6 months. However, if bleeding persists after the initial 6 months, evaluation should be undertaken. Bleeding outside the time of progestin withdrawal is deemed atypical for women using cyclic progestins, and requires investigation.

HISTORY

- All vaginal bleeding should be investigated.
- Dark, blood stained or 'unusual for the woman' discharge is a possible symptom of endometrial cancer. However, clear or yellow vaginal discharge is usually not indicative of a malignant aetiology.
- Review the patient's history, especially with regard to risk factors, pattern of bleeding, the relationship between bleeding and the use of HRT.

INVESTIGATIONS

Pelvic Examination

- All women presenting with post-menopausal bleeding should have a pelvic examination. The speculum examination should include the cervix and vagina, and inspection of the vulva.

Ultrasound

- Ultrasonography of endometrial thickness alone, using best quality studies cannot be used to accurately rule out endometrial hyperplasia or carcinoma.

Transvaginal Ultrasound (TVUS)

- TVUS is an initial screening tool for identifying high and low risk; it is not a diagnostic tool.
- TVUS should be performed by an experienced examiner using high quality ultrasound equipment and a standardised measurement technique.
- When a TVUS is ordered, GPs should request that the report includes the endometrial thickness. The GP should also indicate on the request form the menopausal status of the patient (eg. pre, peri or post).
- For patients on sequential HRT, TVUS measurements should take place during the first half of the cycle.

DEFINITIONS

Post-menopausal bleeding: spontaneous vaginal bleeding that occurs more than one year after the last episode of bleeding.

Endometrial Biopsy

- Invasive procedures should be undertaken (when possible) by the relevant specialist (gynaecologist, gynaecological oncologist).
- If a patient has post-menopausal bleeding and an endometrial thickness of greater than 4mm, an endometrial biopsy should be undertaken with an endometrial sampling device.
- Adequate samples from biopsies are more likely to be obtained if performed simultaneously with a hysteroscopy.

Diagnostic Hysteroscopy

- Diagnostic hysteroscopy is a highly specific, accurate, safe and clinically useful tool for detecting intrauterine abnormalities and to direct treatment at the specific pathology while avoiding unnecessary surgery.
- Undertaking a hysteroscopy at the same time as a biopsy increases the chance of an adequate sample.
- Hysteroscopy with biopsy is preferable as the first line of investigation in women taking tamoxifen.
- Patients recover significantly faster from outpatient hysteroscopy than from day case hysteroscopy, though this may not always be available as a diagnostic tool in all areas.
- Aerosol lignocaine on the cervix significantly reduces pain and discomfort.

Dilation and Curettage (D&C)

- If a D&C is undertaken, a concurrent hysteroscopy should be performed.

GP SURVEILLANCE*

Practitioners should ask their patients to come back for a follow up appointment if they notice any changes, have any concerns or experience further bleeding.

Ongoing repeat TVUS is not recommended for women in the absence of ongoing symptoms.

https://canceraustralia.gov.au/system/tdf/publications/abnormal-vaginal-bleeding-pre-peri-and-post-menopausal-women-diagnostic-guide-general-practitioners/pdf/ncgc_a3_menopause_chart_june_2012_final.pdf?file=1&type=node&id=2789

Women's Business

Improving Health Outcomes for Aboriginal and Torres Strait Islander women

Culturally Safe Women's Health Service

- Shared service model between Metro North Health and the Institute for Urban Indigenous Health
- Culturally appropriate patient-centred care for Aboriginal and Torres Strait Islander women
  - Nundah Community Health Centre - Maternity and Gynaecology
  - Morayfield ATSICH Clinic - Gynaecology
  - Ngarrama Royal Maternity Service
  - RBWH/STARS Gynaecology Surgery Services

How to refer

Eligibility

- *Gynaecology:* Women who identify as Aboriginal and/or Torres Strait Islander needing gynaecology or women's health physiotherapy
  - Women requiring speciality gynaecology oncology or urogynaecology will be seen by existing services
- *Maternity:* Women and/or baby who identify as Aboriginal and/or Torres Strait Islander
  - Physiotherapy: antenatal and up until 12 months postnatal
  - Dietitian: antenatal and up until 3 months postnatal
  - Social work: antenatal only

How to refer

- Maternity or Gynaecology referral to CPIU
- **Please indicate on referral if woman/baby identifies as Aboriginal and/or Torres Strait Islander**
- Can address to "Women's Business Aboriginal and Torres Strait Islander Gynaecology/Maternity Service"

Fertility

- Hailey is 30 yo G0P0 BMI 26kg/m2
- Ceased COCP 2021
- Partner, Justin is 35 yo
- “Trying to conceive” for 9 mo.
- Semen analysis:
  - Concentration 35 million/mL
  - Motility 65%
  - Normal 4%
- Outline your approach

Fertility

- History
  - female - menstrual cycle, previous contraception, timing & frequency of intercourse, smoking, alcohol, drugs, STIs, pelvic surgery
  - male – medical/surgical/reproductive history, smoking, alcohol, drugs, mumps, testicular conditions

- Examination
  - female – abdomen and pelvis
  - male – testes

Fertility

- Investigations female
  - Pelvic/transvaginal USS
  - Day 2-3 FSH, LH, oestradiol
  - Luteal phase progesterone (1 week prior to period e.g. day 21 of a 28 day cycle)
  - PRL, TSH
  - FBC, group & antibodies, Rubella IgG, Varicella IgG, Syphilis serology, HBV/HCV/HIV serology, cervical swab or urine PCR Chlamydia/Gonorrhoea
  - Cervical Screening Test
- Investigations male
  - semen analysis

Fertility

- Role of AMH testing
- Role of genetic carrier screening
- Testosterone & free androgen index
- Hysterosalpingogram or sonosalpingogram
- Folic acid 500mcg daily
- Lifestyle counselling – diet, exercise, smoking, alcohol, encourage BMI <25
- Conception counselling

Fertility

- Refer female
  - >35yo unprotected intercourse >6mo.
  - < 35yo unprotected intercourse >12mo.
  - oligo-amenorrhoea (indicates anovulation), previous pelvic surgery, previous STI, abnormal pelvic examination or pelvic USS, evidence of endometriosis

Fertility

- Refer male
  - Azoospermia, low sperm count or motility, poor sperm morphology, impotence, spinal surgery, erection or ejaculation problems

GYNAECOLOGY WORKSHOP SATURDAY 4 June 2022

Interactive Skill Sessions

- GPs allocated into 5 groups
- Each group has a ‘Team Leader’
- ‘Team Leader’ will lead group through 5 Skill Stations

1. Q&A	Dr Meg Cairns Dr David Baartz Clair DeBats Maria Yaxley
2. Bladder & Bowel Diaries/ Pelvic Floor Exercises	Clare Cotterell Margaret Bambrick Catherine Willis
3. Vaginal Pessaries	A/Prof. Thangeswaran Rudra Dr Catherine Dash Melissa Wright
4. Introduction to Mirena	Dr Mamta Vyas Dr Divya Viswanathan Grace Adams
5. Contraception/Menopause Hormone Therapy	Dr Kathryn Green Dr Monika Jha Dr Srishti Dutta

GP Liaison Officer Program

GYNAECOLOGY WORKSHOP

SATURDAY 4 June 2022

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