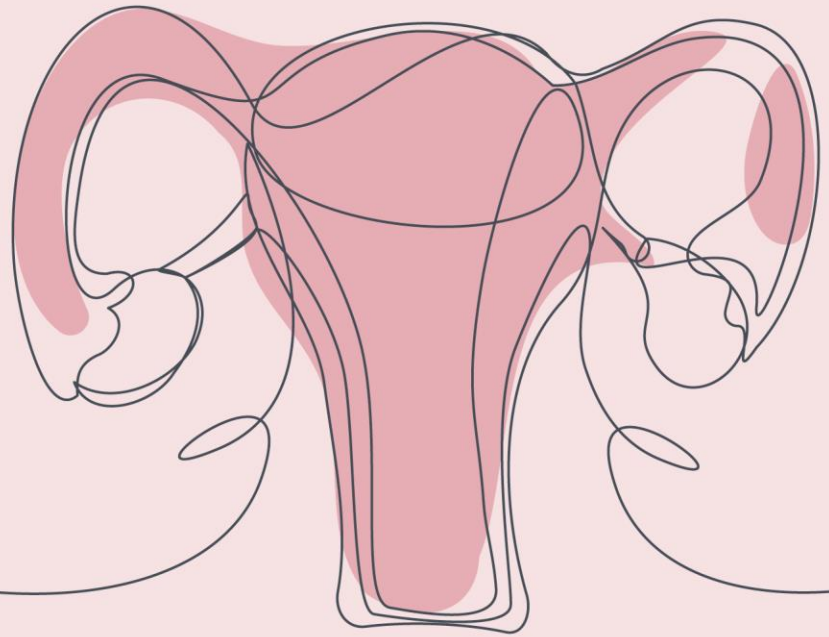
Metro North **GP Alignment Program**

Gynaecology Workshop



SATURDAY 31 AUGUST 2024

Clinical Skills Development Service | RBWH

phn BRISBANE NORTH
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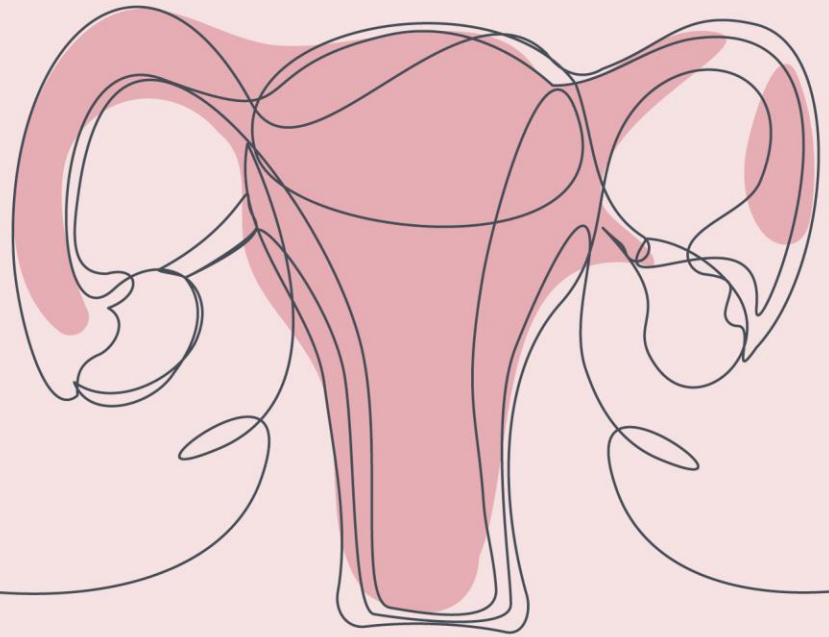
Metro North Health

Metro North **GP Alignment Program**

Gynaecology Workshop



WELCOME

Dr Meg Cairns
GPLO | Metro North Health & Brisbane North PHN

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Metro North Hospital and Health Service and Brisbane North PHN respectfully acknowledge the Traditional Owners of the land on which our services and events are located. We pay our respects to all Elders past, present and future and acknowledge Aboriginal and Torres Strait Islander people across the State.

Acknowledgements

- ***Metro North Health***
- ***Brisbane North PHN***
- ***Caboolture Hospital, Redcliffe Hospital, Royal Brisbane & Women's Hospital and The Prince Charles Hospital***
- ***Metro North Health – Women, Children and Families Clinical Stream***
- ***Metro North Health - Outpatient Strategies***

Metro North **GP Alignment Program**

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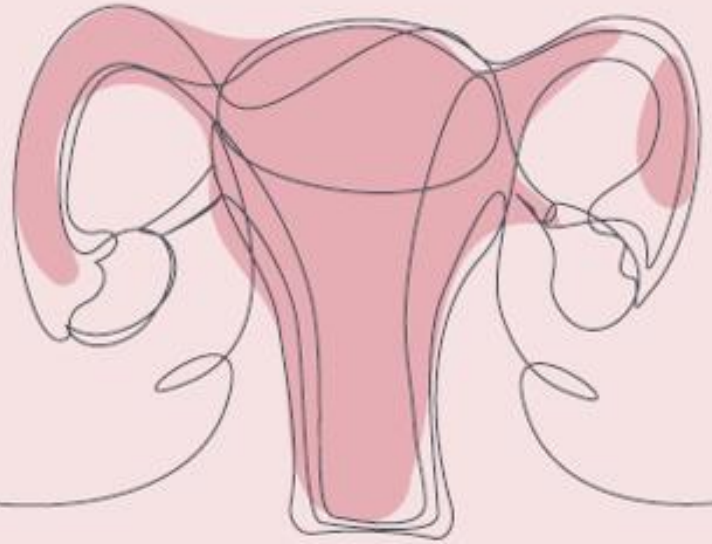


Kindly sponsored by:

BESINS HEALTHCARE
By your side, for life

BAYER

SULLIVAN NICOLAIDES PATHOLOGY

QueenslandFertilityGroup
A MEMBER OF VIRTUS HEALTH

TODAY

Session 1	
8:30am	• Welcome • Paediatric & Adolescent Gynaecology • Endometriosis • Commonwealth Endometriosis & Pelvic Pain Clinics
10:25am	*Morning Tea*
Session 2	

10:45am	• Termination of Pregnancy
	• Gynaecology services & referral processes
	• Case studies
	  • Prolapse
	  • Incontinence
	  • Heavy menstrual bleeding
	  • Fertility & PCOS

1:00pm	*Lunch*
Session 3	

1:45pm	• Interactive skills stations
	  • Bladder & bowel charts + pelvic floor physiotherapy
	  • Cervical Screening Test
	  • Contraception
	  • Q + A
	• Menopause

4:00pm	• Workshop close

Useful resources

Metro North Gynaecology Referral Guidelines

Gynaecology | Metro North Health

Brisbane North HealthPathways

Username: ***Brisbane***

Password: ***North***

Home - Community HealthPathways Brisbane North

GP Smart Referrals

GP Smart Referrals - Practice Support - Brisbane North PHN

Useful resources

Australian Journal of General Practice

RACGP – Home

RACGP gplearning and check

RACGP - Online learning

RACGP clinical guidelines

RACGP - Clinical guidelines

RANZCOG statements & guidelines

Statements and guidelines directory - RANZCOG

Useful resources

RCOG Green-top guidelines

Green-top Guidelines | RCOG

NICE guidelines

Gynaecological conditions | Topic | NICE

Gynaecological Cancer

National Cervical Screening Program

Cervical Cancer Screening Guidelines | Cancer Council

Health professionals | Cancer Australia

Useful resources

TRUE

Factsheets & free resources | True

Family Planning NSW

Resources | Family Planning NSW (fpnsw.org.au)

Jean Hailes

Jean Hailes | Creating a healthier future for all women

Australasian Menopause Society

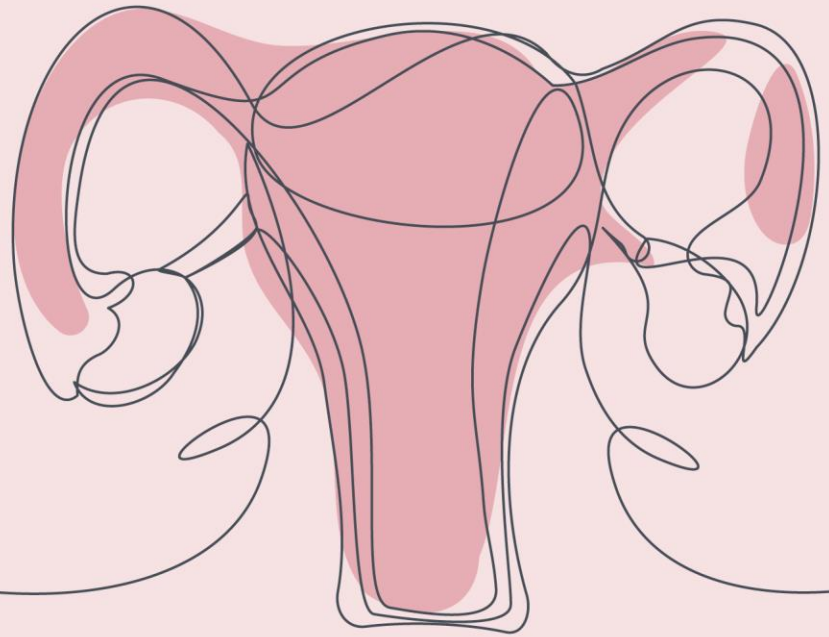
Australasian Menopause Society

British Menopause Society

British Menopause Society

Metro North **GP Alignment Program**

Gynaecology Workshop



WELCOME ADDRESS

Professor Rebecca Kimble

Pre-eminent Staff Specialist Obstetrics & Gynaecology | RBWH

Clinical Lead Statewide Paediatric & Adolescent Gynaecology Services

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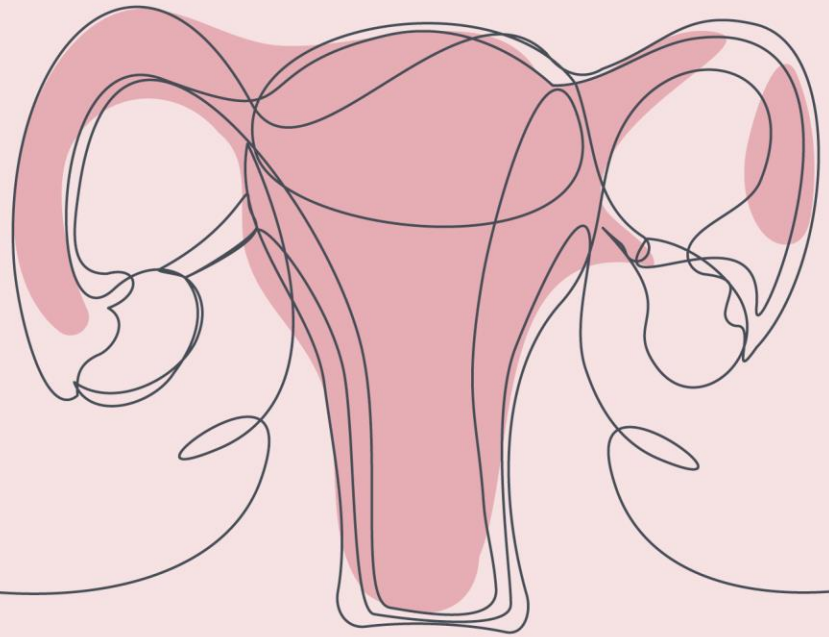

Paediatric & Adolescent Gynaecology

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phn BRISBANE NORTH
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Metro North Health

Paediatric and Adolescent Gynaecology

Menstrual Disorders and Endometriosis

Professor Rebecca Kimble

MBBS, FRANZCOG, MHLM, GAICD, AFRACMA

MNHHS GP Education 31 August 2024

Queensland Government

The University Of Queensland AUSTRALIA

Lady Cilento Children's Hospital

The Adolescent- ABLE & DISABLED

Develop a psychologically safe space to discuss their wellbeing, build trust, be empathetic, explore other needs

Self-esteem - reassure them that they are growing and developing, and things generally settle – mostly there's NOTHING ABNORMAL

Importantly, validate their pain and suffering and that you can help them - they don't need to have menses until they want to have a baby

FIGO Definition of HMB

" An excessive menstrual loss that interferes with the woman's physical, emotional, social, and material quality of life, and can occur alone or in combination with other symptoms such as dysmenorrhoea, headache or fatigue."

Paediatric and Adolescent Population
Prevalence of HMB 37% Dysmenorrhoea 93%

Full Gynaecological maturation can take up to 8 years post menarche- HMB & Dysmenorrhoea largely attributed to Immature HPO Axis

First two years post menarche 50% cycles anovulatory

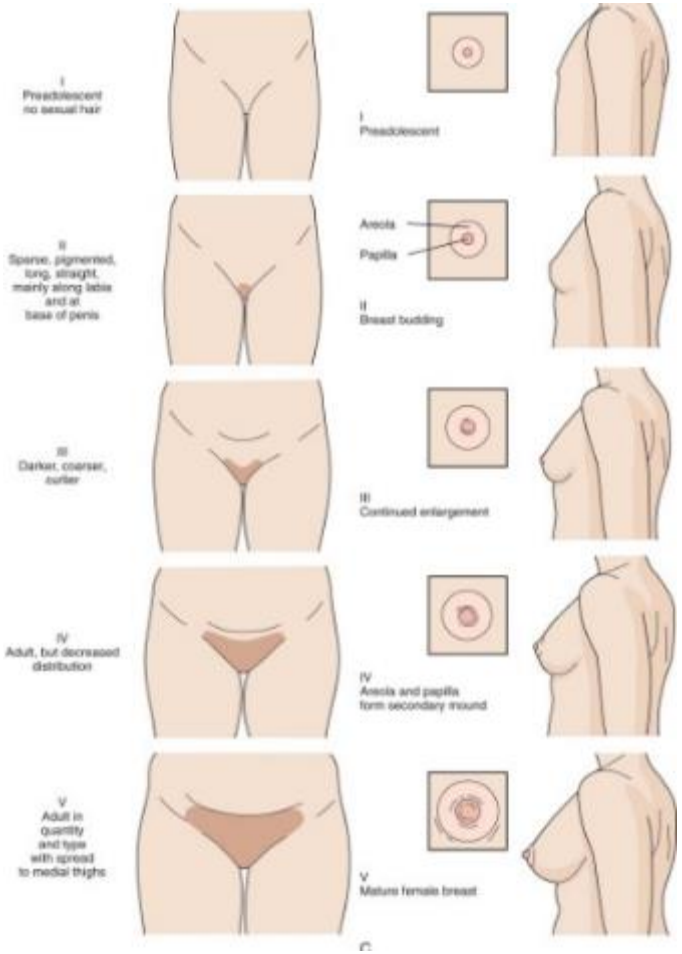
Pecchioli Y, Oyewumi L, Allen LM, Kives S. The Utility of Routine Ultrasound in the Diagnosis and Management of Adolescents with Abnormal Uterine Bleeding. J Pediatr Adolesc Gynecol. 2017;30(2):239-42

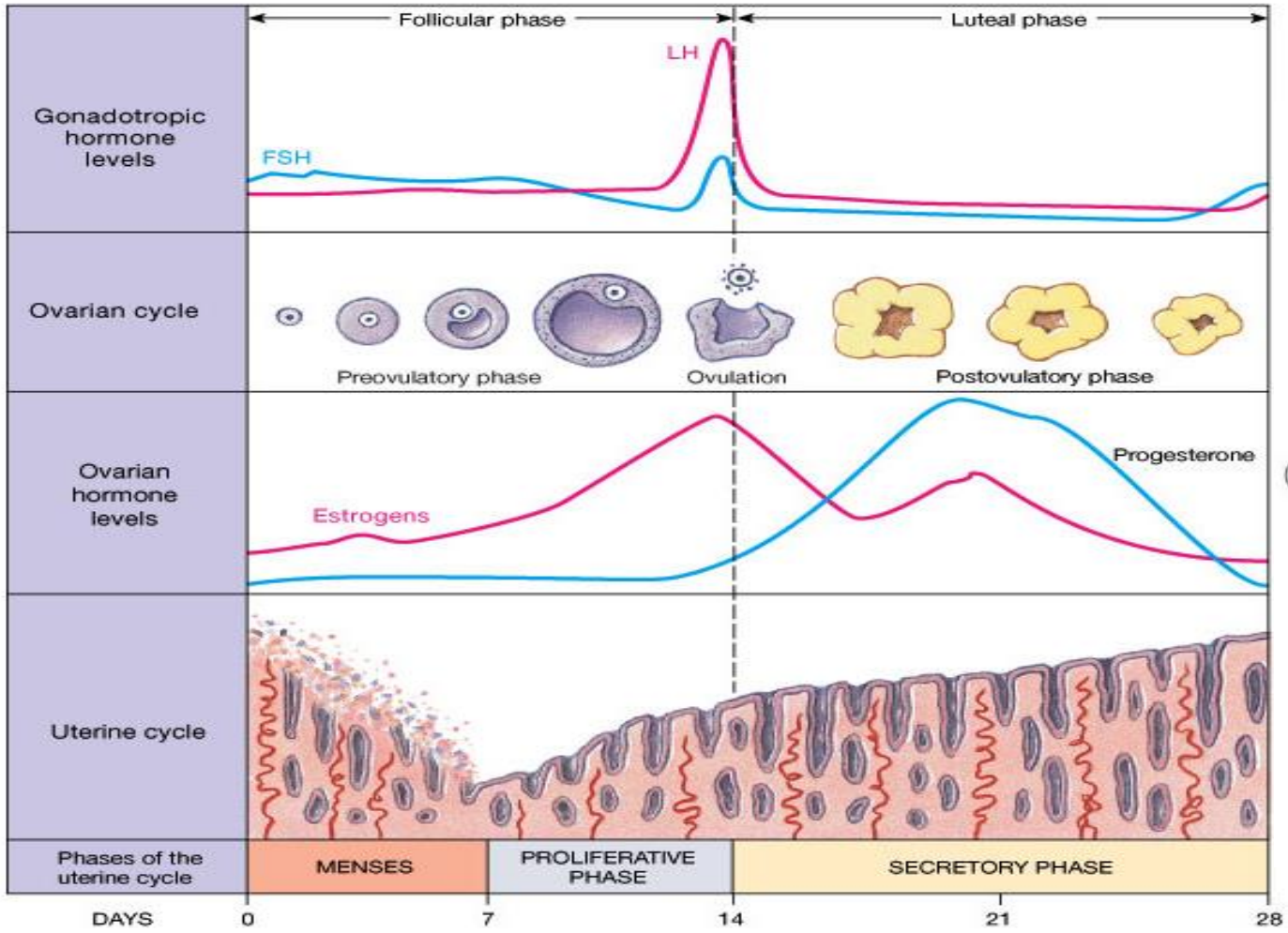
Campbell MA, McGrath PJ. Use of medication by adolescents for the management of menstrual discomfort. Arch Pediatr Adolesc Med. 1997;151(9):905-13.

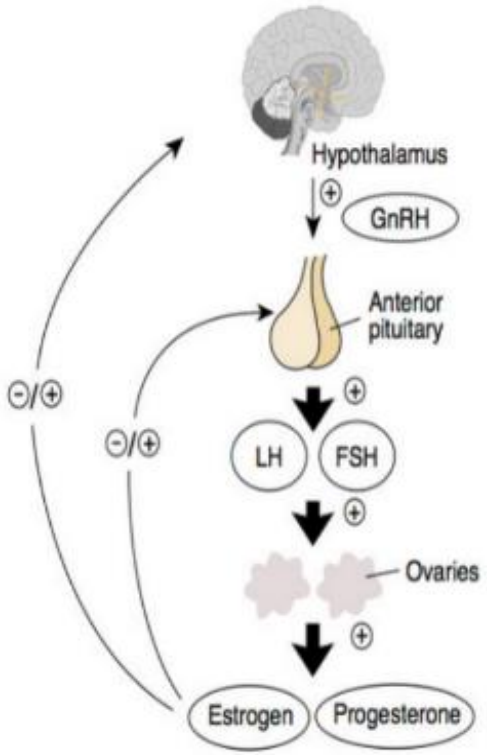
Latthe P, Latthe M, Say L, Gülmezoglu M, Khan KS. WHO systematic review of prevalence of chronic pelvic pain: a neglected reproductive health morbidity. BMC Public Health. 2006;6:177.

Metcalf MG, Skidmore DS, Lowry GF, Mackenzie JA. Incidence of ovulation in the years after the menarche. J Endocrinol. 1983;97(2):213-9.

Pubertal Development

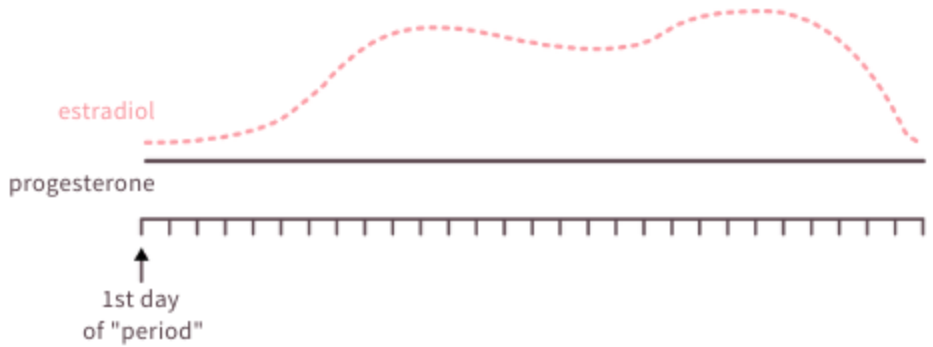




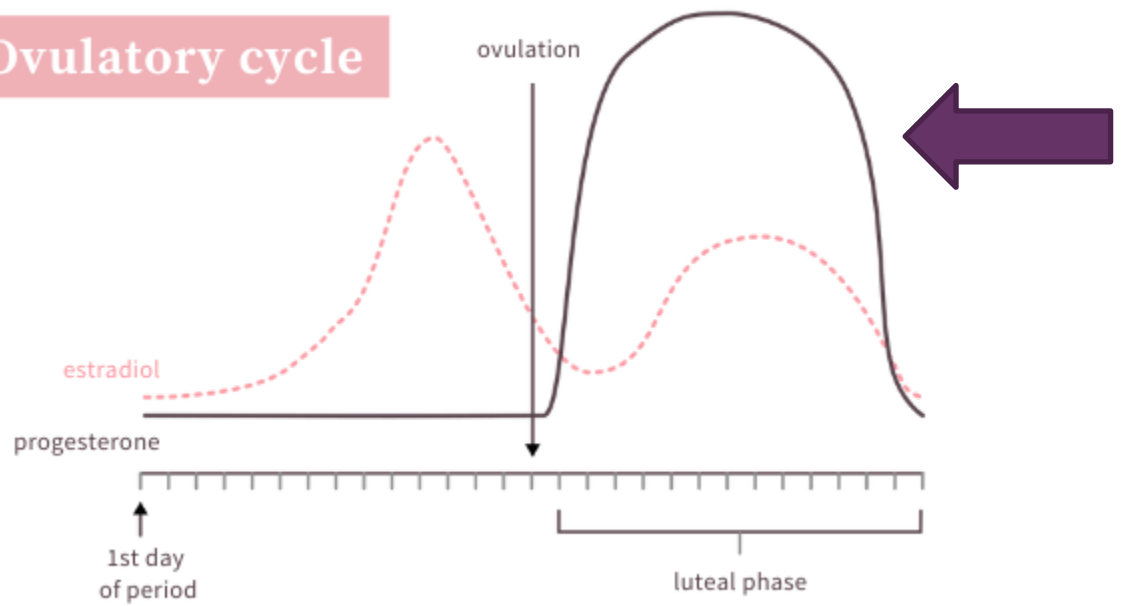


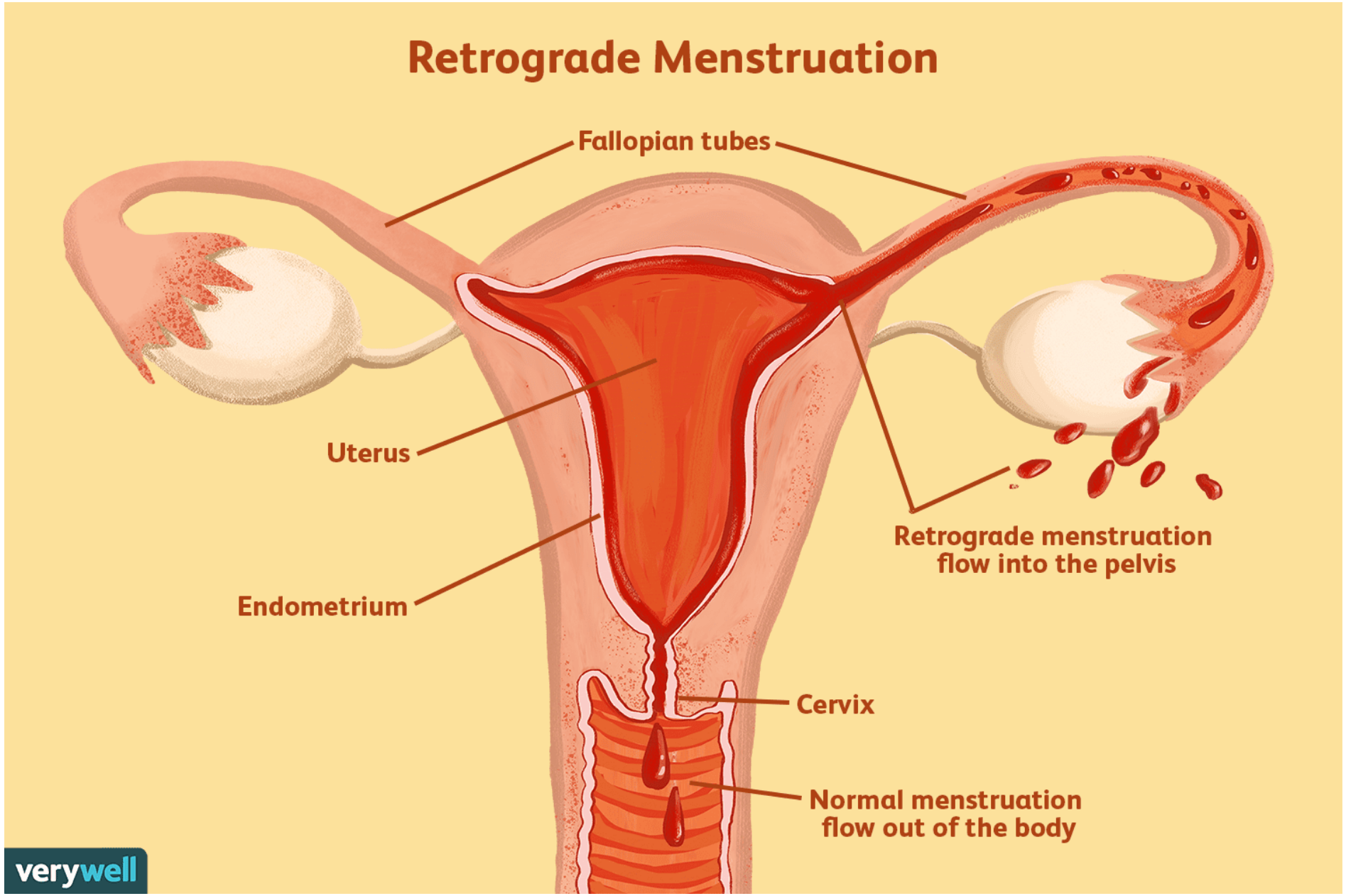
Anovulatory cycle

- no ovulation
- no luteal phase
- no progesterone



Ovulatory cycle




Retrograde Menstruation
Fallopian tubes
Uterus
Endometrium
Retrograde menstruation
flow into the pelvis
Cervix
Normal menstruation
flow out of the body
verywell

Heavy Menstrual Bleeding - Quality of Life Impact

Physiological Progesterone Deficiency

Unopposed estrogen effect - thick endometrium = HMB & irregular cycles

Tight cervix - pinpoint opening

Retrograde menses - abdominal pain/endometriosis

Prostaglandin release

Severe Pain

Bowel symptoms/nausea/vomiting

Iron Deficiency Anaemia

Fatigue

Reduced school performance

1:4 Australian school girls miss school – menses related suffering

HMB Accidents

Anxiety/ Depression

Social isolation ……

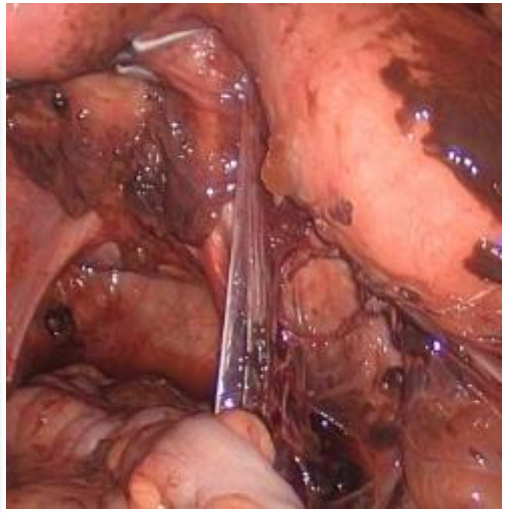
Endometriosis ⇨ Chronic condition

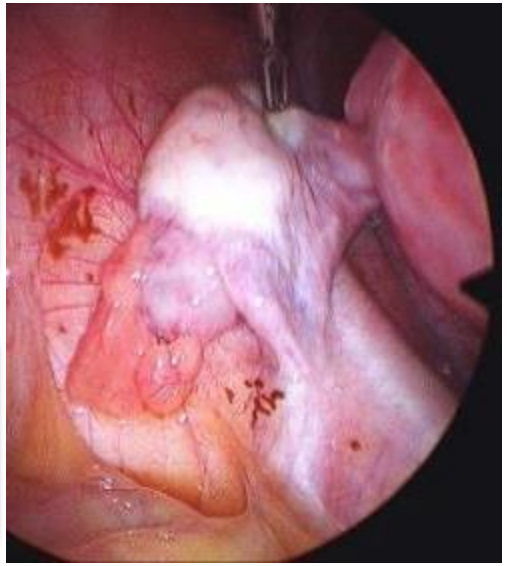
Growth of endometrial tissue outside the uterine cavity.

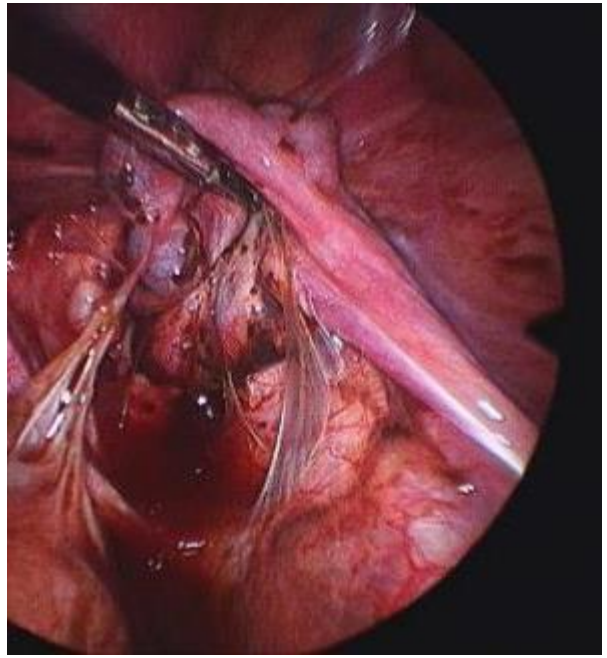
Typically, ectopic endometriotic implants are found on pelvic peritoneal surface, within the ovary or invading the rectovaginal septum and bowels.

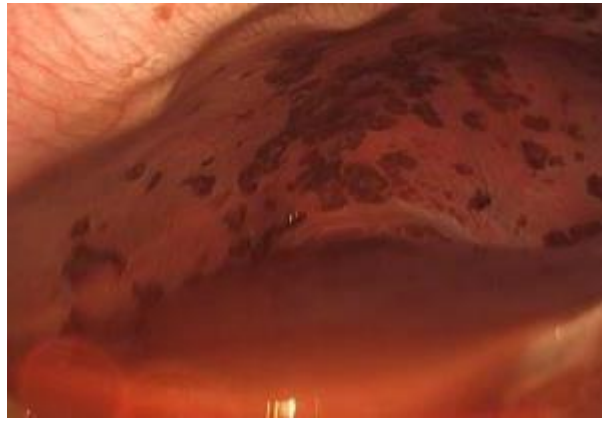
More widely distributed lesions have been described.

Endometriosis is a progressive chronic condition that can start at puberty and continue through to old age.









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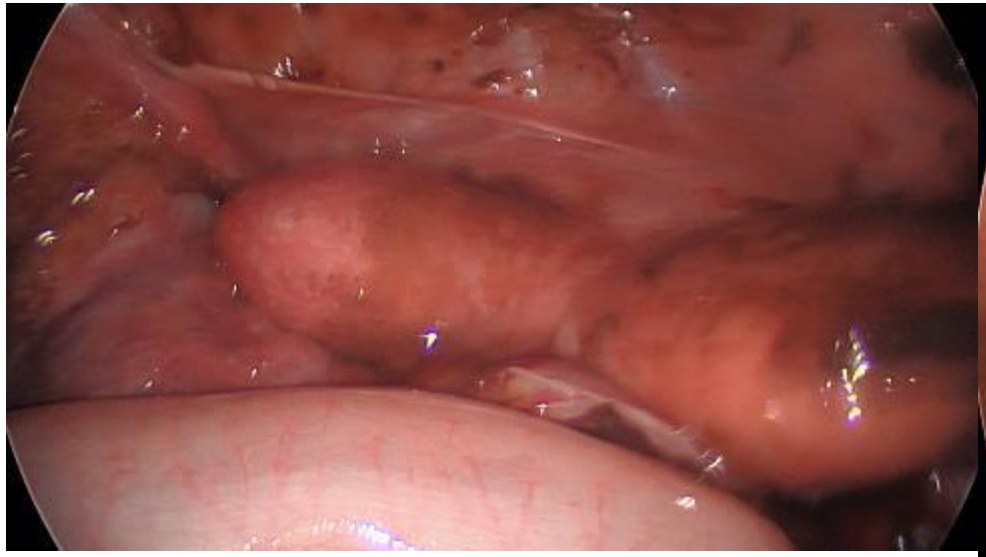
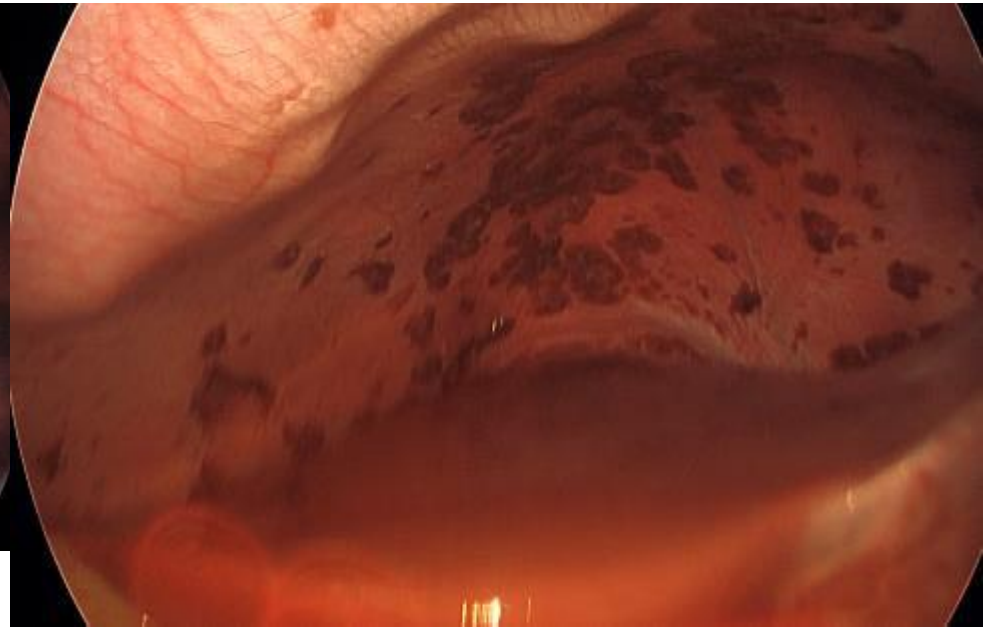
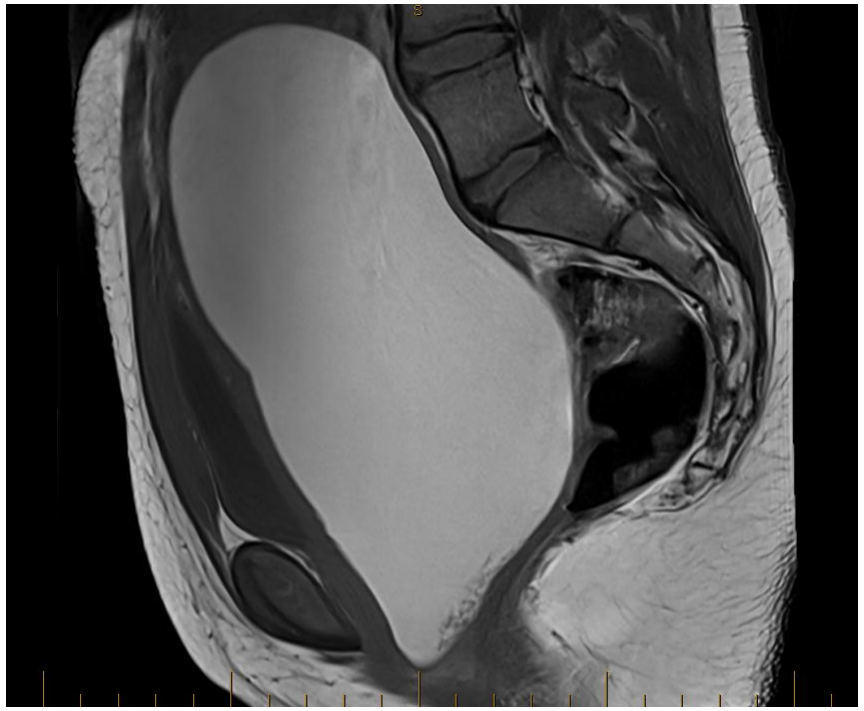
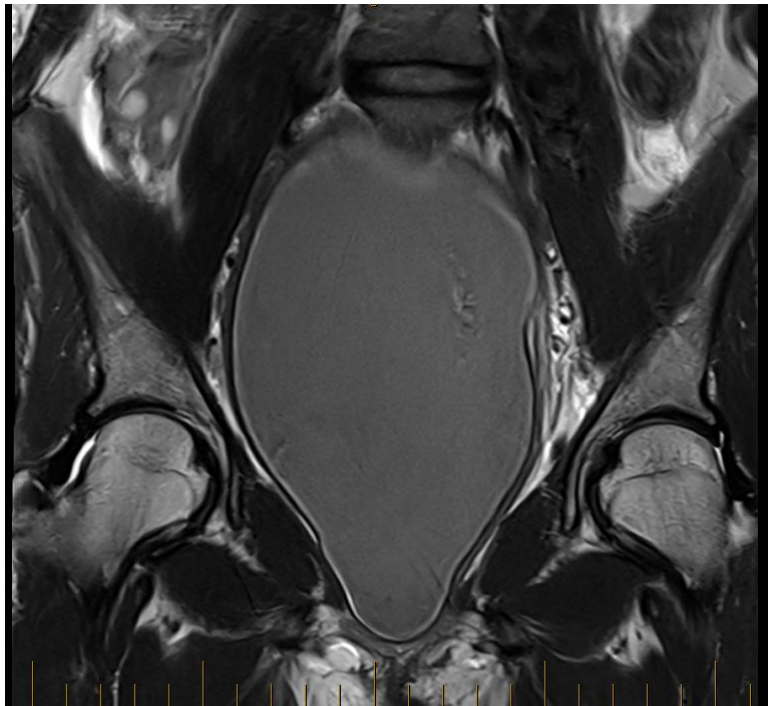


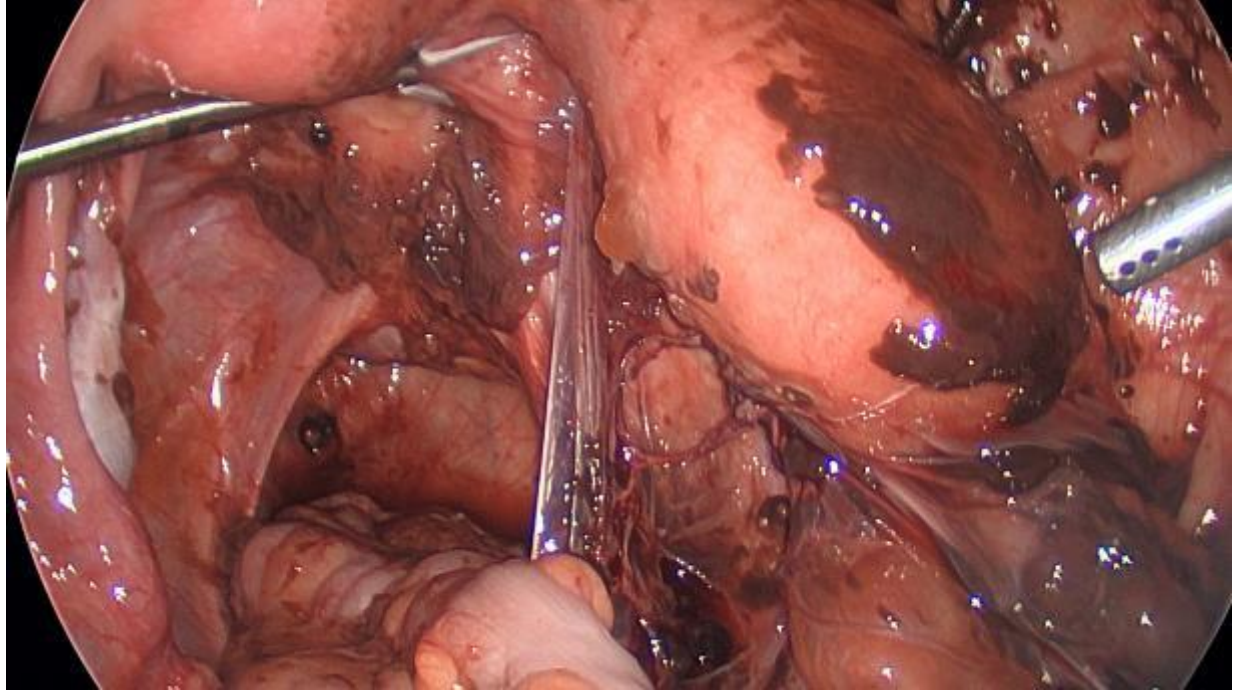


Uterus Didelphys Obstructed R hemi-vagina
Absent R Kidney Menarche 13 yo Surgery 17 yo

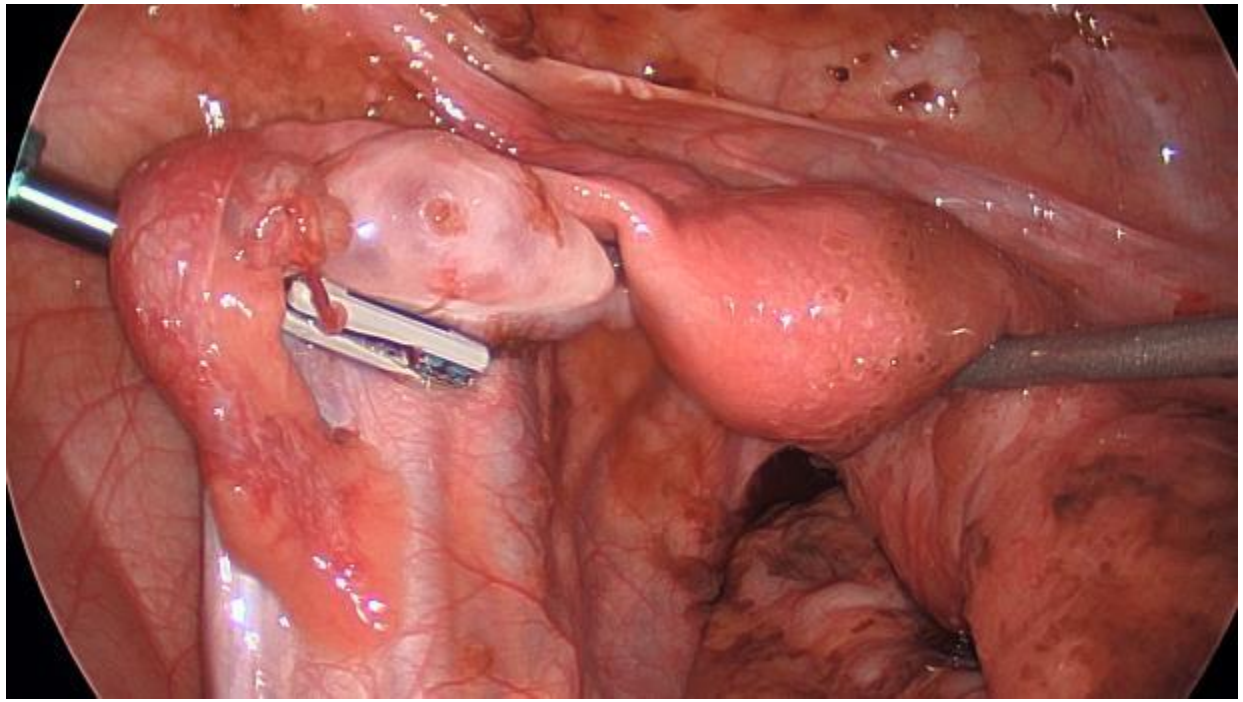
October 2023



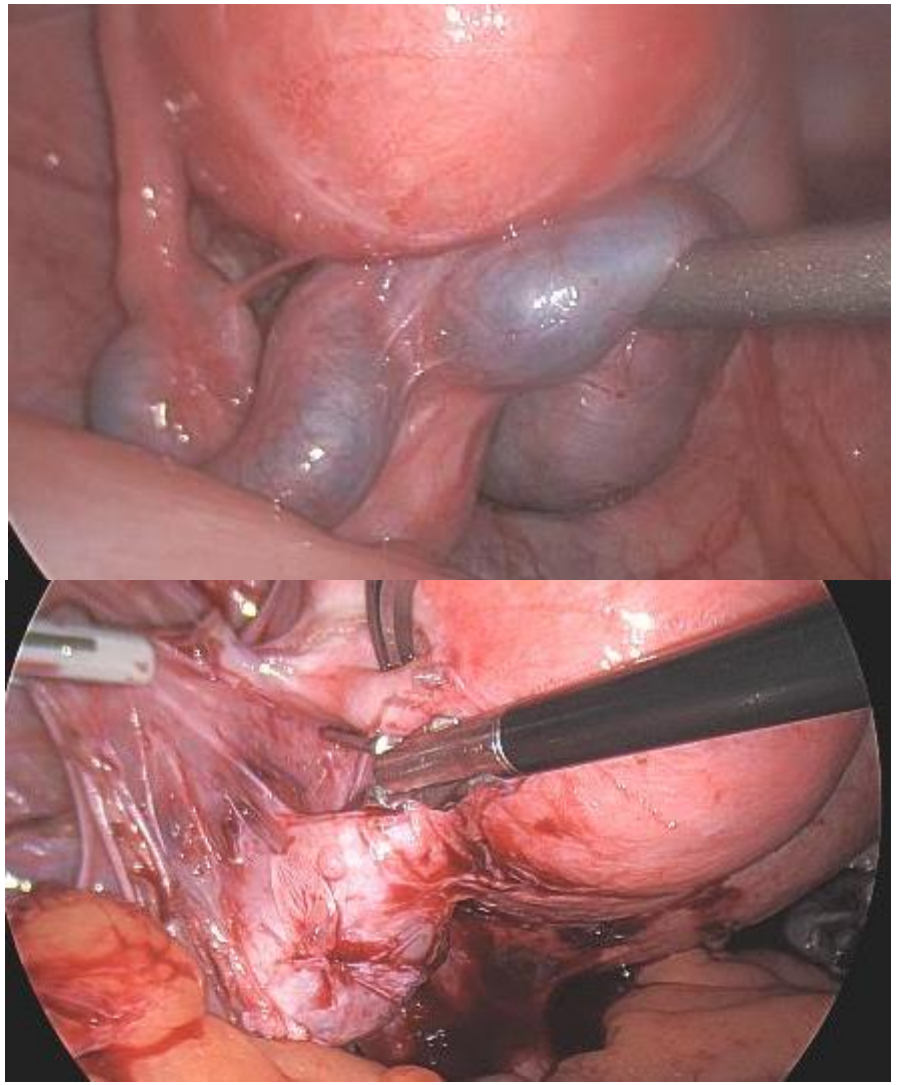




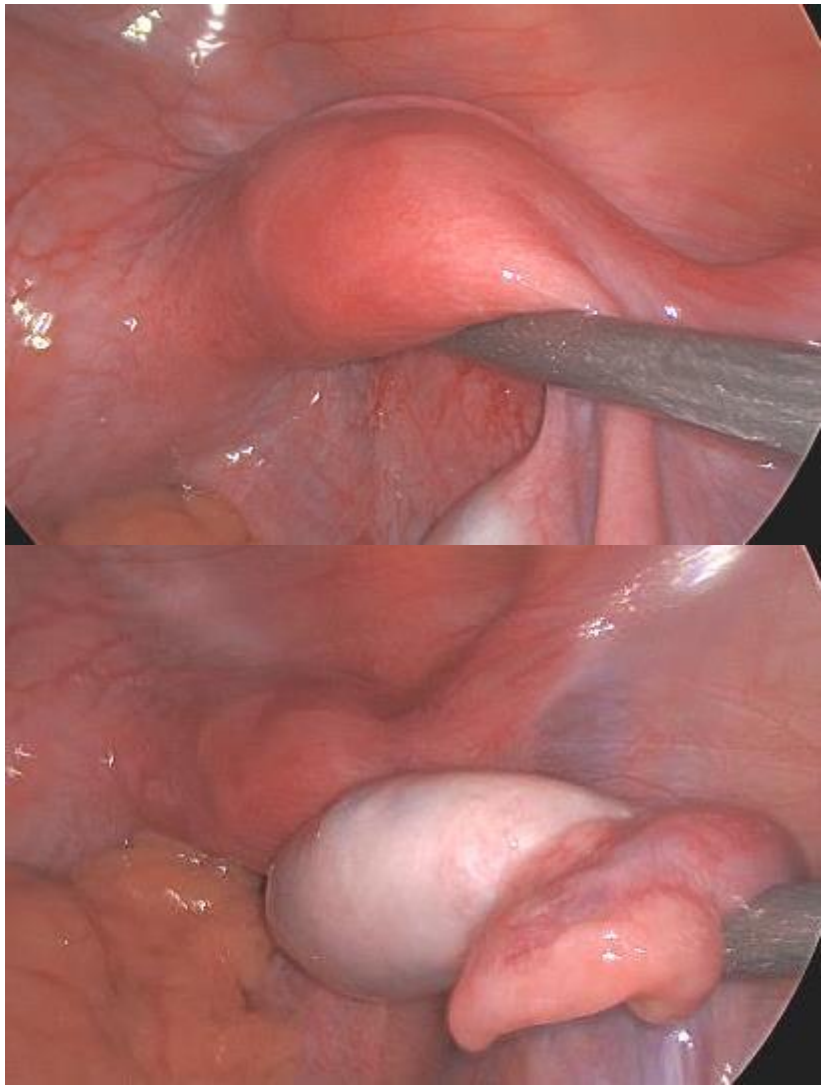
Uterus Didelphys
Obstructed R hemi-vagina with **retrograde menstruation and damage**



Patent Left Hemi-vagina with **minimal impact**



L side cervical aplasia with retrograde menses & related damage



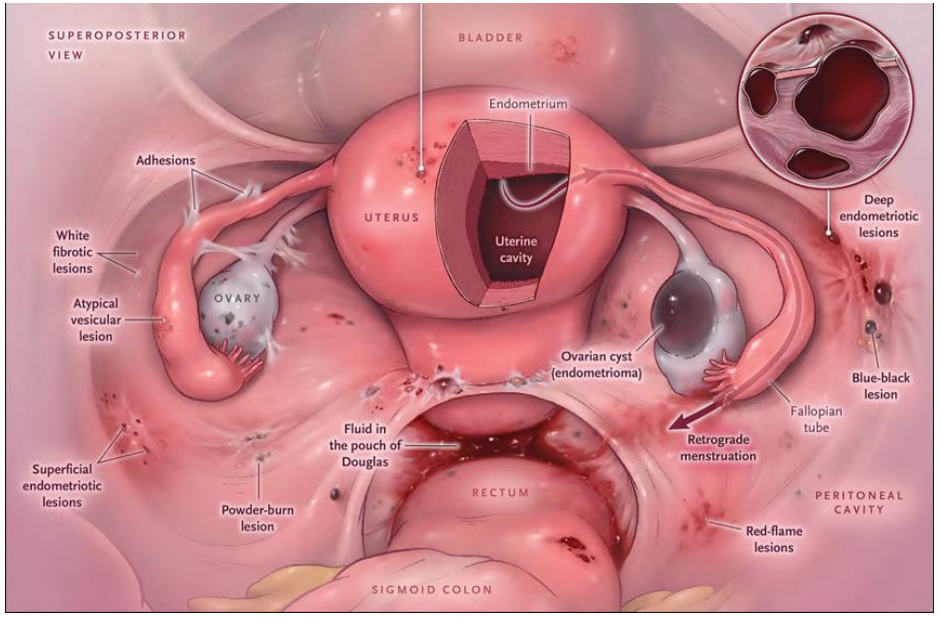
Patent R side with no damage

Symptoms and impact on quality of life

- severe and chronic pelvic pain
- painful periods
- heavy periods
- painful bowel movement
- feeling bloated
- pain when urinating
- bleeding from the bladder or bowel
- fatigue and lack of energy
- pain during or after sex
- difficulty getting pregnant
- anxiety or depression related to pain

Individual burden

- Symptoms are associated with:
- Absenteeism
- Social isolation
- Poor quality of life
- Psychosocial distress
- Sexual dysfunction & marital problems



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AUSTRALIA

Endometriosis in Australia: Prevalence and Hospitalisations

Systematic Review 2020 M Hirsch et al

Prevalence of Endometriosis in Adolescents **64%** (25 -100%)

In Australia, endometriosis affects **1:9 girls**, female @ birth

1:4 Australian Girls miss school related to menstrual pain & Suffering

Approximately 176 million women and girls suffer from endometriosis worldwide.

AIHW National Hospital Morbidity Database (NHMD)

40,500 endometriosis-related hospitalizations in 2021–22.

Hospitalizations 312: 100,000 females

The cost of endometriosis in Australia

A report for EndoActive

Building a better working world

Burden of disease

The reduction in the quality of life for women diagnosed with endometriosis has been valued a

$4.04 billion per year

$129,993

The lifetime value of the burden of endometriosis for one woman

Productivity loss

The cost to employers from absenteeism and presenteeism is valued at

$2.6 billion

On average, women suffering from endo use

60% of their sick leave

due to the chronic pain they experience

$7.4 billion

Total economic impact of endo on the Australian economy in FY2018

Direct healthcare costs

$506.4 million

in direct healthcare costs to diagnose and treat endometreosis in FY18.

Non-direct healthcare costs

$75.1 million

in non-direct healthcare costs such as transport to healthcare services

4.4 million hours

spent in transit on a recurring annual basis

Deadweight loss of taxation

the cost to society of the tax required for the government to fund direct healthcare expenses for women diagnosed with endometriosis is

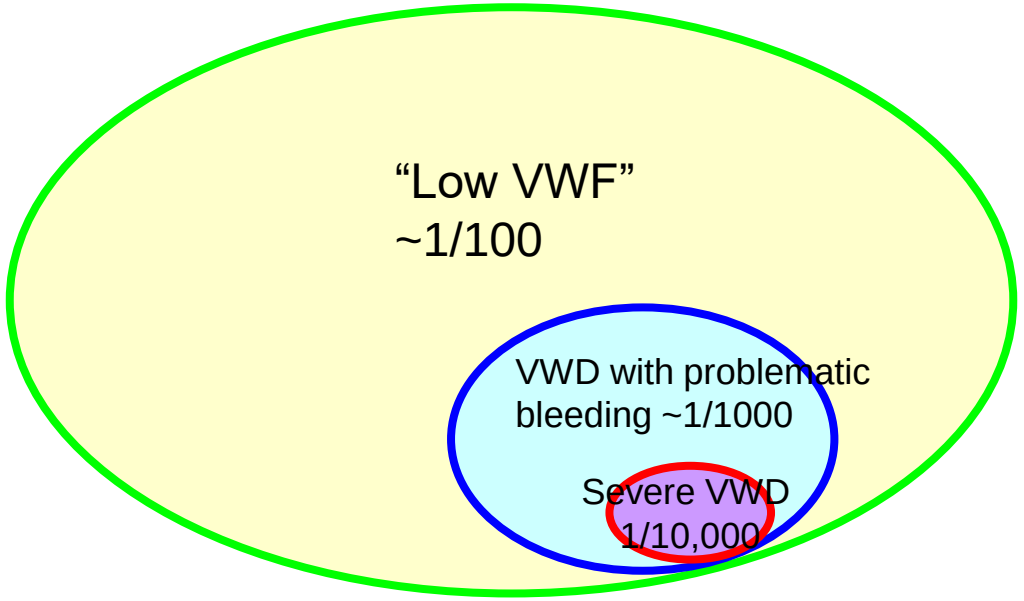
$139.3 million

Bleeding Disorders in Adolescents with Heavy Menstrual Bleeding

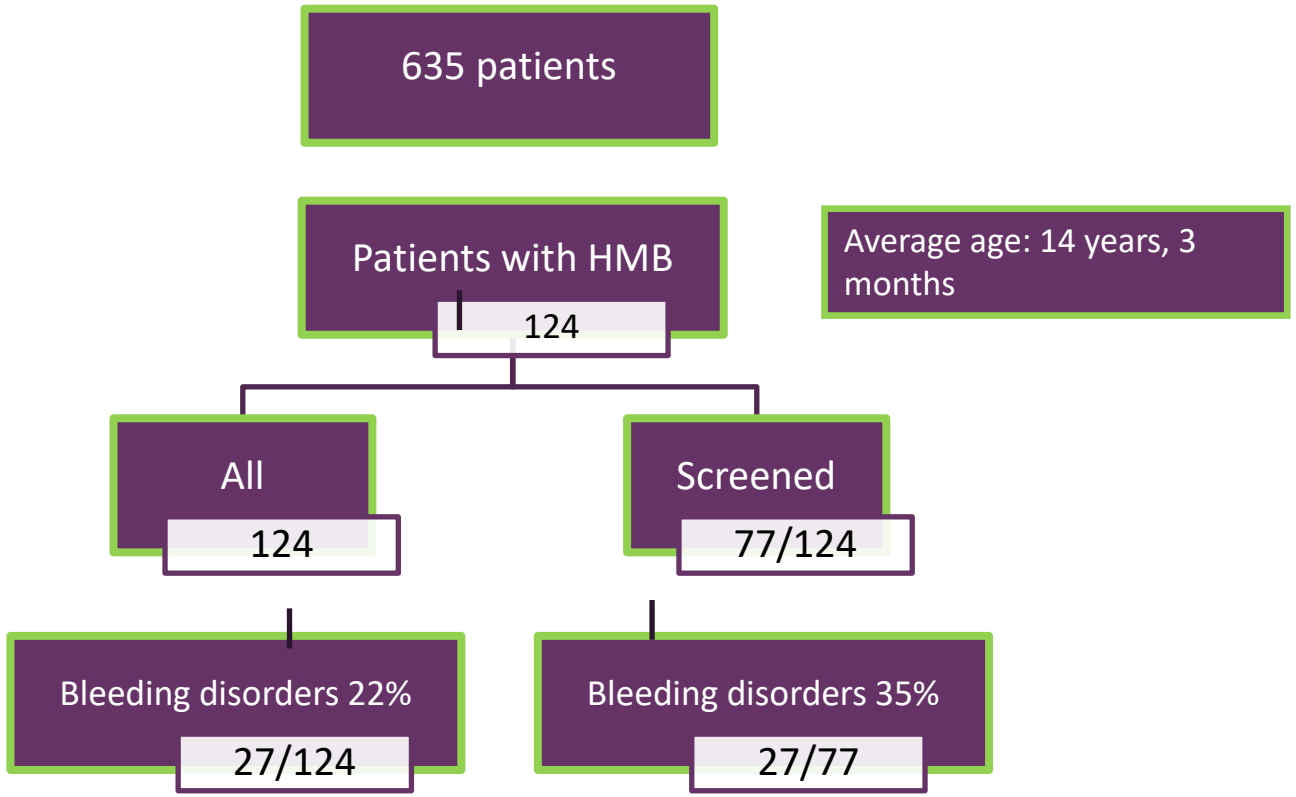
10 – 62% of adolescents with Heavy Menstrual Bleeding (HMB) have an underlying bleeding disorder (BD)

Bleeding Disorder	Prevalence
Von Willebrand's Disease (VWD)	5 - 36%
Platelet Function Disorders	2 - 44%
Thrombocytopenia (Hereditary and Acquired)	13 - 20%
Clotting factor deficiencies	8 - 9%

VWD: How common is it?



Queensland PAG Service 2007-2017



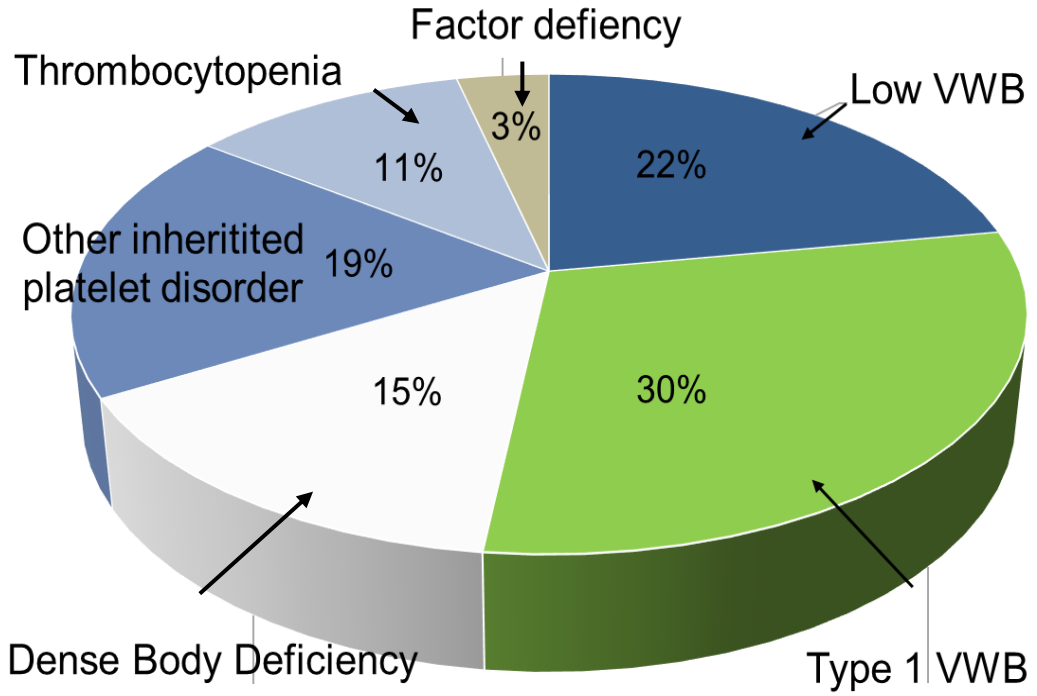
Bleeding disorders in Adolescents with Heavy Menstrual Bleeding : The Queensland Statewide Paediatric and Adolescent Gynaecology Service B O'Brien, J Mason, RMN Kimble Journal of Paediatric and Adolescent Gynaecology December 2019

Bleeding Disorders in Adolescents with Heavy Menstrual Bleeding: The Queensland Statewide Paediatric and Adolescent Gynaecology Service

Brooke O'Brien MBBS (Hons), BMedSc, MRANZCOG [1,2,*], Jane Mason MBBS (Hons), FRACP, FRCPA [3], Rebecca Kimble MBBS (Hons), FRANZCOG, GAICD [1,2]

[1] *Statewide Paediatric and Adolescent Gynaecology Service, Royal Brisbane and Women's Hospital and Lady Cilento Children's Hospital, Brisbane, Queensland, Australia*
[2] *University of Queensland, Faculty of Medicine, Brisbane, Queensland, Australia*
[3] *Queensland Haemophilia Centre, Royal Brisbane and Women's Hospital, Brisbane, Queensland, Australia*

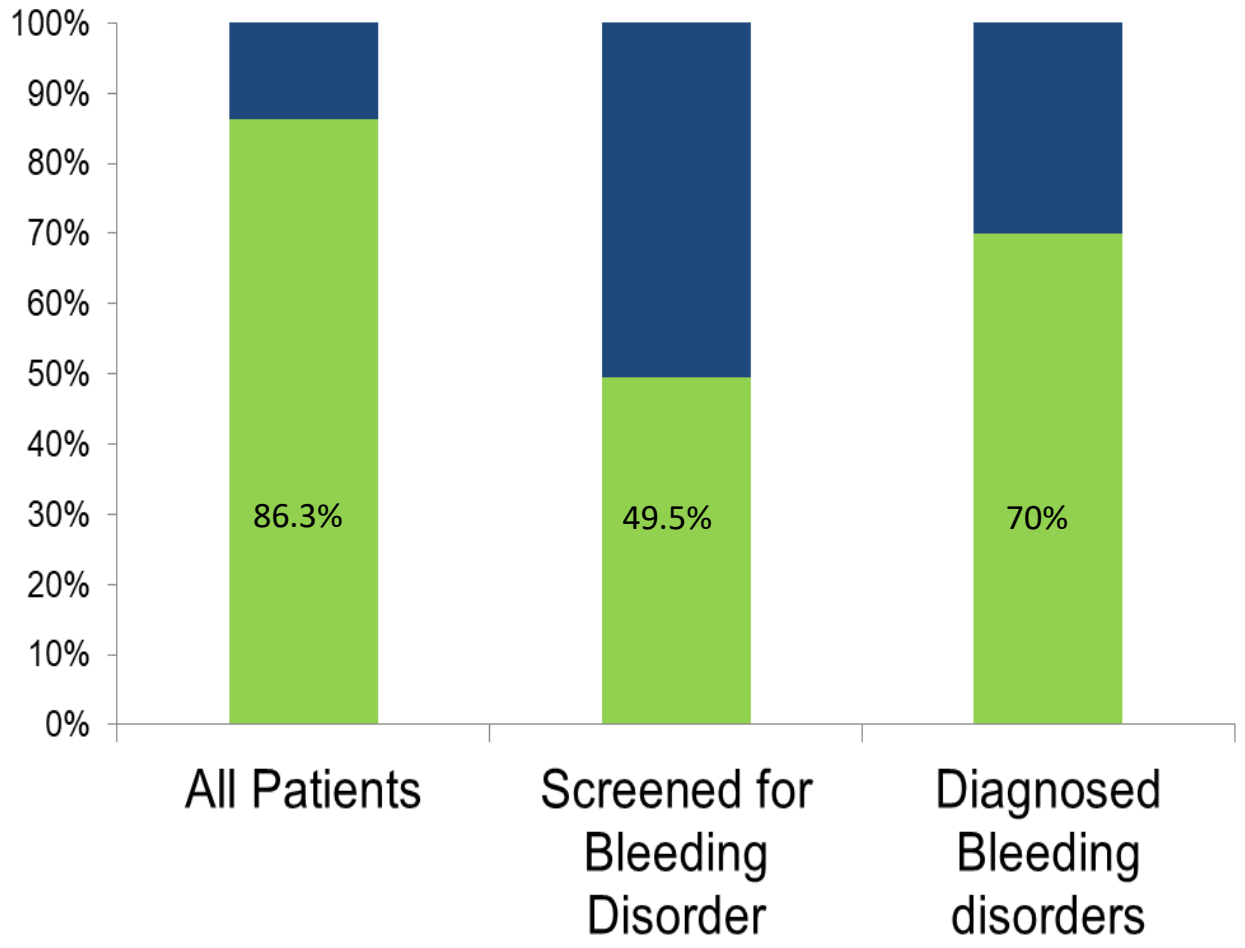
Type of Bleeding Disorder



Number = 27 cases

Journal of Pediatric and Adolescent Gynecology, 2019 Volume 32, Issue 2, 122 - 127

Iron deficiency and/or Anaemia



Management of menses in the adolescent - Goal

- *CYCLICAL & MENSTRUAL REGULATION*
- *CYCLICAL & MENSTRUAL CESSATION*

Alleviate symptoms

Optimise function - improve Quality of Life

What are the expectations - education & counselling

Reassurance

Management Options

IRON / Vit C REPLACEMENT

+

TRANEXAMIC ACID
87% HMB

+

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

Effectiveness of Progesterone only treatment for HMB, painful menses, irregular menses QPAG 2016-2020 N=117 unpublished data RK

Table 1: Summary of patient characteristics at baseline

	Overall (N=117)
Age in years	
Median (Q1, Q3)	13.23(12.34, 13.95)
Age at menarche in years	
Median (Q1, Q3)	11.03 (10.24, 12.00)
Initially presented with HMB	
Yes	110.00 (94.0%)
No	7.00 (6.0%)
Initially presented with Dysmenorrhoea	
Yes	89.00 (76.1%)
No	28.00 (23.9%)
Initially presented with irregular menstrual cycles	
Yes	75.00 (64.1%)
No	42.00 (35.9%)
Initially reported missing school, lethargy, syncope, light headedness, poor mood , reduced confidence,	
Yes	82 (70%)
No	35 (30%)
Previous ED admission for HMB, Dysmenorrhoea or Anaemia	25 (21.4%)
Previous US with GP	64 (54.7%)

Table 2. Results of McNemar's test for improvement in HMB from before to after treatment for oral progesterone, depot and with depot or oral progesterone

		Patients with reduced HMB after treatment (N)	Patients with unimproved HMB after treatment (N)	Total (N)	*p*-value
Oral progesterone	Patients without HMB prior to treatment (N)	4	1	5	<0.001
	Patients with HMB prior to treatment (N)	65 (80%)	16	81	
	Total	69	17	86	
Depot progesterone	Patients without HMB prior to treatment (N)	1	0	1	<0.001
	Patients with HMB prior to treatment (N)	25 (96%)	1	26	
	Total	26	1	27	
depot or oral progesterone.	Patients without HMB prior to treatment (N)	4	1	5	<0.001
	Patients with HMB prior to treatment (N)	84 (91%)	8	92	
	Total	88	9	97	

Table 3. Results of McNemar's test for improvement in dysmenorrhoea from before to after treatment for oral progesterone, depot and with depot or oral progesterone.

		Patients with reduced dysmenorrhoea after treatment (N)	Patients with unimproved dysmenorrhoea after treatment (N)	Total (N)	*p*-value
Oral progesterone	Patients without dysmenorrhoea prior to treatment (N)	21	0	21	<0.001
	Patients with dysmenorrhoea prior to treatment (N)	53 (80%)	13	66	
	Total	74	13	87	
Depot progesterone	Patients without dysmenorrhoea prior to treatment (N)	8	0	8	<0.001
	Patients with dysmenorrhoea prior to treatment (N)	18 (90%)	2	20	
	Total	26	2	28	
depot or oral progesterone.	Patients without dysmenorrhoea prior to treatment (N)	24	0	24	<0.001
	Patients with dysmenorrhoea prior to treatment (N)	67 (90%)	7	74	
	Total	91	7	98	

Original Report

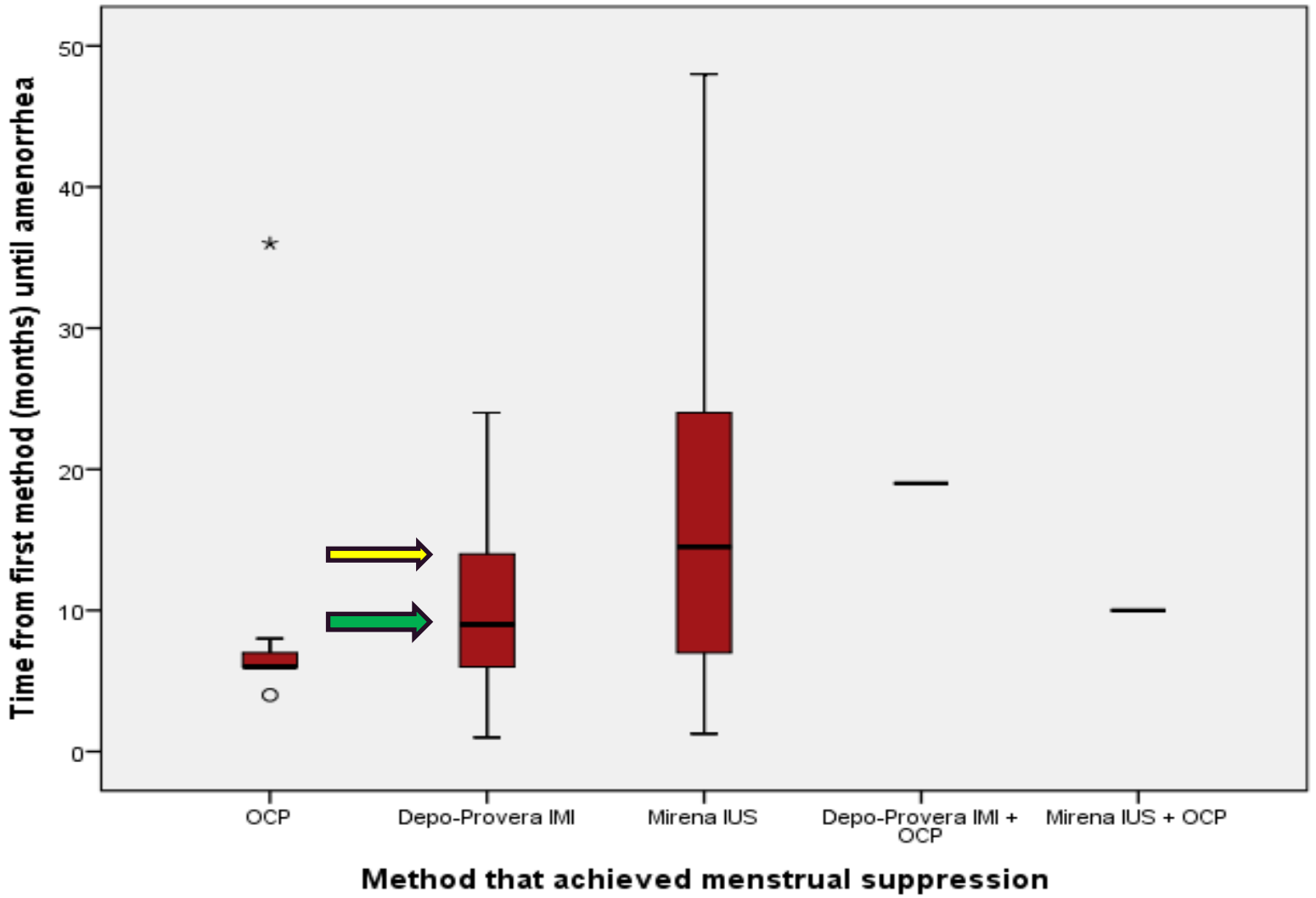
Menstrual Suppression in Pediatric and Adolescent Patients with Disabilities Ranging from Developmental to Acquired Conditions: A Population Study in an Australian Quaternary Pediatric and Adolescent Gynecology Service from January 2005 to December 2015

R. Leeks MBBS, BEd [1,2,*], C. Bartley MBBS, Postgraduate Diploma Obstetrics & Gynaecology, AM [1], B. O'Brien MBBS (Hons), BMEdSc, MRANZCOG [1,3], T. Bagchi MD, FRANZCOG, AMC [1,3], R.M.N. Kimble MBBS, FRANZCOG, GAICD [1,3]

[1] Queensland Paediatric and Adolescent Gynaecology Service, Royal Brisbane and Women's Hospital and Queensland Children's Hospital, Brisbane, Queensland, Australia
[2] Queensland Institute of Medical Research Berghofer, Brisbane, Queensland, Australia
[3] University of Queensland, Faculty of Medicine, Brisbane, Queensland, Australia

Menstrual suppression by 6 months	33.8%
Menstrual suppression by 12 months	55.9%
Mean age within 12 months	13.1years
Mean age >12 months	14.6years

Method that achieved menstrual cessation



Key Messages

- Heavy Menstrual Bleeding and painful menses frequent symptoms in PAG
- Immature Hypothalamic-Pituitary-Ovarian Axis
- Anovulatory cycles the norm
- Physiological Progesterone Deficiency
- Progesterone supplementation
- Counselling -Prevention of Endometriosis for patients/parents/ carers/society









Queensland Statewide Paediatric & Adolescent Gynaecology Services

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The University Of Queensland
AUSTRALIA

International Evidence-based Guideline for the assessment and management of **polycystic ovary syndrome 2023**

Here, we progress evidence-based diagnostic criteria and in adults recommend that this requires two of i) clinical/biochemical hyperandrogenism, ii) ovulatory dysfunction or iii) polycystic ovaries on ultrasound and here add elevated anti-mullerian hormone (AMH) levels. We have included the role of AMH in diagnosis in adults but do not recommend AMH or ultrasound in adolescents, due to overlap with normal reproductive physiology.

International Evidence-based Guideline for the assessment and management of polycystic ovary syndrome 2023
https://www.monash.edu/medicine/mchri/pcos/guideline

1.1		Irregular cycles and ovulatory dysfunction	
1.1.1	CR	Irregular menstrual cycles are defined as: • Normal in the first year post menarche as part of the pubertal transition • > 1 to < 3 years post menarche: < 21 or > 45 days • > 3 years post menarche to perimenopause: < 21 or > 35 days or < 8 cycles per year • > 1 year post menarche > 90 days for any one cycle Primary amenorrhea by age 15 or > 3 years post thelarche (breast development) When irregular menstrual cycles are present a diagnosis of PCOS should be considered and assessed according to these PCOS Guidelines.	❖❖❖❖
1.1.2	PP	The mean age of menarche may differ across populations.	
1.1.3	PP	In adolescents with irregular menstrual cycles, the value and optimal timing of assessment and diagnosis of PCOS should be discussed with the patient and their parent/s or guardian/s, considering diagnostic challenges at this life stage and psychosocial and cultural factors.	
1.1.4	PP	For adolescents who have features of PCOS, but do not meet diagnostic criteria, an 'increased risk' could be considered and reassessment advised at or before full reproductive maturity, 8 years post menarche. This includes those with PCOS features before combined oral contraceptive pill (COCP) commencement, those with persisting features and those with significant weight gain in adolescence.	
1.1.5	PP	Ovulatory dysfunction can still occur with regular cycles and if anovulation needs to be confirmed serum progesterone levels can be measured.	

International Evidence-based Guideline for the assessment and management of polycystic ovary syndrome 2023
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The guideline aims to facilitate timely and appropriate diagnosis for women with PCOS, whilst avoiding over diagnosis, especially in adolescents. Specific recommendations of relevance here include:

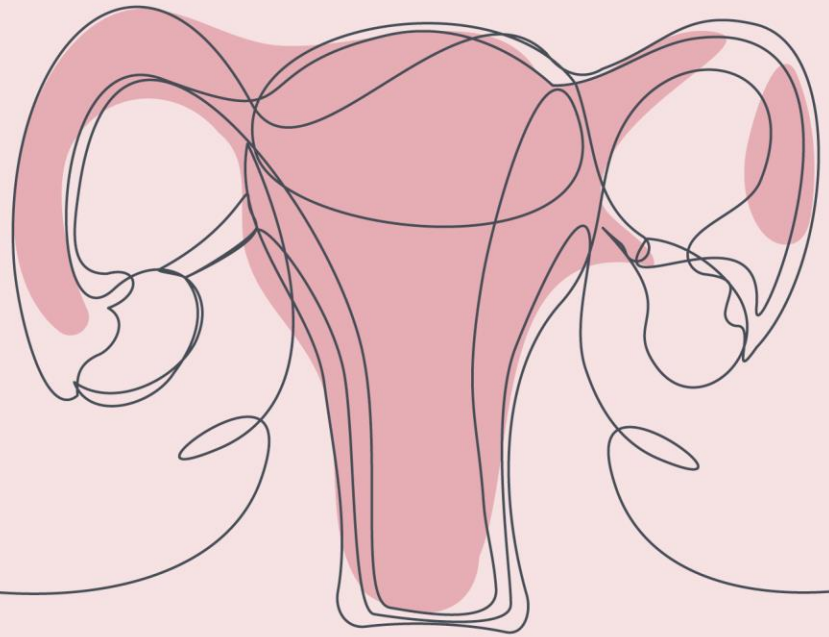
- ultrasound and anti-mullerian (AMH) levels are not recommended in diagnosis in those within 8 years of menarche
- young women 'at risk' can be identified, where diagnosis is unclear, with follow-up reassessment
- diagnostic features are refined, focused on specificity, to improve diagnostic accuracy.

1.4.6	PP	There are no definitive criteria to define polycystic ovary morphology (PCOM) on ultrasound in adolescents, hence it is not recommended in adolescents.	
1.3.3	CR	A comprehensive history and physical examination should be completed for symptoms and signs of clinical hyperandrogenism, including acne, female pattern hair loss and hirsutism in adults, and severe acne and hirsutism in adolescents.	❖❖❖❖
1.2.8	PP	In most adolescents, androgen levels reach adult ranges at 12-15 years of age.	
1.5.4	EBR	Serum AMH should not yet be used in adolescents.	❖❖❖❖ ⊕⊕⊕○

International Evidence-based Guideline for the assessment and management of polycystic ovary syndrome 2023
https://www.monash.edu/medicine/mchri/pcos/guideline

Metro North **GP Alignment Program**

Gynaecology Workshop



Endometriosis

Dr David Baartz | Senior Staff Specialist | Clinical Lead Gynaecology | RBWH
Director Queensland Trophoblastic Centre
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phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Endometriosis

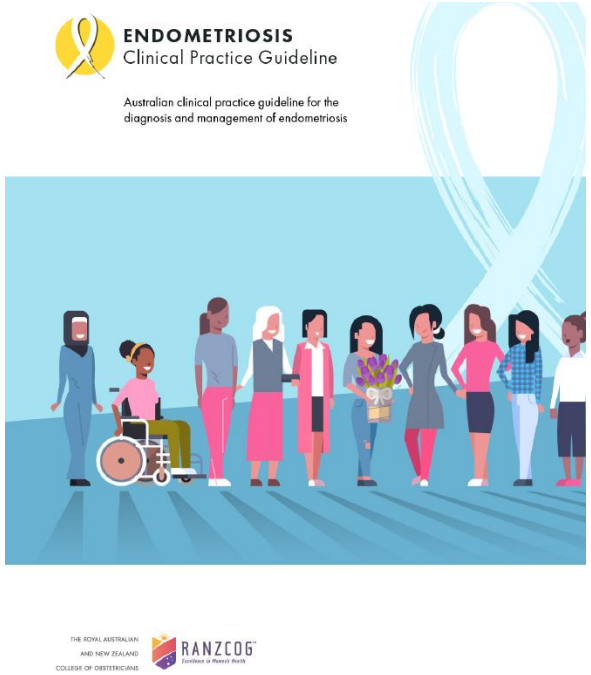
Clinical guidelines and Practical advice

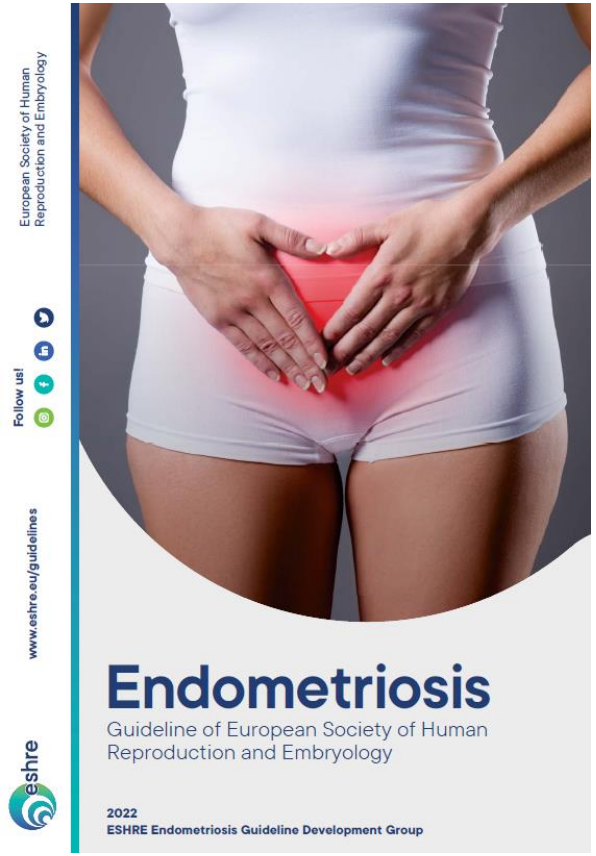
Dr Keisuke Tanaka / David Baartz

Metro North Health | Queensland Government

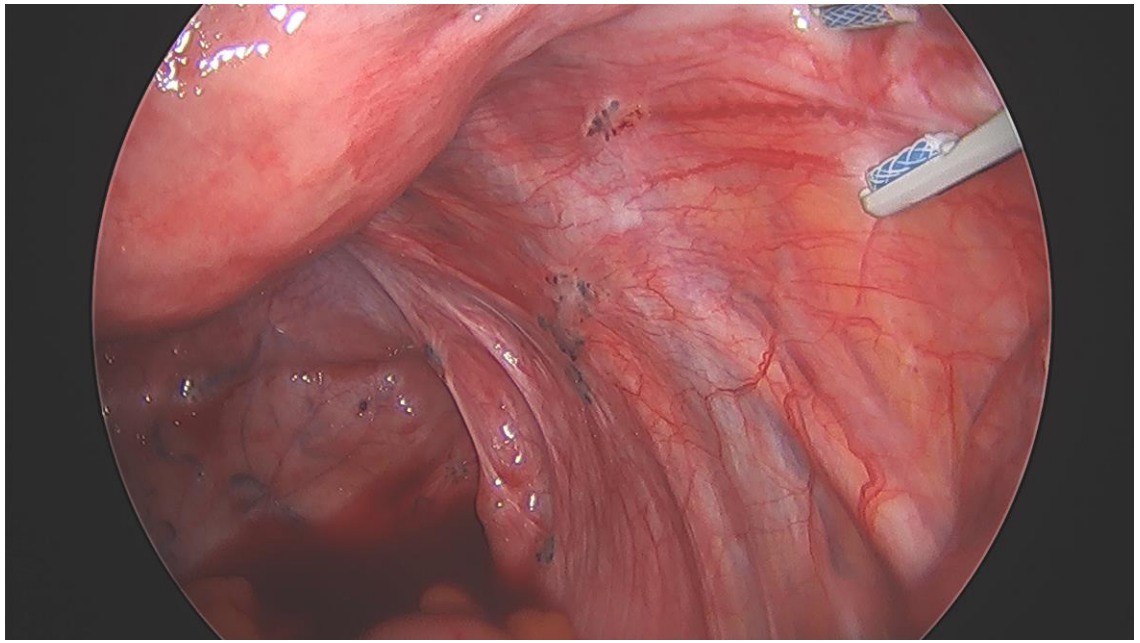
Clinical questions

- **When do we suspect endometriosis?**
- **Should / how do we perform examination?**
- **What investigations do we organise?**
- **How do we manage initially?**
- **When do we refer to gynaecology?**
- **What may happen at hospital**
- **What do we do with patients who have been discharged?**





Pelvic pain vs Endometriosis



Definition: a disease in which tissue similar to the lining of the uterus grows outside the uterus

When do we suspect endometriosis?

Signs and symptoms

PPP

Dysmenorrhoea

Dyspareunia

Dyschezia

Dysuria

Infertility

Suspect endometriosis in people (including those aged 17 years and under) presenting with 1 or more of the following:

- persistent pelvic pain
- period-related pain (dysmenorrhoea) affecting daily activities and quality of life
- deep pain during or after sexual intercourse
- period-related or cyclical gastrointestinal symptoms, in particular, painful bowel movements
- period-related or cyclical urinary symptoms, in particular, blood in the urine or pain passing urine
- infertility in association with 1 or more of the above.

Should / how do we perform examination?

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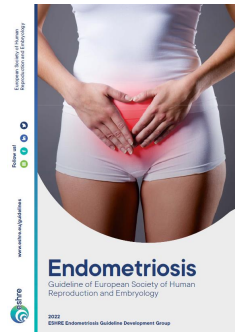
Offer / Consider examination

Offer an abdominal and pelvic examination to people with suspected endometriosis to identify abdominal masses and pelvic signs, such as reduced organ mobility and enlargement, tender nodularity in the posterior vaginal fornix, and visible vaginal endometriotic lesions.

If a pelvic examination is not appropriate in people with suspected endometriosis, offer an abdominal examination to exclude abdominal masses.

Recommendations (2-3)

Clinical examination, including vaginal examination where appropriate, should be considered to identify deep nodules or endometriomas in patients with suspected endometriosis, although the diagnostic accuracy is low.	⊕◯◯◯
In women with suspected endometriosis, further diagnostic steps, including imaging, should be considered even if the clinical examination is normal.	⊕⊕◯◯



What investigations do we organise?

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Imaging

Consider transvaginal ultrasound:

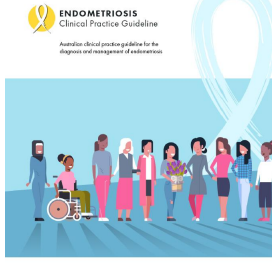
- to investigate suspected endometriosis even if the pelvic and/or abdominal examination is normal.
- to identify endometriomas.

Do not use pelvic MRI as the primary investigation to diagnose endometriosis in people with symptoms or signs suggestive of endometriosis.

Consider pelvic MRI to assess the extent of deep endometriosis involving the bowel, bladder or ureter.

Do not use CT scanning as the primary investigation to diagnose endometriosis in people with symptoms or signs suggestive of endometriosis.

CT scanning may be used to assess the extent of deep endometriosis involving the bowel, bladder, or ureter if MRI is not accessible.

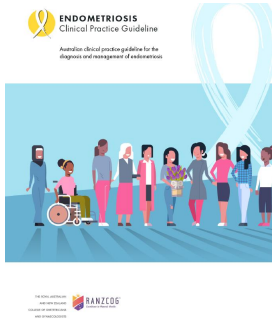


Do not use serum CA125

Do not use serum CA125 to diagnose endometriosis.

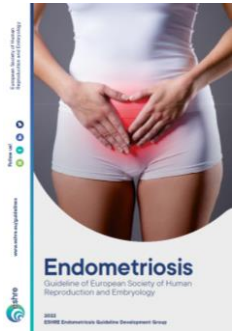
If a coincidentally reported serum CA125 level is available, be aware that:

- a raised serum CA125 (that is, 35 IU/ml or more) may be consistent with having endometriosis
- endometriosis may be present despite a normal serum CA125 (less than 35 IU/ml).



Recommendation (4)

Clinicians should not use measurement of biomarkers in endometrial tissue, blood, menstrual or uterine fluids to diagnose endometriosis.	⊕⊕⊕○



How do we manage initially?

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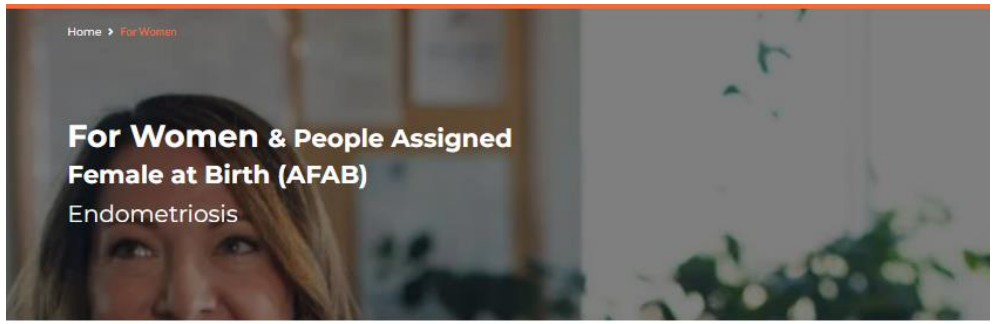
Information and support

Provide comprehensive and ongoing information and support to people with suspected or confirmed endometriosis, to promote their active participation in care and self-management. For example, provide information on:

- what endometriosis is
- endometriosis signs and symptoms
- how endometriosis is diagnosed
- treatment options including care, follow-up, anticipated waiting times and out-of-pocket expenses
- national and local support groups or networks, and resources (hard copy and online).

Pelvic Pain Foundation

Pelvic Pain Foundation
OF AUSTRALIA



Pain Articles

- Period Pain
- Endometriosis
- Stabbing Pain
- Irritable Bowel
- Understanding Long Term (Chronic) Pelvic Pain
- Painful Sex
- Migraine
- Pelvic Pain During Pregnancy
- Pelvic Pain After Pregnancy
- Pregnancy Related Pelvic Girdle Pain (PRPGP)
- Laparoscopy
- Tips and Tricks to Recovering Well From a Laparoscopy

Resources

- Introduction to Pelvic Pain Booklet
- Chronic Pelvic Pain Video
- Easy Stretches to Relax the Pelvis
- Find a Health Professional
- Questions for your Health Provider

Non-surgical management

- **Analgesics**
- **Anti-neuropathic medications**
- **Hormonal medical treatments**
- **Non-pharmacological and non-surgical managements**

Analgesics: NSAID +/- Paracetamol

For people with pain associated with endometriosis-, consider a short trial (for example, 3 months) of a non-steroidal anti-inflammatory drug (NSAID) alone or in combination with paracetamol, if not contraindicated. If such a trial does not provide adequate pain relief, consider other forms of pain management and referral for further assessment.

Anti-neuropathic medications

Advise people that there is no evidence for or against the use of anti-neuropathic medications for pain associated with endometriosis.

People with endometriosis should be referred to a pain specialist and/or a condition-specific specialist at any stage if:

- pain is severe and unresponsive to simple analgesics.
- the pain substantially limits daily activities.
- any underlying health condition has deteriorated.

Hormonal medical treatments

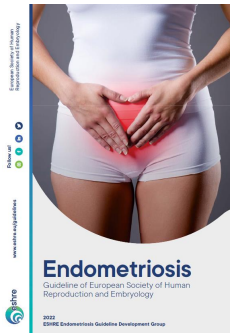
Explain to people with suspected or confirmed endometriosis that hormonal treatment for endometriosis can reduce pain and has no permanent negative effect on subsequent fertility (other than delaying the time to fertility, which may be important, depending on the person's age).

Offer hormonal treatment (for example, the combined oral contraceptive pill or a progestogen as an oral form, a subcutaneous implant or intrauterine device [IUD] form[14]) to people with suspected, confirmed, or recurrent endometriosis. The choice of hormonal treatment should be in a shared decision-making approach, recognising that no hormonal treatment has been demonstrated to be superior.

Hormonal medical treatments

Recommendations (11-12)

It is recommended to offer women hormone treatment (combined hormonal contraceptives, progestogens, GnRH agonists or GnRH antagonists) as one of the options to reduce endometriosis-associated pain.	⊕⊕⊕◯
The GDG recommends that clinicians take a shared decision-making approach and take individual preferences, side effects, individual efficacy, costs, and availability into consideration when choosing hormone treatments for endometriosis-associated pain.	GPP

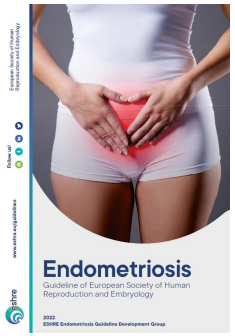


OCP – continuous vs cyclic

Women suffering from endometriosis-associated dysmenorrhea can be offered the continuous use of a combined hormonal contraceptive pill.	⊕⊕◯◯

Efficacy

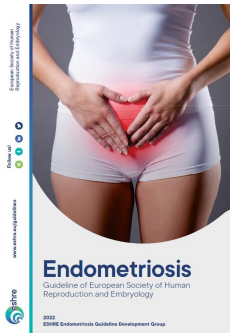
A systematic review and meta-analysis by Muzii and colleagues compared continuous versus cyclic OCP use for the treatment of endometriosis-associated pain and reported that the continuous regimen appears to be more efficacious with regards to dysmenorrhea recurrence (RR 0.24; 95%CI 0.06-0.91) (Muzii, *et al.*, 2016). Nonsignificant differences between continuous and cyclic OCP use were reported for chronic pelvic pain and dyspareunia, and a trend toward lower cyst recurrence rates for a continuous OCP (RR 0.54; 95%CI 0.28 to 1.05).



GnRH agonists – second line

Recommendations (18-20)

It is recommended to prescribe women GnRH agonists to reduce endometriosis-associated pain, although evidence is limited regarding dosage or duration of treatment.	⊕⊕◯◯
The GDG recommends that GnRH agonists are prescribed as second line (for example if hormonal contraceptives or progestogens have been ineffective) due to their side-effect profile.	GPP
Clinicians should consider prescribing combined hormonal add-back therapy alongside GnRH agonist therapy to prevent bone loss and hypoestrogenic symptoms.	⊕⊕⊕◯



Non-pharmacological and non-surgical managements

- behavioural/psychological medicine – includes cognitive behavioural therapy, relaxation techniques, pain management programs, pain management physiotherapy, pain management psychology, expert patient program, hypnosis, psychosexual therapy and biofeedback
- lifestyle medicine – includes exercise (e.g. yoga, Pilates and tai chi), meditation, mindfulness and dietary therapies (e.g. gluten free, dairy free, vegetarian and FODMAP diet)
- physical methods – includes acupuncture, transcutaneous electrical nerve stimulation (TENS), manual and physical therapy, massage (e.g. shiatsu), osteopathy, chiropractic treatment and reflexology
- other – includes dietary supplements, herbal medicine (e.g. Chinese herbal medicine), naturopathy, homeopathic therapy, ayurvedic therapies and aromatherapy.

Rationale - Non-pharmacological and non-surgical managements

Advise people that there is no evidence to support the use of Chinese herbal medicines or supplements for treating endometriosis, and that there are concerns relating to potential harms associated with their use.
Advise people that there is limited evidence on the effectiveness of acupuncture for the management of endometriosis pain.

- “The RANZCOG Endometriosis Expert Working Group discussed that people with pain associated with endometriosis should not be discouraged from trying alternative treatment options, but should be cautioned about particular diets and herbal medicines because of uncertainty about interactions and concerns regarding side effects and lack of supporting evidence.”

Hormonal medical treatments

What can I do about period pain?
Could I have endometriosis?

Simple things first

Period pain medications work best when they are taken before the pain gets bad, so keep some with you all the time and take them regularly during periods. The commonly used medications include ibuprofen 200mg, naproxen 275mg, or diclofenac 25mg. Take two straight away then one, three times a day with food. All these medications can cause stomach irritation.

The Contraceptive Pill is often helpful. Ask your doctor for a pill with more progestogen than estrogen for the best effect. Many women skip periods on the pill because fewer periods means less pain. To do this, you need to be on a pill where all the hormone tablets are the same colour. Plan a period only every 3-4 months or preferably not at all. Ask your doctor or pharmacist how to do this. If pills don't suit your mood, try one called Qlaira.

A Mirena ® intrauterine device (IUCD) is currently the most effective treatment for pain from the uterus and lasts 3-5 years, when used for pain. It slowly releases a progestogen medication to the uterus that makes periods lighter and less painful. It is also a useful contraceptive. Remember that it is common to have irregular bleeding and crampy pains for the first few months, but these problems usually settle.

If you have not had children, or have a tender pelvis you can ask to have it inserted under an anaesthetic if you wish. The best time is just after a period, sometimes at the same time as a laparoscopy.

Complementary therapies that can help include acupuncture, Vitex Agnus Castus (1000mg daily) and magnesium (100-200mg every 2 hours at period time for 2 days only).

If simple treatments for period pain don't help, you may have endometriosis. This is where tissue like the lining of the uterus grows in places outside the uterus around the pelvis. Most endometriosis can't be seen on an ultrasound.

When simple things don't help

Laparoscopy. A laparoscopy is an operation where a doctor puts a telescope through a small cut in your umbilicus (belly button) to look inside your pelvis. He or she can then:

- Diagnose if endometriosis is present
- Remove the endometriosis if possible

There are different types of surgery available to treat endometriosis. Sometimes the endometriosis is *excised* which means cut out and sometimes it is *cauterised* (diathermied) which means burnt.

Some laparoscopies for endometriosis are fairly short and straight forward, while others take longer and are more difficult. It depends on where the endometriosis is and how severe it is.

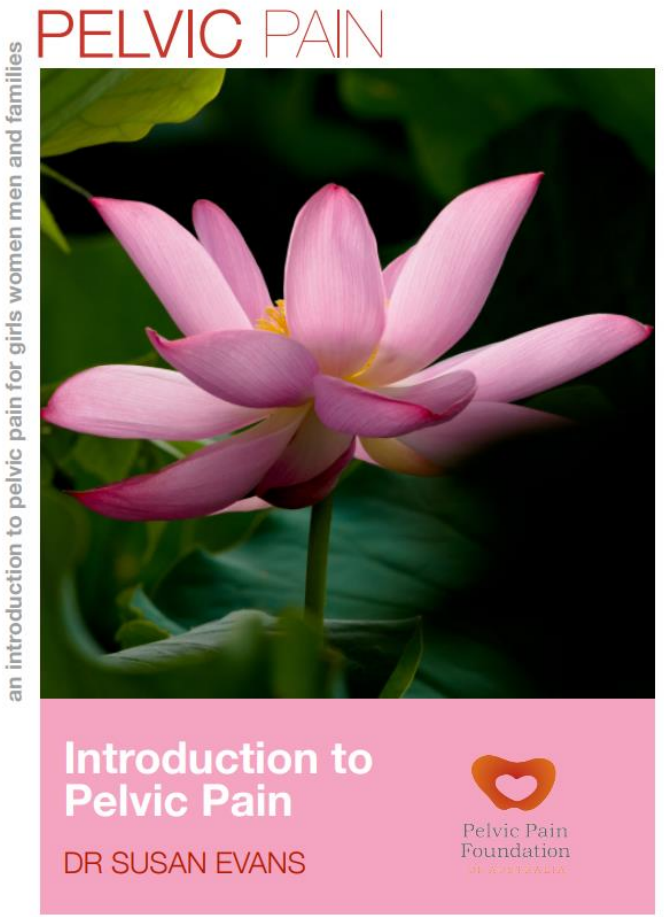
We know that the amount of endometriosis found at a laparoscopy doesn't fit with the amount of pain, and some women have pain but no endometriosis. So, you may have a little bit of endometriosis and a lot of pain, or a lot of endometriosis and very little pain.

Things to remember about laparoscopy

After surgery, avoiding periods will reduce your pain even further, and reduce the chance that new areas of endometriosis will develop.

You will recover from surgery quicker by keeping moving and going for a gentle walk every day.

Some women have too many laparoscopies. They, or their doctor, think that surgery should be able to treat all types of pain. This isn't correct. Even if you have endometriosis, it is common for pain from the bladder, bowel, pelvic muscles or nerve pathways to be present too. They might even be your worst pain, but can't be seen at a laparoscopy. This booklet has lots of ideas on how to manage pain without surgery, and how to use a range of different treatments, as well as surgery, to get the best outcomes for your pain.



Pelvic Pain Foundation OF AUSTRALIA

When do we refer to gynaecology?

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Referral to secondary care

Recommendation

Consider referring people with suspected or confirmed endometriosis to a gynaecologist if:

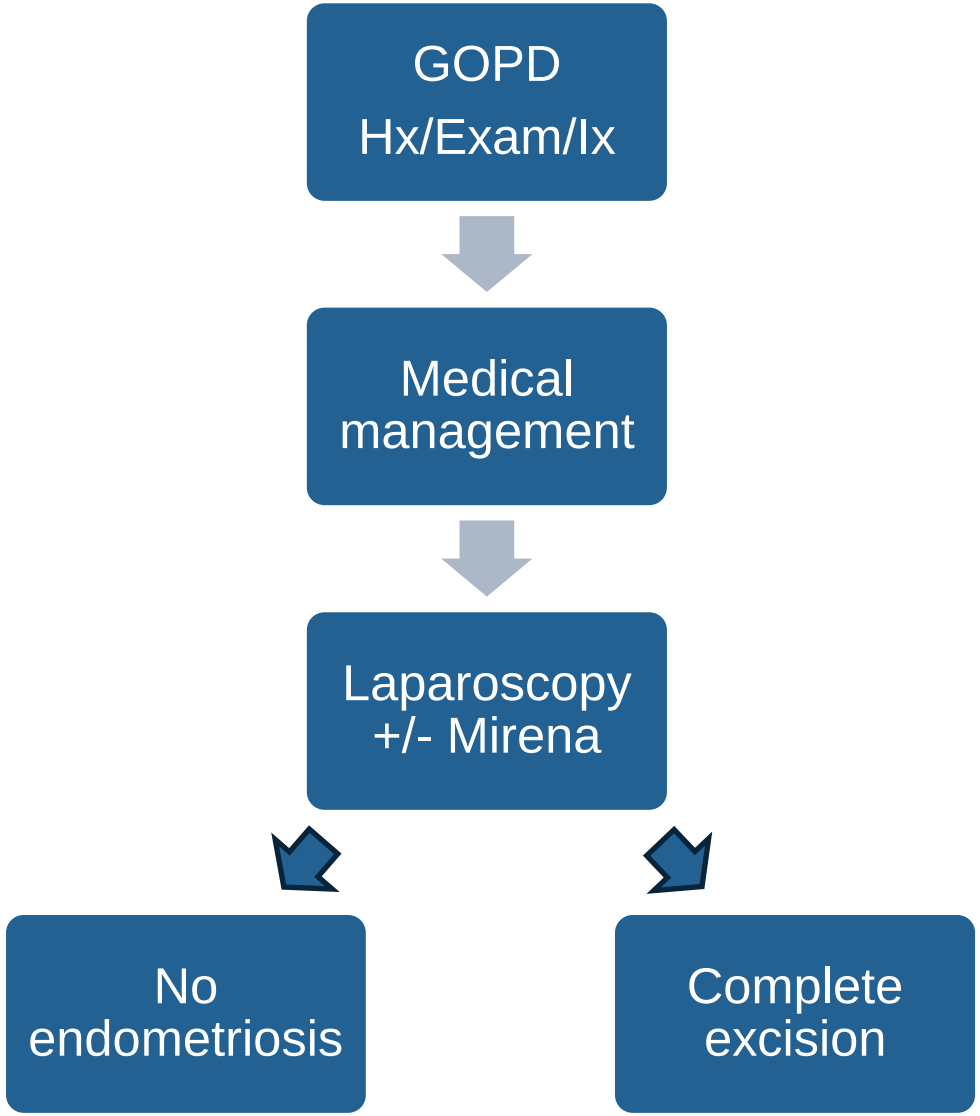
- ultrasound or imaging are suggestive of a higher stage or deeply infiltrating disease (e.g. endometrioma, adenomyosis, or disease invading other organs)
- they have severe, persistent or recurrent symptoms of endometriosis
- they have signs of endometriosis on examination
- initial management is not effective, not tolerated, or contraindicated.

What may happen at hospital

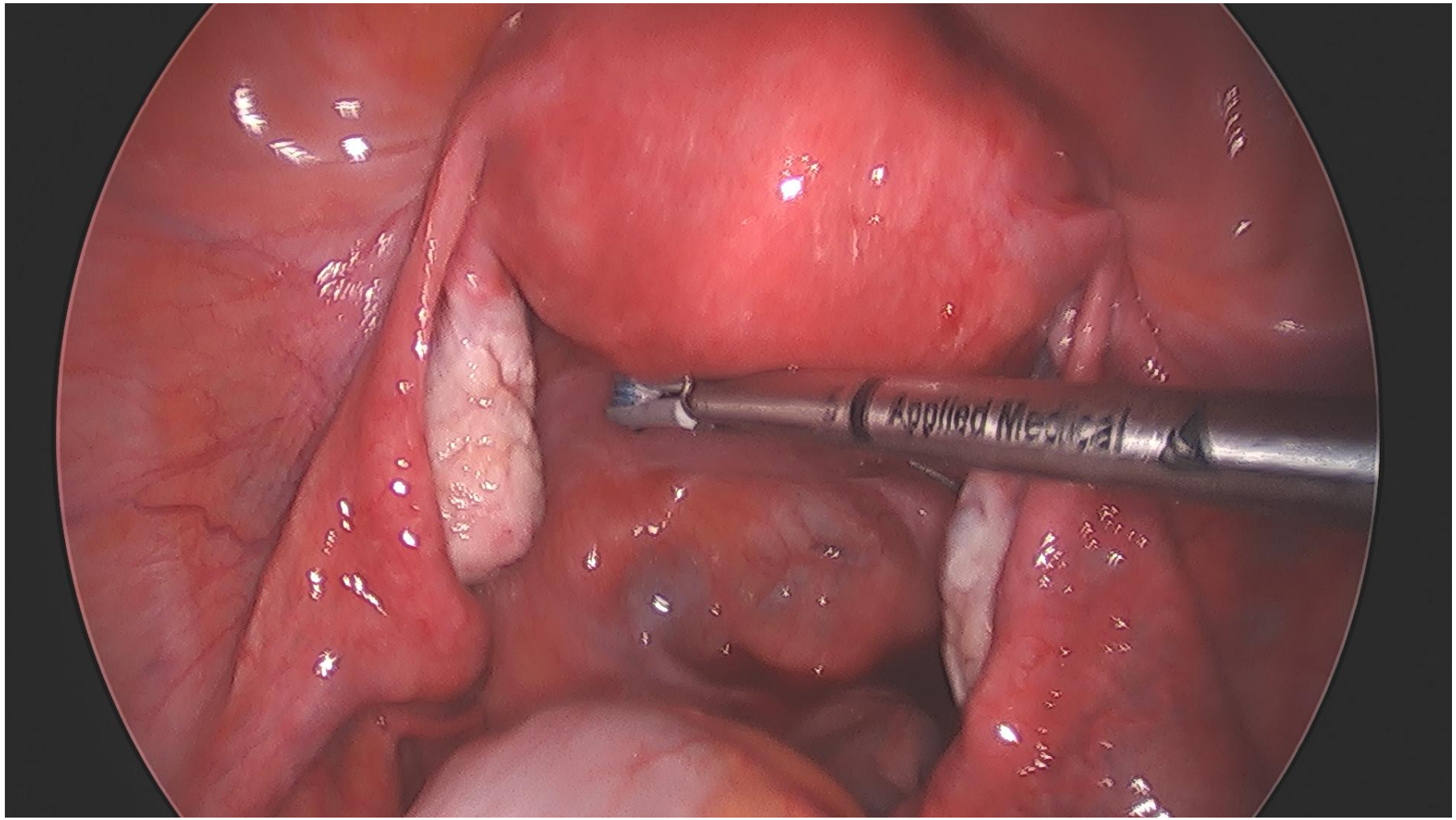
Metro North Health

Queensland Government

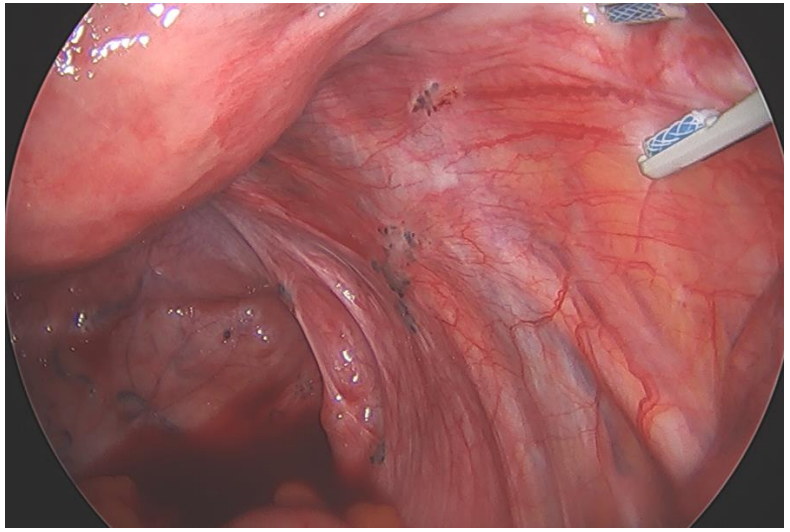
Typical examples



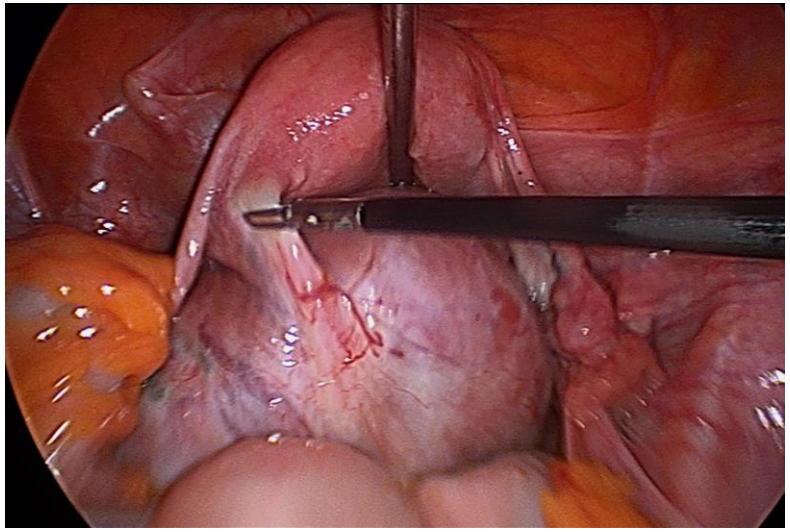
Diagnostic laparoscopy



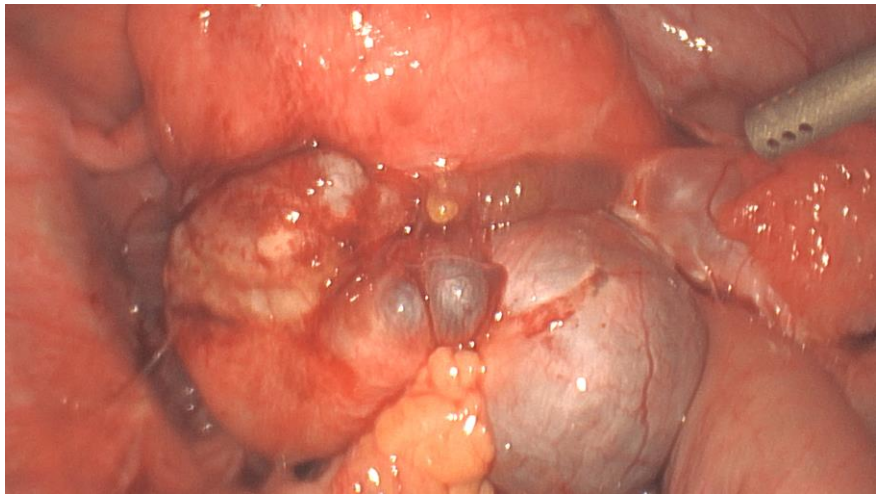
Endometriosis – 3 phenotypes



Superficial peritoneal endometriosis



Ovarian endometrioma



DIE: Deeply infiltrating endometriosis

76

Endometriosis – Stages

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
REVISED CLASSIFICATION OF ENDOMETRIOSIS

Patient's Name _____ Date _____

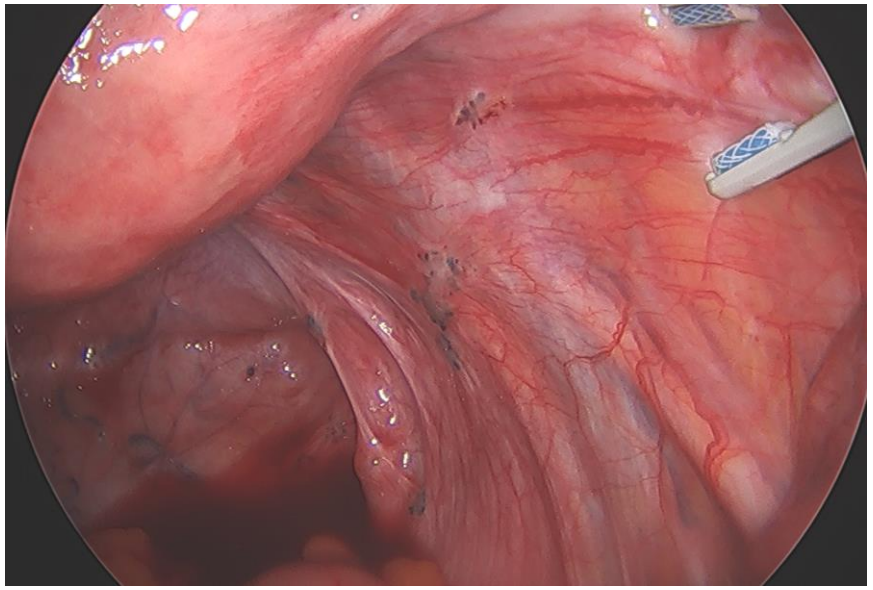
Stage I (Minimal) - 1-5
Stage II (Mild) - 6-15
Stage III (Moderate) - 16-40
Stage IV (Severe) - >40
Total _____

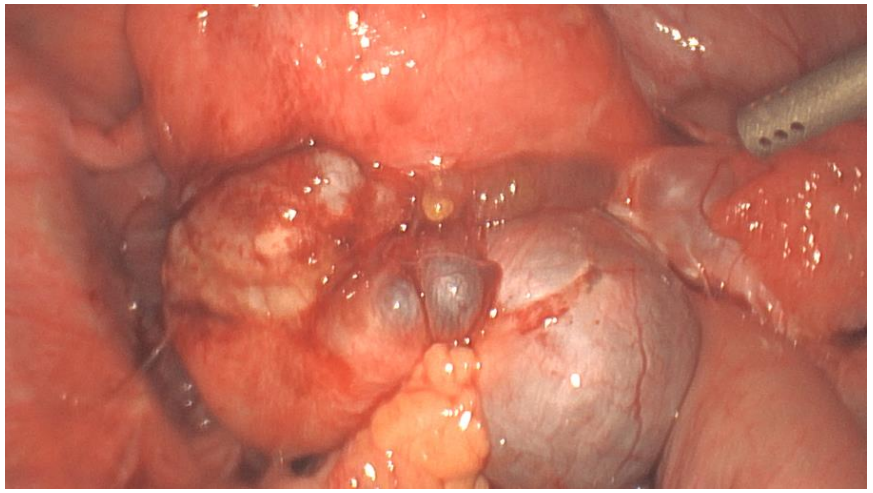
Laparoscopy _____ Laparotomy _____ Photography _____
Recommended Treatment _____
_____
Prognosis _____

PERITONEUM	ENDOMETRIOSIS	<1cm	1-3cm	>3cm
	Superficial	1	2	4
	Deep	2	4	6
OVARY	R Superficial	1	2	4
	Deep	4	16	20
	L Superficial	1	2	4
	Deep	4	16	20
	POSTERIOR CULDESAC OBLITERATION	Partial	Complete	
		4	40	
OVARY	ADHESIONS	<1/3 Enclosure	1/3-2/3 Enclosure	>2/3 Enclosure
	R Filmy	1	2	4
	Dense	4	8	16
	L Filmy	1	2	4
	Dense	4	8	16
TUBE	R Filmy	1	2	4
	Dense	4*	8*	16
	L Filmy	1	2	4
	Dense	4*	8*	16

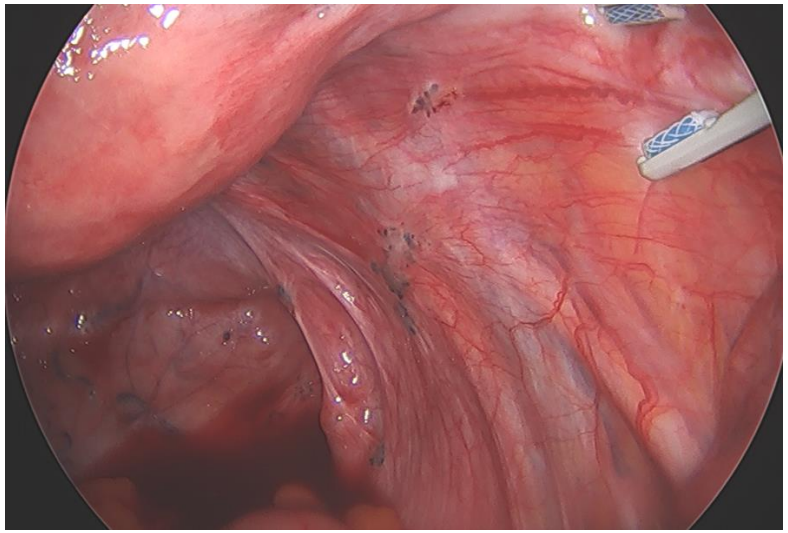
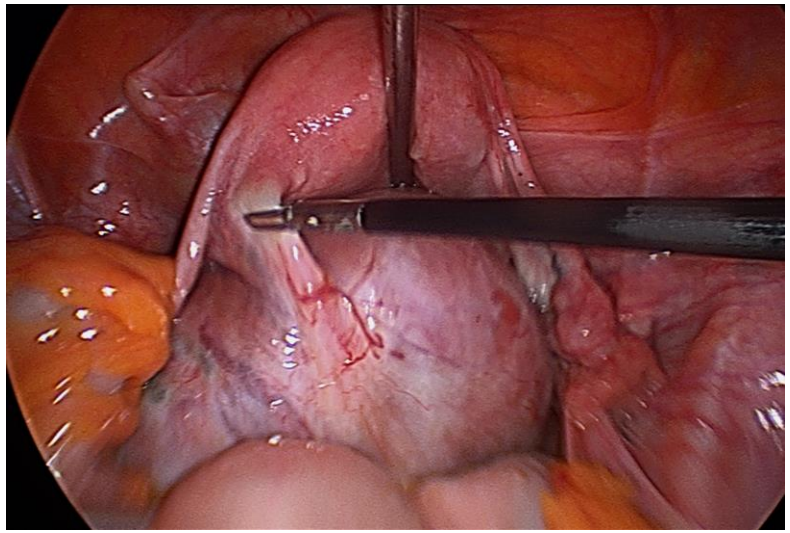
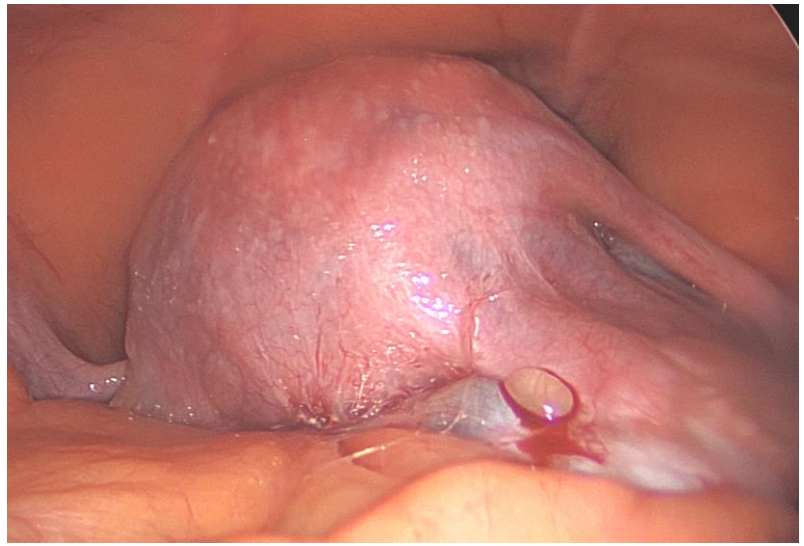
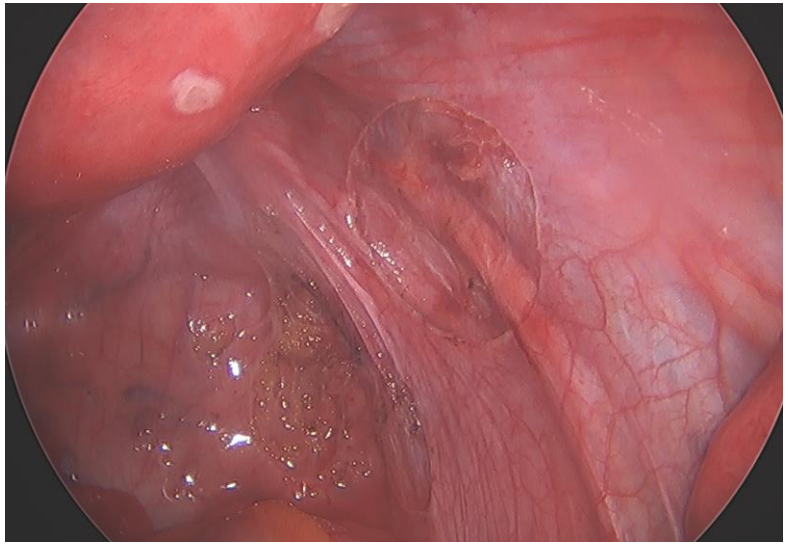
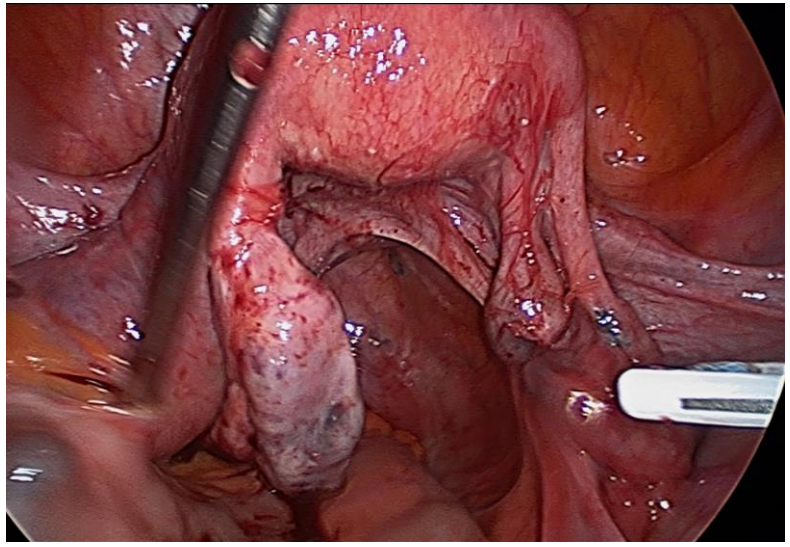
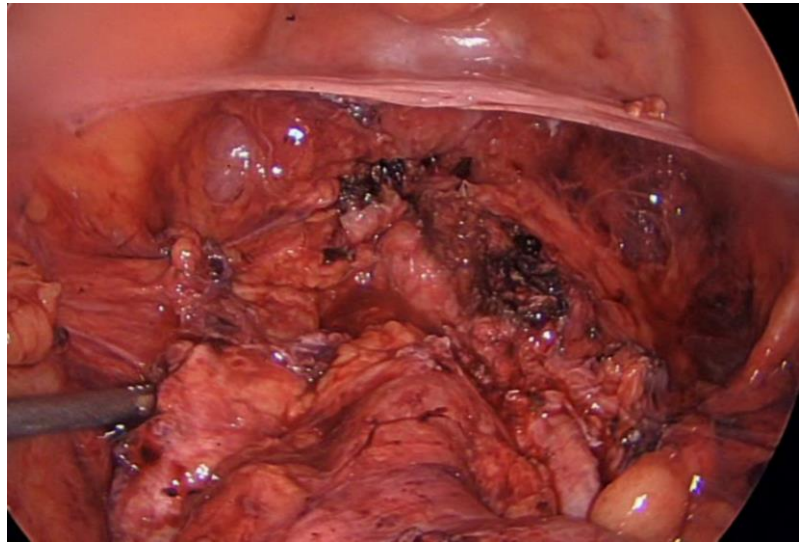
*If the fimbriated end of the fallopian tube is completely enclosed, change the point assignment to 16.

Denote appearance of superficial implant types as red [(R), red, red-pink, flamelike, vesicular blobs, clear vesicles], white [(W), opacifications, peritoneal defects, yellow-brown], or black [(B) black, hemosiderin deposits, blue]. Denote percent of total described as R___%, W___% and B___%. Total should equal 100%.





Surgical treatment

Combination of surgery and hormonal treatment

After laparoscopic excision or ablation of endometriosis, consider hormonal treatment, to prolong the benefits of surgery and manage symptoms. Clinical judgement and patient preference are factors that may influence the particular hormonal therapy chosen.

What do we do with patients who have been discharged?

Metro North Health

Queensland Government

- **Start fresh – history / examination / investigation**
- **Previous treatments and their outcomes**
- **Laparoscopy**
- **Did they have endometriosis?**
- **Was it all treated?**
- **Did symptoms improve after the surgery?**
- **Urinary or bowel symptoms?**
- **Family completed?**

Irritable bowel

An irritated bowel or bloating
An Irritable or Sensitive Bowel

An irritable or sensitive bowel is a good example of a pain you can't see. The bowel looks normal at a laparoscopy or ultrasound, but certainly doesn't feel normal.

Women feel bowel pain low in their abdomen, in the same place that they feel period pain, pelvic muscle pain, ovary pain, bladder pain and endometriosis pain, so it's easy for all these pains to get confused.

The most typical feature of bowel pain is that the pain gets better after a bowel action has been passed, and there are usually other bowel symptoms too, such as diarrhoea, constipation or bloating.

Bloating

Doctors often think of bloating as an inconvenience rather than a major problem. This is because bloating rarely means a serious illness. The trouble is that bloating makes women feel unattractive and uncomfortable. It also makes any other pelvic pain worse. Luckily, there is lots you can do to help.

Before you do anything about bloating, you should see your doctor. Sometimes women feel bloated because they have an ovarian cyst. Your doctor can check this for you.

If this check is normal, then think about what type of bloating you have.

The first type of bloating is where the abdomen swells up and your stomach *looks* big. Women often feel like this near period time, but it is also aggravated by certain foods. These foods are described further below.

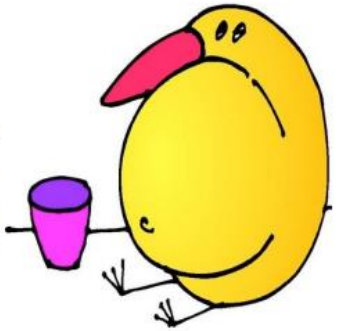
Cutting down on these foods often makes a big difference to pain.

The second type of bloating is a *feeling* of being bloated, when you look normal. This is often due to a change in the way nerves work causing abnormal sensations such as bloating, and sensitivity to touch. You may find your clothes uncomfortable or dislike anyone touching your abdomen.

This type of problem is described more on page 17, but other useful treatments include:

- Peppermint oil capsules taken 3-4 times daily or peppermint tea
- Iberogast liquid 20 drops from a chemist, drunk in warm water as tea 2-3 times daily

Many women with pelvic pain have a mix of both types of bloating.



Remember to tell your doctor if you have:

- bleeding from the bowel
- undigested food in your bowel action
- bowel incontinence, or
- unexplained weight loss.

What can I do about bowel pain?
Sometimes it's my worst problem

Which foods might be a problem?

Some of the foods most likely to cause problems are a special group of carbohydrates, sometimes called FODMAP foods. Common FODMAP foods include lactose, wheat products (bread, pasta, pizza etc), onions, corn syrup, apples, and artificial sweeteners, but there are many others.

Most people absorb these foods quite quickly in their 'small bowel' (small intestine). This means that very little of those foods reaches the 'large bowel' further down.

Some people absorb these foods slowly, which means that more of these foods reaches the large bowel undigested. In the large bowel, the food is fermented by bacteria to form gas and other substances that irritate the bowel and cause pain, diarrhoea and bloating. A small amount of these foods may be no problem at all, but a larger amount can cause lots of pain. If they also have a sensitive bowel, which many women with pelvic pain do, then they will really suffer.

This means that while your friends may be able to eat any food and feel fine, your bowel will be painful unless you are careful.

Should I go 'gluten-free'?

A gluten free diet is a special diet for people with Coeliac Disease. Women with coeliac disease need to be on a strict 'gluten free' diet for the rest of their life.

Women with an irritable bowel often feel much better on a 'gluten free' diet, because by cutting out gluten they are also cutting out wheat, a major FODMAP food. They do not have a problem with gluten and may be able to tolerate small amounts of wheat.

Before you change your diet, ask your doctor for a blood test that checks for coeliac disease. This test isn't reliable if you have already cut out wheat from your diet, so it's much easier to get it done first.

Are there other problem foods?

Yes, definitely, but everyone is different. You might have a problem with rich or fatty foods (cream, takeaway, animal fats), alcohol, coffee, fizzy drinks, and spicy food.

A low fat, low salt, high fibre diet is good for everyone, but even more important if you have bowel problems.

If you find it all too hard to work out, a dietitian may be able to help.

Constipation

We have been brought up to think that it's important to have a bowel action every day. Actually, it's OK to have a bowel action every couple of days or so, as long as it is soft and easy to pass when it happens.

It is easiest to open your bowels when the bowel motion is soft and your bowel is contracting strongly enough to pass it easily.

You can make the bowel action softer by:

- Drinking enough water
- Increasing the fibre in your diet
- Taking a fibre supplement such as Sterculia (normafibe ®). This supplement is useful as it causes less wind than most other supplements

You can increase bowel contractions by:

- Regular exercise, brisk walk every day
- Allowing *unhurried* time to go to the toilet after breakfast in the morning
- Avoiding medications such as codeine
- A herbal treatment such as slippery elm

But my constipation is severe

Some women have severe constipation, even when they do everything right. It is very unfair. They feel bloated and uncomfortable most of the time. If so, it is time to talk to your doctor, or maybe a gastroenterologist (bowel physician).

Painful bladder syndrome

Bladder troubles
Why am I always in the bathroom?

You may know all about **cystitis**. If so, you probably mean bacterial cystitis, which is the medical word for a bladder infection (urine infection). The word 'cystitis' really only means an irritated bladder. It does not say what caused the irritation.

Women with pelvic pain often have another type of bladder irritation called either **Interstitial cystitis** (IC) or **Painful Bladder Syndrome** (PBS). This type of cystitis is different from a urine infection. There is irritation of the bladder wall but no infection. It is another pain you can't see at a laparoscopy.

If you have endometriosis, bladder troubles and pain on most days, then it is quite possible that you have PBS. Sometimes it is the bladder which causes most of the pain.

The Evil Twins:

Endometriosis and Interstitial Cystitis are so commonly found together, they are sometimes called the 'Evil Twins'

Dr Maurice Chung

What problems does painful bladder syndrome cause?

The common symptoms include:

- **Frequency.** (Needing to go to the toilet a lot)
- **Nocturia.** (Needing to get up to the toilet at night)
- **Urgency.** (Needing to rush to the toilet and finding it difficult to 'hold on')
- **Pain.** Which gets worse as the bladder fills, and improves once the bladder empties
- **Pain with intercourse.** Especially in positions that put pressure on the front wall of the vagina (near the bladder)

Many women with a painful bladder describe having 'frequent urine infections'. Sometimes there *is* a bladder infection, but often it is a flare up of their painful bladder that feels like a urine infection. If urine is sent to a laboratory, it often shows some blood, but no infection.

Simple things first

A urine test with your doctor to check for infection or other problems is a good idea. They can also check for a chlamydia infection if a sexual infection is possible.

Make sure you are drinking enough (but not too much) fluid each day. For most women, this will be around one and a half, to two litres of mostly water daily. If you drink a lot more than this, that may be part of the problem.

If you still have problems, think about whether any of the foods or drinks on the next page trigger your bladder problems. Use the 'bladder first aid' treatment if your pain flares up, and try a bladder medication such as amitriptyline from your doctor.

What can I do about my bladder troubles?
Sometimes they are the worst pain

Dietary changes.

There are many foods that can make bladder pain worse, but most women only have problems with some of these foods. They include:

- **Foods high in acid** such as citrus fruit, cranberries, vitamin C, some herbal or green teas or tomatoes. A plain mint/ chamomile tea or just water is best
- **Foods that stimulate nerves** such as caffeine, chocolate or cola drinks
- **Foods high in sodium or potassium** such as bananas
- **Artificial Sweeteners** including aspartamine etc
- **Fizzy drinks** (including mineral water)

Diet cola drinks are probably the worst as they contain acid, caffeine and artificial sweeteners. Cigarettes can also affect the bladder.

If you eat these foods, remember how you feel afterwards. If you feel worse, this may be a trigger food for you. You may also find trigger foods of your own.

Medications

There are several different medications for a painful bladder, but you may need to try a few different ones to find the right one for you:

- ***Low dose amitriptyline*** from your doctor. This is a good first choice as it helps frequency, urgency, pain and the number of times you pass urine at night. It can also sleep, bloating and headaches. A dose starting at 5mg *taken around 3 hours before bed* and increasing slowly to between 5 and 25mg daily suits around half the women who try it. Sleepiness in the mornings usually wears off in a week or so, but start with a small dose.
- **Mirabegron (betmiga®)** 25 or 50mg taken once a day is particularly useful for those with a painful bladder who find amitriptyline causes side effects. It won't help other pains or headaches.
- **Tolterodine** 1-2mg daily, or **oxybutinin** 5-15mg daily - or as a skin patch.

Bladder First Aid

If there are times when your pain or urgency comes on suddenly, you may be able to help it quickly by:

- Drinking 500ml of water mixed with
  - 1 teaspoon of bicarbonate of soda, or
  - a sachet of Ural ® or Citravescent ®.
- Then drinking 250ml water every 20 min for the next few hours
- If no better, have a urine test for infection. Only take antibiotics if an infection is found.

Remember that if your bladder problems continue, you should discuss this with your doctor.

It is common for women with painful bladder syndrome to also have painful pelvic muscles.

Australian Government
Department of Health and Aged Care

Home Topics Our work Resources

Home › Our work

Endometriosis and pelvic pain clinics

We are establishing endometriosis and pelvic pain clinics across Australia to provide more appropriate and timelier endometriosis care and management. This will lead to reduced diagnosis timeframes and better pain management for those suffering from endometriosis and pelvic pain.

On this page

Qld	MATSICHS (Institute for Urban Indigenous Health Ltd)	Morayfield, QLD
Qld	Benowa Super Clinic	Benowa, QLD
Qld	Family Planning Queensland	Cairns, QLD
Qld	Neighbourhood Medical	Bardon, QLD

Queensland Government

Contact us Newsroom Eve

Royal Brisbane and Women's Hospital
Metro North Health

Healthcare services Patients & visitors Health professionals Research Careers Abo

Home / Healthcare Services / Tess Cramond Pain and Research Centre

Tess Cramond Pain and Research Centre

Our service has relocated to a new facility – the Surgical, Treatment and Rehabilitation Service (STARS) located at 296 Herston Rd, Herston – and is co-located with other specialist outpatient services.

The Tess Cramond Pain and Research Centre provides an assessment and management service for people with chronic pain and cancer pain.

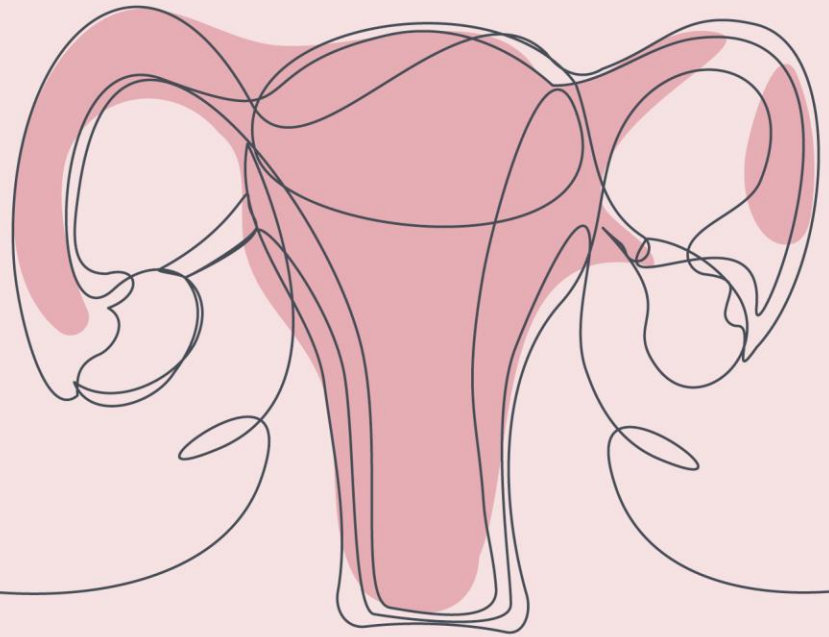
Our services

We offer the following services to help you manage persistent pain:

- A specialised outpatient clinic.
- Individualised physiotherapy, psychology and occupational therapy assessment.
- Pain interventions.
- Pain education and pain management programs.
- An inpatient consultation service.
- Consultative service to referring medical practitioners.

Metro North **GP Alignment Program**

Gynaecology Workshop



Commonwealth Endometriosis & Pelvic Pain Clinics

Dr Louisa Gilles | Neighbourhood Medical Bardon
Dr Halina Clare & Dr Caroline Harvey | IUIH

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Endometriosis and Persistent Pelvic Pain (EPP) Clinics in Primary Care

Dr Louisa Gilles
BSC MBBS FRANZCOG FRACGP
E: pelvicpain@neighbourhoodmedical.com.au

Endometriosis & Pelvic Pain Clinic

AT NEIGHBOURHOOD MEDICAL, BRISBANE

Scope of presentation

- EPP clinics – how they came about
- Our clinic model
- What we've learnt
- How to refer to us

EPP Clinics – what are they?

- 22/23 Commonwealth government- **$16.4m** over **4 years** for Endometriosis and Pelvic Pain Clinics in primary care settings
- $700k per clinic over 3 years
- Pilot program
- 4 clinics in Qld (varied contexts)
- PHN partnered – administer funding, collect data
- for women/ AFAB only
- medicare + grant funding can’t be billed together

EPP Clinic– Our model of care:

- 3 experienced women's health GPs -2 sessions dedicated to EPP clinic per week – (within our Women and Children's focused GP clinic)
- Pelvic pain nurse navigator 0.4 FTE – grant funded
- Capacity: 6 NPs per week + follow ups
- Allied Health team – offsite but connected

Eligibility Criteria

- Previous dx of endo with pain not adequately Mx OR possible symptoms of endo not fully Ix
- OR persistent pelvic pain>5days/month not fully Ix or not adequately managed by a team including a GP, Physio and other specialists/allied health
- Must be current Qld resident
- (telehealth for rural and remote)

Exclusion Criteria

- Endo/PPP well managed or already have a care team and seeking GP care only (can see our GPs outside of EPP clinic)
- Period pain 1-2 days only easily managed with medication, not impacting school, work, ADLs
- Known or suspected endo seeking laparoscopy only and don't want a holistic approach
- Fertility concerns without pain (we have no access to expediated surgery)
- Current pregnancy

Clinic Services & Structure

Step 1: To Connect

- **self-referral form** or **send a referral directly via MO** to Neighbourhood Medical Pelvic Pain Clinic
- can phone reception for information
- Our team contacts patients - *no online booking*
- Waiting time 2 months for nurse appt then 2 months to see GP
- Eligibility and safety criteria -

https://www.neighbourhoodpelvicpain.com.au/

Clinic Services & Structure

Step 2: Understand

- **To feel heard and be understood is the most important thing for patients**
- 45 min tele/video appointment with our pelvic pain nurse navigator (experienced practice RN, chronic disease/ trauma informed background)
- No out-of-pocket fee - grant funded
- Detailed history – outline the journey so far, key concerns, questionnaires, DASS21
- Screen for trauma history, red flags, gather information, provide education and resources

GP Consult

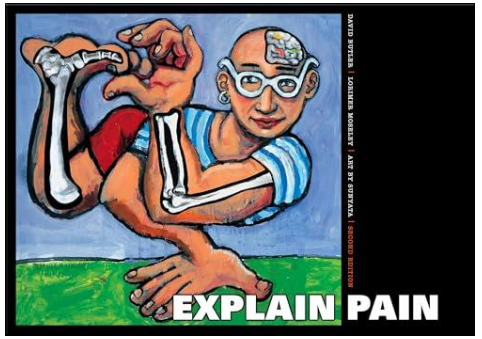
Step 3: Educate & Empower

- GP appointment (45 -60 mins) – FTF or TH – 60 min appt - $310 ($112.10 oope, BB for <18 or CC)
- patients don't have to prove their pain
- build a shared understanding and explanation
- make a plan

GP Consult

- **Pain science framework** to explain pain, its sources, and possible drivers within a whole person context
- **3 top concepts: pain is real, pain as a danger signal, neuroplasticity**
- **Non-pharmacological Mx:** Physio, movement, psychological approaches, stress reduction, dietary, TENS machine, sleep
- **Optimise pharmacological Mx:** cycle suppression, flare management (non-opioid), neuromodulators
- Written resources for patient: “Team and Toolkit”, folder

of resources



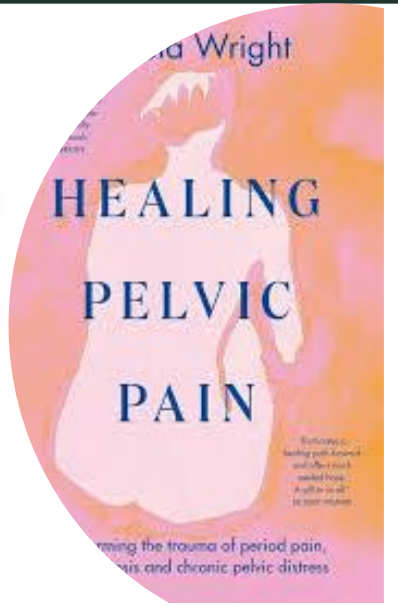
Clinic Structure & Services

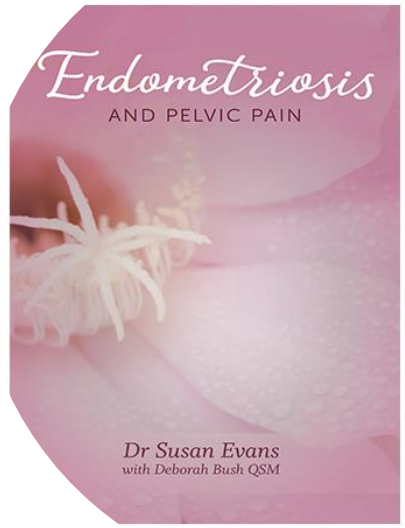
Step 4: Build the team

- Allied Health – funded individual sessions
- Group Programs - funded
- Additional referrals (non-funded)
- Communication with usual GP
- MDT meetings – education and case discussion.

Additionally funded

- TENS provided to financially vulnerable patients
- Education –AProf. Susan Evans “Endometriosis and Pelvic Pain” book and Dr Peta Wright “Healing Pelvic Pain”
- Fully grant funded IUD insertions and check ups





What have we learnt ?

- **Rewarding work**, making tangible differences to qol, ”easier” to deliver care with grant funded scaffolding
- **Community demand** exists for comprehensive EPP care
- **Resources required**–GP doesn’t need to do it all (need non FFS funding)
- **Team approach** benefits patient
- trauma history, central sensitization and non-endo contributors to pain common– **biopsychosocial approach** needed
- **Pain science** education helps so much

Grant funding allows:

- TIME with patients
- Less OOPE to patient
- Training for staff
- Funding for allied health and additional services
- Improved collaboration with community and tertiary care services
- Resources for the patient

How to help?

- Determine if fit eligibility criteria
- Investigate red flag symptoms: PCB, IMB, PR bleeding
- Mental health support and GPMP (chronic pelvic pain is an eligible criteria)
- Trial treatment options
- Referral (including investigations) or direct patients to self refer

We welcome connection and collaboration!

- E: pelvicpain@neighbourhoodmedical.com.au

- Website – neighbourhoodpelvicpain.com.au

Endometriosis and Pelvic Pain- A model of care for First Nations Women

Dr Halina Clare, Clinical Director MATSICHS

Dr Caroline Harvey, Senior GP Sexual & Reproductive Health, IUIH

Keighley Pascua, Research Assistant IUIH

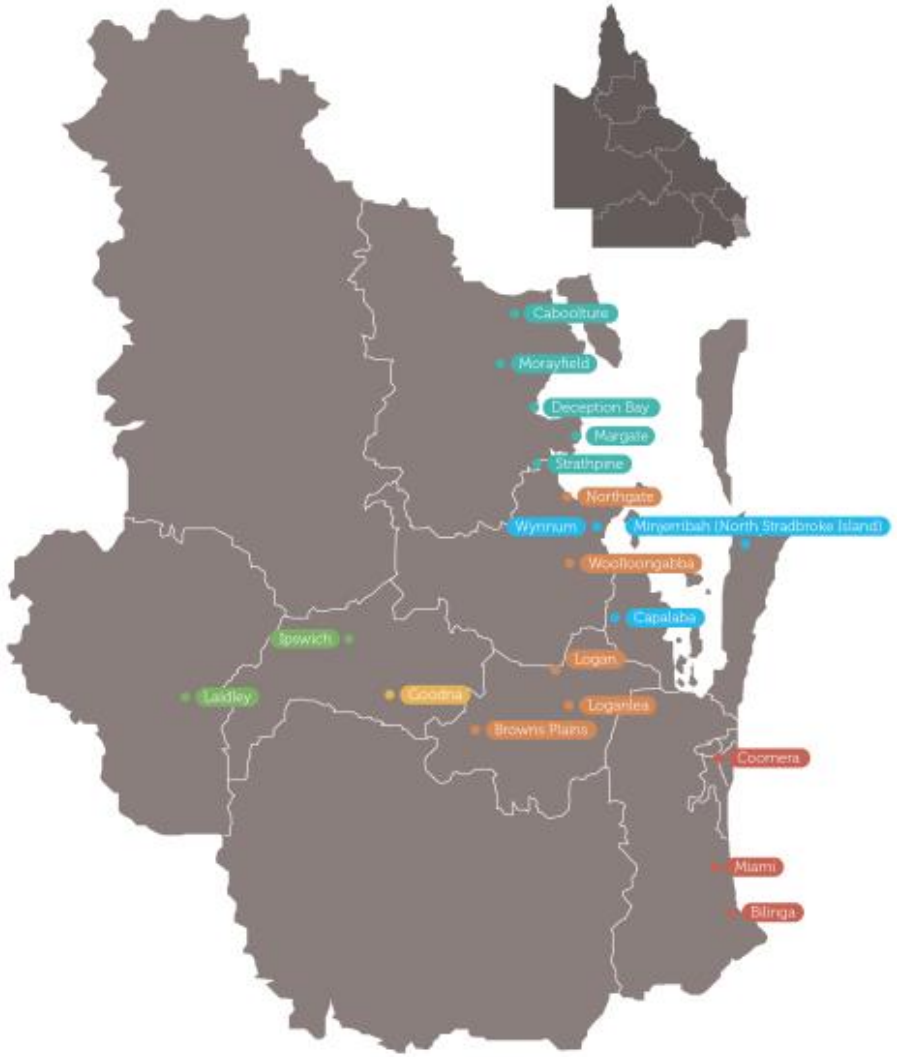
Moreton ATSICHS

Acknowledgement

We would like to acknowledge the Traditional Owners of the lands in which we are meeting across today, the Turrbul and Yuggera Peoples.

We acknowledge the wisdom of Elders past, present and emerging and recognise the positive contribution of First Nations people to the health and wellbeing of our communities through cultural heritage, values and beliefs.

Moreton ATSICHS



IUIH Network

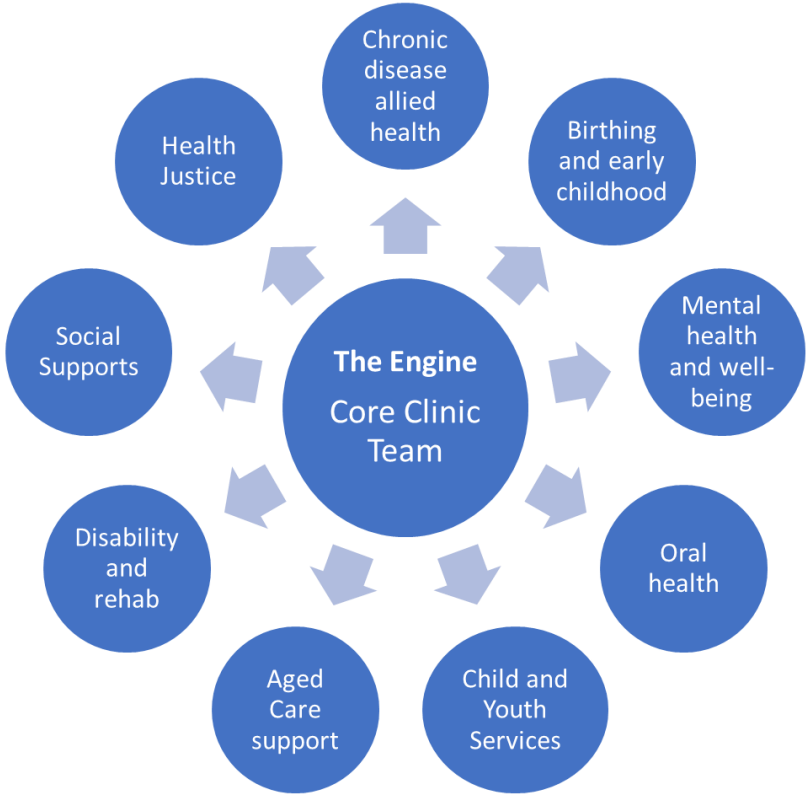
- The Institute for Urban Indigenous Health (IUIH) was ***established in 2009 by its four founding member ACCHS*** (Aboriginal Community Controlled Health Services) to collectively strive towards our vision of strong and health Aboriginal and Torres Strait Islander children, families and communities

- Our footprint is the urban South East Queensland region – home to around ***115,000 Aboriginal and Torres Strait Islander people, nearly 12% of Australia's Indigenous population***

Moreton ATSICHS

IUIH System of Care

- “One stop shop” – create a safe environment, address key service access barriers, and bring as many services and supports under one roof as possible
- Focus on the Cycle of Care – from screening and prevention to chronic disease management and follow up the PHC Clinic facilitates access to the broader system of care that clients and families need to be strong and healthy
- MobLink- Where care is needed outside the health “home”, connector functions in place to secure access- (transport, care coordinators, digital systems, shared service models, other)



Designing an EndoPP Program by Mob for Mob

- Working Group for collaborative yarns to gather knowledge and develop a model of care
- Rapid Literature review to inform the model
- Progressive roll out
- Responsive to feedback
- Community of Practice and yarns with partners

IUIH/ MATSICHS- Existing services

- Womens Health GP- MTOP provision, Implanon and IUS
- Community Liaison Officer, Womens Health Physio, Pharmacist, OT, Exercise Physiologist, Psychologist, Dietitian
- Senior GP Sexual and Reproductive Healthcare
- In our Hands- Cervical Screening Program
- Birthing In Our Community (BIOC)
- Social Health and Family Wellbeing
- Deadly Choices School Program
- Cultural Integrity Lead
- Research team
- Womens Business Shared Gynaecology Pathway with Metro-North

A Rapid Literature review- to Inform planning and development of a First Nations Endometriosis and Pelvic Pain Pathway

1) Aboriginal and Torres Strait Islander patients with endometriosis may express pain differently to non-Indigenous patients *(e.g., lack of expression, non-verbal)*

2) Aboriginal and Torres Strait Islander people face significant barriers in communicating pain to health professionals

3) Indigenous women from Australia, New Zealand and Canada have low menstrual health literacy, similar to that of young non-Indigenous people

Findings- Broader Context

4) Significant impact on quality of life (QOL) and psychosocial health

5) Significant amount of stigma

6) The journey of care is mentally, physically and financially intensive

7) Health professionals also experienced barriers in providing care

8) Current management plans are ineffective in managing endometriosis- short term, fail to remove financial barriers or provide integrated care

9) Self-management strategies should be carefully utilised based on current evidence, patient's needs and in conjunction with care from health providers- 89% of women with endometriosis engage in self-management

11) Websites and online resources have the potential to improve health literacy, health-seeking behaviour and engagement in self-management among women with endometriosis

12) Screening tools offer a lower cost diagnostic pathway for endometriosis but require cultural adaptations

Model of Care- Endo PP

To ensure Aboriginal and/or Torres Strait Islander people born female, between puberty and menopause can access culturally appropriate care and management for persistent pelvic pain.

Endo PP Feedback

- *‘It’s a great program. The Women’s Health Physio, it’s the first time I have had anything like that. Previously it has been swept under the carpet and I just had to deal with it’*
- *‘I like the holistic approach. It’s a positive different approach to endometriosis’*
- *It was a positive experience, it changed my quality of life. It has validated the way I was feeling’*
- *‘It’s been a great experience, has been realty great and friendly. I am feeling positive’ ‘I felt thoroughly listened too’.*
- *‘Before starting the program I wanted a hysterectomy, now I see things a different way, being active made a huge change’*

Future Work

- Yarns with clients and community led by a UQ Masters Student to:
  - Review existing client facing resources
  - Reflect and improve the pathway
  - Develop a group based/ peer support program
- Research Opportunities building on the Rapid Literature Review.

How to refer

Please send a referral letter detailing relevant history including medications trialled, surgery and investigations to date, Past Medical History, current medications, and allergies via **Medical Objects - IUIH VISITING (VI45100009P) or HealthLink EDI: endomppc**

Clients will be contacted once a completed referral form with client consent is received.

For further information please contact the

Pelvic Pain and Endometriosis Management Program

0461 378 348 | EndoPPC@iuih.org.au

Moreton ATSICHS

phn BRISBANE NORTH

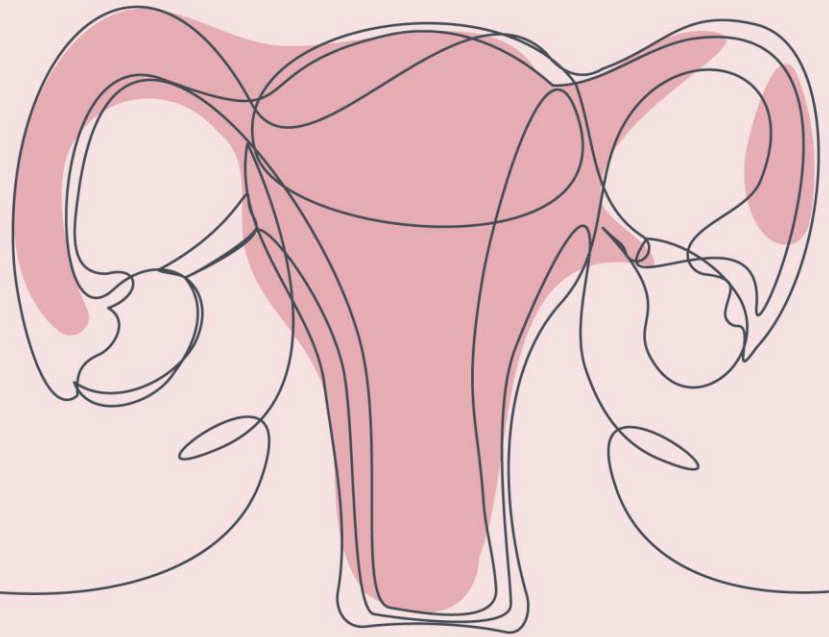
An Australian Government Initiative

women's business

Moreton ATSICHS

Metro North **GP Alignment Program**

Gynaecology Workshop



Termination of Pregnancy

Dr Angela Smith| GPwSI Gynaecology | RBWH

Stacey West| Nurse Navigator | Metro North Termination of Pregnancy

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Nurse Navigator Termination of Pregnancy MNHHS

(RBWH, Caboolture & Redcliffe)

Referral Requirements

Mandatory requirement

USS Report
(Confirming live IUP – FHR)

Reside within Metro North Catchment

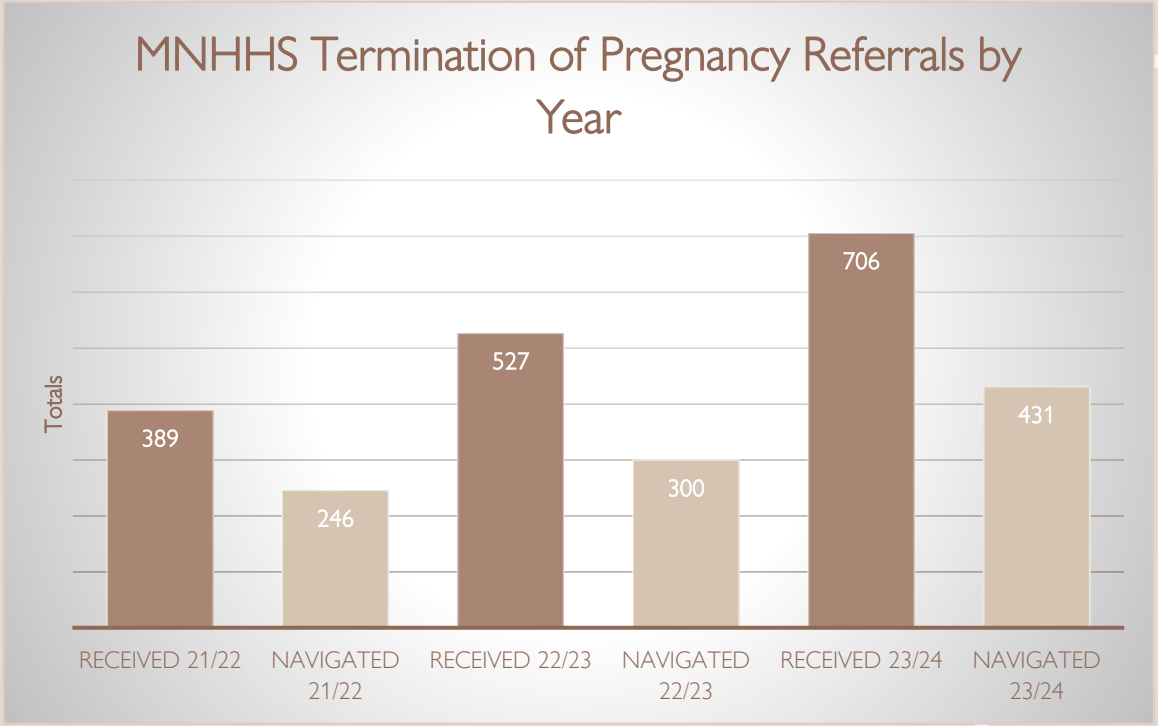
(Please discuss referrals from outside of catchment with Nurse Navigator.)

Desirable

Blood group
STI Screen
Antenatal Screen

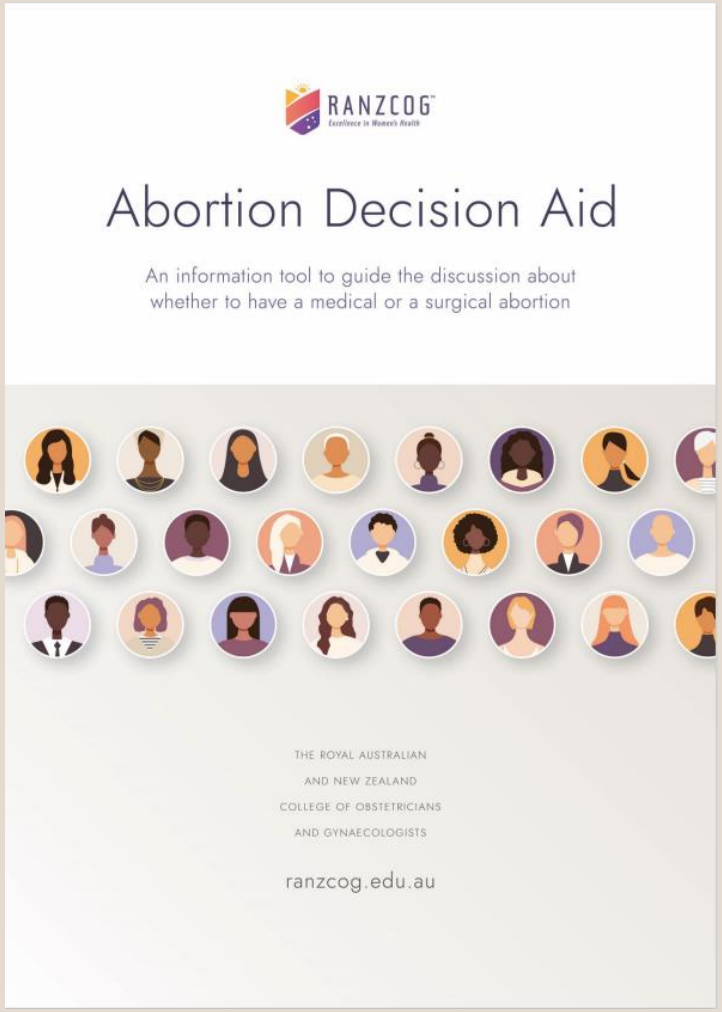
Metro North Hospital & Health Service

- Provides women with a choice of
  - Surgical Termination of pregnancy (SToP)
    - RBWH 18 wks
    - Caboolture 16 wks
    - Redcliffe 12 wks
  - Medical Termination of pregnancy (MToP)
    - All gestations.
    - From 22+1 wks gestation 2 Obs / Gyn Dr's required to sign off.
    - Feticide performed from 22+1 wks gestation
    - Legal requirement of birth registration and burial or cremation required from 20 wks gestation or if signs of life at birth or weighing > 400 gms..
  - Please note MNHHS offers MToP after 9 weeks gestation. This process is undertaken as an inpatient.

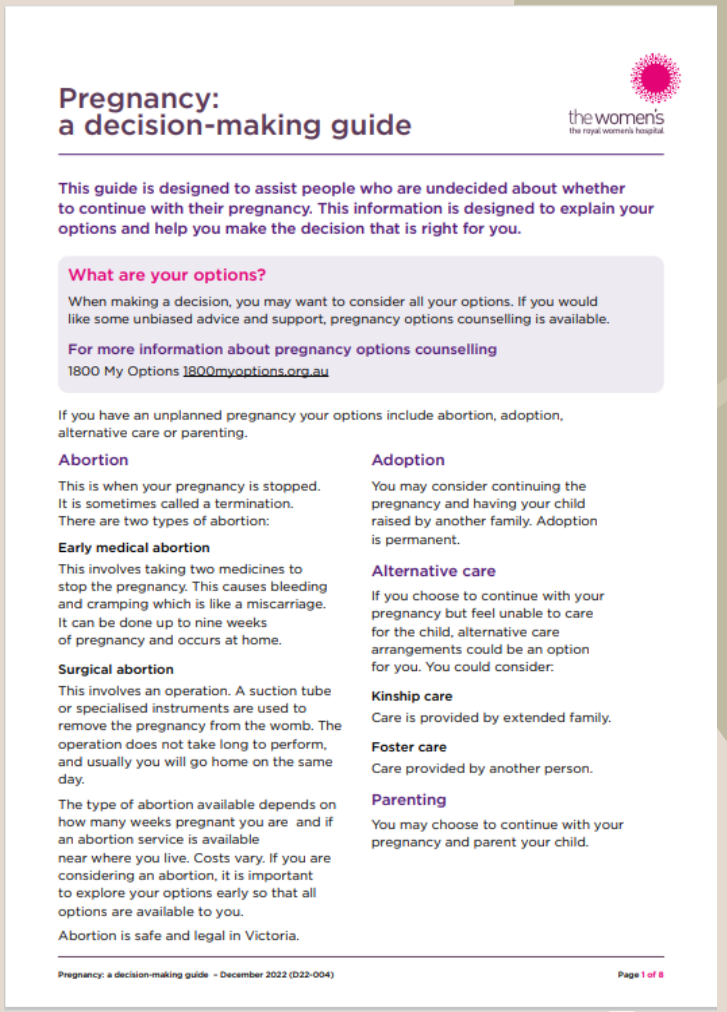


Please note the ToP Service contact all women with declined referrals to advise of service requirement to reduce risk of delay in care.

Decision Making Tools



[Abortion Decision Aid (ranzcog.edu.au)]



Pregnancy: a decision-making guide

the women's
the royal women's hospital

This guide is designed to assist people who are undecided about whether to continue with their pregnancy. This information is designed to explain your options and help you make the decision that is right for you.

What are your options?

When making a decision, you may want to consider all your options. If you would like some unbiased advice and support, pregnancy options counselling is available.

For more information about pregnancy options counselling

1800 My Options 1800myoptions.org.au

If you have an unplanned pregnancy your options include abortion, adoption, alternative care or parenting.

Abortion

This is when your pregnancy is stopped. It is sometimes called a termination. There are two types of abortion:

Early medical abortion

This involves taking two medicines to stop the pregnancy. This causes bleeding and cramping which is like a miscarriage. It can be done up to nine weeks of pregnancy and occurs at home.

Surgical abortion

This involves an operation. A suction tube or specialised instruments are used to remove the pregnancy from the womb. The operation does not take long to perform, and usually you will go home on the same day.

The type of abortion available depends on how many weeks pregnant you are and if an abortion service is available near where you live. Costs vary. If you are considering an abortion, it is important to explore your options early so that all options are available to you.

Abortion is safe and legal in Victoria.

Adoption

You may consider continuing the pregnancy and having your child raised by another family. Adoption is permanent.

Alternative care

If you choose to continue with your pregnancy but feel unable to care for the child, alternative care arrangements could be an option for you. You could consider:

Kinship care

Care is provided by extended family.

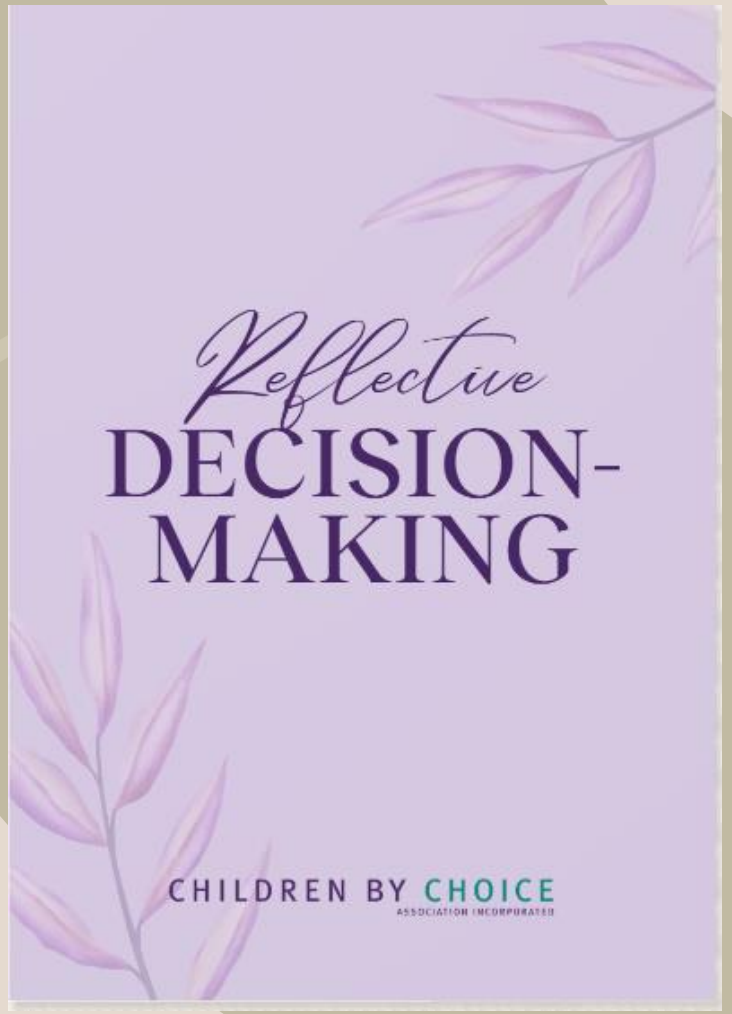
Foster care

Care provided by another person.

Parenting

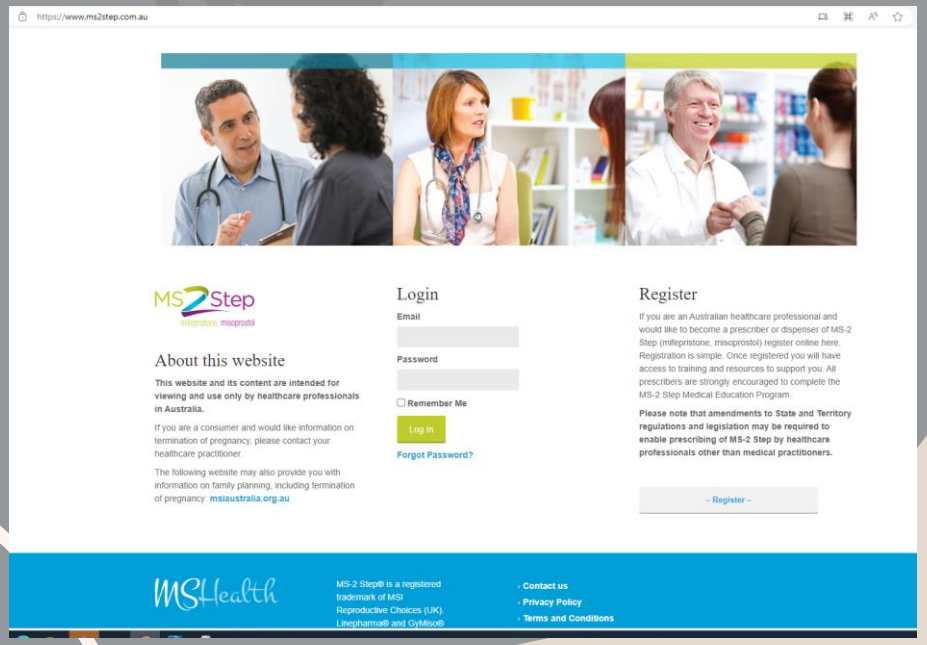
You may choose to continue with your pregnancy and parent your child.

[Pregnancy: a decision-making guide (worldssl.net)]

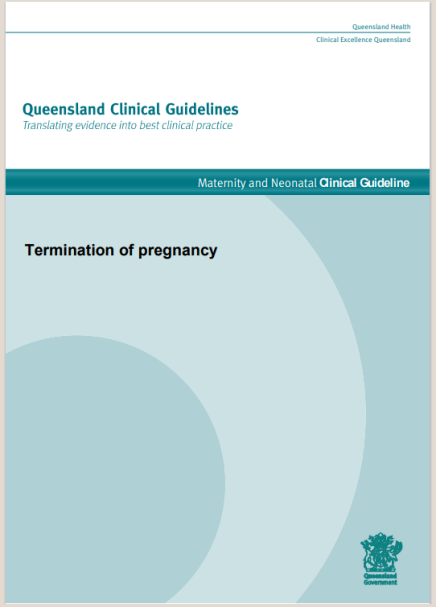


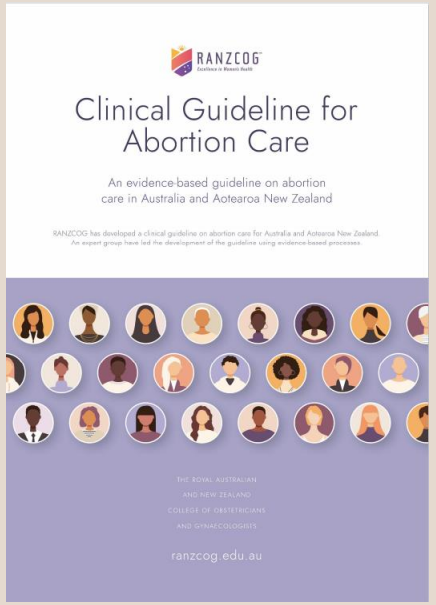
[Decision Making - Children by Choice]

Termination of Pregnancy Resources



ms2step.com.au





Termination of pregnancy | Metro North Health

Metro North HHS Nurse Navigator – Termination of Pregnancy

Service supporting GPs and women from the point of referral, pre and post termination of pregnancy.

Clinical Advice Line (This is for Metro North GPs only and not open to patients)
Hours: Monday – Friday 8.30am– 3.30pm
Ph: 1800 569 099
Email: metronorthtop@health.qld.gov.au

Does your patient wish to be referred?

Minimum referral criteria

Does your patient meet the minimum referral criteria?

Category 1
Appointment within 30 days is desirable

- Any patient requesting a termination of pregnancy. For optimum care, an assessment appointment should be offered within 5 days of referral.

NB: Full termination of pregnancy services may not be offered by individual hospitals. Referral may well be accompanied by a telephone call to the local Hospital and Health Service to establish local guidelines. This could include discussion with the responsible clinician or delegate. Request for termination service 22+1 weeks have additional complexities and should be discussed with the responsible clinician.

Conscientious Objection

I'm a conscientious objector...

As a GP – What do I need to do?

Health care professionals may decline to provide ToP healthcare on the basis of conscientious objection

Conscientious objectors are required under the *ToP Act 2018* to:

Disclose their conscientious objection to the woman and/or other practitioners who request assistance

Refer care to another practitioner who is not a conscientious objector or to another service

Respect

Compassion

Kindness

Judgement free care

Gold standard of care.

Contraception

We would greatly appreciate:

- conversation about contraception
- written information provided to the patient
- script for contraception provided to patient for Mirena/Kyleena/copper IUD/Implanon if appropriate

Thank you

DR ANGELA SMITH

GPWSI, RBWH GYNAECOLOGY OUTPATIENT DEPARTMENT

SEXUAL HEALTH PHYSICIAN, METRO NORTH SEXUAL HEALTH AND HIV SERVICE (BIALA CITY COMMUNITY HEALTH CENTRE)

STACEY WEST

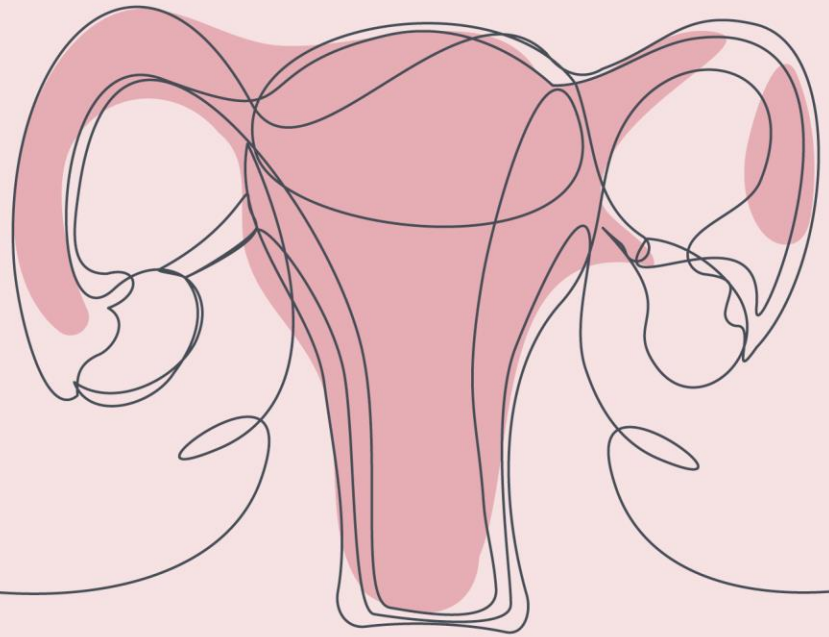
ACTING NURSE NAVIGATOR TOP

0408 940 183

metronorthtop@health.qld.gov.au

Metro North **GP Alignment Program**

Gynaecology Workshop



Gynaecology services & referral processes

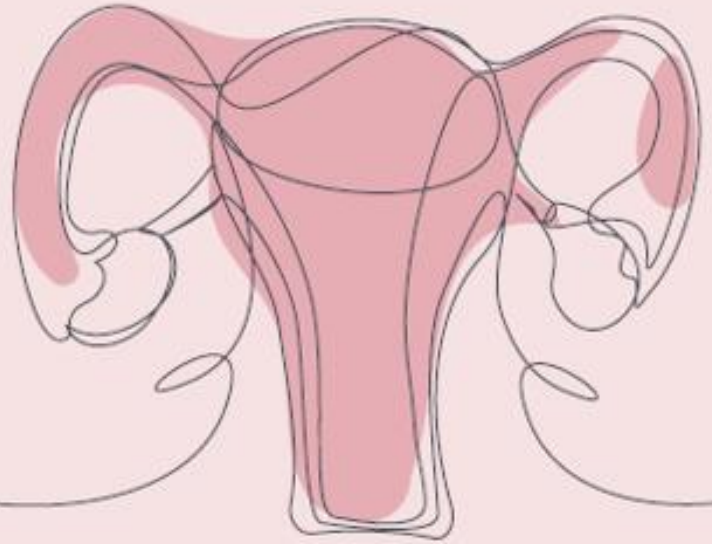
Dr Meg Cairns | GPLO
Emily Sanders | Nurse Unit Manager Gynaecology Outpatients | RBWH
Santhi (Chippy) Philip | Gynaecology Care Coordinator Outpatients | Caboolture

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Metro North **GP Alignment Program**

Gynaecology Workshop



Metro North Gynaecology Services:

- Caboolture Hospital
- Redcliffe Hospital
- Royal Brisbane and Women's Hospital

Gynaecology Services

- *> 15 yo Gynaecology services at Caboolture, Redcliffe & RBWH*
- *< 15 yo Gynaecology services at Queensland Children's Hopsital*
- *Emergency Gynaecology services at TPCH ED (no elective services)*
- *Refer patients when they are "ready for care" to their closest hospital*
- *Commonwealth Endometriosis & Pelvic Pain clinics*

RBWH Clinics

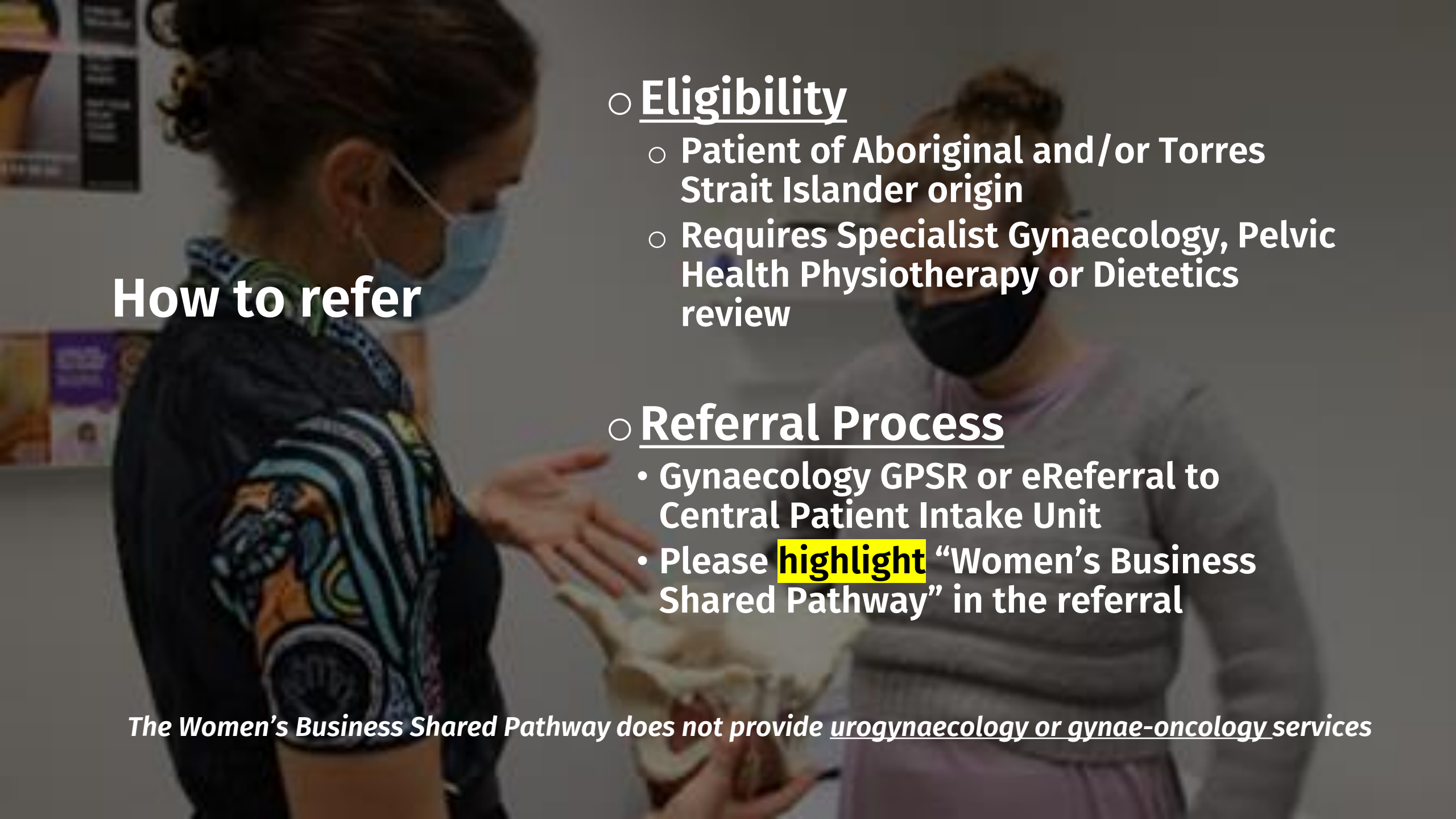
- *General Gynaecology*
- *Early Pregnancy Assessment Unit*
- *Termination of Pregnancy*
- *Fertility/ Reproductive Endocrinology*
- *Urogynaecology*
- *Paediatric and Adolescent Gynaecology Service*
- *Gynaecology Oncology*
- *Queensland Trophoblast Centre*
- *Continence Nurse Advisory Service*

The Women's Business Shared Pathway

- Metro North Health + Institute for Urban Indigenous Health partnership
- Culturally safe Specialist Gynaecology care for Aboriginal and Torres Strait Islander Women
- 4 community-based clinics per month
  - Nundah Community Health Centre
  - Morayfield MATSICHS
  - Deception Bay MATSICHS
- 1 theatre list per month at RBWH
- Pelvic Health Physiotherapy + Dietician available weekly

IUIH institute for urban indigenous health

Metro North Health | Queensland Government

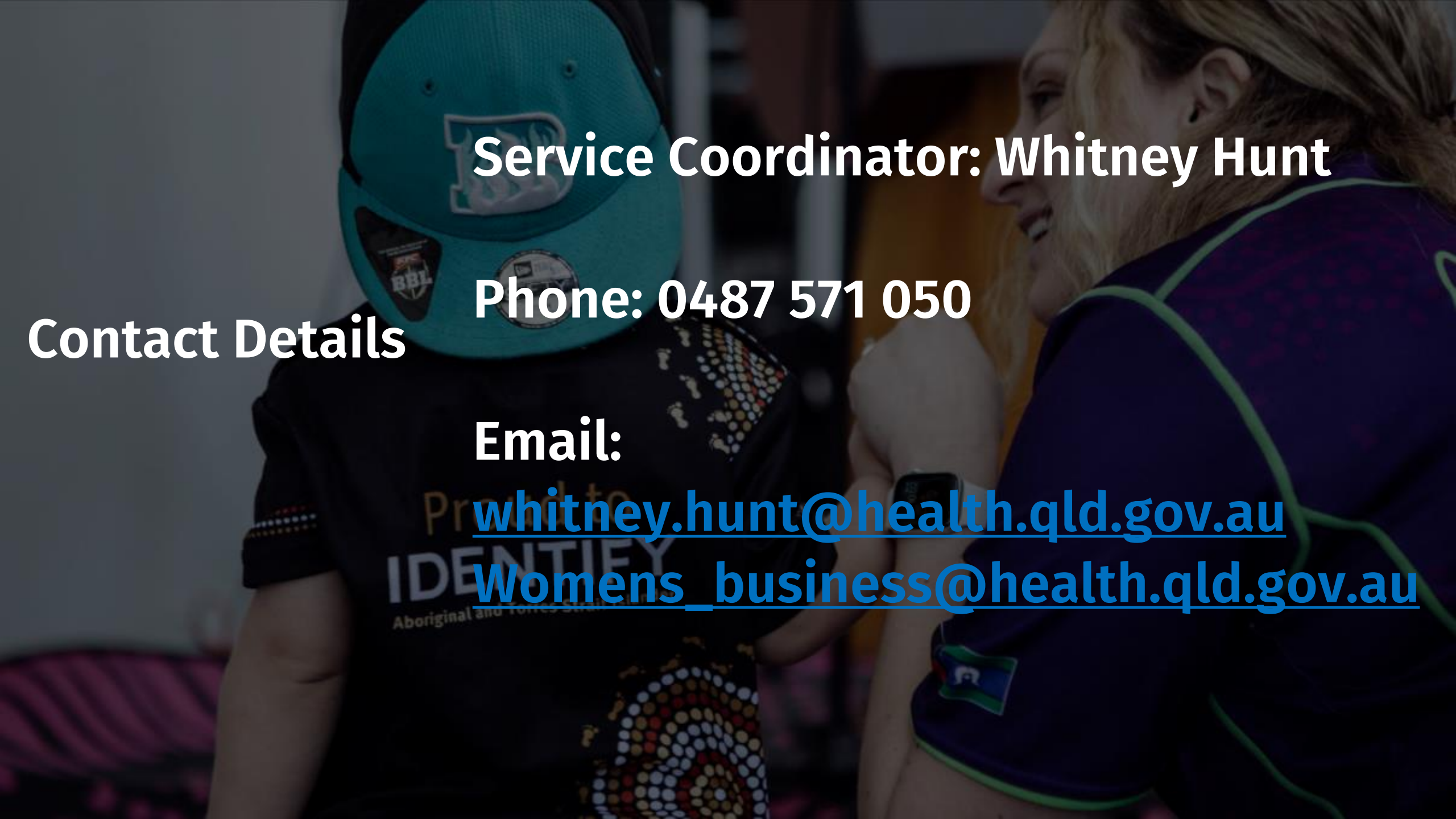


How to refer

- **Eligibility**
  - Patient of Aboriginal and/or Torres Strait Islander origin
  - Requires Specialist Gynaecology, Pelvic Health Physiotherapy or Dietetics review

- **Referral Process**
  - Gynaecology GPSR or eReferral to Central Patient Intake Unit
  - Please highlight “Women’s Business Shared Pathway” in the referral

The Women’s Business Shared Pathway does not provide urogynaecology or gynae-oncology services



Contact Details

Service Coordinator: Whitney Hunt

Phone: 0487 571 050

Email:
whitney.hunt@health.qld.gov.au
Womens_business@health.qld.gov.au

Incontinence - Metro North Services

- Caboolture - Pelvic Health Physiotherapy (accepts GP referrals) + Gynaecology
- Redcliffe – Pelvic Health Physiotherapy + Gynaecology
- TPCH – Physiotherapy Continence Clinic (accepts GP referrals)
- RBWH – Pelvic Health Physiotherapy (accepts GP referrals), Continence nurse linked with Urology (accepts GP referrals), Gynaecology

Pelvic Health Physiotherapy Screening Clinic RBWH

- **Gynaecology referrals for prolapse and/or incontinence directed through a Physio led clinic prior to assessment by a Medical Officer**
- **Women assessed by Women's Health Physiotherapist**
- **Women treated by Physiotherapist and Continence Nurse → discharged or redirected to see Medical Officer**
- **GPs can refer to Pelvic Health Physiotherapy**

Pelvic Health Clinic Caboolture Hospital

- **GPs can refer to Gynaecology Physiotherapy Screening Clinic**
- **Women assessed by Women's Health Physiotherapist**
- **Women treated by Physiotherapist → discharged or redirected to see Medical Officer**

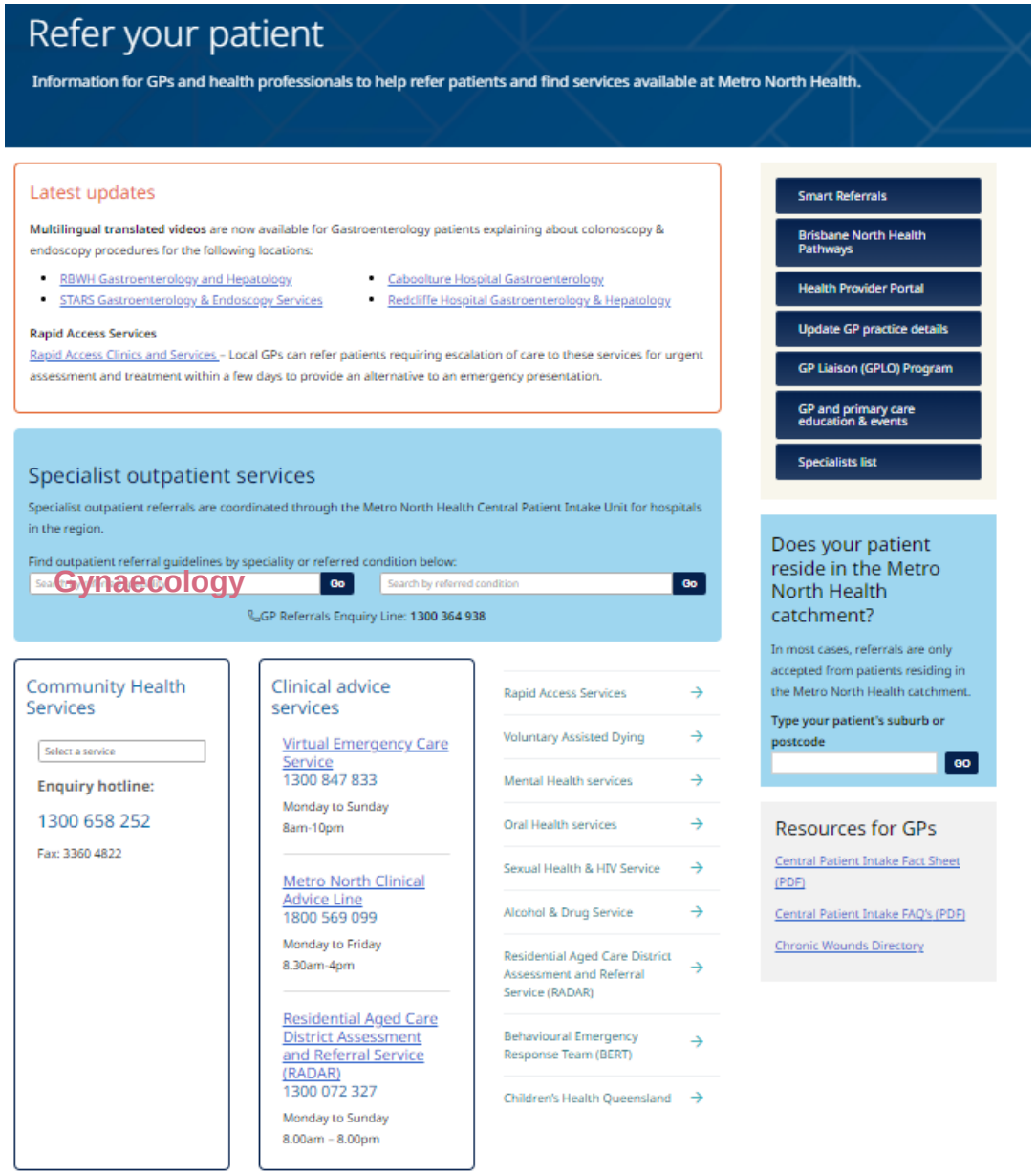
Pelvic Health Pathway Redcliffe Hospital

- **Relevant Gynaecology referrals directed to Gynaecology Physiotherapy Screening Clinic for Continence Nurse and Physiotherapy consult**

Metro North referral processes

- ***Please provide essential referral information for the condition***
- ***GP Smart Referrals (preferred) and eReferrals accepted via Central Patient Intake Unit (CPIU)***

Refer your patient



Refer your patient

Information for GPs and health professionals to help refer patients and find services available at Metro North Health.

Latest updates

Multilingual translated videos are now available for Gastroenterology patients explaining about colonoscopy & endoscopy procedures for the following locations:

- RBWH Gastroenterology and Hepatology
- STARS Gastroenterology & Endoscopy Services
- Caboolture Hospital Gastroenterology
- Redcliffe Hospital Gastroenterology & Hepatology

Rapid Access Services

Rapid Access Clinics and Services – Local GPs can refer patients requiring escalation of care to these services for urgent assessment and treatment within a few days to provide an alternative to an emergency presentation.

Specialist outpatient services

Specialist outpatient referrals are coordinated through the Metro North Health Central Patient Intake Unit for hospitals in the region.

Find outpatient referral guidelines by speciality or referred condition below:

Gynaecology

Go

Search by referred condition

Go

GP Referrals Enquiry Line: **1300 364 938**

Community Health Services

Select a service

Enquiry hotline:

1300 658 252

Fax: 3360 4822

Clinical advice services

Virtual Emergency Care Service
1300 847 833
Monday to Sunday
8am-10pm

Metro North Clinical Advice Line
1800 569 099
Monday to Friday
8.30am-4pm

Residential Aged Care District Assessment and Referral Service (RADAR)
1300 072 327
Monday to Sunday
8.00am – 8.00pm

- Rapid Access Services
- Voluntary Assisted Dying
- Mental Health services
- Oral Health services
- Sexual Health & HIV Service
- Alcohol & Drug Service
- Residential Aged Care District Assessment and Referral Service (RADAR)
- Behavioural Emergency Response Team (BERT)
- Children's Health Queensland

- Smart Referrals
- Brisbane North Health Pathways
- Health Provider Portal
- Update GP practice details
- GP Liaison (GPLO) Program
- GP and primary care education & events
- Specialists list

Does your patient reside in the Metro North Health catchment?

In most cases, referrals are only accepted from patients residing in the Metro North Health catchment.

Type your patient's suburb or postcode

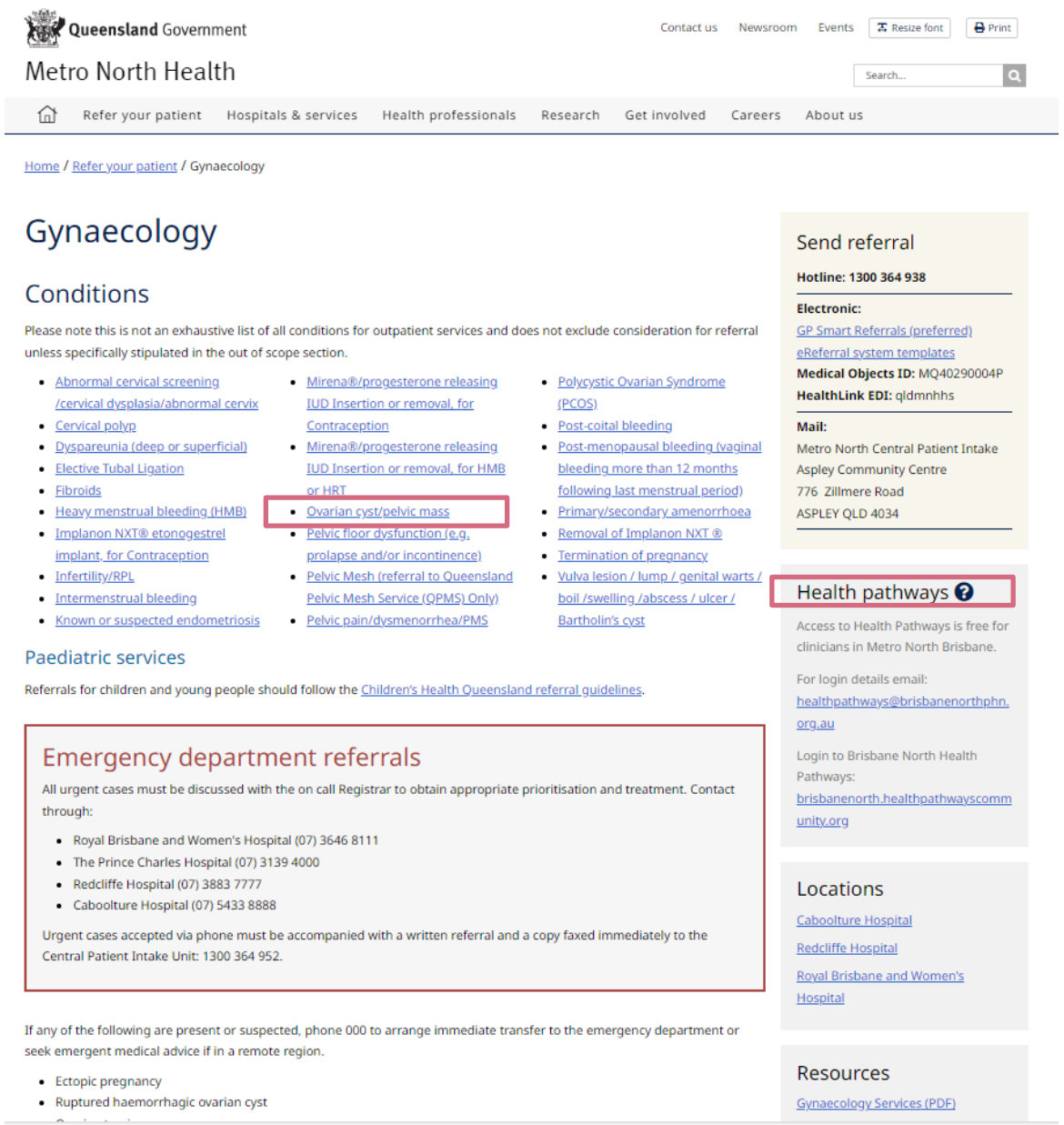
GO

Resources for GPs

Central Patient Intake Fact Sheet (PDF)

Central Patient Intake FAQ's (PDF)

Chronic Wounds Directory



Queensland Government

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Metro North Health

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Home / Refer your patient / Gynaecology

Gynaecology

Conditions

Please note this is not an exhaustive list of all conditions for 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)
- Elective Tubal Ligation
- Fibroids
- Heavy menstrual bleeding (HMB)
- Implanon NXT® etonogestrel implant, for Contraception
- Infertility/RPL
- Intermenstrual bleeding
- Known or suspected endometriosis
- Mirena®/progesterone releasing IUD Insertion or removal, for Contraception
- Mirena®/progesterone releasing IUD Insertion or removal, for HMB or HRT
- Ovarian cyst/pelvic mass
- Pelvic floor dysfunction (e.g. prolapse and/or incontinence)
- Pelvic Mesh (referral to Queensland Pelvic Mesh Service (QPMS) Only)
- Pelvic pain/dysmenorrhea/PMS
- Polycystic Ovarian Syndrome (PCOS)
- Post-coital bleeding
- Post-menopausal bleeding (vaginal bleeding more than 12 months following last menstrual period)
- Primary/secondary amenorrhoea
- Removal of Implanon NXT ®
- Termination of pregnancy
- Vulva lesion / lump / genital warts / boil /swelling /abscess / ulcer / Bartholin's cyst

Paediatric services

Referrals for children and young people should follow the Children's Health Queensland referral guidelines.

Emergency department referrals

All urgent cases must be discussed with the on call Registrar to obtain appropriate prioritisation and treatment. Contact through:

- Royal Brisbane and Women's Hospital (07) 3646 8111
- The Prince Charles Hospital (07) 3139 4000
- Redcliffe Hospital (07) 3883 7777
- Caboolture Hospital (07) 5433 8888

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.

If any of the following are present or suspected, phone 000 to arrange immediate transfer to the emergency department or seek emergent medical advice if in a remote region.

- Ectopic pregnancy
- Ruptured haemorrhagic ovarian cyst

Send referral

Hotline: 1300 364 938

Electronic:
GP Smart Referrals (preferred)
eReferral system templates
Medical Objects ID: MQ40290004P
HealthLink EDI: qldmnhhs

Mail:
Metro North Central Patient Intake
Aspley Community Centre
776 Zillmere Road
ASPLEY QLD 4034

Health pathways

Access to Health Pathways is free for clinicians in Metro North Brisbane.

For login details email:
healthpathways@brisbanenorthphn.org.au

Login to Brisbane North Health Pathways:
brisbanenorth.healthpathwayscommunity.org

Locations

Caboolture Hospital
Redcliffe Hospital
Royal Brisbane and Women's Hospital

Resources

Gynaecology Services (PDF)

Ovarian cyst/pelvic mass

Emergency department referrals

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- Redcliffe Hospital (07) 3883 7777
- Caboolture Hospital (07) 5433 8888

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.

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Ruptured haemorrhagic ovarian cyst
- Ovarian torsion

Does your patient wish to be referred?

Minimum referral criteria

Does your patient meet the minimum referral criteria?

Category 1
Appointment within 30 days is desirable

- Suspicious of malignancy or high risk features:
  - USS findings such as solid areas, papillary projections, septations, abnormal blood flow, bilaterally or ascites
  - ovarian cyst >12cm
  - elevated CA125 and cyst >5cm in premenopausal patients or any size cyst in post-menopausal patient
- 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

- Hydrosalpinx

+ Other Gynaecology conditions

Send referral

Hotline: 1300 364 938

Electronic:
GP Smart Referrals (preferred)
eReferral system templates
Medical Objects ID: MQ40290004P
HealthLink EDI: qldmnhhs

Mail:
Metro North Central Patient Intake
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Locations

Caboolture Hospital

Redcliffe Hospital

Royal Brisbane and Women's Hospital

Resources

Specialists list

If your patient does not meet the minimum referral criteria

Consider other treatment pathways or an alternative diagnosis.

If you still need to refer your patient:

- Please explain why (e.g. warning signs or symptoms, clinical modifiers, uncertain about diagnosis, etc.)
- Please note that your referral may not be accepted or may be redirected to another service

Other important information for referring practitioners

Not an exhaustive list

- Refer to HealthPathways for assessment and management information if available
- If cyst simple or haemorrhagic corpus luteal cyst and <5 cm repeat scan in 6 – 12 weeks
- If recurrent cysts, consider COCP or Implanon®

Referral requirements

A referral may be rejected without the following information.

− Essential referral information

- History including pain and other symptoms
- CA125 results
- ROMA score in premenopausal women with elevated CA125
- AFP, HCG, Inhibin, LDH in paediatric and adolescent patients if complex cyst
- Pelvic USS (TVS preferable), TA in PAG patients

Additional referral information (useful for processing the referral)

- Body mass index (BMI)
- Family history of breast and ovarian cancer

Out of catchment

Metro North Health is responsible for providing public health services to the people who reside within its boundaries. Special consideration is made for patients requiring tertiary care or services that are not provided by their local Hospital and Health Service. If your patient lives outside the Metro North Health area and you wish to refer them to one of our services, inclusion of information regarding their particular medical and social factors will assist with the triaging of your referral.

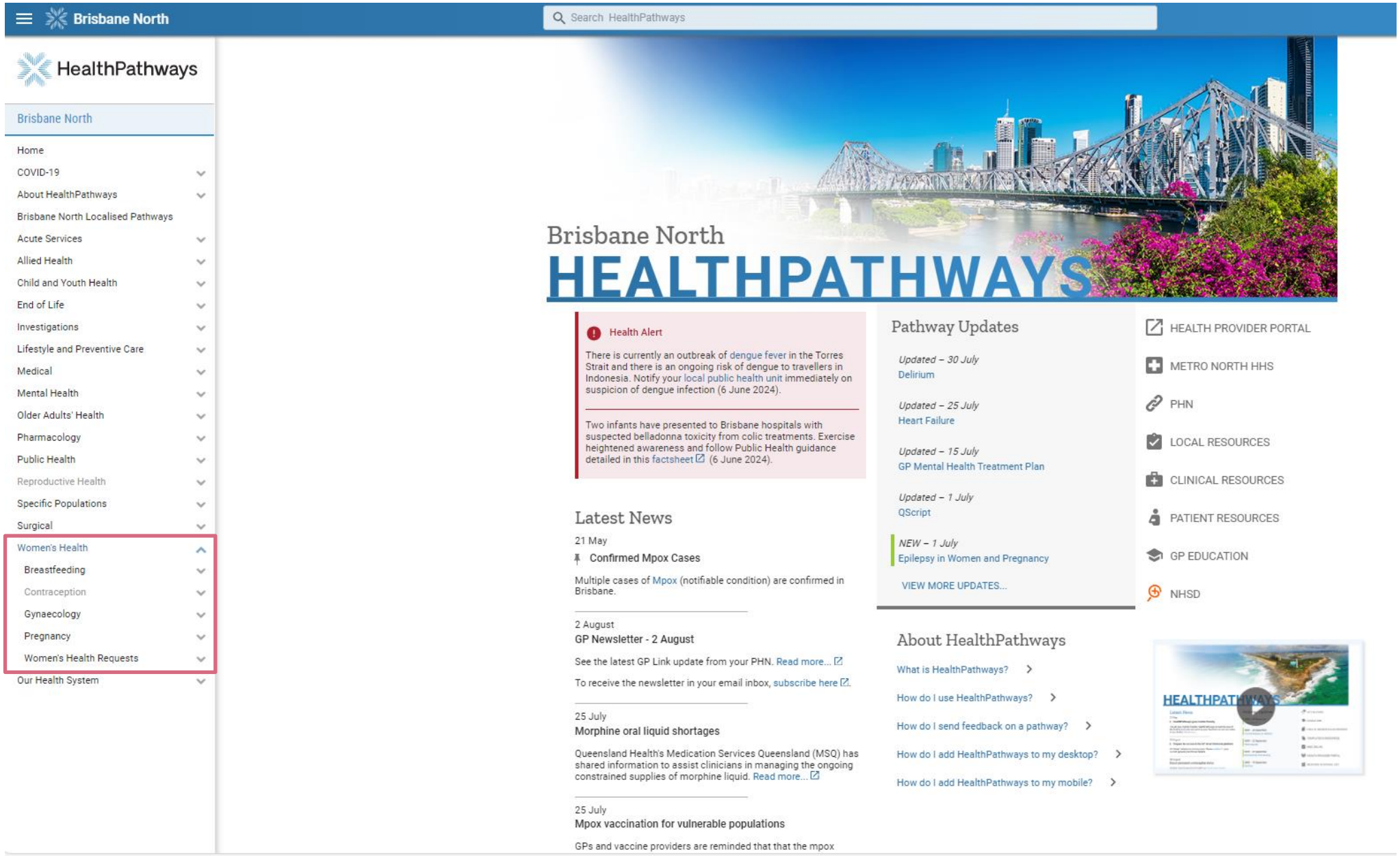
+ Clinical Modifiers (where relevant)

+ Reason for Referral (essential)

+ Clinical Information (essential)

+ Patient's Demographic Details (essential)

Health Pathways



Brisbane North

HealthPathways

Brisbane North

- Home
- COVID-19
- About HealthPathways
- Brisbane North Localised Pathways
- Acute Services
- Allied Health
- Child and Youth Health
- End of Life
- Investigations
- Lifestyle and Preventive Care
- Medical
- Mental Health
- Older Adults' Health
- Pharmacology
- Public Health
- Reproductive Health
- Specific Populations
- Surgical
- Women's Health
  - Breastfeeding
  - Contraception
  - Gynaecology
    - Abnormal Vaginal Bleeding
    - Amenorrhoea
    - Cervical Cancer Screening
    - Cervical Polyps
    - Cervical Shock
    - Dysmenorrhoea
    - Endometrial Cancer Low Risk Follow-up
    - Female Genital Mutilation (FGM)
    - Fibroids
    - Hysteroscopy
    - Menopause
    - Ovarian Cancer Symptoms
    - Ovarian Cyst or Pelvic Mass

Search HealthPathways

Women's Health / Gynaecology / Ovarian Cyst or Pelvic Mass

Ovarian Cyst or Pelvic Mass

Red flags

- Ectopic pregnancy
- Torsion of uterine appendages
- Suspected malignancy

Background

About ovarian cysts or pelvic mass

Assessment

1. Consider the possibility of ovarian cancer if the patient presents with persistent or recurrent unexplained abdominal, pelvic or genitourinary symptoms.
2. Take a history for:
   - Symptoms of ovarian cyst or pelvic mass
   - Gynaecological and reproductive history
   - Risk factors for sexually-transmitted infection (STI)
   - Risk factors for ovarian cancer
3. Perform abdominal and pelvic examinations, and look for inguinal or supraclavicular lymphadenopathy – follow recommended protocol and consider a chaperone.
   - Avoid pelvic examination if the patient has never had vaginal intercourse.
   - Note masses, tenderness, cervical excitation, and mobility of organs.
   - Perform speculum examination – check the vulva, vagina, cervix, urethra meatus, and anus.
   - Consider rectovaginal examination.
   - Consider STI screening if increased sexually-transmitted infection (STI) risk.
   - Perform a cervical screening test if due, or if symptomatic e.g., unusual or abnormal vaginal bleeding (post-coital, inter-menstrual or post-menopausal), pain during intercourse, unusual vaginal discharge. Request a co-test if patient is symptomatic.
4. Arrange investigations:
   - Pregnancy test – if indicated e.g., exclude ectopic pregnancy.
   - Pelvic ultrasound – preferred over CT or MRI for evaluating pelvic masses at first presentation.
     - Arrange transvaginal ultrasound unless contraindicated.
     - Look for suspicious ultrasound findings.
   - CA 125 – if indicated.
   - Alpha-fetoprotein, LDH, and beta hCG – if indicated.
   - HE4 and risk of malignancy algorithm (ROMA) score – consider arranging in premenopausal women with elevated CA 125.

Management

1. Request acute gynaecology assessment if:
   - acute severe pelvic pain.
   - suspected ectopic pregnancy.
   - suspected torsion of uterine appendages, including intermittent severe pelvic pain, which may be due to intermittent ovarian torsion – the patient may need surgery to salvage ovary.

Search HealthPathways

Women's Health / Gynaecology / Chronic Pelvic Pain

Chronic Pelvic Pain

This pathway is about chronic pelvic pain in women and people assigned female at birth. See also:

- Endometriosis
- Chronic Non-cancer Pain

Red flags

- Onset of pelvic pain after menopause
- Pelvic mass
- Any abnormal bleeding (vaginal bleeding, rectal bleeding, haematuria)

Background

About chronic pelvic pain

Assessment

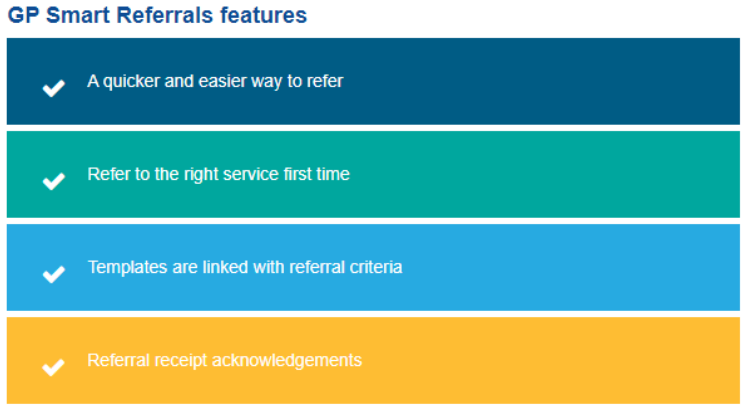
1. Take a history – ask about:
   - pain and associated symptoms and consider asking the patient to use a Pelvic Pain Assessment Form.
   - triggers and relieving factors including association with menstruation, intercourse, bowel motions, micturition, movement and posture.
   - history of trauma (see also Trauma-informed care).
   - other relevant factors.
2. Consider common psychological co-morbidities, which may contribute to pain, and which may be exacerbated by the presence of pain:
   - Depression
   - Anxiety
   - Post-traumatic stress disorder (PTSD)
3. Perform examination, as appropriate. Consider:
   - Height, weight, and BMI
   - Lower back and hips
   - Abdomen – check for any tenderness, obvious masses, organomegaly, ascites.
   - Pelvic examination (unless patient has never had vaginal intercourse)
   - Rectal
4. Consider differential diagnosis, which may be multifactorial. A specific cause may not be found.
5. Arrange investigations but avoid extensive investigation:
   - FBC, CRP
   - Urine microscopy, culture, and sensitivities (MCS)
   - Urine pregnancy test
   - High vaginal swab for MCS

Smart Referrals

Why should I use Smart Referrals?

1. Allows you to attach test results, imaging reports and other clinical documents (e.g. ECGs, photos) from the patient's clinical record or your PC
2. Supports you to provide essential referral information
3. Integrated service directory identifies the speciality closest to home
4. Can be used for *Request for Advice (RFA)*
5. Shows where the referral is in the system (received, accepted, not accepted)
6. Shows appointment date linked to the referral
7. Includes an increasing number of allied health and community services

Smart Referrals



- Integrated with *Best Practice* and *Medical Director*
- Aligned with state-wide referral guidelines to prompt essential referral information required for triage, decreasing the number of referrals returned requesting additional clinical information.

Brisbane North PHN Digital Health Support Officers
GPSR@brisbanenorthphn.org.au

Request information

Request date	7 Aug 2024
* Request type	New referral | Update | Continuation | Request for advice
* Reason for referral	(•) New condition requiring specialist consultation ( ) Deterioration in condition, recently discharged from outpatients < 12 months ( ) Other
* Priority	Urgent | Routine
* Provider	QHSR | Private

Consents

* Date patient consented to request	07 Aug 2024
* Patient is willing to have surgery if required?	Yes | No | Not applicable
* Condition and Specialty	Gynaecology - Ovarian cyst / pelvic mass (Gynaecology) (Adult) HealthPathways ▸
Suitable for Telehealth?	Yes | No
* Are you the patient's usual GP?	Yes | No

Request recipient

* Service/Location	Gynaecology - ROYAL BRISBANE & WOMEN'S HOSPITAL - 1.7 km
Service/Location information	**Wait times** Wait times for this service at this location are Cat 1 27 days, Cat 2 125 days, Cat 3 464 days. **Restrictions** PLEASE MARK URGENT FOR TERMINATION OF PREGNANCY UP TO 22 WEEKS. PATIENTS 18 YEARS OR OLDER ONLY **Service Attributes** For detailed information read the "Restrictions" above for the selected Service/Location GP Referrals are accepted Does not treat paediatric patients Treats adult patients Treats geriatric patients Not a state-wide service Telehealth options available for patients
Specialist name	Dr Andrea Garrett
Organisation details	...

Send request | Park request | Refresh content | Cancel request | Missing fields 7

* Condition and Specialty: Gynaecology - Ovarian cyst / pelvic mass (Gynaecology) (Adult) HealthPathways

Suitable for Telehealth? Yes No

* Are you the patient's usual GP? Yes No

Request recipient

* Service/Location: Gynaecology - ROYAL BRISBANE & WOMEN'S HOSPITAL - 1.7 km

Service/Location information

Wait times
Wait times for this service at this location are Cat 1 27 days, Cat 2 125 days, Cat 3 464 days.

Restrictions
PLEASE MARK URGENT FOR TERMINATION OF PREGNANCY UP TO 22 WEEKS. PATIENTS 18 YEARS OR OLDER ONLY

Service Attributes
For detailed information read the "Restrictions" above for the selected Service/Location

GP Referrals are accepted
Does not treat paediatric patients
Treats adult patients
Treats geriatric patients
Not a state-wide service
Telehealth options available for patients

Specialist name: Dr Andrea Garrett

Organisation details

Condition specific clinical information

Show emergency referral criteria: Show Hide

Minimum Referral Criteria

High risk features: Show Hide

* Minimum referral criteria
- [ ] Suspicion of malignancy or high risk features (see above)
- [ ] Significant pain and/or risk of torsion
- [ ] Pre-pubertal patient
- [ ] Persistent ovarian cyst >5cm on 2 pelvic USS 6 weeks apart
- [ ] Complex cyst (haemorrhagic, endometriotic or dermoid)
- [ ] Persistent pelvic pain
- [ ] Hydrosalpinx
- [ ] Request clinical override of minimum referral criteria

Send request | Park request | Refresh content | Cancel request | Missing fields 7

Additional referral information:

The most recent height, weight and BMI recorded in the practice software will automatically be included in the referral, please ensure that these are up to date

- Family history of breast and ovarian cancer

Referral Letter

Referral letter

Pathology and Test Results

Essential referral information:

- CA125 results
- ROMA score in premenopausal women with elevated CA125

In paediatric and adolescent patients if complex cyst:

- Alpha fetoprotein
- LDH
- HCG
- Inhibin (please attach manually)

If any laboratory investigations are listed below, they have NOT been automatically selected by the software. Please manually select or attach

Laboratory investigations NOT found by the software:	CA125 Alpha fetoprotein LDH HCG
Click link to manually select investigations	Go to Investigations
Click link to manually attach investigations	Go to Attachments
Request to override essential referral information requirement	Yes / No

Imaging and Reports

Essential referral information:

- Pelvic USS results (TVS preferable in adults, TA in paediatric and adolescent patients)

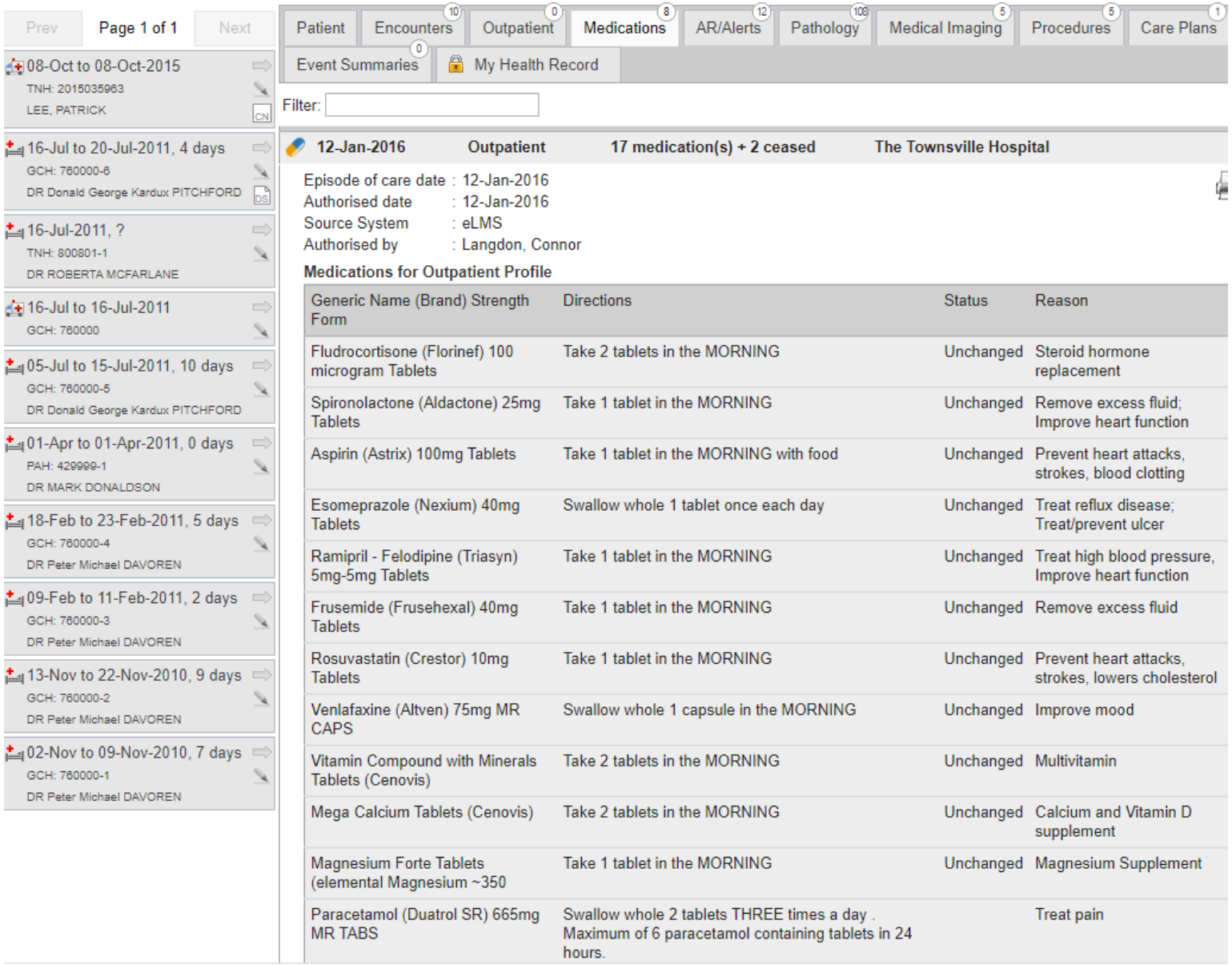
* Imaging performed	☐ Pelvic USS ☐ Other ☐ Request to override essential referral information requirement
* All essential imaging is attached to this referral	☐ Essential imaging attached
Click link to manually select imaging	Go to Investigations

Send request | Park request | Refresh content | Cancel request | Missing fields 7

Health Provider Portal

- **Provides *eligible Queensland health practitioners (HPs) secure online access to their patients' Queensland Health records.**
- **Read-only online access allows HPs to view public hospital information including appointments, clinic letters, inpatient & ED discharge summaries, radiology & pathology reports, and medications.**

*** Queensland AHPRA registered GPs, nurses, midwives, optometrists, paramedics & pharmacists**



Queensland Virtual Hospital
Virtual Emergency Care Service

Fact Sheet for General Practitioners

The Virtual Emergency Care Service (VECS) provides Queensland General Practitioners (GPs) with access to specialist emergency medicine advice by telephone or live streamed video-conference.

The VECS Emergency Medicine (EM) Physicians can assist you with advice, support, and access to HHS services:

- This service is available to GPs across Queensland and can be accessed as either a consultation about a patient or a joint consultation with the patient.
- Advice and support are available for any patient with any condition.
  - **NOTE: For life threatening emergencies call triple zero (000) and request Ambulance Services. The VECS is not intended to be used for patients experiencing a life-threatening emergency.**
- The VECS EM Physicians can help you manage your patient in the community by:
  - Providing advice for ongoing management
  - Facilitating access to HHS based community services such as community nurses and HITH
  - Facilitating access to an outpatient specialist review
- The VECS EM Physicians can consult with you to assist in navigation to access other local services:
  - Urgent outpatient review in Rapid Access Clinic or sub-specialty telephone advice.
  - "Direct to bed" admission in HITH or subspecialty inpatient services where local pathways are in place for your HHS.

How to access the VECS

Call 1300 847 833

Monday to Sunday 8am -10pm

The VECS team are aware that your time is precious. Clinician calls are prioritised, however if you prefer, we can schedule a call back.

You will be connected to an experienced emergency nurse. Please have the following information ready:

1. Your name and phone number
2. The patient's name, date of birth, hospital number (if available) and brief description of the problem
3. The practice phone number

Queensland Virtual Hospital
Virtual Emergency Care Service
Queensland Government

Queensland Virtual Hospital
Virtual Emergency Care Service

Clinician service

Open: 7 days
(8am-10pm Monday to Sunday)

The triage nurse will be accessing previous hospital information on your patient while you consult with the medical staff. The VECS EM Physician will speak with you as soon as possible.

During busy times they will sometimes need to call you back and the triage nurse will be able to advise of the likely time frame for the call. You may prefer to ask your patient to sit in the waiting room for a short period until both medical practitioners are available for the consultation.

- If you request a face-to-face consultation and you have a computer with a camera or a smartphone, the VECS team will send you an appointment link.
- While the consultation is in progress, VECS staff may contact your practice for further patient details if required, to complete the registration process.
- During the consultation a management plan will be agreed and later documented by the VECS clinical team. These notes will be uploaded into the Health Practitioner Portal/The Viewer.
- The following day, you will be contacted via email for feedback about the service and the patient will be contacted as indicated.

Examples of presentations the VECS service can be used for*

- Asymptomatic hypertension
- Soft tissue infections/cellulitis
- Deep Vein Thrombosis (DVT)
- Urinary tract infection
- Diabetic patient with high BSLs
- Fever in children
- Vertigo
- Acute Low back pain
- Gastroenteritis
- Minor sports injuries
- Minor head injuries
- Viral illness (including COVID-19)
- Headache

***Please note this is not an exhaustive list and if you are unsure whether the VECS team can assist please feel free to call and speak with one of the friendly VECS team.**

Further information is available on the VECS webpage.

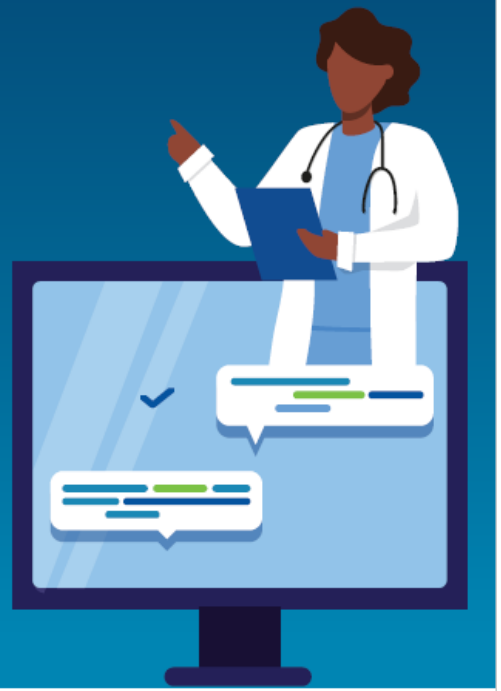
Queensland Virtual Hospital
Virtual Emergency Care Service

Queensland Health

Is the Virtual Emergency Care Service right for me?

We've partnered with healthdirect to take the guesswork out of your health care options.

Visit the healthdirect Symptom Checker



Check your symptoms online, answer some questions, and get the recommended care you need for your health concern.

This might include the Virtual Emergency Care Service, but it might also suggest visiting an Urgent Care Clinic, seeing your GP or heading to a pharmacy.

In an emergency, always call **Triple Zero (000)**

Queensland Government

Metro North Clinical Advice Line

Connecting GPs directly to Metro North specialties.

The Metro North Health Clinical Advice Line connects local GPs to specialist advice from hospital and community clinicians. There are two pathways:

1. Phone line
2. Written request for advice.

The range of adult specialities currently available to support patient care in the community includes:
(This list will expand over time so keep coming back for the latest advice services available)

1. Phone advice

Specialty	Catchment*	Exclusion Criteria
General Medicine and Rapid Access Clinic	TPCH	• Excludes Cardiology, Heart Failure or Respiratory Conditions • Excludes Residential Aged Care residents (Call RADAR - 1300 072 327)
Haematology	Metro North	• Excludes Patients under 16 years
Heart Failure Service and Rapid Access Clinic	Redcliffe TPCH	• Excludes New heart failure patients • Excludes Patients seen by another heart failure service
Inflammatory Bowel Disease	Redcliffe Caboolture	• Excludes Patient anticipated to require surgical input
Metro North Persistent Pain Centre/ Tess Cramond Pain and Research Centre Clinical advice available Tuesday – Friday 9:00am – 12:00pm	Metro North Central Queensland Central West Darling Downs West Moreton	• Excludes patients under 16 years • Excludes outside catchment
Metro North Virtual Ward	Metro North Central West Norfolk Island	• Excludes patients under 16 years • Excludes Residential Aged Care residents (Call RADAR - 1300 072 327)
Healthy Ageing Assessment Rehabilitation Team (HAART)	Kallangur Satellite Hospital	Patients may be ineligible if: • Currently accessing equivalent services in public or private sector • Reside outside of catchment area • Medically unstable requiring inpatient assessment or currently an inpatient • Only require therapy for maintenance of chronic condition • Residential aged care facility residents
Rapid Access to Community Care	Metro North	• Excludes Patients under 16years • Excludes Acute mental health, alcohol or drugs related. • Excludes Residential Aged Care Facility Residents (Call RADAR - 1300 072 327)
Sexual Health	Metro North	• Excludes Patients under 14 years
Sleep Disorders	TPCH Caboolture Redcliffe	• Excludes Patients seen by another Sleep Unit
Termination of Pregnancy	Metro North	• Excludes Outside Metro North referral catchment
Vestibular Rapid Access Service	TPCH	• Out of catchment for TPCH

***Catchment** – where the patient would usually be referred for a face to face specialist outpatient clinic appointment.*

Note: If you think your patient is new to any of these services on the page, please ensure your patient is aware you are seeking advice and they consent to their demographic details, including Medicare number, being provided to Metro North Health at the time of the call.

Call the Clinical Advice Line, Monday to Friday 8:30am to 4.00pm on

1800 569 099

Note: this is for GPs only and the phone line is not open to patients.

Other advice lines and services for GPs can be found in our Services contact list (PDF)

Clinical Advice Line
1800 569 099
Open Monday to Friday
8.30am – 4.00pm

Note: This is for GPs only and the phone line is not open to patients.

Want to learn more?

For more information, please call the advice line or email MNH_SpecialtyAdviceLine@health.qld.gov.au.

The team can also undertake engagement sessions with interested GPs (Virtual or Face to Face).

Request for Advice (RFA)

2. Written request for advice

GPs can seek advice via the written "request for advice" (RFA) via GP Smart Referrals (GPSR) for the specialties listed below. Details of how to send the RFA in GPSR and how the response is provided via the Request for Advice function on GPSR information sheet. (PDF)

Specialty	Catchment*	Exclusion Criteria
General Medicine	TPCH	• Cardiology, Heart Failure or Respiratory Conditions • Residential Aged Care residents (Call RADAR)
Metro North Persistent Pain Centre/ Tess Cramond Pain and Research Centre	Metro North Central Queensland Central West Darling Downs West Moreton	• Excludes patients under 16 years • Excludes outside catchment
Paediatric Medicine	Redcliffe	• Out of catchment for Redcliffe
Rheumatology	Redcliffe	• Out of catchment for Redcliffe
Urology	RBWH	• Out of catchment for RBWH

****Catchment* – where the patient would usually be referred for a face to face specialist outpatient clinic appointment.**

Please do not request urgent advice via this method. If there are no in-catchment services that offer Request for Advice for your patient, the Service will show as 'Out of Catchment'. In this instance it is recommended that a referral is created to an appropriate service within catchment for the patient.

metronorth.health.qld.gov.au

Queensland Government | Virtual Ward
Metro North Health

Search...

About the Virtual Ward | Health professionals | COVID-19 | Monkeypox

Home » Health professionals

Health Professionals

If you are a Queensland Health employee, please refer to the Metro North Virtual Ward Intranet Page (QH network only) available on QHEPS to access the internal referral form.

The Metro North Virtual Ward (VW) is an additional telehealth service that complements the current Virtual Emergency Department, Covid Virtual Ward, and Hospital-in-the-home services available within the Metro North Health region. Given the success of the virtual care model, the Metro North VW can now admit and manage patients with conditions other than COVID.

The VW can assist GP's by providing an inpatient equivalent admission for eligible patients.

On admission patients will be provided with team-based care via regular phone calls and/or video consults. The ward is based at the Royal Brisbane and Women's Hospital, from 0700 to 1930, 7 days a week, with overnight access to medical support. The patients will have access to medical, nursing, pharmacy, and social work support.

What can Virtual Ward provide?

Monitoring determined by patient's primary illness and co-morbidities.

Where required, patients will be provided with the following monitoring equipment free of charge and delivered to their home:

- Oxygen saturation probe
- Blood pressure monitor
- Thermometer
- Facilitation of relevant investigations i.e.- Blood tests, medical imaging including MRI, ECG, Echo
- Facilitation of Specialist opinion
- Pharmacy review
- Referral to Allied Health

Which patients are eligible for admission to the VW?

Patients who require a brief period of monitoring and treatment which would otherwise require them to stay in hospital.

Patients at risk of deterioration, which if detected early, can be managed at home with the aim that hospital admission be avoided.

Patients where daily review in between planned GP review would be helpful.

Examples of conditions that may be suitable for admission include:

- COVID
- community acquired pneumonia, infective exacerbations of asthma and other chronic obstructive airway conditions
- infections including cellulitis, osteomyelitis, UTI
- severe hypertension without neurological red flags for short term monitoring, medication adjustment
- hyperglycaemia without ketoacidosis for short term monitoring, medication adjustment.
- electrolyte abnormalities requiring monitoring
- supratherapeutic INR for short term monitoring
- serendipitous lumps to expedite investigation and Specialist review.

How to refer your patients to VW?

Phone **07 3074 2109** in hours (0800-1700hrs) or phone RBWH switchboard out of hours on **07 36468111** and ask to speak to the Virtual Ward Consultant.

If your patient is accepted, please complete the VW referral form (available as Best Practice template or PDF) and email MN-VirtualWardAdmin@health.qld.gov.au.

How to monitor your patients progress?

You can review your patient's daily progress via the Health Provider Portal/ Viewer.

A discharge summary will be sent at the end of the admission.

If you would like to contribute further information at any stage about your patient, please phone the Virtual Ward Consultant on 07 3074 2109.

GP Link

Local positions | Research surveys | Studies and trials | GP training

phn BRISBANE NORTH
An Australian Government Initiative

GP LINK
Your local source of GP news

In this edition / 1 August 2024

- New care models for endometriosis and pelvic pain patients
- Annual My Health Record review for registered healthcare providers
- Support for socially isolated patients or those experiencing loneliness
- Specialist Pain Assistance Network (SPAN) • BreastScreen patient resources for women with disability and from CALD communities
- Gynaecology Workshop | GP Alignment Program • Bent, broken and locked: An acute orthopaedic multidisciplinary update for GPs

GP News
Clinical news for our local GPs

New care models for endometriosis and pelvic pain patients

Join us this Women's Health Week

Two clinics in the North Brisbane and Moreton Bay region – Neighbourhood Medical and Moreton ATSICHS – are piloting new models of care to support women and people assigned female at birth experiencing endometriosis and pelvic pain (EPP). In partnership with our EPP GP clinics, join Brisbane North PHN this Women's Health Week for a webinar for local health professionals with an interest in women's health.

GPs and clinical staff from a general practice background are invited to hear directly from the GPs and allied health providers delivering these specialist services to learn more about the unique model of care each clinic provides, and how to:

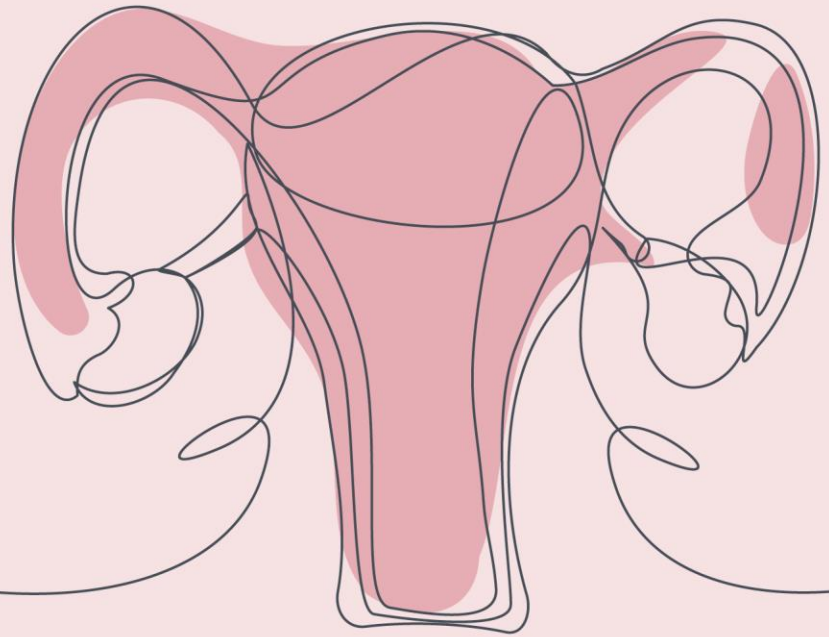
- appropriately refer to the two endometriosis and pelvic pain clinics
- develop a management plan utilising allied health professionals to support patients experiencing endometriosis and pelvic pain
- source appropriate care, support and resources for these patients.

Date: Tuesday 3 September 2024
Time: 6.30 pm to 8.00 pm

This webinar is a CPD approved activity, hosted online with no cost to attend. Find out more and register now.

Metro North **GP Alignment Program**

Gynaecology Workshop



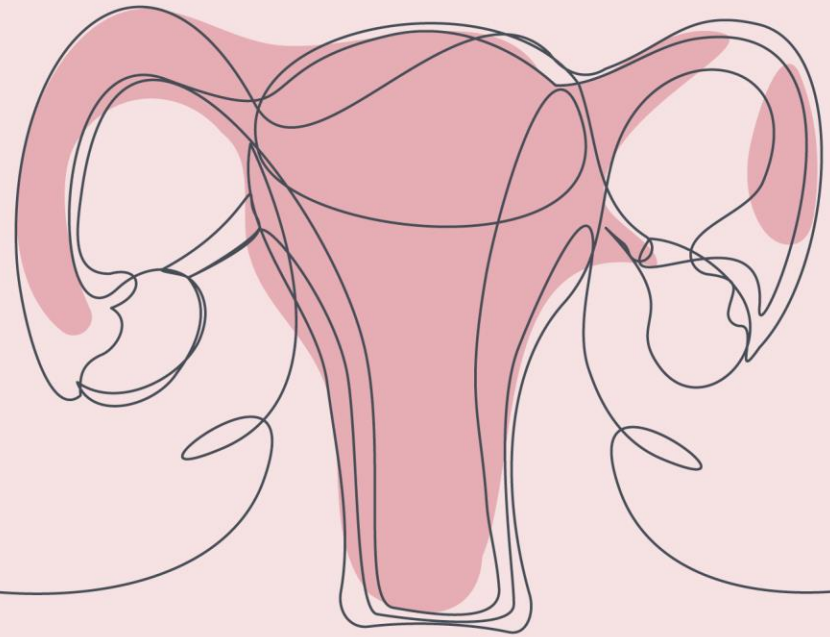
CASE STUDIES

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Metro North **GP Alignment Program**

Gynaecology Workshop



CASE STUDY: Prolapse

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Prolapse – Case Study

- Helen is 43 years old
- Healthy
- 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

Prolapse - Assessment

- Obstetric and Gynaecological history
- Previous prolapse or incontinence surgery
- Prolapse symptoms
  - protruding lump
  - dragging sensation
  - difficulty with defecation (requiring manual evacuation)/micturition including incontinence
- Grading of prolapse
  - POP-Q
  - Baden-Walker
  - Other
- MSU M/C/S
- Pelvic USS (TV preferred)

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

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)

[australian-pelvic-floor-questionnaire]

[Home - MyPelvicFloor]

Prolapse - Management

- Weight loss – healthy eating and exercise
- Smoking cessation
- Treat constipation
- Pelvic floor muscle training (PFMT)
- Bladder & bowel retraining
- Vaginal oestrogen
- Pessaries
- Surgery

Prolapse – Metro North Services

- Caboolture - Pelvic Health Physiotherapy (accepts GP referrals) + Gynaecology
- Redcliffe – Pelvic Health Physiotherapy + Gynaecology
- TPCH – Physiotherapy Continence Clinic (accepts GP referrals)
- RBWH – Pelvic Health Physiotherapy (accepts GP referrals), Continence nurse linked with Urology (accepts GP referrals), Gynaecology

Prolapse - Resources

Australian Family Physician – pelvic organ prolapse

RACGP - Pelvic organ prolapse – a review

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

urogynaecology.com.au

Prolapse - Resources

RACGP Handbook of Non-Drug Interventions

RACGP - Handbook of Non-Drug Interventions (HANDI)

Pathway for the surgical treatment of pelvic organ prolapse

ICI 2022 Surgical Pathway POP - (urogynaecology.com.au)

Assess your pelvic floor

Home - MyPelvicFloor

UroGynaecological Society of Australasia – Patient Information

Patient Resources (ugsa.com.au)

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:

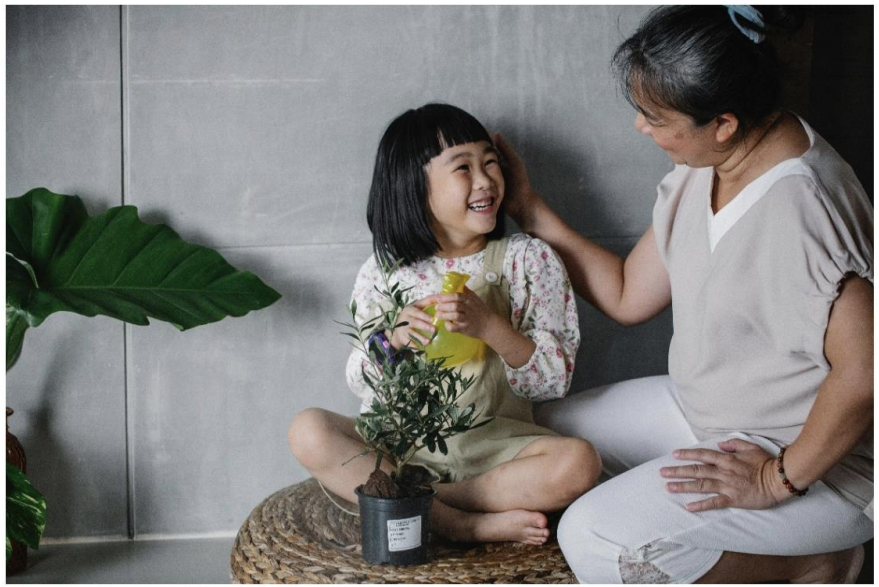
Bladder problems: urinary leakage or retention
Bowel problems: faecal urgency/leakage or incomplete evacuation
Vaginal prolapse or bulge
Sexual problems: vaginal laxity or painful sex

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 ›

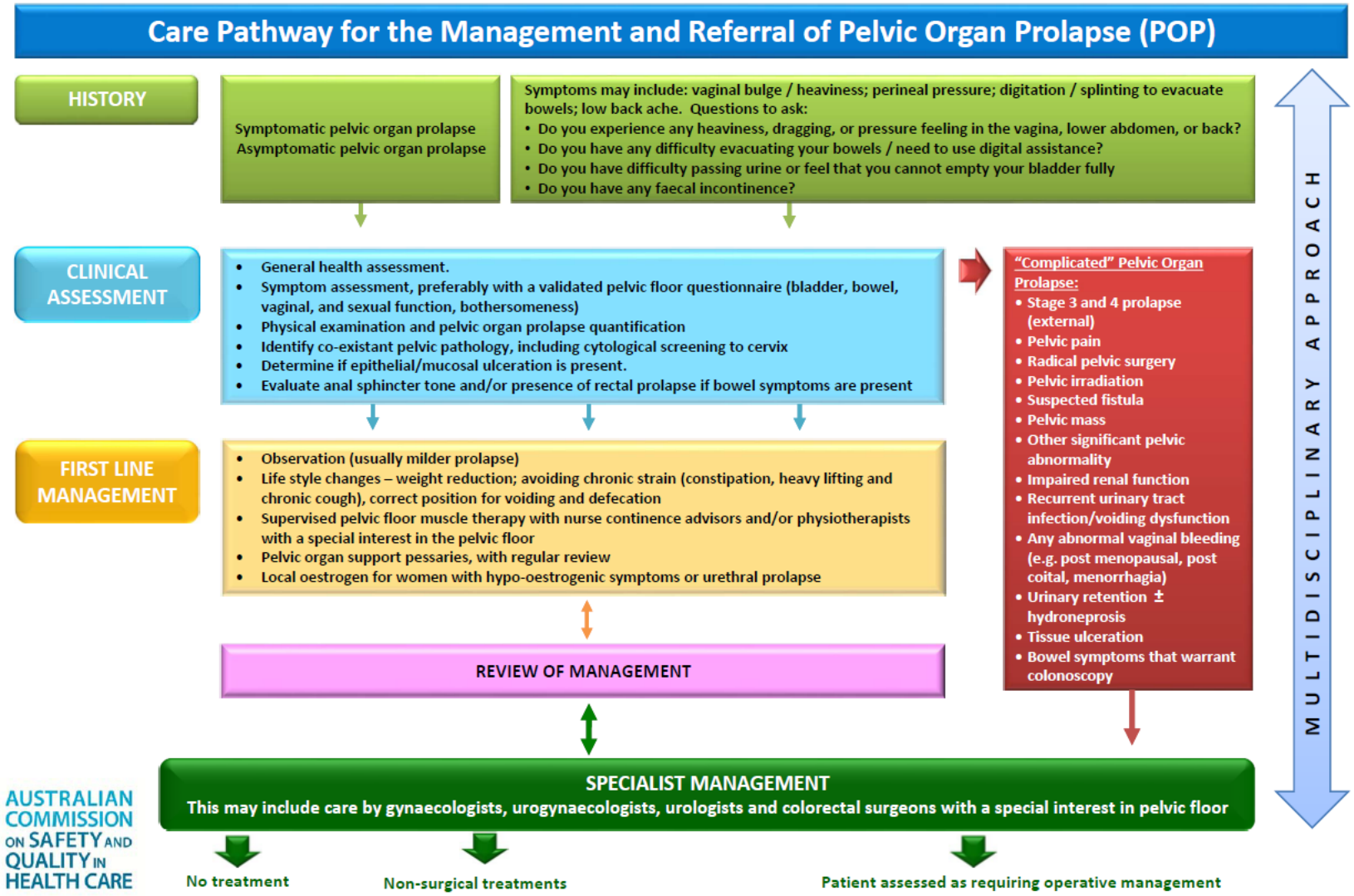
Patient Resources



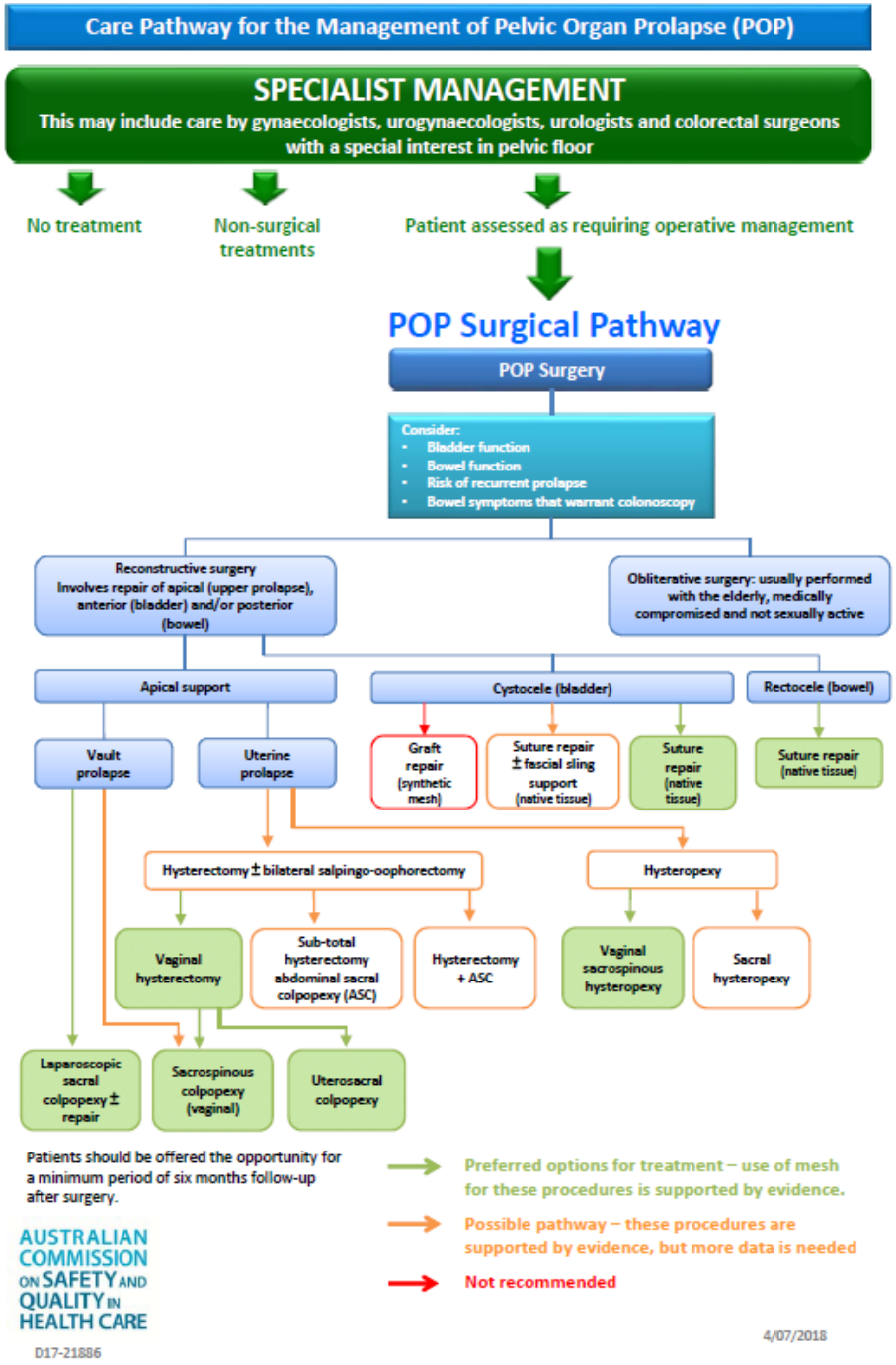
UGSA Patient Resources

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.



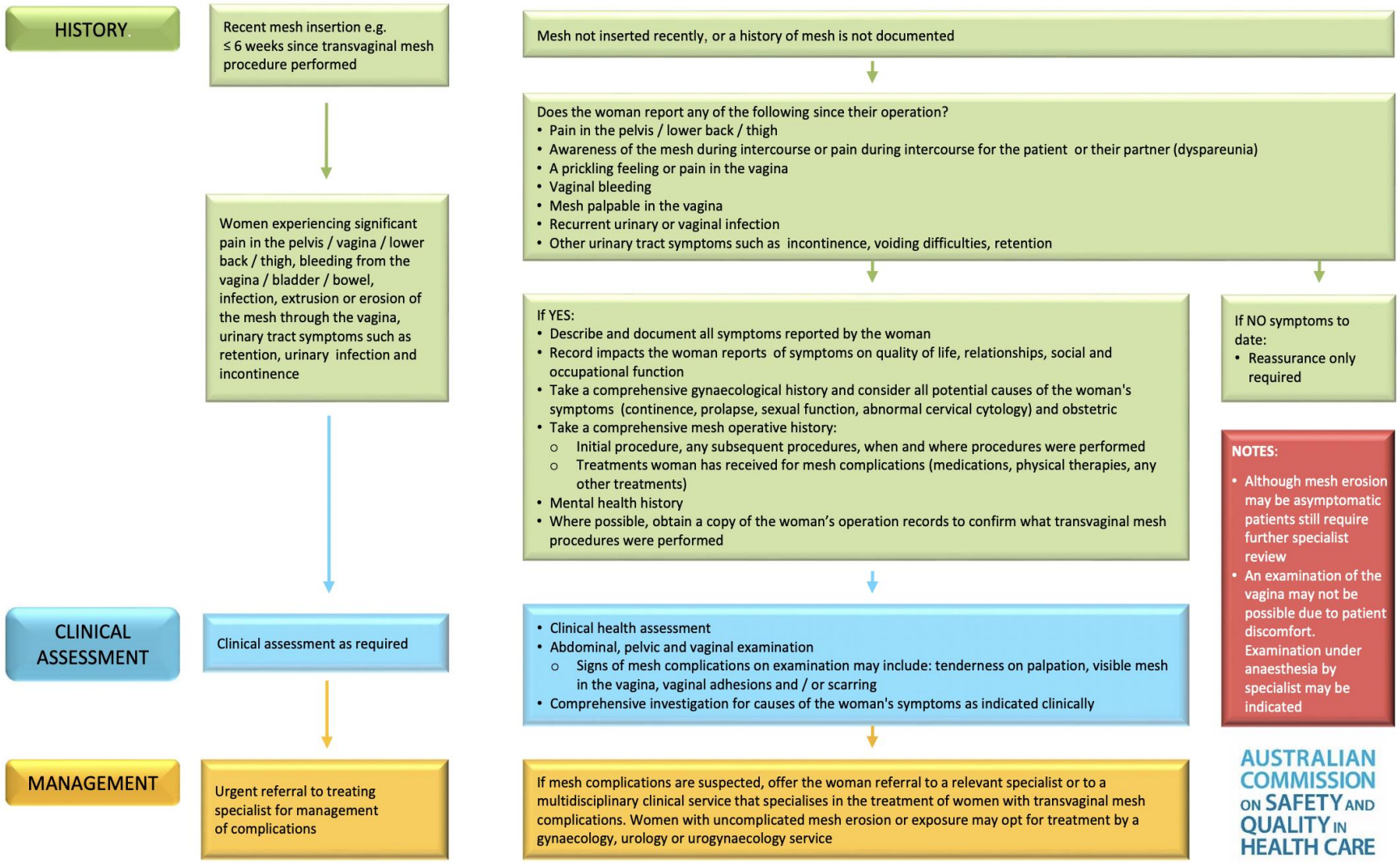
Pelvic Organ Prolapse GP management and referral



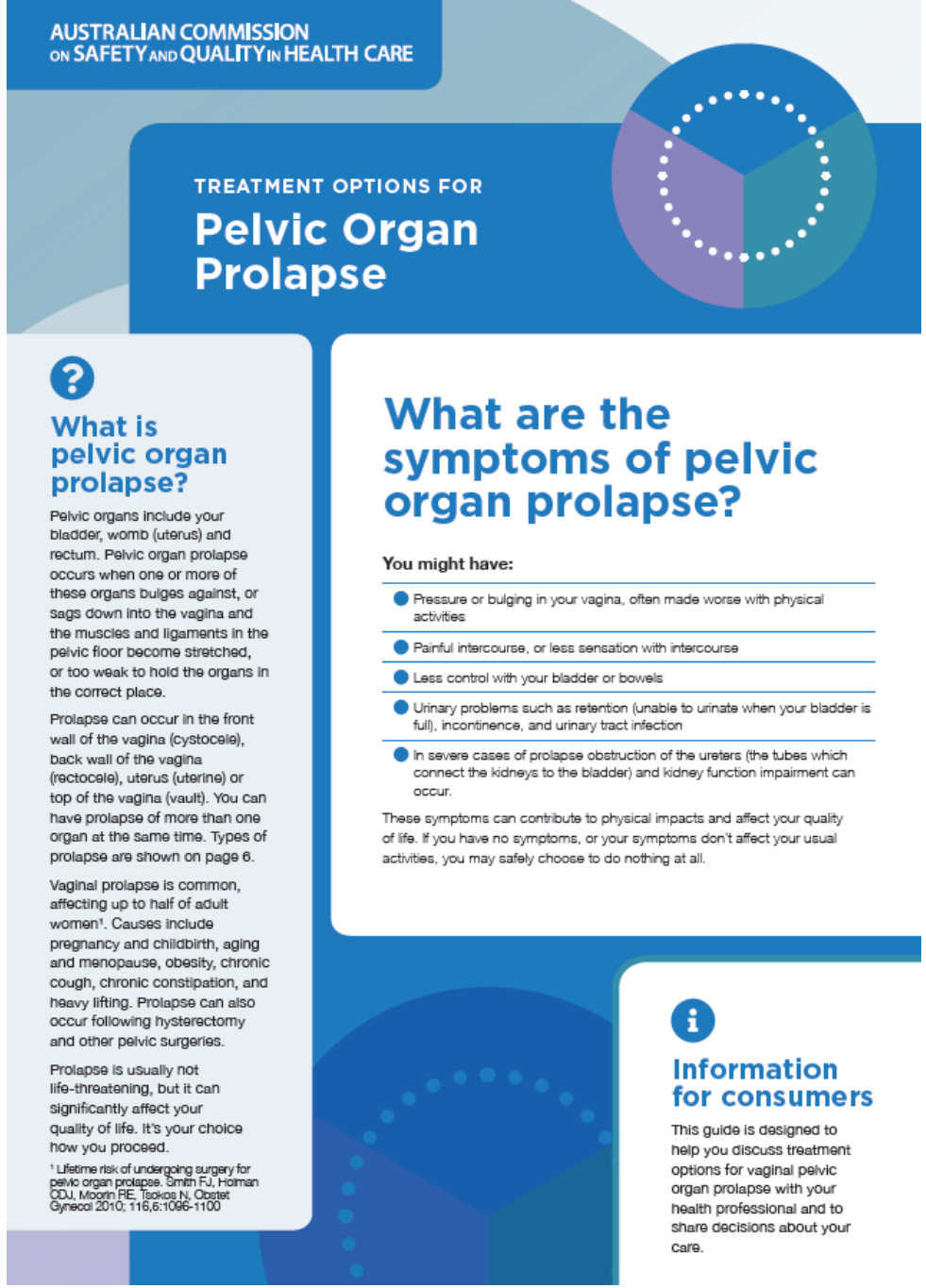
Pelvic Organ Prolapse Specialist Management

Care Pathway for the Management and Referral of Transvaginal Mesh Complications

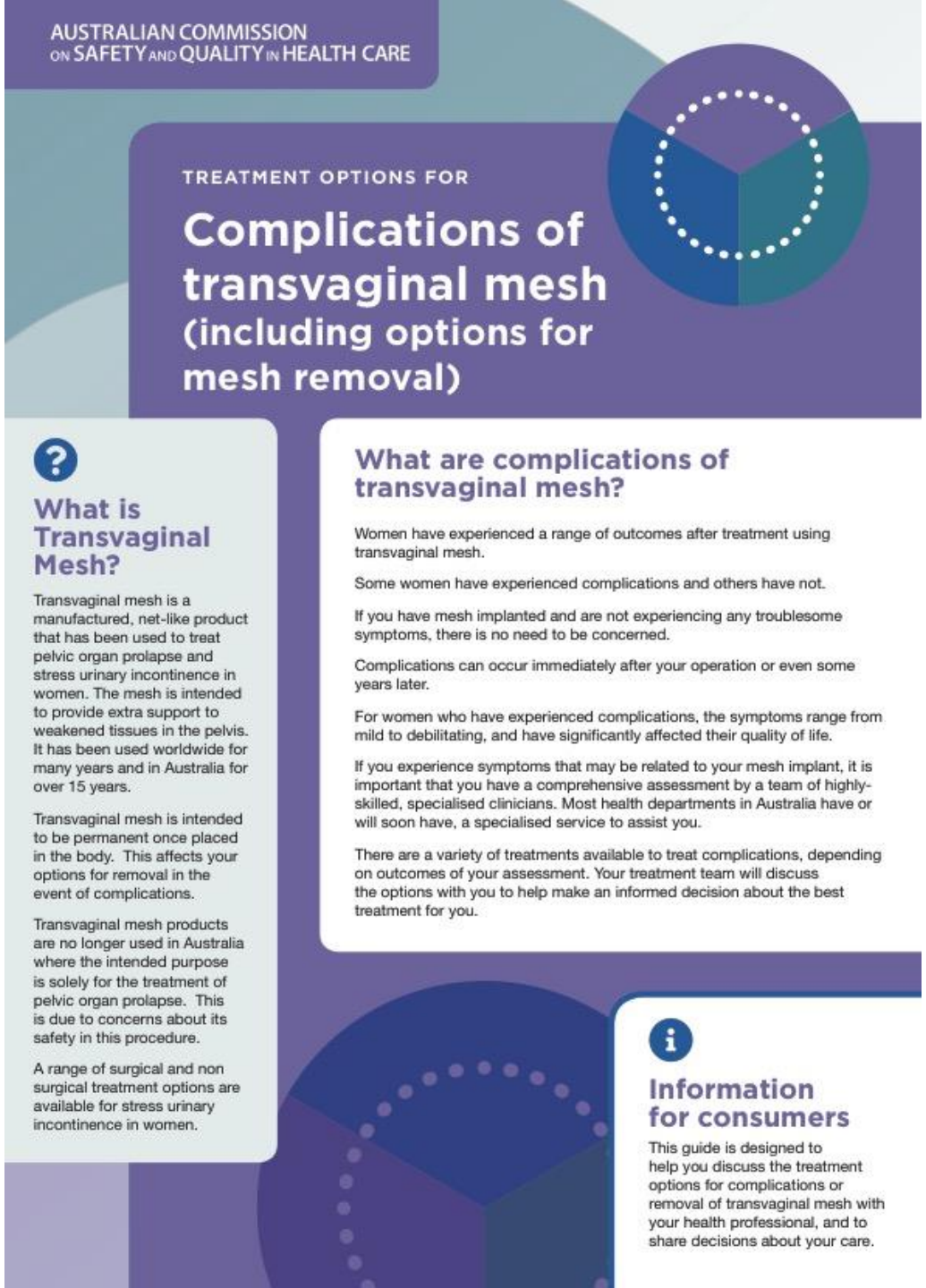
Synthetic transvaginal mesh has been used to manage pelvic organ prolapse (POP) and stress urinary incontinence (SUI) in Australian women for over 15 years. In November 2017 the Therapeutic Goods Administration removed transvaginal mesh products where the sole use is the treatment of POP. Transvaginal 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.



Transvaginal TV mesh management care pathway for GPs



[Treatment options for pelvic organ prolapse (for consumers)]



[Complications of transvaginal mesh (for consumers)]

Prolapse Referral – Pelvic Floor Dysfunction

Minimum Referral Criteria	
Category 1 (appointment within 30 calendar days)	• Uterine procidentia • Difficulty voiding with renal impairment
Category 2 (appointment within 90 calendar days)	• Difficulty voiding +/- significant residuals on bladder screening (without renal impairment) • Recurrent UTIs • Genital fistulae • Mesh erosion or bleeding/pain refer to Pelvic mesh (referral to Queensland Pelvic Mesh Service (QPMS) CPC)
Category 3 (appointment within 365 calendar days)	• Any other prolapse or incontinence • Obstructive defecation

[Pelvic floor dysfunction (e.g. prolapse and/or incontinence) | Clinical Prioritisation Criteria (health.qld.gov.au)]

[Pelvic floor dysfunction (e.g. prolapse and/or incontinence) | Metro North Health Refer your patient]

1. Reason for request Indicate on the referral

- 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

2. Essential referral information Referral will be returned without this

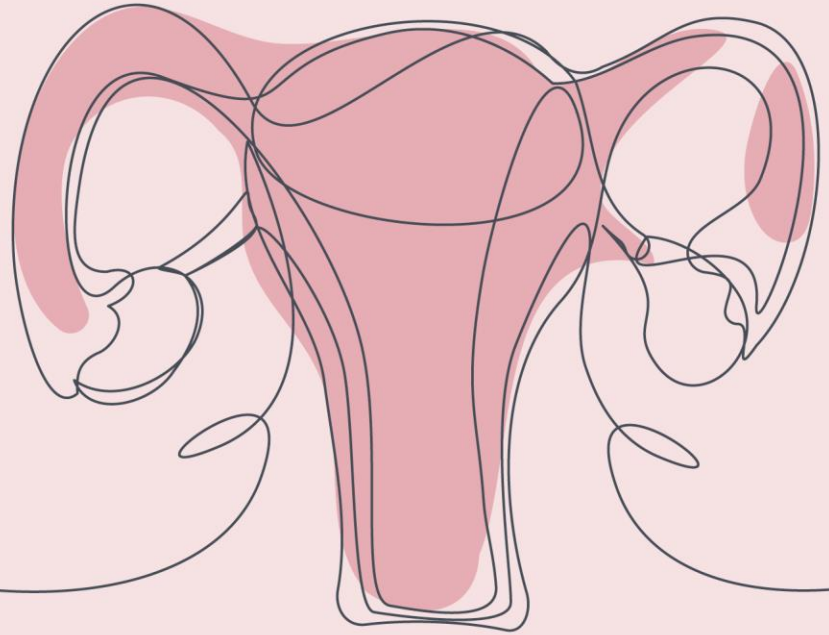
- Obstetric and gynaecological history
- History of:
  - prolapse symptoms
  - protruding lump
  - dragging sensation
  - difficulty with defecation (requiring manual evacuation)/micturition including incontinence
- MSU M/C/S results

3. Additional referral information Useful for processing the referral

- BMI
- Previous failed or complicated prolapse surgery
- Pelvic USS (TVS preferable) if available
- Bladder diary
- Renal USS if major uterine procidenta

Metro North **GP Alignment Program**

Gynaecology Workshop



CASE STUDY: Incontinence

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Incontinence – Case Study

- Joan is 78 years old
- G3P3
- BMI 35 kg/m2
- Anterior and posterior vaginal repair (15 years ago - no mesh)
- Hypertension, chronic back pain, anxiety and depression, right TKR 2023
- Mixed urinary incontinence
  - urgency
  - sometimes ‘flooding’ with no warning
  - increasing nocturia and urgency at night (3 x per night)
- Wears 'pullups' daily, most bothersome symptoms are ‘flooding’ episodes and nocturia
- 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

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)

[australian-pelvic-floor-questionnaire]

[Home - MyPelvicFloor]

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 ›

‘TANGO’ Questionnaire

Please tick the box on the left, for each statement that is applicable to you.

	My ankles, feet or legs swell during the day.	CARDIO / METABOLIC
	I take fluid tablets (e.g. Lasix).	
	I have kidney disease.	
	I take tablets to control my blood pressure.	
	I often get dizzy when standing up.	
	I have high blood sugar OR diabetes.	
	My blood sugar levels are difficult to keep stable.	

	I have 5 hours or less sleep per night.	SLEEP
	I would describe my sleep quality as *bad*.	
	It takes me longer than 30 minutes to fall asleep at night.	
	I have difficulty staying asleep at night because of my bladder.	
	I often experience pain at night.	
	I have been told I snore loudly OR stop breathing at night.	

	I need to get up to pass urine within 3 hours of going to sleep.	URINARY TRACT
	I experience a sudden urge to urinate on most days.	
	I have a bladder urgency accident once a week or more.	
	I often need to strain or push to start urinating.	
	I have an enlarged prostate gland. (Males only)	

	In general, I would say that my health is *not* good.	WELLBEING
	I have trouble staying awake while driving, eating or during social activities.	
	I have had a fall in the last 3 months.	
	I don’t look forward to things with as much enjoyment as I used to.	

[RACGP - Questions to ask a patient with nocturia]

Ask about the occurrence of urinary incontinence in women and people who are at higher risk (see Specific populations).

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 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 as 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.

RACGP The Red Book | Miscellaneous | Urinary Incontinence

Incontinence - Assessment

- Medical conditions – hypertension, COPD, diabetes, pain
- Previous prolapse or incontinence surgery
- Medications
- Caffeine, alcohol, carbonated beverages
- Smoking
- BMI

Incontinence - Assessment

- MSU M/C/S
- USS kidneys, ureters, bladder, including post void residual
- ELFTs including eGFR; HbA1C
- Australian Pelvic Floor Questionnaire
- TANGO questionnaire if nocturia
- Bladder diary
- Bowel diary

Incontinence – Management

- Weight loss – healthy eating, exercise
- Decrease caffeine and alcohol
- Smoking cessation
- Pelvic floor muscle training (PFMT)
- Bladder & bowel retraining
- Treat constipation
- Vaginal oestrogen
- Pessaries e.g. Contiform
- Urge incontinence/overactive bladder
  - Consider Urodynamics
  - Anti-cholinergics (oxybutynin, solifenacin) - potential association of dementia with anticholinergic burden
  - Beta 3 agonist (mirabegron)
  - Intravesical Botulinum toxin A
  - Transcutaneous and percutaneous tibial nerve stimulation
  - Sacral Nerve Stimulator
- Surgery

Bladder Diary

Fill in this diary for three or more days in a row.

Name:

Day and time		Drinks/fluid intake		Urine (wee)				Pads or clothing	What happened at the time of the leak?	Bowel movement
Day	Time	Type of drink or fluid	Amount of drink/ fluid (ml)	Amount of urine passed (ml)	How urgent was your need to pass urine (wee)? 1 = no urge to 3 = normal urge to 5 = strong urge	Did you leak or wet yourself? (Yes or No)	How much did you leak? (Spot, small, medium, large)	Did you change your pad or clothing? (Yes or No)	Where you were and what you were doing at the time you leaked urine	Did you pass a bowel motion (poo)?
Examples: Monday 3 March	*7.00am*			*250ml*	*5*	*Yes*	*Medium*	*Yes - my underwear and pyjama pants*	*I woke up and got out of bed.*	*No*
Monday 3 March	*8.00am*	*Coffee*	*200ml*							

Continence Foundation of Australia Bladder Diary Instructions

Bowel Diary

Fill in this diary for about seven days in a row. Use with the Bristol Stool Chart.

Name:

Day and time		Bowel movement				Pads or clothing	Bowel medication What and when	What happened at the time you passed a bowel motion?
Day	Time	Stool (poo) type (Bristol Stool Chart Type 1-7)	How urgent was your need to use your bowels (poo)? 1 = no urge to 3 = normal urge to 5 = strong urge	Did you leak or soil? (Yes or No)	How much did you leak or soil? (Smear, small, medium or large)	Did you change your pad or clothing? (Yes or No)	Did you take any laxatives, fibre supplements, enemas, suppositories etc?	Where you were, or what you were doing at the time of the accident/soiling
Example: Saturday 3 March	*9.00am*	*5*	*1*	*Yes - both wee and poo*	*Medium*	*Yes - my underpants and jeans*	*Psyllium husks the night before*	*Went for a walk after breakfast. Did not realise I leaked wee and poo at the time*

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, mushy stool
Type 7		Watery, no solid pieces. ENTIRELY LIQUID

Continence Foundation of Australia Your 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 including transcutaneous tibial nerve stimulation for overactive bladders.
- 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, Wednesday, Thursday, Friday 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
- Email TPCH-Allied-Health-Admin@health.qld.gov.au

V4 Effective: Aug 2024 Review: Aug 2026

Metro North Health | Queensland Government

Incontinence- Metro North Services

- •Caboolture - Pelvic Health Physiotherapy (accepts GP referrals) + Gynaecology
- Redcliffe – Pelvic Health Physiotherapy + Gynaecology
- TPCH – Physiotherapy Continence Clinic (accepts GP referrals)
- RBWH – Pelvic Health Physiotherapy (accepts GP referrals), Continence nurse linked with Urology (accepts GP referrals), Gynaecology

Incontinence- Resources

Overactive bladder

RACGP - Overactive bladder syndrome

Overactive Bladder - (urogynaecology.com.au)

Stress Urinary Incontinence

RACGP - Managing Female Stress Incontinence

Nocturia

RACGP - Questions to ask a patient with nocturia

Incontinence- Resources

Veterans' MATES – impact of commonly used medicines on urinary incontinence

Urinary incontinence - Veterans' MATES (veteransmates.com.au)
Anticholinergic burden - Veterans' MATES (veteransmates.com.au)

Deprescribing anticholinergics

Primary Health Tasmania - a guide to deprescribing anticholinergics

Surgical Treatment Female Stress Urinary Incontinence

UGSA Surgical treatment of SUI pathway 2016 - (urogynaecology.com.au)

Incontinence - Continence Foundation of Australia

Good bladder habits can help improve bladder control

Poor bladder habits can lead to poor bladder control. This includes wetting yourself. Here are some easy steps you can take to keep your bladder healthy.

Step 1 - Drink well

- Have plenty of fluids. Fluid can include milk, juice and soup, however water is best
- Cut down on how much caffeine and alcohol you drink. These may upset your bladder. There is caffeine in chocolate, milo, coffee, tea and fizzy drinks. Fizzy drinks include cola and sports drinks.

Step 2 - Eat well

- Eat plenty of vegetables, fruit, legumes (beans), grains, nuts and seeds every day. This will increase your fibre and help you go to the toilet regularly
- When increasing fibre in your diet, drink more water to help prevent constipation.

Step 3 - Be active

- Keep active. Exercise for 30 minutes most days or as advised by your doctor or pelvic health physiotherapist
- Physical activity such as brisk walking may help keep your bowel regular.

Step 4 - Look after your pelvic floor muscles

- Keep your pelvic floor muscles strong with pelvic floor muscle exercises
- Try to avoid putting extra strain on the pelvic floor muscles by maintaining a healthy weight and preventing constipation
- See a pelvic health physiotherapist or nurse continence specialist to check that you are exercising your pelvic floor muscles the right way
- Call the **National Continence Helpline 1800 33 00 66** and ask for information on pelvic floor muscle exercises.

Step 5 - Follow these toilet tips

- It is normal to go to the toilet four to six times a day
- You shouldn't get up to go to the toilet more than once a night, or twice if you are over 65 years of age
- Do not go 'just in case'. Try to go to the toilet only when your bladder is full. Going to the toilet just before you go to bed is fine
- Women should sit down to go to the toilet. Do not hover over the toilet seat. Your feet should touch the ground
- Take your time. Relax when you are on the toilet. This helps your bladder to empty out fully. If you rush, you may not empty your bladder fully and over time you could get a bladder infection
- Do not strain when using your bowels. This puts extra load onto your pelvic floor muscles and may weaken the muscles. The pelvic floor muscles help with bladder and bowel control.

Continence Foundation of Australia

One in four Australians aged 15 years and over have a bladder control problem

Ask yourself

Do I:

- ☐ leak or wet myself when I cough, laugh or sneeze?
- ☐ leak or wet myself when I lift something heavy?
- ☐ leak or wet myself when I play sport?
- ☐ sometimes wear pads to absorb urine (wee), or 'just in case'?
- ☐ often have to rush to use the toilet?
- ☐ sometimes not make it to the toilet in time?
- ☐ ever worry I might lose control of my bladder?
- ☐ wake up more than once during the night to use the toilet?
- ☐ plan my day around the nearest toilet?
- ☐ sometimes feel my bladder is not quite empty?
- ☐ leak or wet myself when I stand up?
- ☐ leak or wet myself as I get out of bed?
- ☐ dribble urine after going to the toilet?
- ☐ have a urine stream that stops and starts?
- ☐ wet the bed?

If you said YES to any of these questions, you may have a bladder control problem.

What is poor bladder control?

People with poor bladder control may:

- have accidents and leak urine. This is called urinary incontinence
- need to hurry to get to the toilet to pass urine
- wet themselves before they can get to the toilet
- go to the toilet often through the day
- be woken up more than once a night by the need to empty their bladder
- leak urine when they get up from a bed or chair
- leak urine when they lift, laugh, cough or sneeze
- wet themselves and be unaware of it
- have a stream that stops and starts instead of a smooth flow
- wet the bed.

How common is poor bladder control?

One in four Australians aged 15 years and over have a bladder control problem.

If you have a bladder control problem, you are not alone.

Men and women of all ages can have poor bladder control. Women and older people are the most likely to be affected.

You don't have to put up with it

Continence Foundation of Australia

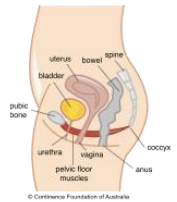
Strong pelvic floor muscles mean good bladder control

What are the pelvic floor muscles?

The pelvic floor is the base or the floor of the pelvis and is made up of layers of muscle and other tissues. These layers stretch like a hammock from the tailbone (coccyx) at the back, to the pubic bone at the front and from side to side.

A woman's pelvic floor muscles support her bladder, uterus (womb) and bowel. The urethra (urine tube), the vagina, and the anus (back passage) all pass through the pelvic floor muscles. Pelvic floor muscles help control your bladder and bowel. They may also help sexual function.

It is vital to have pelvic floor muscles that are strong and able to relax fully.



© Continence Foundation of Australia

Pelvic floor muscles can be made weaker by:

- not keeping them active
- being pregnant
- giving birth
- being menopausal
- being constipated and straining.

Should I do pelvic floor muscle exercises?

When the pelvic floor muscles have to support heavy loads they may not be strong enough.

Heavy loads press down on the pelvic floor muscles when you:

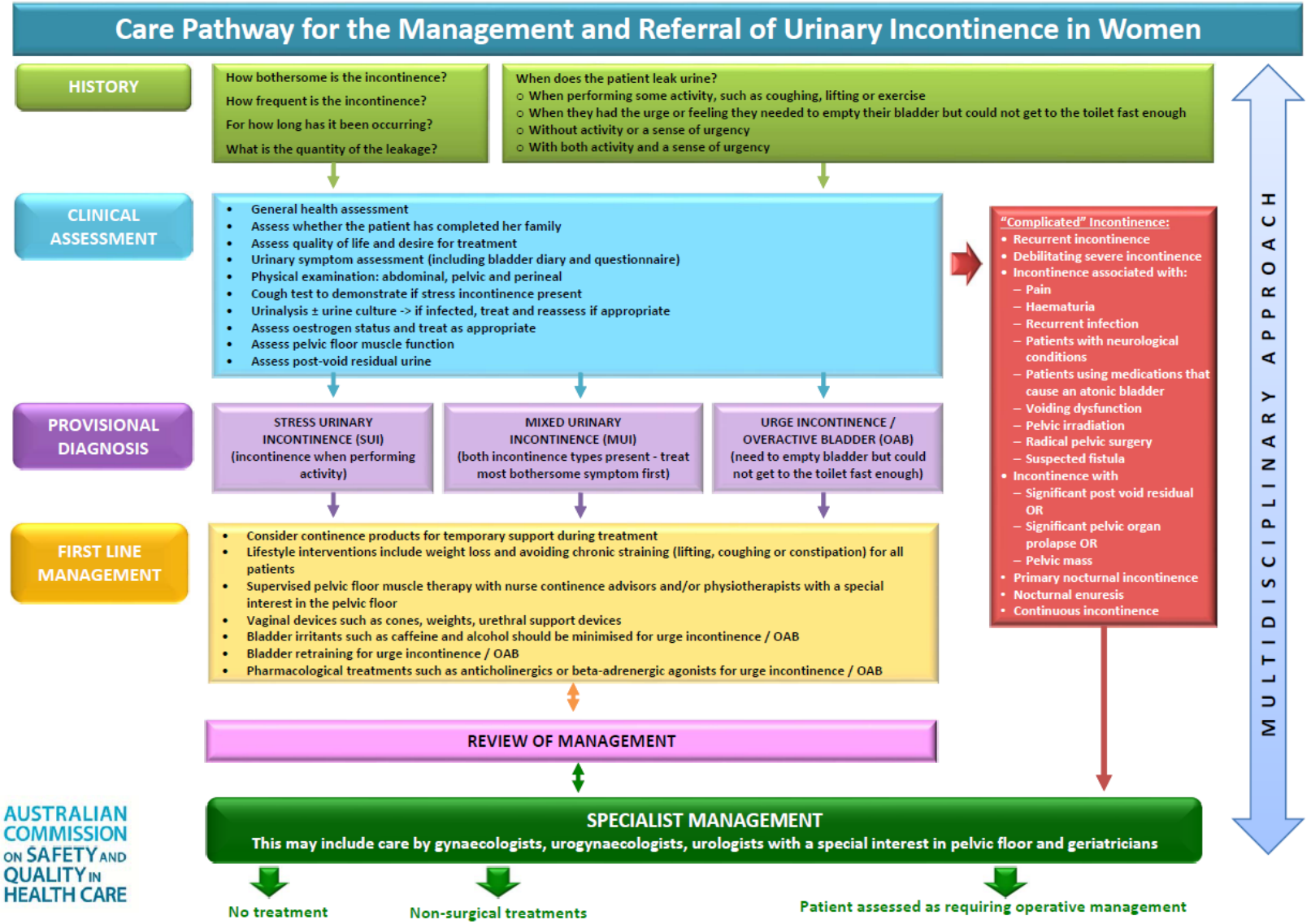
- are pregnant
- are overweight
- push and strain to use your bowels if you are constipated
- carry heavy weights
- have a cough that goes on for a long time such as with asthma, bronchitis or a chronic cough.

Women who wet themselves leaking urine when they cough, sneeze or are active have stress incontinence. Pelvic floor muscle exercises can help improve this problem.

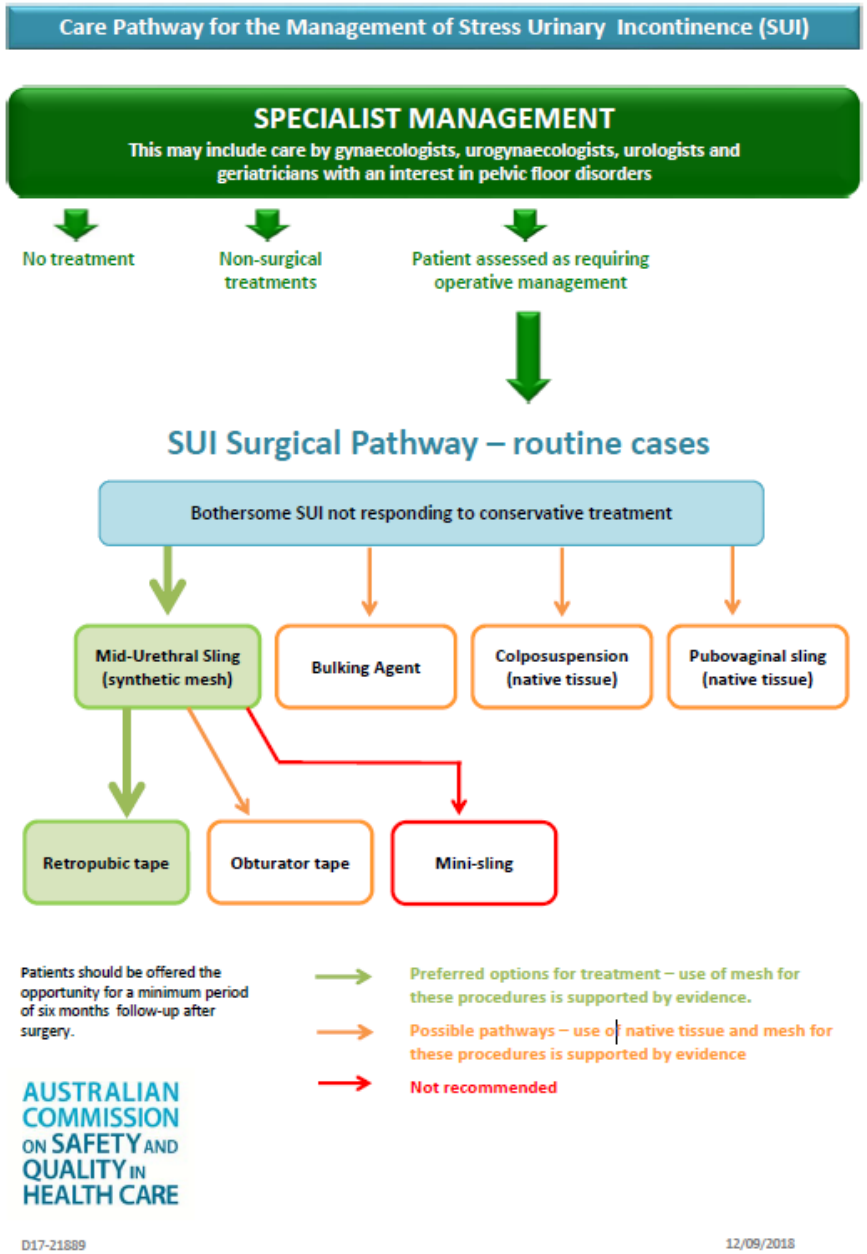
For pregnant women, pelvic floor muscle exercises will help the body support the growing baby. Pelvic floor muscle exercises will also reduce the chance of having a bladder or bowel problem after birth. Healthy muscles before the baby is born return to normal more easily after birth.

Continence Foundation of Australia

Bladder & Bowel Resources



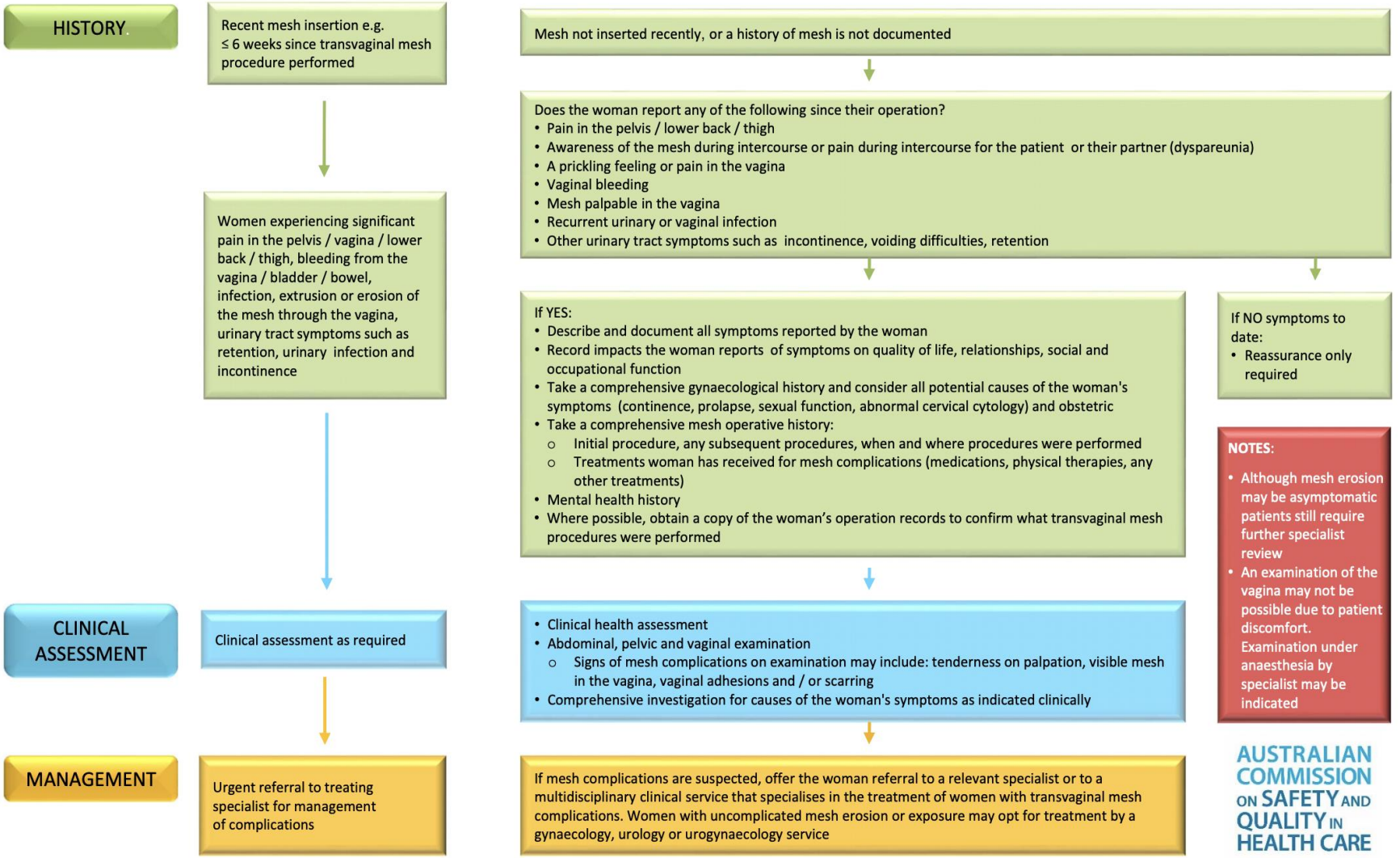
[Care pathway for Management & Referral of Urinary Incontinence in Women for GPs]



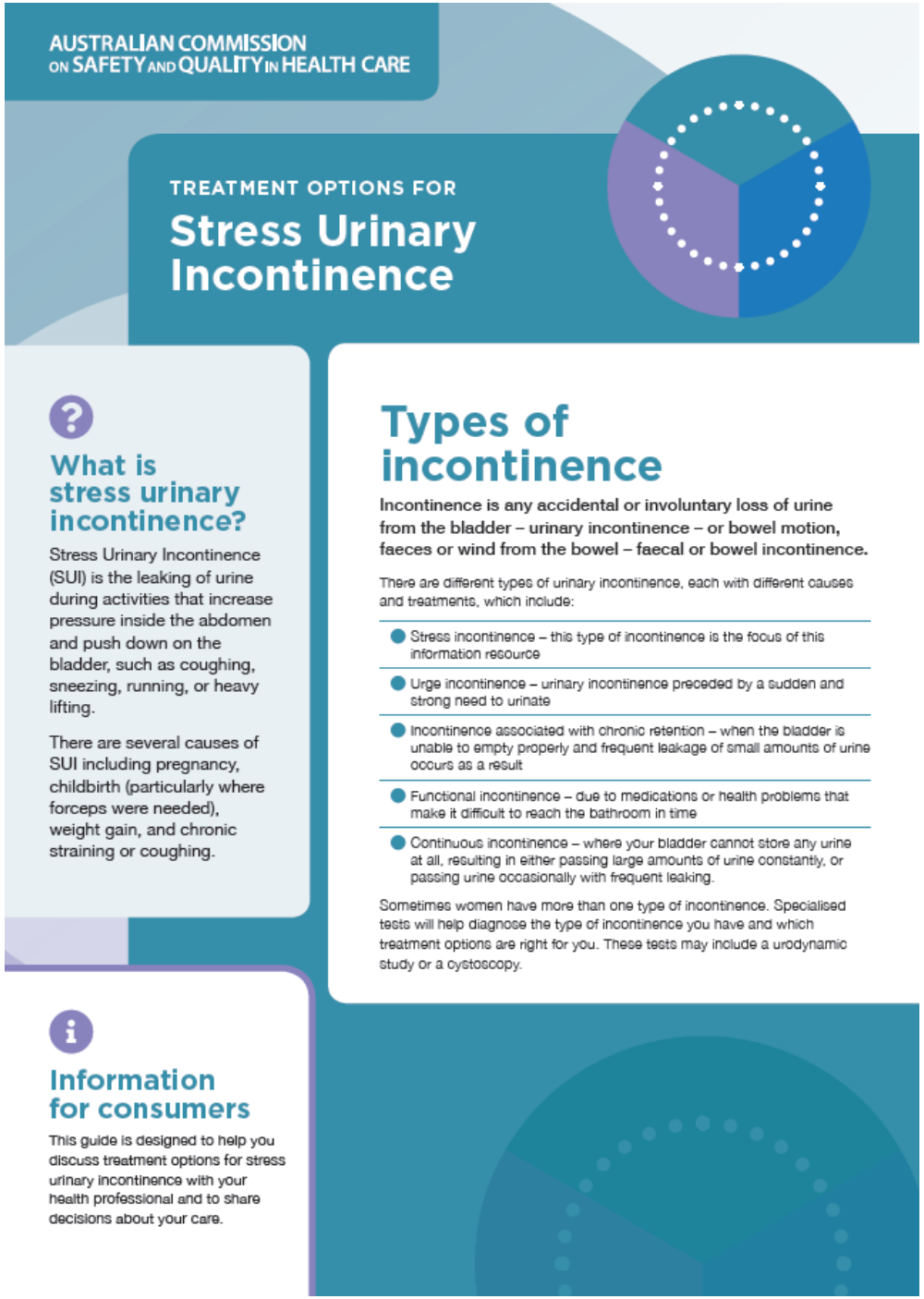
[Care Pathway for the Management of Stress Urinary Incontinence (SUI) | Australian Commission on Safety and Quality in Health Care]

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.



Transvaginal TV mesh management care pathway for GPs



AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

TREATMENT OPTIONS FOR

Stress Urinary Incontinence

What is stress urinary incontinence?

Stress Urinary Incontinence (SUI) is the leaking of urine during activities that increase pressure inside the abdomen and push down on the bladder, such as coughing, sneezing, running, or heavy lifting.

There are several causes of SUI including pregnancy, childbirth (particularly where forceps were needed), weight gain, and chronic straining or coughing.

Types of incontinence

Incontinence is any accidental or involuntary loss of urine from the bladder – urinary incontinence – or bowel motion, faeces or wind from the bowel – faecal or bowel incontinence.

There are different types of urinary incontinence, each with different causes and treatments, which include:

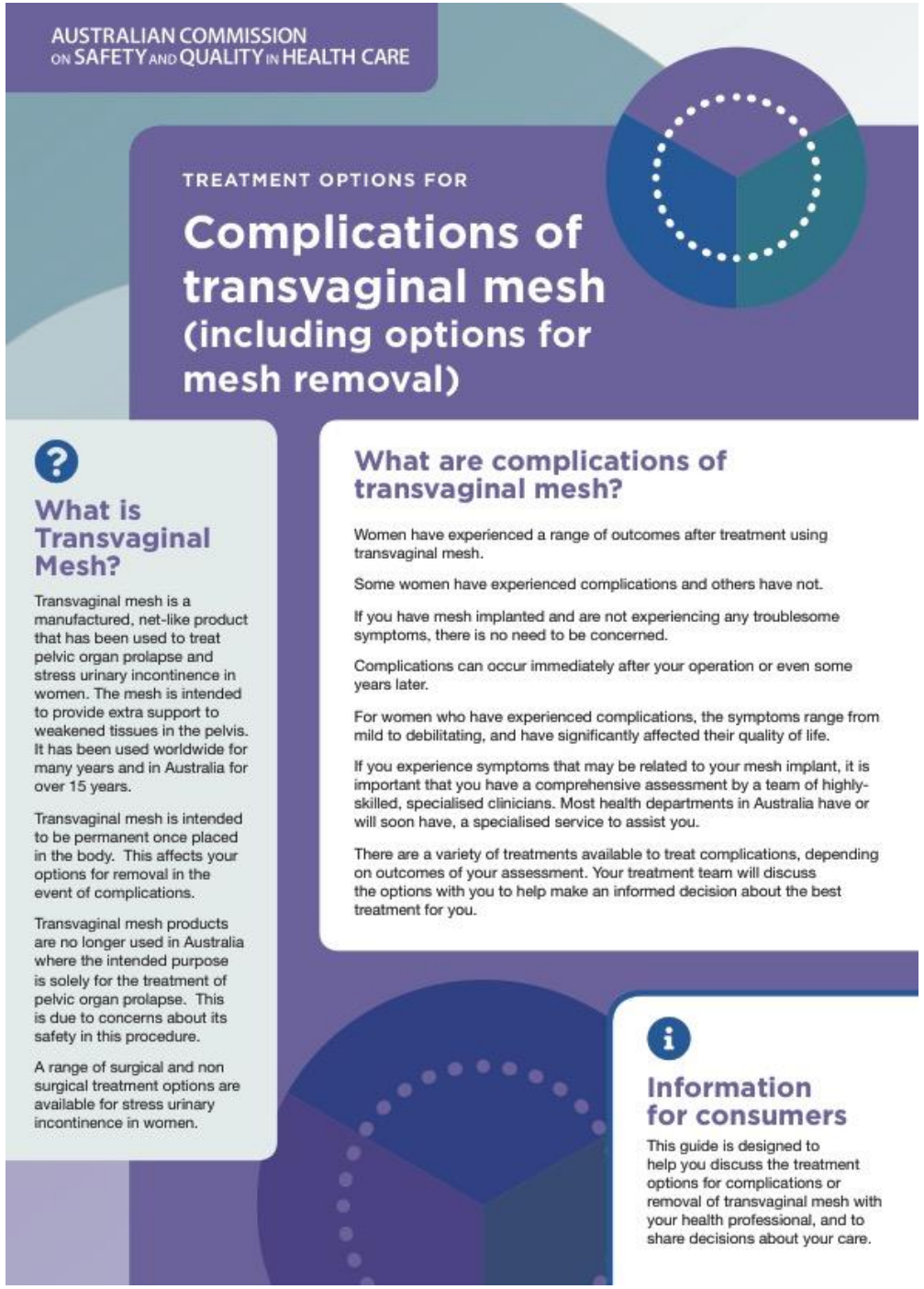
- Stress incontinence – this type of incontinence is the focus of this information resource
- Urge incontinence – urinary incontinence preceded by a sudden and strong need to urinate
- Incontinence associated with chronic retention – when the bladder is unable to empty properly and frequent leakage of small amounts of urine occurs as a result
- Functional incontinence – due to medications or health problems that make it difficult to reach the bathroom in time
- Continuous incontinence – where your bladder cannot store any urine at all, resulting in either passing large amounts of urine constantly, or passing urine occasionally with frequent leaking.

Sometimes women have more than one type of incontinence. Specialised tests will help diagnose the type of incontinence you have and which treatment options are right for you. These tests may include a urodynamic study or a cystoscopy.

Information for consumers

This guide is designed to help you discuss treatment options for stress urinary incontinence with your health professional and to share decisions about your care.

[Treatment-Options-SUI-Consumer-Info.pdf (safetyandquality.gov.au)]



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.

[Treatment-Options-Complications-Consumer-Info.pdf (safetyandquality.gov.au)]

Incontinence Referral
Pelvic Floor Dysfunction
Pelvic Mesh Service

Minimum Referral Criteria	
Category 1 (appointment within 30 calendar days)	• Fistula (constant urinary or faecal incontinence per vagina) • Mesh in viscus • Unexplained haematuria potentially related to mesh within the bladder
Category 2 (appointment within 90 calendar days)	• Recurrent urinary tract infections or unexplained haematuria potentially related to mesh within the bladder • Vaginal bleeding related to mesh exposure • Offensive vaginal discharge
Category 3 (appointment within 365 calendar days)	• Stable mesh related pelvic or vaginal pain • Asymptomatic mesh exposure • Dyspareunia

[Pelvic mesh (referral to Queensland Pelvic Mesh Service (QPMS) ONLY) | Clinical Prioritisation Criteria (health.qld.gov.au)]

Urinary incontinence referral information can be found under [Pelvic floor dysfunction (e.g. prolapse and/or incontinence) | Metro North Health Refer your patient]

1. Reason for request Indicate on the referral

- 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

2. Essential referral information Referral will be returned without this

- Confirmation of type of mesh product i.e. whether for prolapse or incontinence and when it was inserted if at all possible
- Name of commerical pelvic mesh product inserted i.e. Prolift mesh, Elevate mesh, tension free vaginal tape (TVT) etc.
- Patient symptoms, onset and treatment to date
- Quality of life affected by mesh related issues
- FBC, LFTs, U&E's
- Urine microscopy, culture and sensitivity/susceptibility.

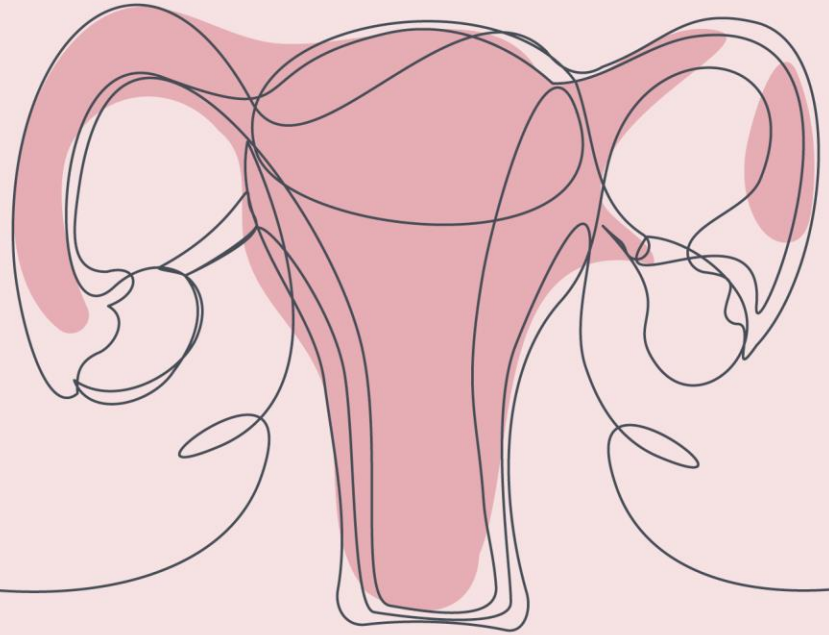
* In order to progress your patient's referral through the service in a timely manner it is essential to try to obtain confirmation of type of mesh product and when it was inserted if at all possible. This should occur before communicating with the QPMS. Without this information being provided there may be a lengthy delay in your patient being seen in the service

3. Additional referral information Useful for processing the referral

- BMI
- Provide and other relevant history, clinical examination findings and treatment to date (if required)
- Provide social factors and impact on patient
- Provide Mental health history
- What are the patient's goals of care?
- Imaging reports (if available)

Metro North **GP Alignment Program**

Gynaecology Workshop



CASE STUDY: Heavy Menstrual Bleeding

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Heavy menstrual bleeding - Case Study

- Marlene is 45 years old
- Aboriginal woman
- G4P4, all vaginal births
- 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 childcare

Outline your approach

Heavy menstrual bleeding - History

International Federation of Gynecology and Obstetrics (FIGO) classification system for causes of abnormal uterine bleeding (PALM-COEIN)

Abnormal uterine bleeding (including heavy menstrual bleeding)*			
Structural causes (PALM)		**Non-structural causes (COEIN)**	
P	Polyps	C	Coagulopathy
A	Adenomyosis	O	Ovulatory dysfunction
L	Leiomyoma (fibroids)	E	Endometrial
M	Malignancy or hyperplasia	I	Iatrogenic
		N	Not otherwise classified

International Journal of Gynecology and Obstetrics 113 (2011) 3-13. Image: Table 1. Heavy Menstrual Bleeding Clinical Care Standard (June 2024).

Heavy menstrual bleeding - History

- Nature of bleeding - duration, frequency, heaviness and pattern (regular or irregular)
- Post-coital, intermenstrual and postmenopausal bleeding require specific investigation
- Impact on quality of life
- Related symptoms e.g. pelvic pain or pressure
- Symptoms suggestive of iron deficiency, with or without anaemia
- Sexual and reproductive health
  - parity, desire for future fertility
  - contraception use
  - likelihood of pregnancy or miscarriage
  - risk of sexually transmitted infection
  - cervical screening status
- Symptoms suggestive of systemic causes of bleeding e.g. bleeding disorder, polycystic ovary syndrome (PCOS), thyroid disease
- Relevant family history e.g. bleeding disorders, endometriosis, endometrial or colorectal cancer
- Current medications and use of over-the-counter supplements that may be associated with ovulation or bleeding
- Comorbidities or previous treatments for heavy menstrual bleeding

Heavy menstrual bleeding – History

- **Risk Factors for Endometrial Cancer include**
  - **Chronic anovulation**
  - **PCOS**
  - **Exposure to unopposed oestrogen or tamoxifen**
  - **Age >45 years**
  - **Personal or family history endometrial, colorectal cancer, Lynch Syndrome**
  - **Obesity particularly with diabetes or hypertension**
  - **Nulliparity**
  - **Young age at menarche or older age at menopause**
  - **Endometrium on TV ultrasound day 5-10 - premenopausal > 12mm; perimenopausal 5mm or greater**

Heavy menstrual bleeding - Examination

Conduct a physical examination if appropriate and with consent

Speculum examination

Bimanual pelvic examination

Heavy menstrual bleeding - Investigation

- Urinary beta HCG if indicated
- Cervical co-test (HPV + LBC)
- Genital swab tests (if indicated)
- FBC, ferritin, TSH
- Coagulation profile and von Willebrand's disease screening test in adolescents
- Pelvic USS (TV preferred) on day 5-10 – specify this on the request

Heavy menstrual bleeding - Management

- Offer women oral treatment at first presentation when clinically appropriate, including when a woman is undergoing further investigation or waiting for other treatment

- Medical – correct iron deficiency, tranexamic acid, NSAIDs, COCP, oral progesterone , DMPA, LNG-IUD

- Surgical - endometrial ablation, hysteroscopic resection of polyps/fibroids, myomectomy, uterine artery embolisation, hysterectomy

Heavy menstrual bleeding - Referral

Minimum Referral Criteria

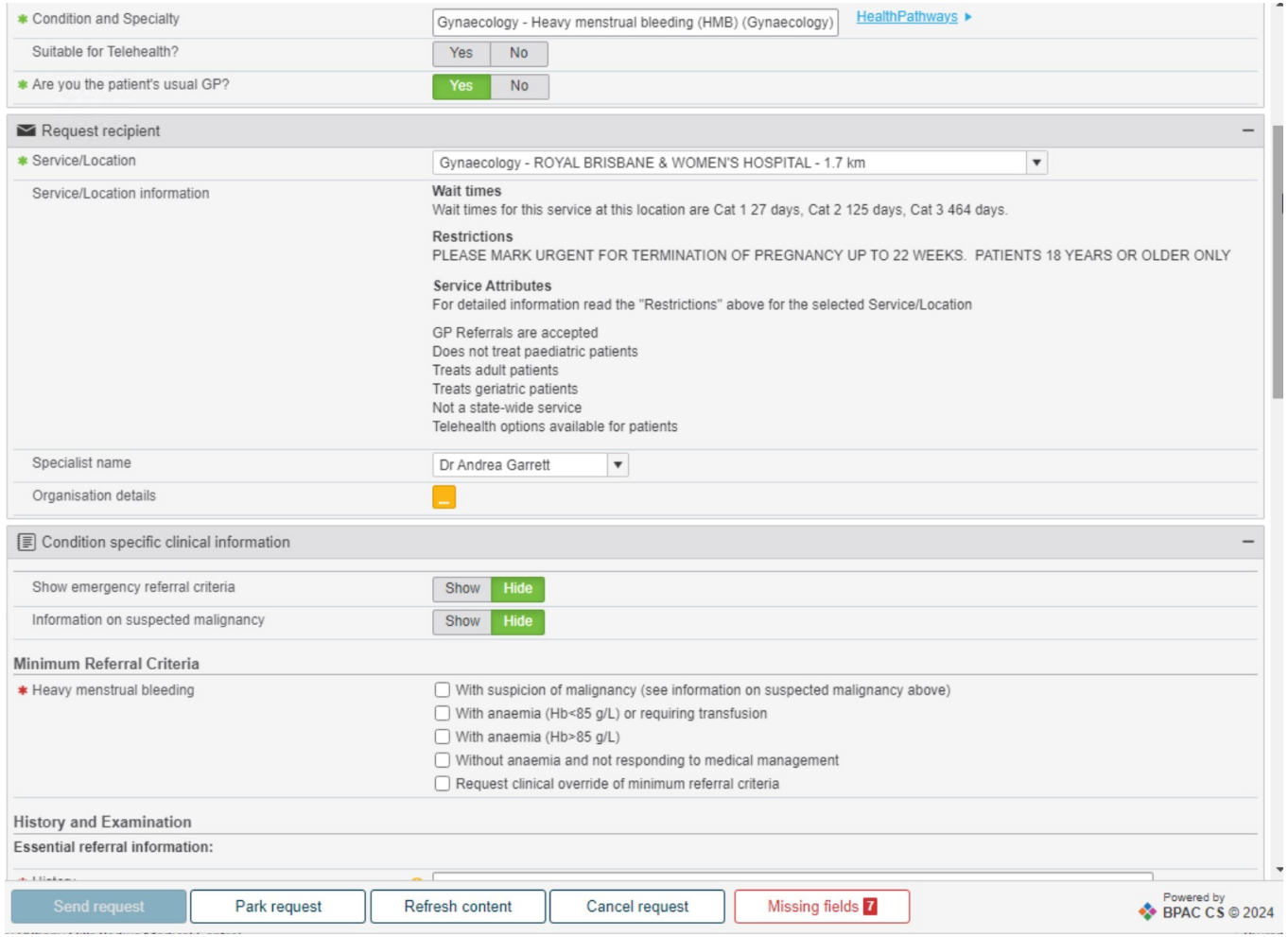
Category 1 (appointment within 30 calendar days)	• Suspicion of malignancy (see other useful information) • HMB with anaemia (Hb<85) or requiring transfusion
Category 2 (appointment within 90 calendar days)	• HMB with anaemia (Hb>85). In paediatric and adolescent patients the impact on quality of life with missing school, tiredness, anxiety and depression necessitates referral to SPAG services as category 2, and not category 3 if not responding to primary medical management. There is a significant risk of having an underlying bleeding disorder that needs to be excluded.
Category 3 (appointment within 365 calendar days)	• HMB without anaemia not responding to medical management

2. Essential referral information Referral will be returned without this

- Brief description of periods
- Medical management to date
- Most recent or current cervical screening if indicated (not a requirement for adolescents)
- FBC, Serum, ferritin results
- Pelvic USS (TVS preferable)
- **Adolescent patient** - COAG profile including von Willebrand's disease (vWD), platelet function disorders screen, TFT. TA Scan in the first instance

3. Additional referral information Useful for processing the referral

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



[Heavy menstrual bleeding (HMB) | Clinical Prioritisation Criteria (health.qld.gov.au)]

[Heavy menstrual bleeding (HMB) | Metro North Health Refer your patient]

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

Updates:

- **Offer women oral treatment at first presentation when clinically appropriate, including when a woman is undergoing further investigation or waiting for other treatment**
- **Evidence supports the use of 52mg levonorgestrel releasing-IUD to treat heavy menstrual bleeding in patients without malignancy or other significant pathology**
- **No specific time interval before referring to Gynaecology for a woman not responding to medical management**

[Heavy Menstrual Bleeding Clinical Care Standard | Australian Commission on Safety and Quality in Health Care]

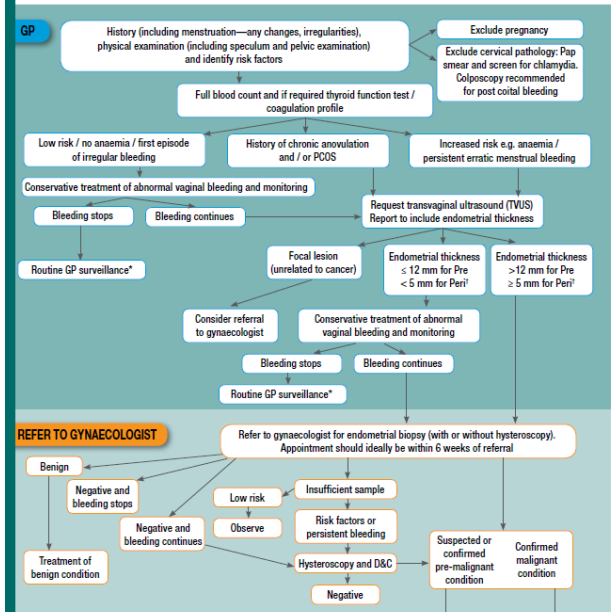
ABNORMAL VAGINAL BLEEDING IN PRE- AND PERI-MENOPAUSAL WOMEN

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



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 should be undertaken (when possible) by the relevant specialist (gynaecologist, gynaecological oncologist).
- If insufficient material is obtained for a histological diagnosis, no further investigation is required in the absence of ongoing bleeding, unless the woman has an endometrial thickness over 12mm for pre-menopausal women and 5mm for peri-menopausal women
- 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 needless surgery.
- A thick endometrium can obscure a complete view of the uterine cavity, so to achieve optimal visualisation diagnostic hysteroscopy should be performed in the follicular phase of the cycle.
- 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 menstruation transition or hormonal variability.

Peri-menopause: about or around the menopause. The average length of this stage is 5 years. Cyclic irregularities increase as women enter this stage with prolonged ovulatory and anovulatory cycles. Levels of follicle stimulating hormone and oestradiol oscillate frequently with decreasing luteal function.

ROUTINE GP SURVEILLANCE*

Practitioners should ask their patients to come back for a follow up appointment if they notice any changes or have any concerns about their menstrual/ blood loss pattern. Ongoing repeat TVUS is not recommended for women in the absence of ongoing symptoms.

ENDOMETRIAL THICKNESS IN PERI-MENOPAUSAL WOMEN†

Interpretation of endometrial thickness in the peri-menopausal woman is dependent on the time of the menstrual cycle during which the ultrasound is performed. Most accurate results are achieved if performed on days 4–7 of cycle, when menses have ceased.

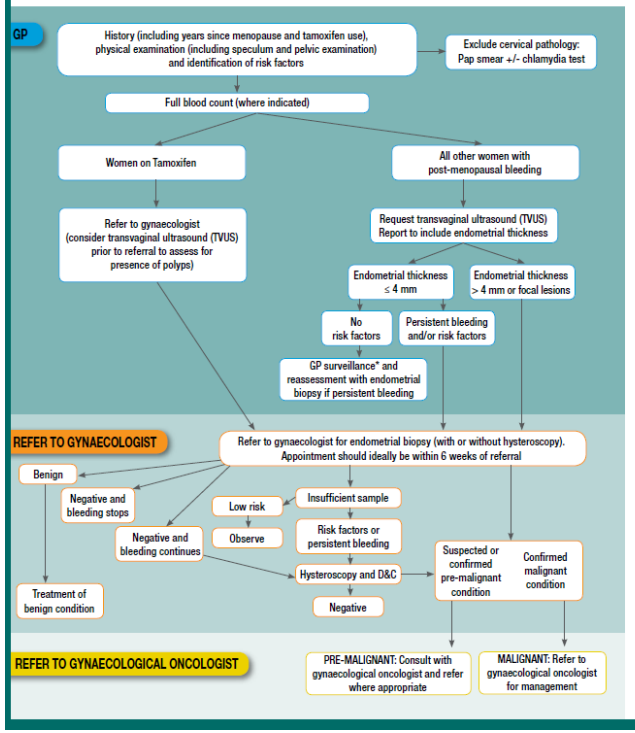
VAGINAL BLEEDING IN POST-MENOPAUSAL WOMEN

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



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.

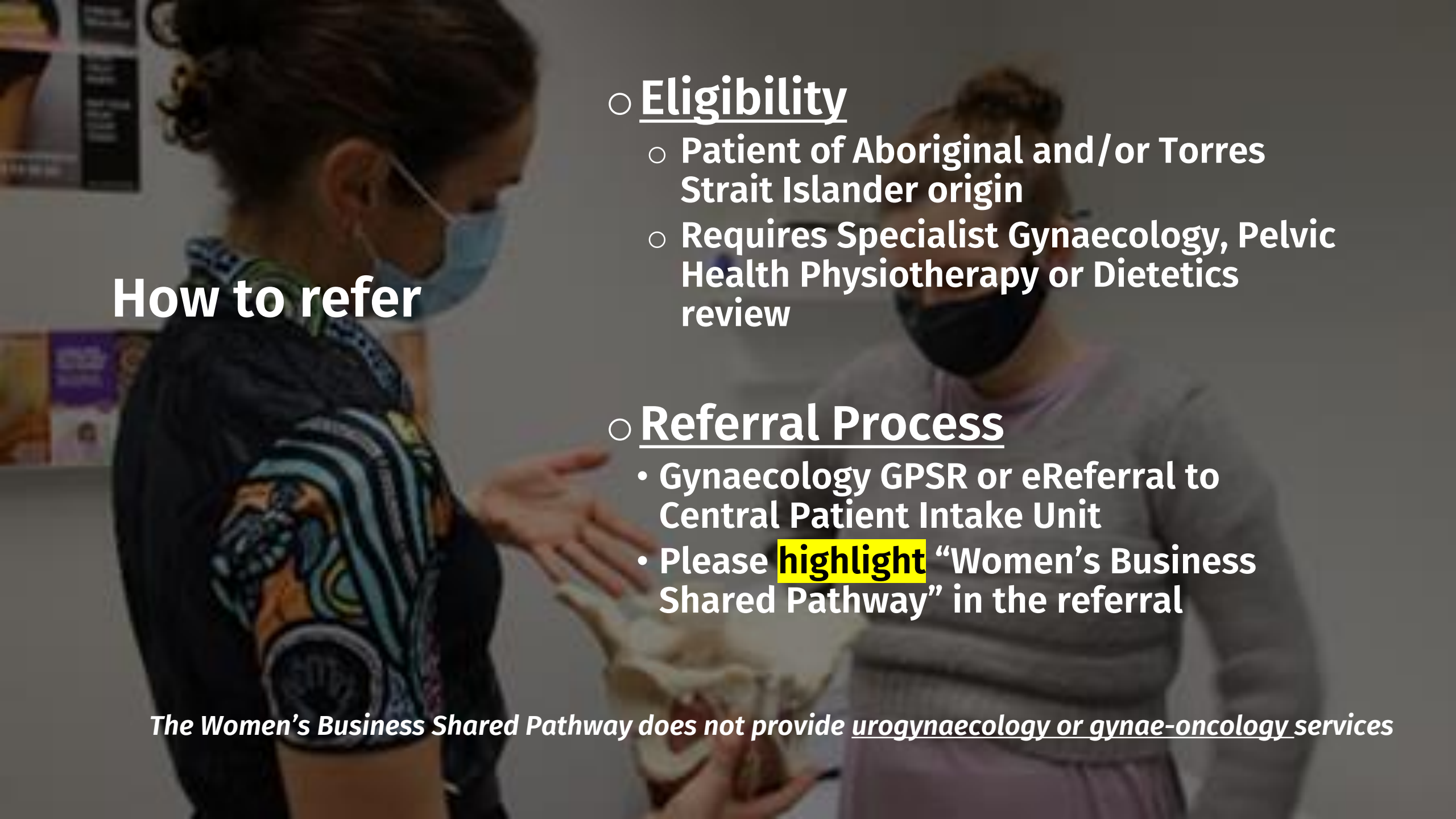
[ncgc-vaginal-bleeding-flowcharts-march-20111_504af02038614.pdf (canceraustralia.gov.au)]

The Women's Business Shared Pathway

- Metro North Health + Institute for Urban Indigenous Health partnership
- Culturally safe Specialist Gynaecology care for Aboriginal and Torres Strait Islander Women
- 4 community-based clinics per month
  - Nundah Community Health Centre
  - Morayfield MATSICHS
  - Deception Bay MATSICHS
- 1 theatre list per month at RBWH
- Pelvic Health Physiotherapy + Dietician available weekly

IUIH institute for urban indigenous health

Metro North Health | Queensland Government

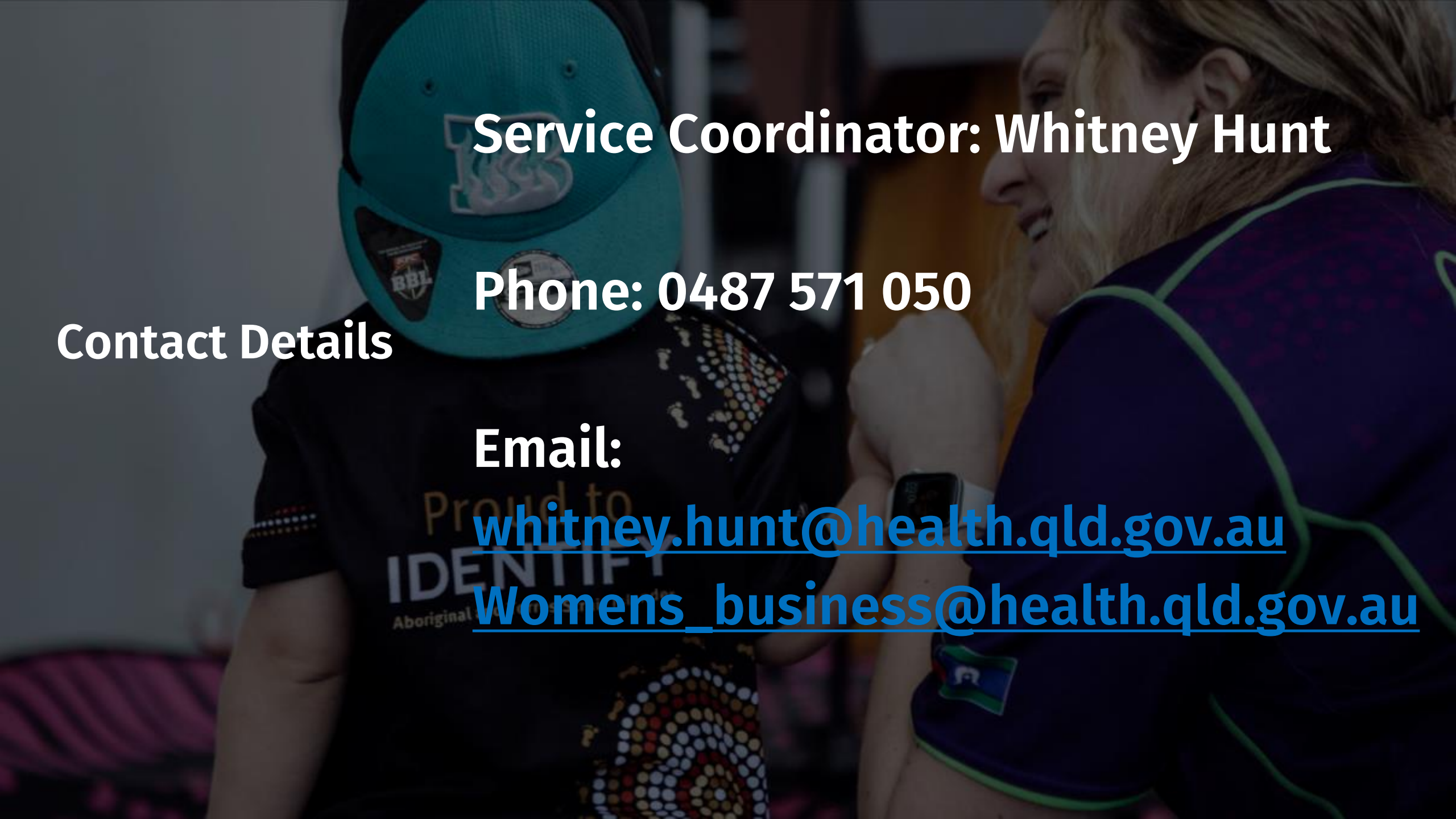


How to refer

- **Eligibility**
  - Patient of Aboriginal and/or Torres Strait Islander origin
  - Requires Specialist Gynaecology, Pelvic Health Physiotherapy or Dietetics review

- **Referral Process**
  - Gynaecology GPSR or eReferral to Central Patient Intake Unit
  - Please highlight "Women's Business Shared Pathway" in the referral

The Women's Business Shared Pathway does not provide urogynaecology or gynae-oncology services



Contact Details

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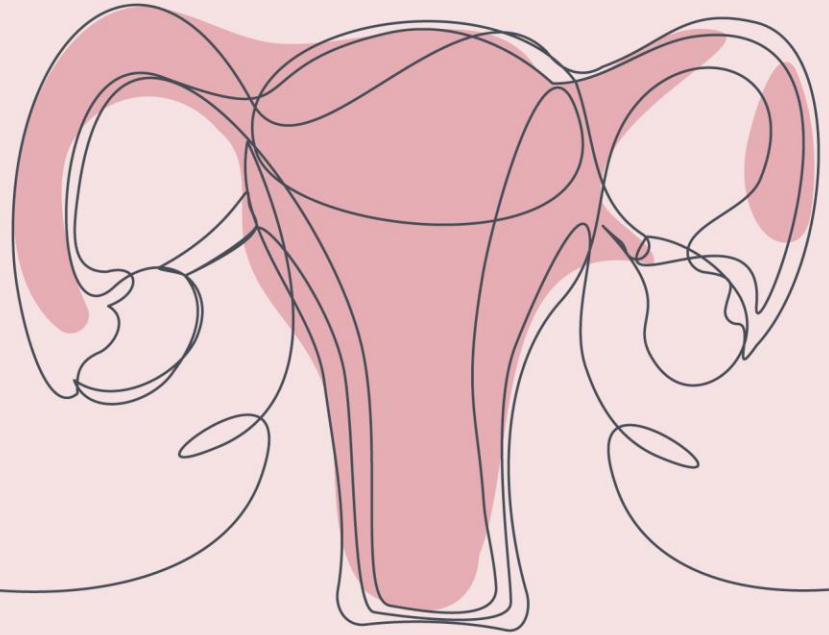
Womens_business@health.qld.gov.au

Metro North **GP Alignment Program**

Gynaecology Workshop



CASE STUDY: Fertility

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Fertility – Case Study

- Hailey is 30 years old
- G0P0
- BMI 31kg/m^2
- Ceased COCP 2023, no period since
- Worsening acne since stopping COCP
- Sister had gestational diabetes
- Partner Justin is 35 years old
- “Trying to conceive” for 9 mo.
- Semen analysis:
  - Concentration 35 million/mL
  - Progressive Motility 65%
  - Normal Morphology 4%

Outline your approach

Fertility – History + Examination

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

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

Fertility - Investigations

- **Investigations female**
  - Pelvic USS (TV preferred)
  - 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, blood group & antibodies, Rubella IgG, Varicella IgG, Syphilis serology, HBV/HCV/HIV serology, cervical swab or urine PCR for Chlamydia/ Gonorrhoea
  - Cervical Screening Test
- **Investigations male**
  - Semen analysis

PCOS Evidence-based Guideline 2023 (Monash)

Fertility - Considerations

- AMH testing
- Genetic carrier screening
- Testosterone, free testosterone & Free Androgen Index
- Androstenedione & DHEAS
- Hysterosalpingogram, hystero-salpingo contrast sonography (HyCoSy), saline sonohysterography
- Folic acid 2.5 - 5mg and iodine 150micrograms
- Lifestyle counselling – healthy eating, exercise, smoking, alcohol, encourage BMI <25

Fertility - Referral

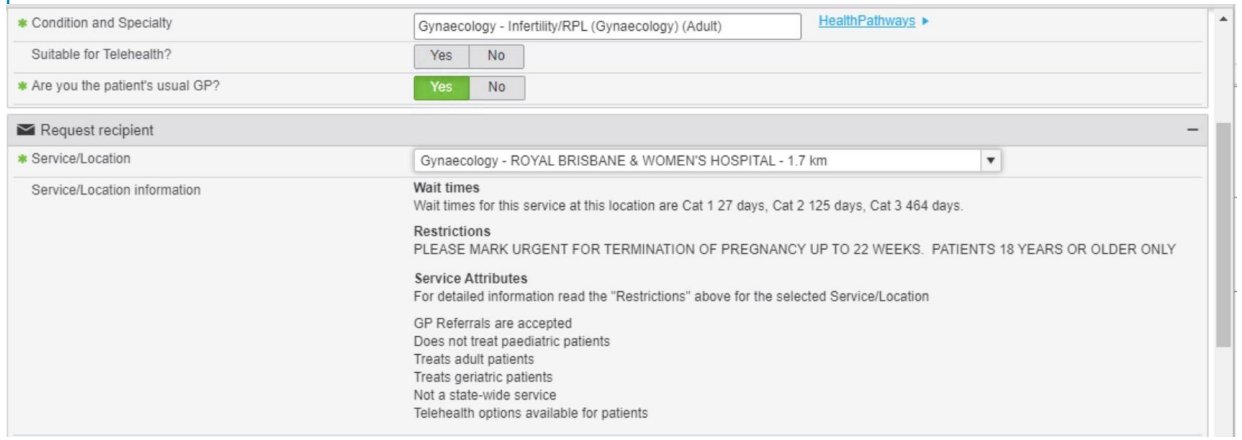
- Refer female
  - >35yo unprotected intercourse >6mo.
  - < 35yo unprotected intercourse >12mo.
  - oligo-amenorrhoea (indicates anovulation), previous pelvic surgery, previous STI, abnormal pelvic examination or pelvic USS, evidence of endometriosis
- Refer male
  - Azoospermia, low sperm count or motility, poor sperm morphology, impotence, spinal surgery, erection or ejaculation problems

Fertility/RPL Referral

Minimum Referral Criteria

Category 1 (appointment within 30 calendar days)	• Reproductive counselling for fertility sparing options prior to chemotherapy treatment • All other Category 1 referral for infertility are not accepted, refer to a private specialist to avoid delay
Category 2 (appointment within 90 calendar days)	• Category 2 referral for infertility not accepted, refer to a private specialist to avoid delay

Category 3 (appointment within 365 calendar days)	• All referrals for infertility for example but not limited to:
	  • Surgical management of hydrosalpinx
	  • Anovulation for ovulation induction (selected cases)
	  • Unexplained infertility (selected cases)
	  • Recurrent pregnancy loss
	(**Definition**: - infertility is the failure to achieve pregnancy after 12 months or more of regular unprotected intercourse)



[Infertility/RPL | Clinical Prioritisation Criteria (health.qld.gov.au)]
[Infertility/RPL | Metro North Health Refer your patient]

2. Essential referral information Referral will be returned without this

Essential Referral Information (for Infertility and RPL)

- 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, semen analysis
  - a referral letter for the partner is required
- Weight/ BMI
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- FBC group and antibodies rubella IgG varicella IgG, syphillis serology, HBV/HCV/HIV serology results
- FSH, LH (Day 2-5), prolactin, TSH if cycle prolonged and/or irregular
- Pelvic USS (TVS preferable)
- If **PCOS** is suspected include the following:
  - Free androgen index (FAI) or Free Testosterone
  - Fasting blood glucose result
  - Lipids, TSH results

Infertility – additional Essential Referral Information

- Day 21 serum progesterone level (7 days before the next expected period)

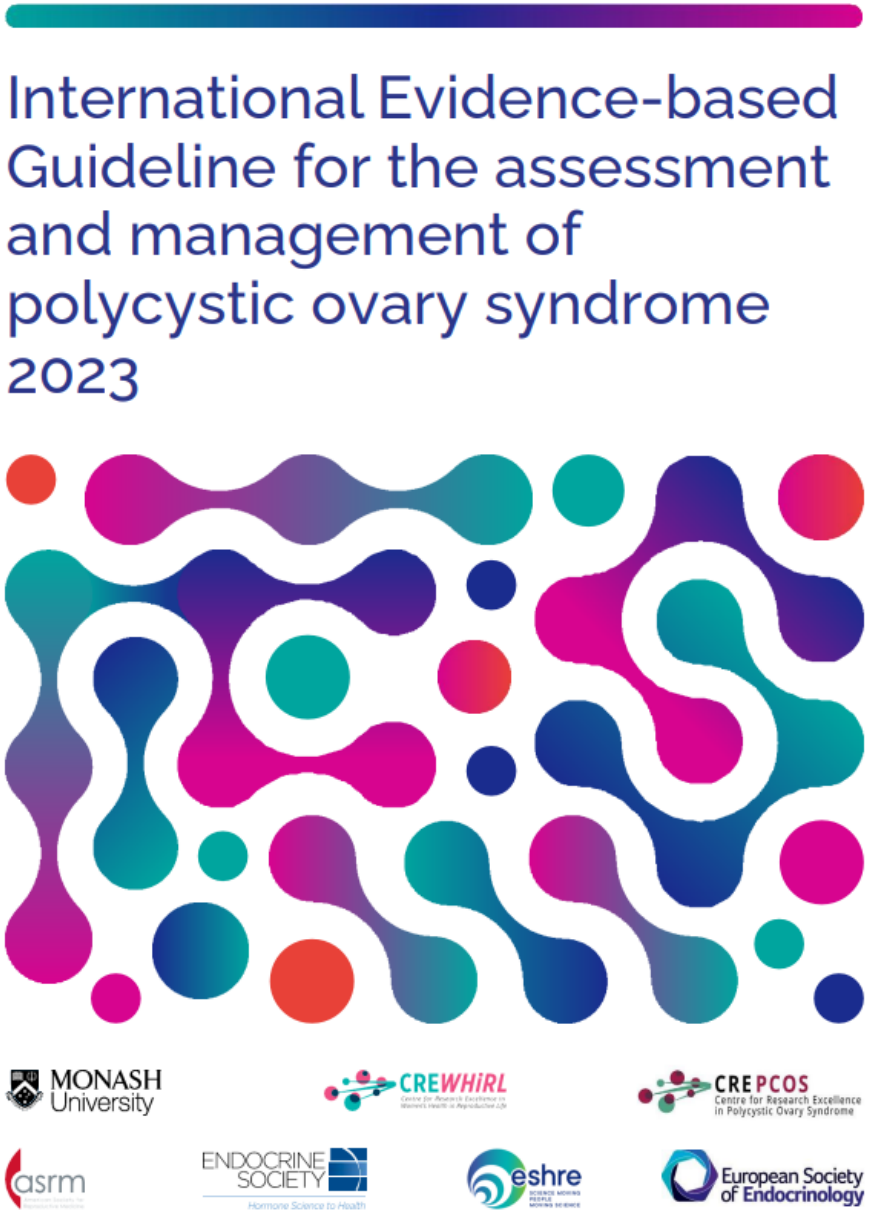
First trimester RPL – additional Essential Referral Information

- Thrombophilia screen, antiphospholipid syndrome (APS)
- Autoimmune screen
  - Coeliac serology – serum deamidated gliadin peptide (DGP), tTG Ab
  - Antinuclear antibodies (ANA) only if personal or family history indicates higher risk of autoimmune disease
- Karyotype for both parents

Second trimester RPL – additional Essential Referral Information

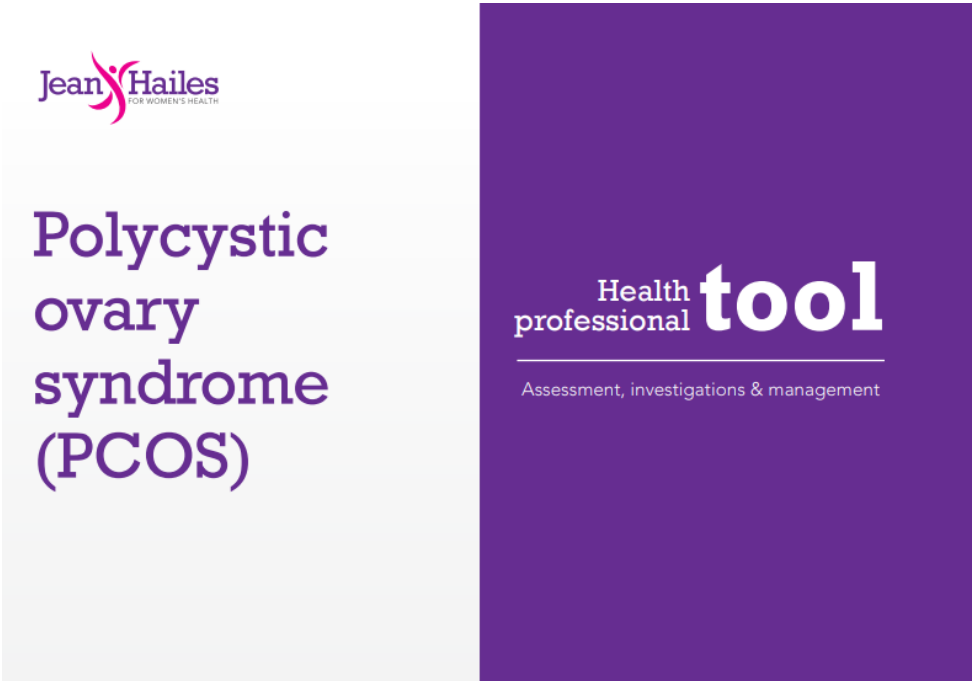
- Hysterosalpingogram (HSG) or hystero-sonogram
- US with cervical length

PCOS Resources



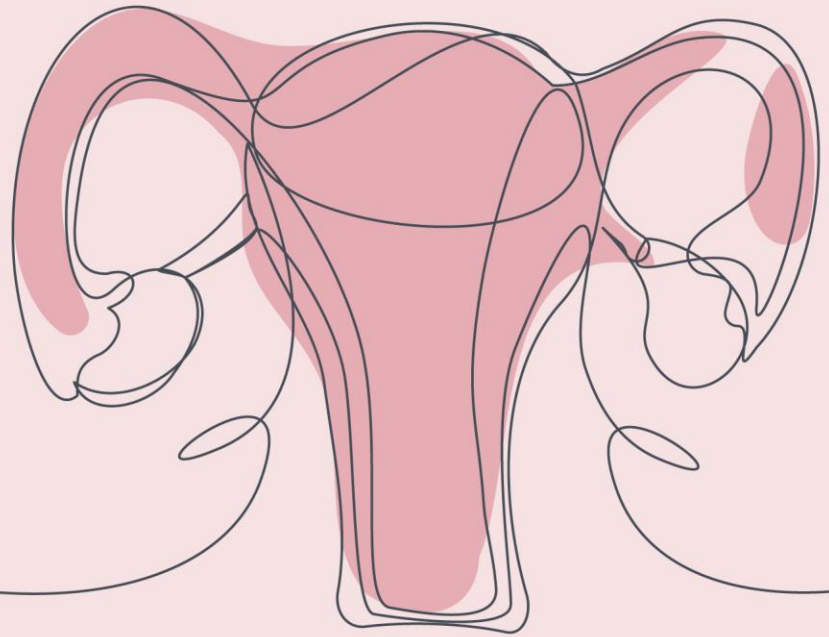
[PCOS Evidence-based Guideline 2023 (monash.edu)]

[Polycystic ovary syndrome (PCOS): Health professional tool (jeanhailes.org.au)]



Metro North **GP Alignment Program**

Gynaecology Workshop



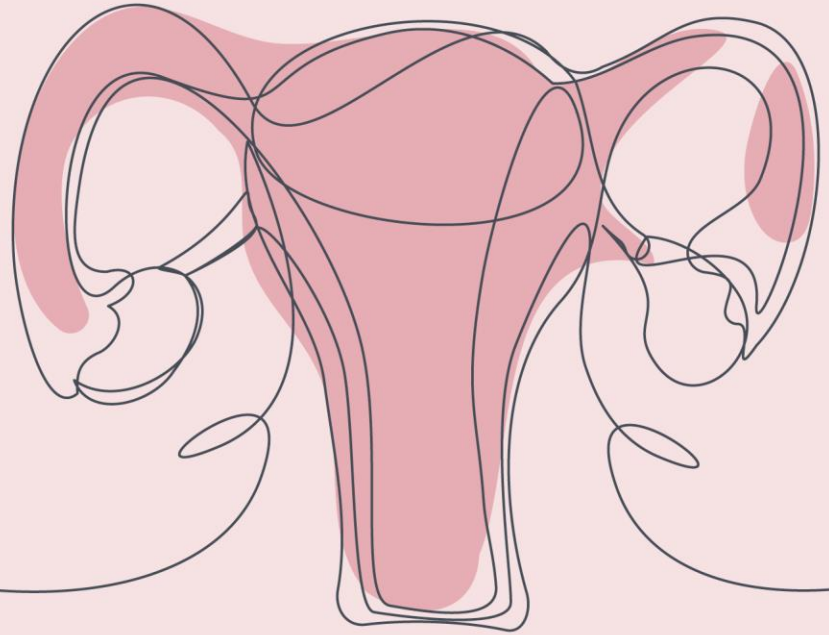
INTERACTIVE SKILLS STATIONS

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Metro North **GP Alignment Program**

Gynaecology Workshop



Interactive Skills Station: CST

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

SULLIVAN NICOLAIDES PATHOLOGY

Cervical Screening

Elimination of cervical cancer

CST self-collect, CINtec *PLUS*,
self-collect HPV test clinical audit

Dr Lauren Furnas

Global elimination of cervical cancer

World Health Organization

Cervical Cancer Elimination Initiative

In May 2018, the WHO Director-General announced a global call for action to eliminate cervical cancer, underscoring renewed political will to make elimination a reality and calling for all stakeholders to unite behind this common goal.

In August 2020 the World Health Assembly adopted the Global Strategy for cervical cancer elimination (90:70:90 targets). Campaign launch November 2020.

In November 2021, the Minister of Health announced a collaboration with the Australian Centre for Prevention of Cervical Cancer (ACPCC) to develop a National Strategy for the Elimination of Cervical Cancer in Australia (Strategy). Funded by the Australian Government, outlines Australia's commitment (objectives and actions) to achieving equitable elimination of cervical cancer as a public health problem by 2035.

We are on track to be the first country in the world to eliminate cervical cancer.

Australia making advances…

2020

- 80.5% girls fully vaccinated by 15 years
- 62% women aged 25–74 years participated in cervical screening (2018–2021), 67.3% 45–49 years
- 85.8% of those with pre-cancer treated within 6 months (QLD data showed over 90% treatment rates for cervical cancer – no national data)

Sadly, Australian women are still dying of cervical cancer:

- In 2021 in Australia, there were **851 new cases** of cervical cancer
- In 2020 there were **209 deaths** attributable to cervical cancer

Equity – screening participation

~80% women diagnosed with invasive cancer are under/never screened

- Indigenous – 2x develop and 3.8x likely to die from cervical cancer
- Geographical – NT, outer regional/remote/very remote
- Age 25–29 and >70 years
- Socioeconomic disadvantage
- Cultural and linguistic diversity
- LGBTIQ+
- Gender (versus sex) identify as male; assigned female at birth
- Disability
- History of sexual violence

Ref: C4 2021 Cervical Cancer Elimination Progress Report
VCCR. Statistical Report: Victorian Cervical Cytology Registry; 2015.

Cervical Screening Test Self-collection

(CST self-collect)

CST Self-collects

- Initial hesitancy and mistrust combined with (extremely) restricted access – very low uptake (0.1%); minimal labs accredited.
- 2018 meta-analysis showed equivalence in accuracy between self-collection and clinician collection for PCR results.
- 2022 offered as a **choice** for all participants, except for the small number who are ineligible (i.e. those who need a co-test)

Ref: Inturrisi F, Aitken CA, Melchers WJG, et al. Clinical performance of high-risk HPV testing on self-samples versus clinician samples in routine primary HPV screening in the Netherlands: An observational study. *Lancet Reg Health Eur*. 2021;11:100235. Published 2021 Nov 9. doi:10.1016/j.lanepe.2021.100235

Original modelling estimated 6% by mid-2025, but anticipation from the NCSP was that **universal self-collection** from July 2022 would do much better than that.

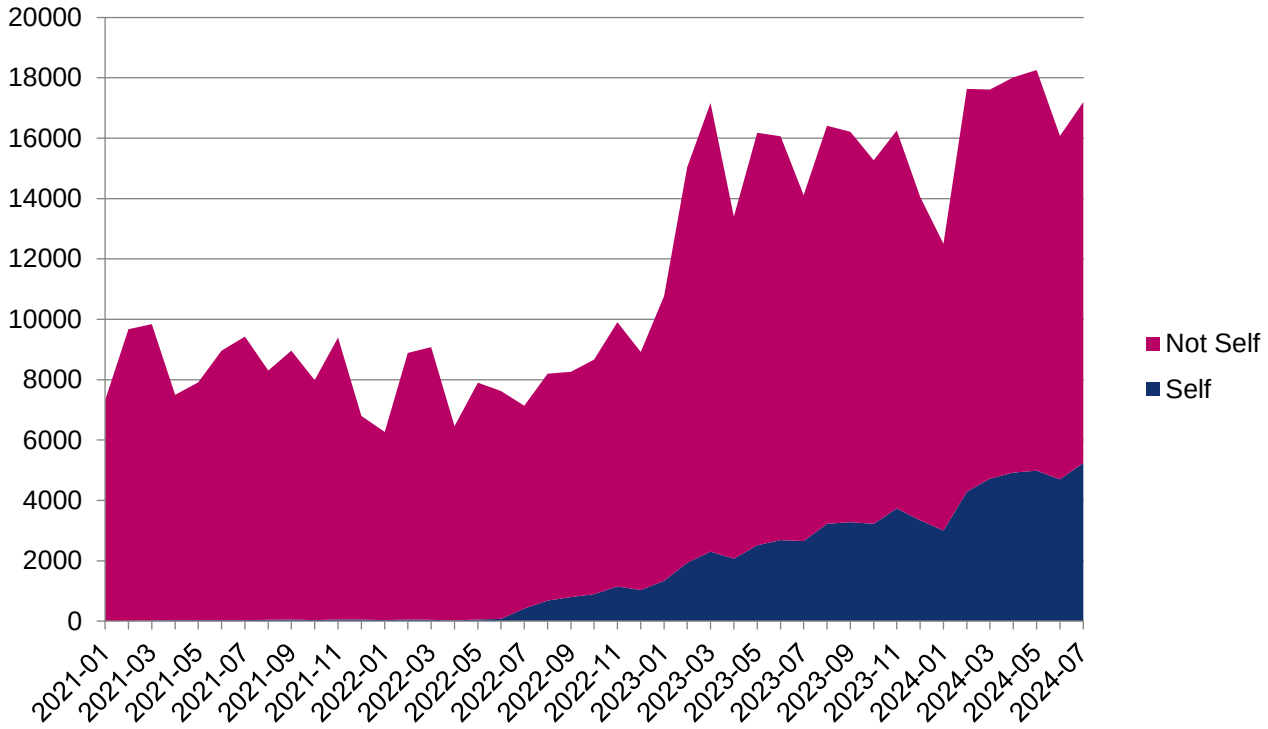


Fig. 1 Sullivan Nicolaides Pathology proportion self collects vs all collects 2021 - current

<u>Nationally:</u>

Increased numbers of self collects in rural/remote areas, Northern Territory residents, 70+ yrs, financially disadvantaged, never screened and under screened populations

Patient eligibility

Eligible:

- Anyone who is eligible for cervical screening (women and people with a cervix aged 25–74 years who have ever had any sexual contact) and *asymptomatic*
- Follow-up HPV testing at 12 or 24 months after an intermediate-risk result
- Cervical screening during pregnancy
- Previous hysterectomy for benign reasons without history of cervical pathology or screening history unknown

Ineligible:

- Symptomatic (e.g. PCB, IMB, PMB, unexplained persistent unusual vaginal discharge)
- Undergoing Test of Cure (TOC) surveillance after treatment for HSIL or history of glandular abnormality
- Total hysterectomy with past history of HSIL
- Diethylstilbestrol (DES) exposure in utero

Remember ….

If HPV is detected in the self-collected sample, a reflex liquid-based cytology (LBC) CANNOT be performed.

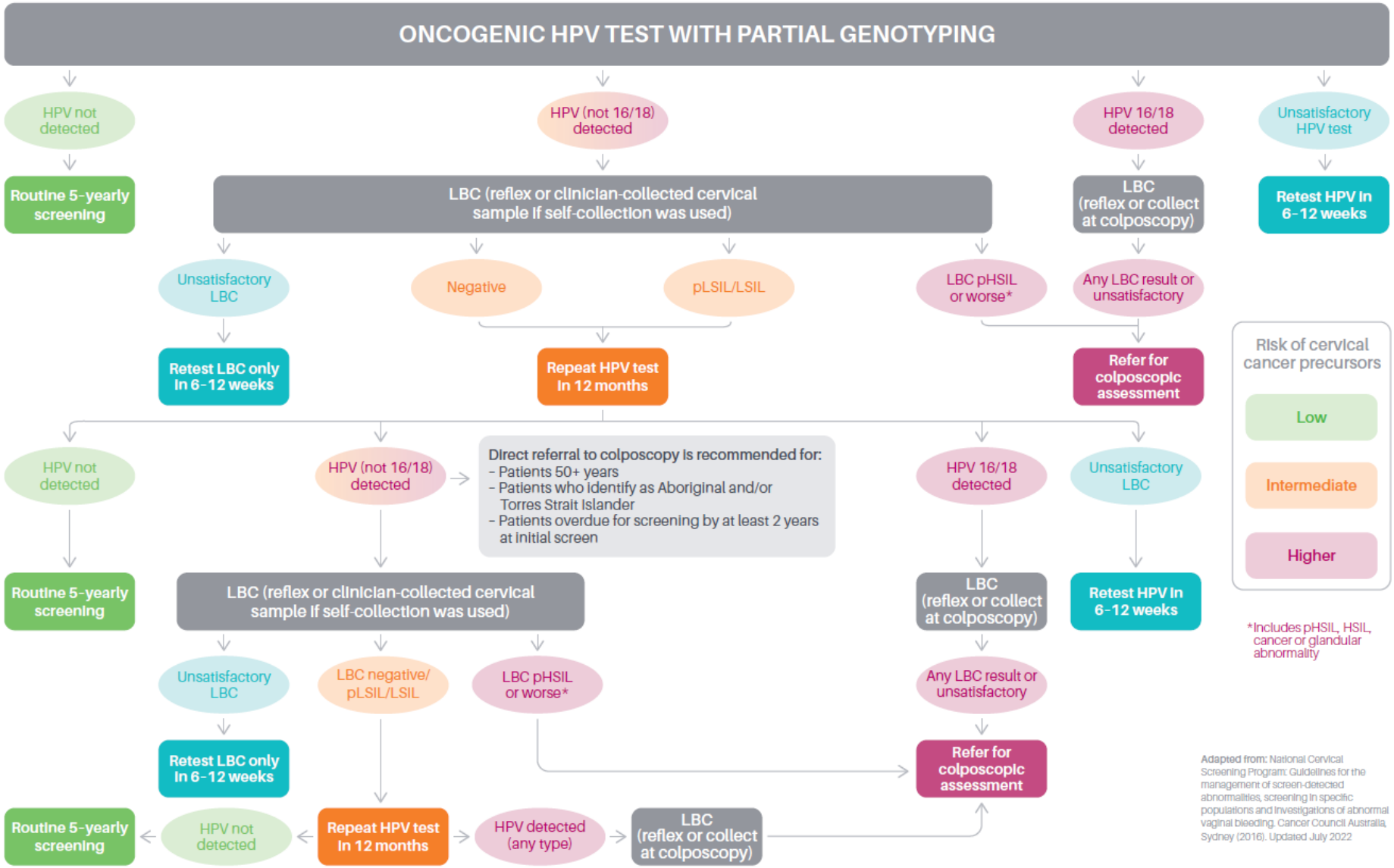
- 2% HPV 16 or 18 → colposcopy referral
- 6–8% HPV non 16/18 → need to return to their local health provider for a clinician-collected cervical sample for LBC triage

Self-collect samples

- Dry red-topped **FLOQ** swab – preferred test
  - NPAAC validated
  - Original approved test for Australian self-collection (data)
  - Prefer swab returned via collecting clinician

- Roche Copan 552C.8 swab immediately suspended in ThinPrep solution
  - SNP ‘verified’ for Roche
  - Anticipate problems with identification of these as self-collects due to similarity with usual clinician-collected specimens

Routine cervical screening (clinician- or self-collected)



Adapted from: National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigations of abnormal vaginal bleeding. Cancer Council Australia, Sydney (2016). Updated July 2022

CINTec *PLUS*

CINtec *PLUS*

- HPV subtypes are changing and moving towards less aggressive types with non-16/18 HPV subtypes increasing
- Vaccinated cohorts are now entering the screening system
- Colposcopy versus surveillance poses a challenge to follow up, for which HPV 16/18 genotyping together with *dual staining* may provide a potential efficient strategy for stratification

CINtec *PLUS*

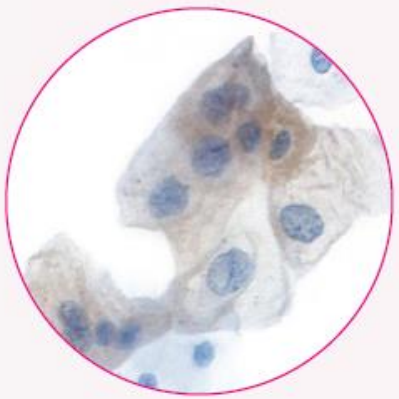
- Dual-stain cytology performed as on a liquid based cytology (LBC) side to detect presence of two proteins: p16 and Ki-67.
- p16 protein expressed in cells that have been transformed by high-risk HPV due to actions of the HPV oncoprotein E7. Overexpression is shown in most cervical pre-cancer lesions and cancers, but is rarely observed in normal tissue.
- Co-expression of anti-proliferative p16 protein and proliferation marker Ki-67 within the same cervical epithelial cell can be used as a surrogate marker for cell-cycle dysregulation mediated by HPV oncoproteins.
- Positive test = co-staining of p16 (brown, cytoplasmic) and Ki-67 (red, nuclear) in same cell means increased risk that CIN2/3 lesions are present.
- **Identifies women that may benefit most from immediate colposcopy.**

CINtec® *PLUS* Cytology increases clarity

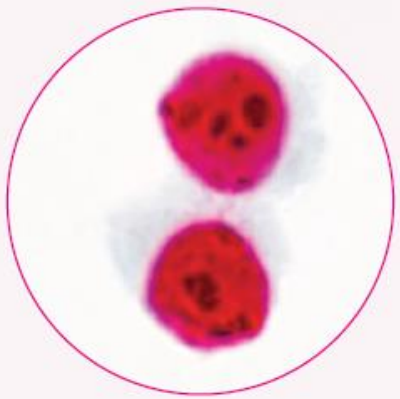
Identify transforming HPV infections with p16 and Ki-67

CINtec® *PLUS* dual stain technology based on immunocytochemistry staining, provides objective and enhanced visual clarity. This is in comparison to Pap cytology, where disease identification is based on morphological characteristics which can be difficult to assess objectively.[3]

CINtec® *PLUS* Cytology



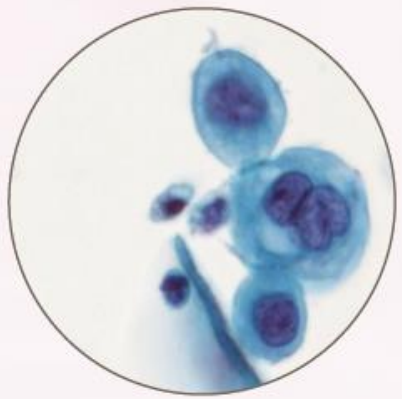
Negative
Expression of p16 ***(brown)*** signals halting of cell division



Negative
Expression of Ki-67 ***(red)*** signals progression of cell division

Positive
Co-expression of p16 & Ki-67 ***(brown and red)*** indicates cell cycle deruglation

Pap cytology



Subjective
Reliant on interpretation of morphology only

Preliminary COMPASS result findings

- Dual Stain can improve risk stratification in conjunction with HPV genotyping
- Potentially more effective than LBC as a triage (that is, following positive HPV result). Interestingly more so in young vaccinated cohort than older age group.
- Dual Stain brings forward the diagnosis of CIN2+/CIN3+ disease.
- Negative Dual Stain is a very strong marker of safety in non-16/18 positive patients.***

Ordering CINtec *PLUS*

- CINtec *PLUS* cytology should be requested by, or in consultation with, a gynaecologist.

- The request must be placed **within four weeks** of receiving the CST report, as LBC material is discarded after four weeks. Cannot be performed on a self-collect sample.

- Write ‘CINtec’ on the standard pathology request form and send a copy of your request to:
- **F** (07) 3377 8278 | **E**: DLSNPcintecplus@bri.sonichealth.com.au

- There is an out of pocket fee of $100.

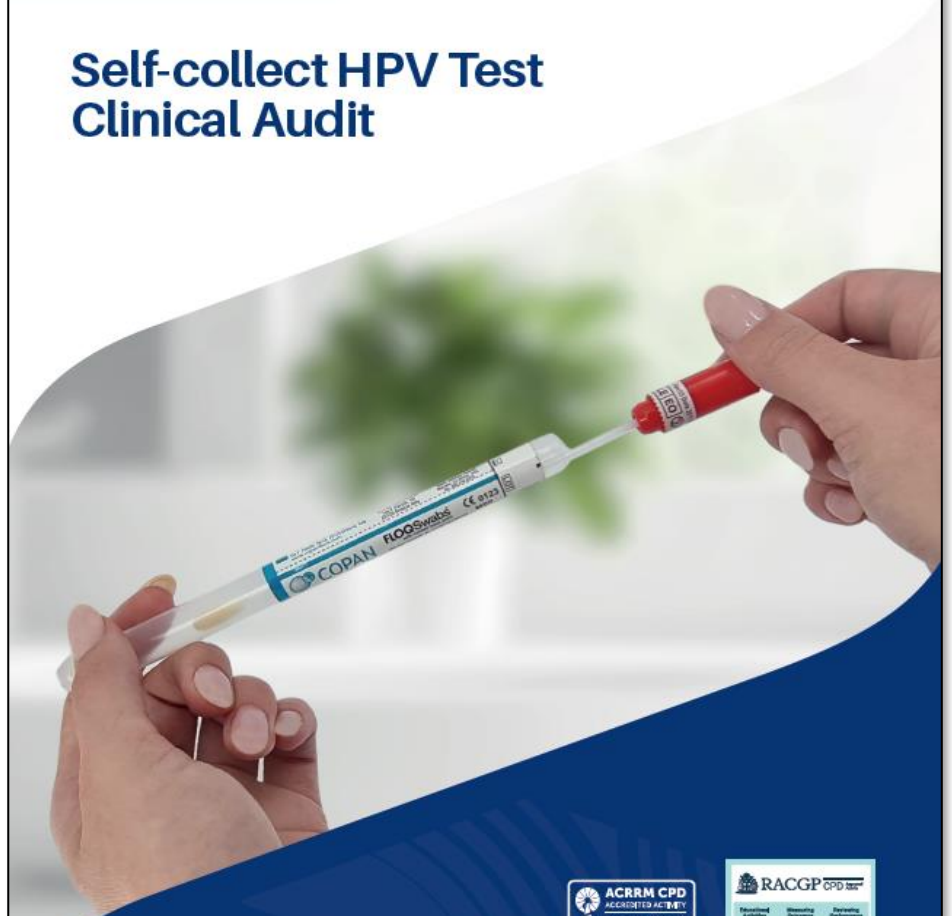
- Results are available within two weeks.

Self-collect HPV test clinical audit

SONIC HEALTHCARE

Information for Doctors

Self-collect HPV Test Clinical Audit



ACRRM CPD ACCREDITED ACTIVITY 2023-2025

RACGP CPD

Educational Activities	Reviewing Outcomes	Reviewing Performance
0 hours	10 hours	3 hours

Self-collect HPV Test Clinical Audit

Approved activity | 2023–2025

The Sonic Healthcare Self-collect HPV Test Clinical Audit is designed to assist doctors to confirm which patients require follow-up based on their HPV test result and allow review of their personal practice findings. A monthly report will provide a list of patients who had a positive HPV result or unsatisfactory sample and require active management according to national guidelines. This audit also allows doctors to better understand the effectiveness of their patient management and cervical screening follow-up protocols when self-collection was performed.

What you receive as a participant

A safety net to ensure follow-up for results requiring active management	Reported outcomes specific to your practice	Accredited activity eligible for CPD hours

How it works

Register online or through your local Sonic Healthcare pathology practice

Register online at support.sonicdx.com.au/register

Alternatively, contact details are listed on the back of this brochure. You will receive confirmation of your registration.

Enrolment is available to any practitioner who refers patients for self-collected HPV testing to any Sonic Healthcare pathology practice.

Automatic data collection

Clinical data is collected for each of your referrals. No additional information is required.

Receive your reports

An audit report will be generated for you to download and review.

Reflect on your learning outcomes

An evaluation link will be shared with you via email. Completing the evaluation provides an opportunity to reflect on your learning outcomes and provide feedback on the audit program.

Features

Recommended to be undertaken with Cervical Screening Test (CST) Clinical Audit

- Interpret self-collect specific data in conjunction with a reported percentage of self-collect samples and overall HPV positive results

Delivered online and accessible any time

Clinically relevant content based on a needs assessment guided by GPs, with measurable learning outcomes

Minimum of 10 referrals required during the audit period

Monthly reporting

- Monthly reports enable review of management outcomes for each patient who tested positive for HPV or had an unsatisfactory result on a self-collected test
- Personal statistic measuring follow-up rate for patients who tested positive for HPV (not 16/18) and require a clinician-collected liquid-based cytology (LBC) sample

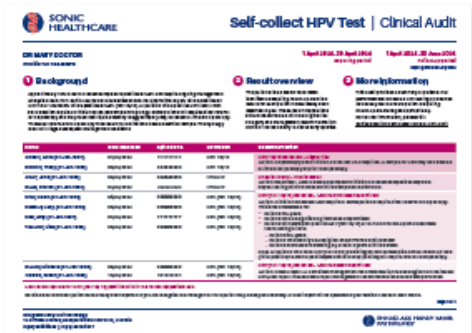
Monthly reporting

Monthly reports are generated automatically and uploaded to your Sonic Dx account. These contain a list of patients who were referred for self-collected HPV testing that require follow-up rather than returning to routine screening protocols. Most of these patients require a clinician-collected LBC sample, and possibly referral to colposcopy. Some will require re-collection for repeat testing.

This report highlights the recommended path of action in line with the National Cervical Screening Program, providing an opportunity to review the follow-up protocols within your practice to ensure optimal patient management.

Your monthly report contains data that is specific to your practice, including:

- Categorisation based on HPV result
  - Tested positive for HPV 16/18
  - Unsatisfactory self-collected HPV test
  - Tested positive for HPV (not 16/18) and a clinician-collected LBC sample has not been submitted
  - Tested positive for HPV (not 16/18) and a clinician-collected LBC sample has been submitted

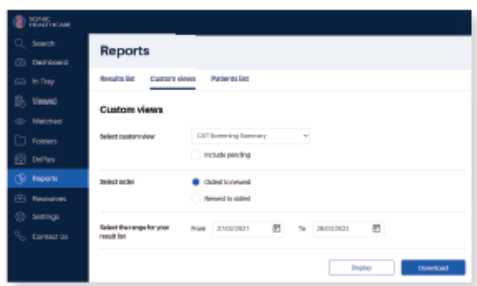


- Management recommendations
- Your personal follow-up rate expressed as the percentage of HPV (not 16/18) positive patients where a follow-up clinician-collected LBC has been performed

Each report reflects the patient cases authorised within the reporting period, that is, it is not a cumulative list. Monthly reports can continue to be accessed via Sonic Dx to confirm that action has been taken for patients previously identified as requiring follow-up.

Custom views available on Sonic Dx

Using Sonic Dx, clinicians can generate a list to assist in review and monitoring of their CST patients who performed self-collected HPV testing. While reflecting on the outcomes provided in the interval report, clinicians can filter patient results for a nominated date range to identify those that require further management, treatment or monitoring. These lists can be viewed on screen (with direct access to the original pathology report) or downloaded for easy patient review and follow-up.



SONIC HEALTHCARE

Self-collect HPV Test | Clinical Audit

DR MARY DOCTOR
Provider No **1234567B**

1 Apr 2024-30 Apr 2024
Reporting period

1 Apr 2024-30 June 2024
Follow-up period

Report generated July 2024

1 Background

Approximately 10% of self-collected samples are positive for HPV and require ongoing management. Analysis of data from Sonic Healthcare laboratories shows that approximately 2% will be positive for HPV 16 or 18 and 8% will be positive for HPV (not 16/18). All patients with a positive HPV result from self-collection require a clinician-collected sample for cytology. Some patients will require direct referral for colposcopy and may have their liquid-based cytology sample (LBC) collected at time of colposcopy. Those not referred for colposcopy must return for a clinician-collected cervical sample. The cytology result will triage subsequent management decisions.

2 Result overview

The patients listed below have been identified as requiring follow-up. Detailed results for each patient have already been reported to you. These recommendations should be correlated with the original risk category and management recommendation. Contact the laboratory to discuss any queries.

3 More information

This audit provides a summary of patients that performed self-collected HPV testing and serves as a safety net to ensure patients requiring follow-up are managed appropriately.

For further information, please visit soniceducation.com.au/self-collect-HPV-audit

Name	Provider no.	Date collected	Episode no.	HPV result	Recommendation
GREEN, Anna (01-Jan-1981)	1234567B	01/04/2024	111111111	HPV 16/18	**HPV 16/18 detected - Higher risk** **Action: Colposcopy and clinician-collected LBC required.** A sample for LBC may be collected at time of colposcopy or prior to colposcopy.
BROWN, Tracy (01-Jan-1982)	1234567B	02/04/2024	222222222	HPV 16/18	
GRAY, Jane (01-Jan-1983)	1234567B	03/04/2024	333333333	INVALID	**Unsatisfactory - Invalid result** **Action: Re-collect.** A self-collected sample or clinician-collected sample is acceptable. Repeat testing within 6 weeks of initial sample collection date.
BLUE, Sharon (01-Jan-1984)	1234567B	04/04/2024	444444444	INVALID	
PINK, Karen (01-Jan-1985)	1234567B	05/04/2024	555555555	HPV (not 16/18)	**HPV (not 16/18) detected - LBC has not been submitted** **Action: Clinician-collected LBC required.** Some patients require direct referral to colposcopy. This is recommended for: ▪ Patients 70+ years ▪ Patients who are significantly immunocompromised ▪ Patients with persistent positive HPV (not 16/18) at 12-month follow-up who also meet the following criteria: – Patients 50+ years – Patients who identify as Aboriginal and/or Torres Strait Islander – Patients overdue for screening by at least 2 years at initial screen Note: All patients who have HPV (not 16/18) persisting on two consecutive annual follow-up tests (initial positive/12-month positive/second follow-up positive) will require referral to colposcopy.
PURPLE, Lucy (01-Jan-1986)	1234567B	06/04/2024	666666666	HPV (not 16/18)	
RED, Amy (01-Jan-1987)	1234567B	07/04/2024	777777777	HPV (not 16/18)	
YELLOW, Lisa (01-Jan-1988)	1234567B	08/04/2024	888888888	HPV (not 16/18)	
BLACK, Michelle (01-Jan-1989)	1234567B	09/04/2024	999999999	HPV (not 16/18)	**HPV (not 16/18) detected - LBC has been submitted** **Action: Check report.** A combined management recommendation has been given on the issued HPV/LBC report. Please check report management recommendations have been performed.
CERISE, Susan (01-Jan-1990)	1234567B	10/04/2024	101010101	HPV (not 16/18)	

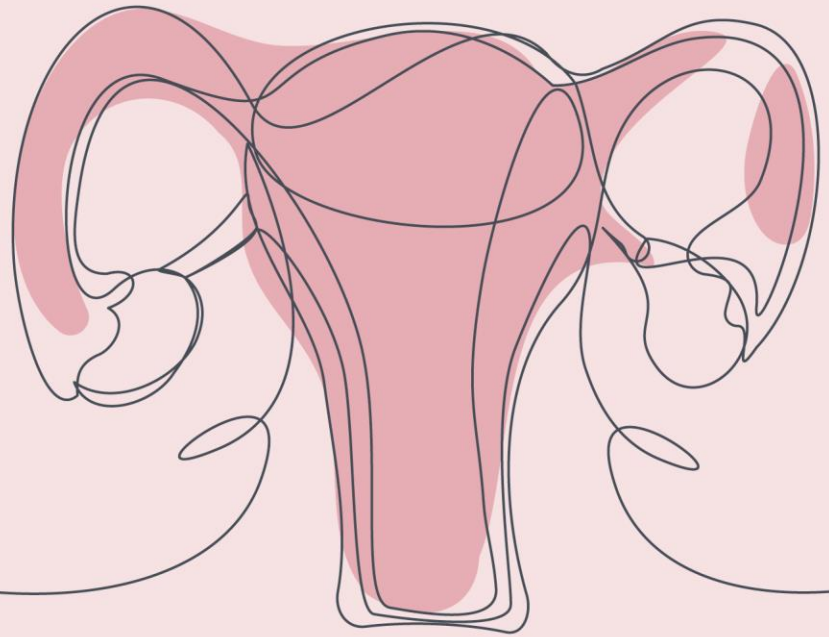
LBC follow-up rate for HPV (not 16/18) positive within the follow-up period: 33%

Detailed results for each patient have already been reported to you. We recognise that management for a patient may already be underway. An audit report will be uploaded to your Sonic Dx account each month.

Thank you

Metro North **GP Alignment Program**

Gynaecology Workshop



Menopause

Dr Hannah Farquhar | Endocrinologist & Obstetric Medicine Physician| RBWH

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Menopause

GP Alignment Gynaecology Workshop

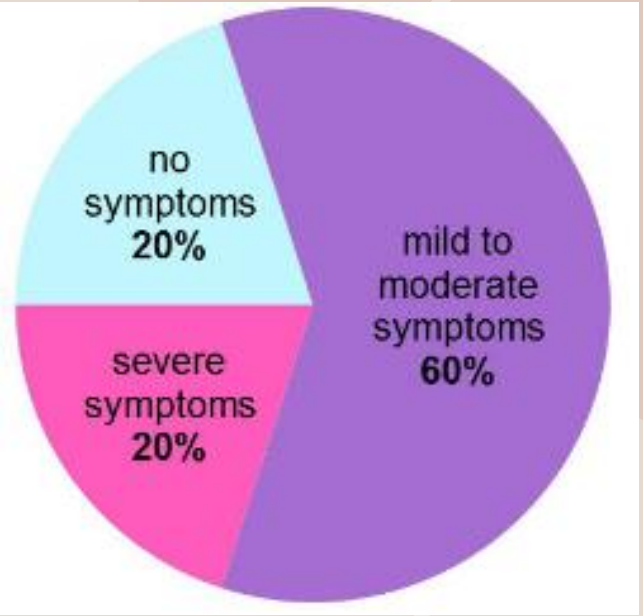
Dr Hannah Farquhar
Endocrinologist and Obstetric Medicine Physician
Rhythm Endocrinology, Greenslopes
The Menopause Centre, Greenslopes
The Royal Brisbane and Women's Hospital

Menopause

1. Definitions
2. Menopausal hormone therapy (MHT)
    1. BENEFITS
    2. RISKS
    3. HOW TO PRESCRIBE
3. Non-hormonal treatment options

Definitions

- Refers to the last menstrual period
  - After 12 months, postmenopausal
- Age 45-55 years, usual 51 years
  - Early < 45 years
  - Premature ovarian insufficiency < 40 years (3-4%)
- 4-8 years average duration of symptoms
  - 20% asymptomatic
  - 10-20% will have symptoms into 60's and 70's



Menopausal Symptoms

- Vasomotor
- Psychological
- Locomotor
- Urogenital – Genitourinary Syndrome of Menopause

AUSTRALASIAN MENOPAUSE SOCIETY
EMPOWERING MENOPAUSAL WOMEN

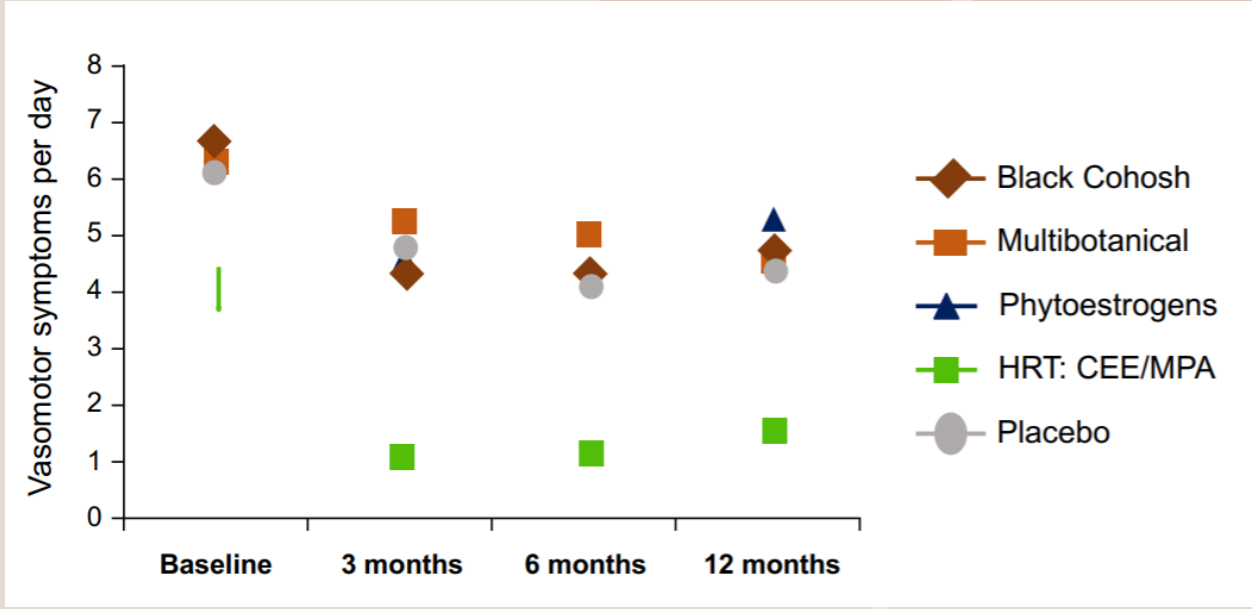
SYMPTOM SCORE (Modified Greene Scale)[1]

	Score before MHT	3 months after starting MHT	6 months after starting MHT
Hot flushes			
Light headed feelings			
Headaches			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle pains			
New facial hair			
Dry skin			
Crawling feelings under the skin			
Less sexual feelings			
Dry vagina			
Uncomfortable intercourse			
Urinary frequency			
TOTAL			

SEVERITY OF PROBLEM IS SCORED AS FOLLOWS
SCORE: None =0; Mild =1; Moderate =2; Severe =3

Benefits - Menopausal Hormone Therapy (MHT)

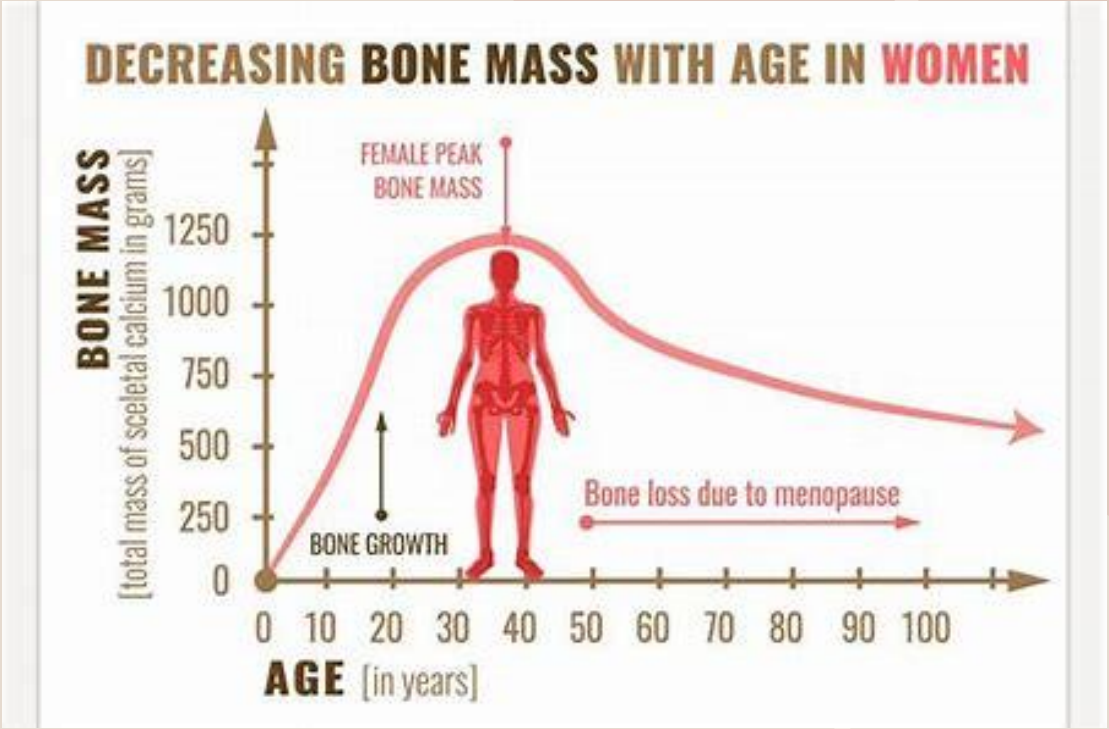
- VMS
  - 75% reduction in frequency and 87% reduction in severity
- Genitourinary syndrome of menopause
- Mood and depression: improved
- Cardiovascular benefits if commenced within 10 years/< 60 yrs
- Bone: protects postmenopausal bone loss



Source: Newton KM, Reed SD, LaCroix AZ, Grothaus LC, Ehrlich K, Guiltinan J. Treatment of vasomotor symptoms of menopause with black cohosh, multibotanicals, soy, hormone therapy, or placebo: a randomized trial. Ann Intern Med. 2006 Dec 19;145(12):869-79. Rowe I, Baber R. Climacteric 2021; 24:57-63. MacLennan A H et al. Maclennan AH, Broadbent JL, Lester S, Moore V. Oral oestrogen and combined oestrogen/progestogen therapy versus placebo for hot flushes. Cochrane Database Syst Rev. 2004 Oct 18;2004(4)

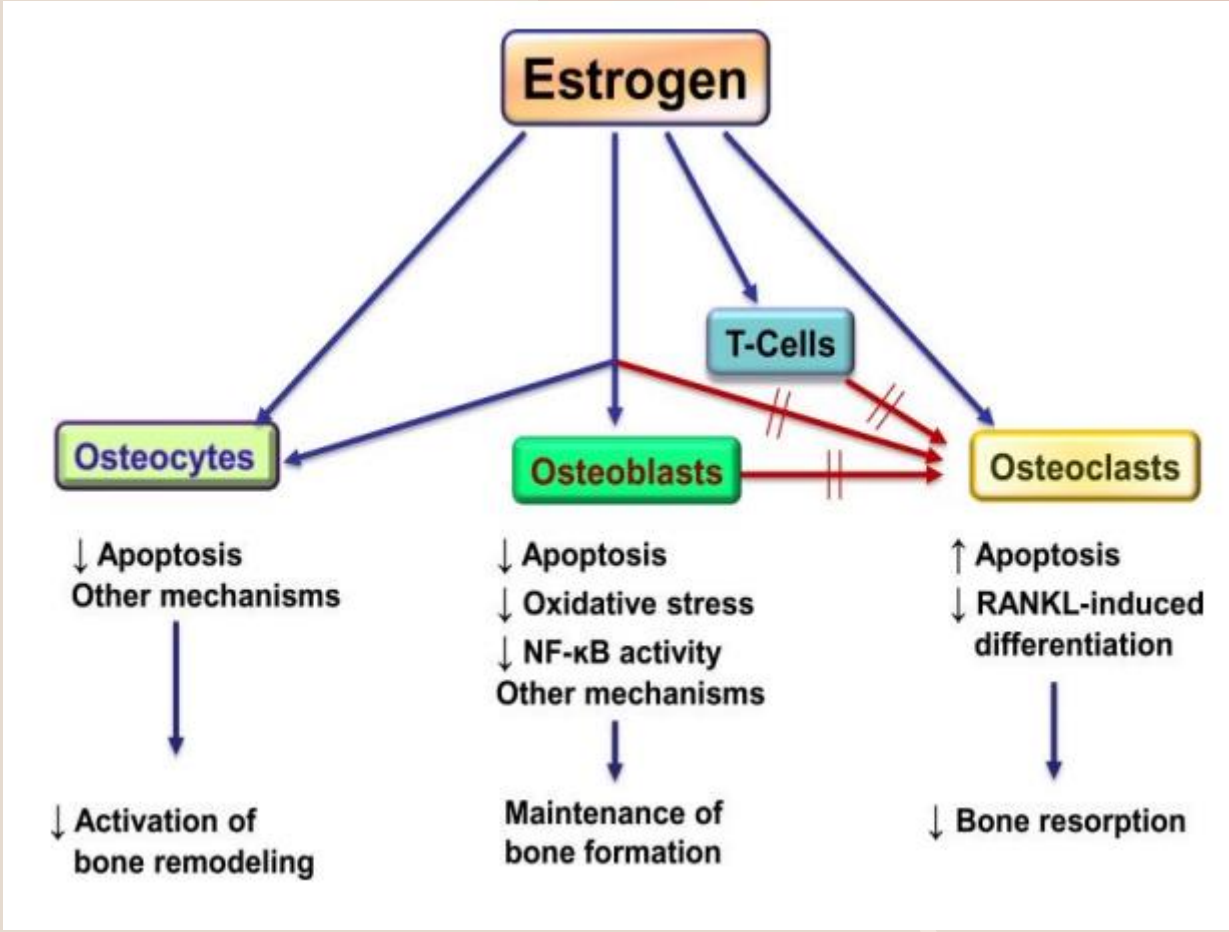
MHT – Bone Health

- >50 years, 1 in 3 women will have an osteoporotic fracture
  - 24% mortality in first year post hip fracture (Bliuc 2013)
- MHT reduces risk of vertebral and hip # by around 40%



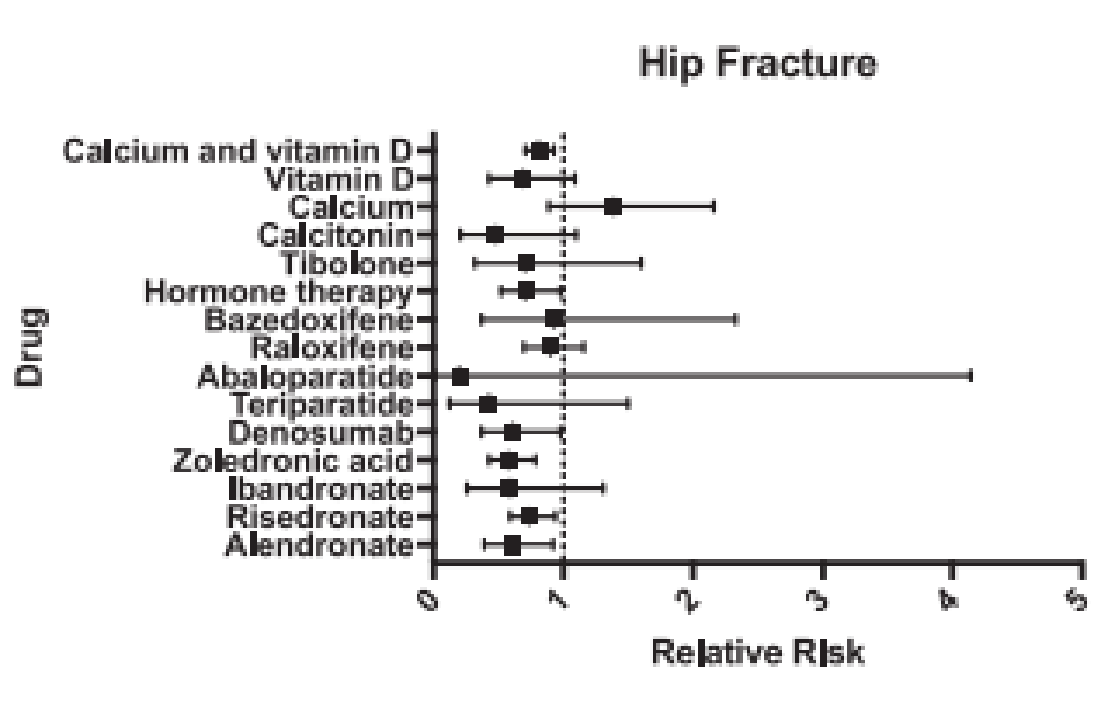
MHT – Bone Health

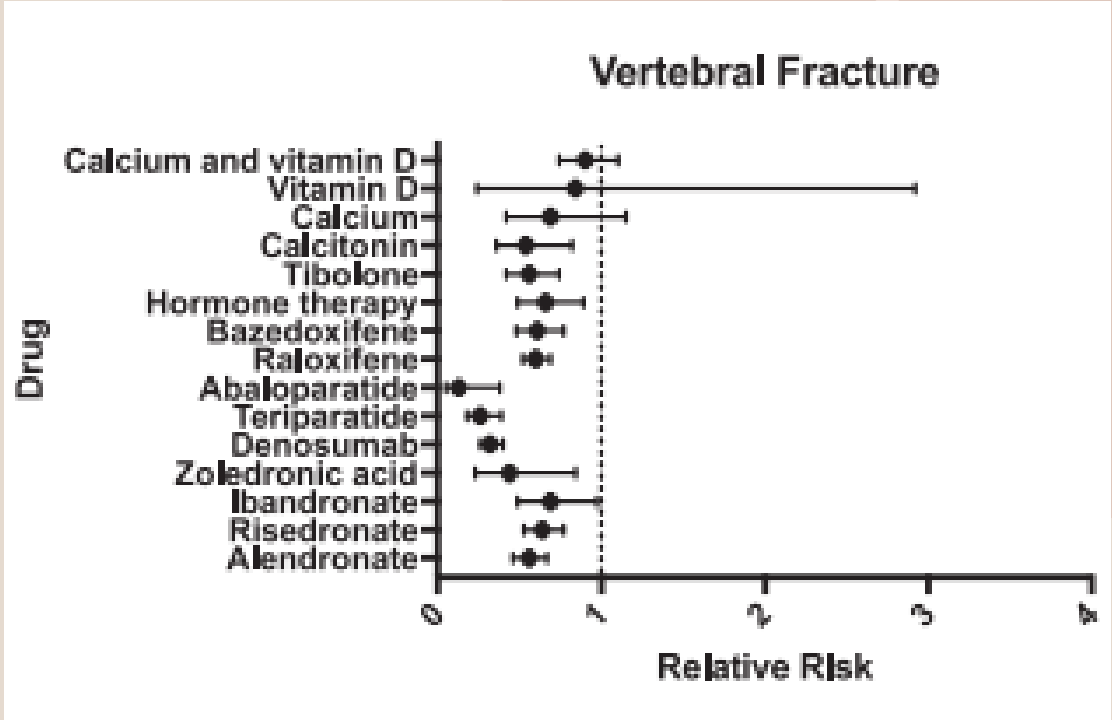
- Oestrogen is antiresorptive:
  - Induces osteoclast apoptosis
  - Decreases RANKL production
  - Regulates T cell action on osteoclasts
- Oestrogen aids bone formation by:
  - Reduces osteoblast apoptosis
  - Reduces oxidative stress
  - Reduces NF-kB activity



Sigl V Cytokine & Growth Factor Reviews 25 (2014) 205–214. Santos et al. J Bone Biol Osteoporosis 2018;4:82-88

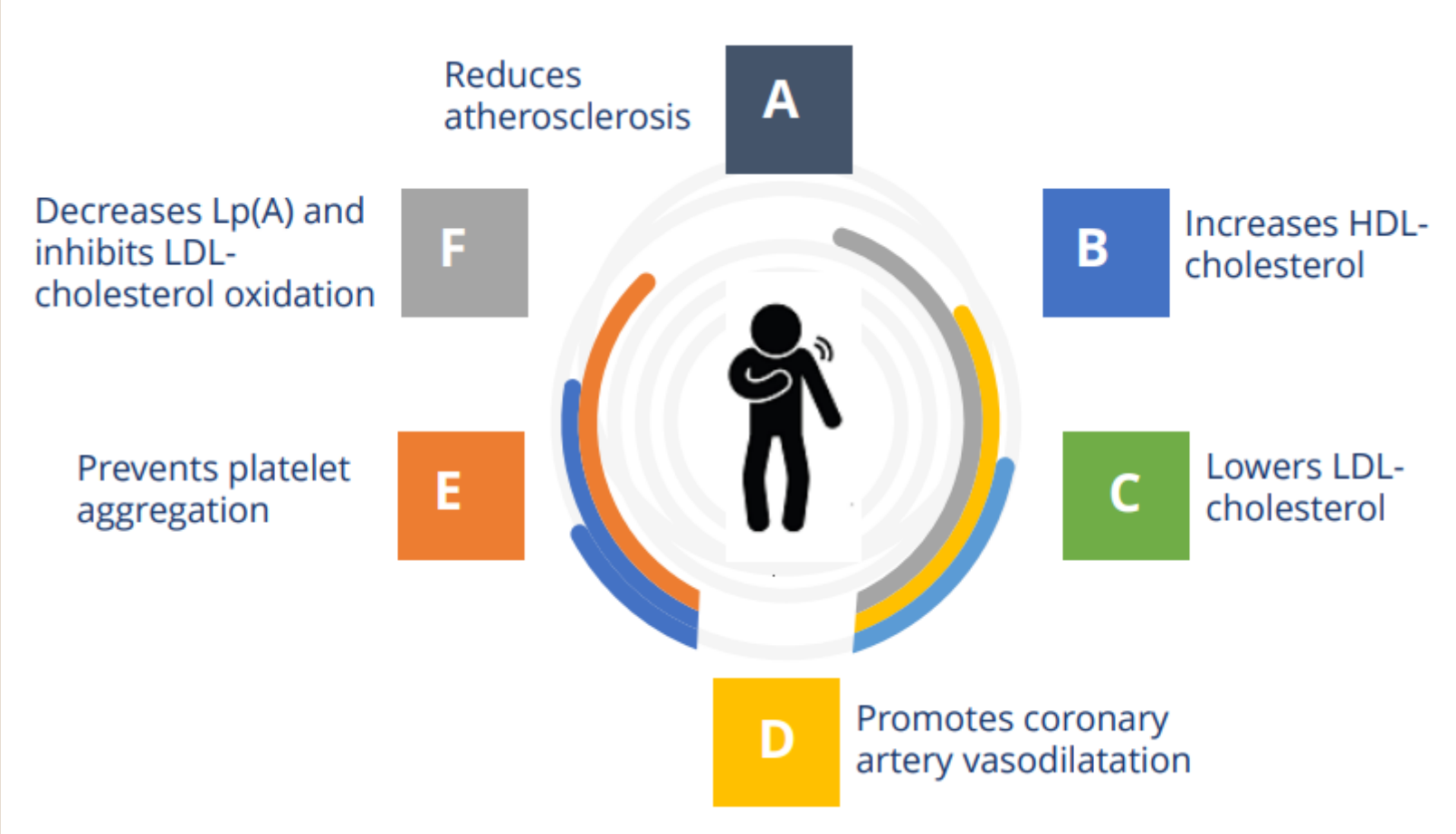
MHT and fracture prevention





Eastell et al Osteoporosis in Postmenopausal Women J Clin Endocrinol Metab, May 2019, 104(5):1595–1622

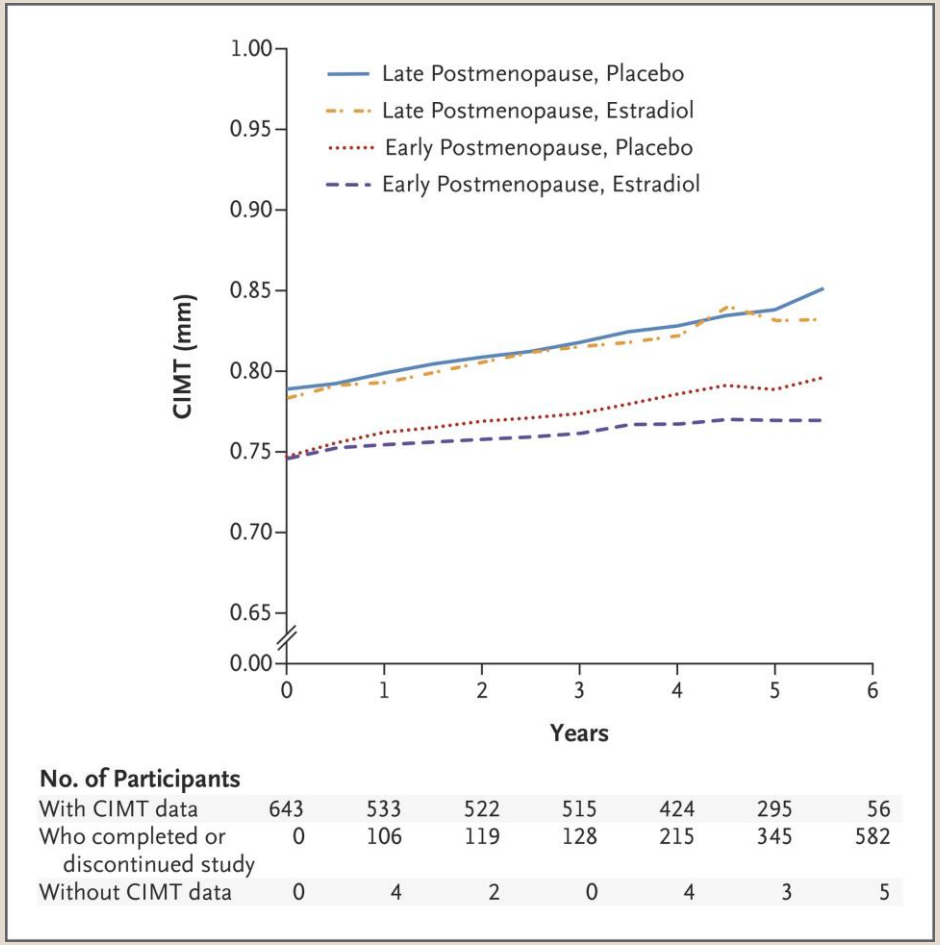
MHT Benefits – CVD



Bakour SH, et al. Obstet Gynaecol. 2015;17:20–28

Cardiovascular Disease

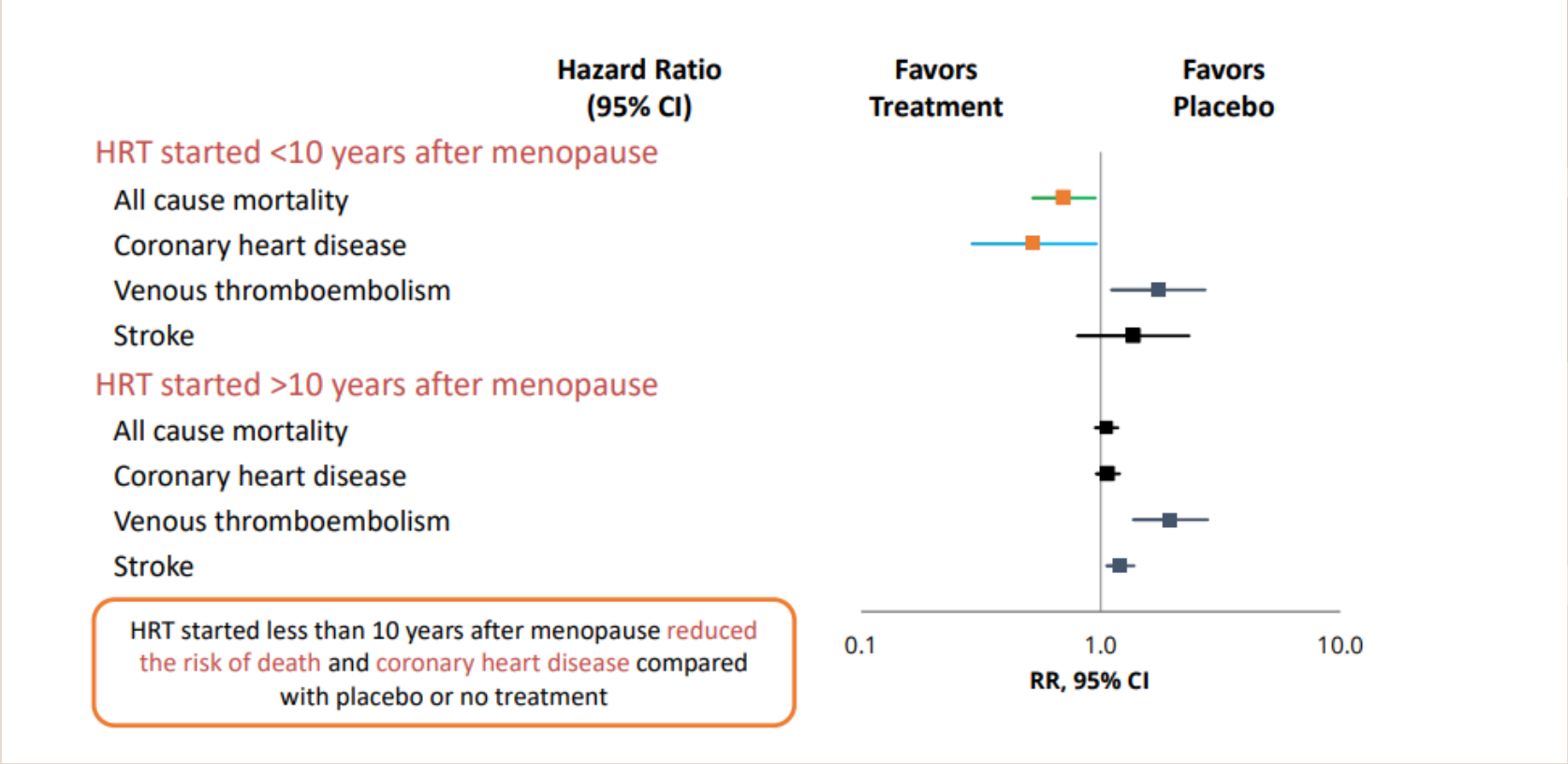
- WHI – timing hypothesis



No. of Participants							
With CIMT data	643	533	522	515	424	295	56
Who completed or discontinued study	0	106	119	128	215	345	582
Without CIMT data	0	4	2	0	4	3	5

Hodis et al NEJM 2016

MHT Benefits - CVD



Boardman HMP, et al. Cochrane Database Syst Rev 2015, Issue 3. Art. No.: CD002229

MHT Risks – Breast Cancer in WHI

3 trials:

1. Low fat diet – breast cancer, fractures and bowel cancer
2. Calcium and vitamin D – CHD, fractures, breast cancer
3. MHT – CEE vs CEE + MPA vs placebo

- 30% of women were within 12 years of MP
- 70% > 60 years, up to 79 years
  - Average 63 years, 12 years post MP

MHT Risks
Breast Cancer – WHI

- 9 year follow up, although MHT CEE + MPA arm stopped at 5 years in 2002
  - Concern re breast cancer rates and increased cardiovascular events – largely VTE
  - A composite of all primary outcomes that 'did not support benefit'
  - Benefits of CEE alone for breast cancer risk, CVD in women <60 years, # prevention largely ignored

Original Contribution

FREE

July 17, 2002

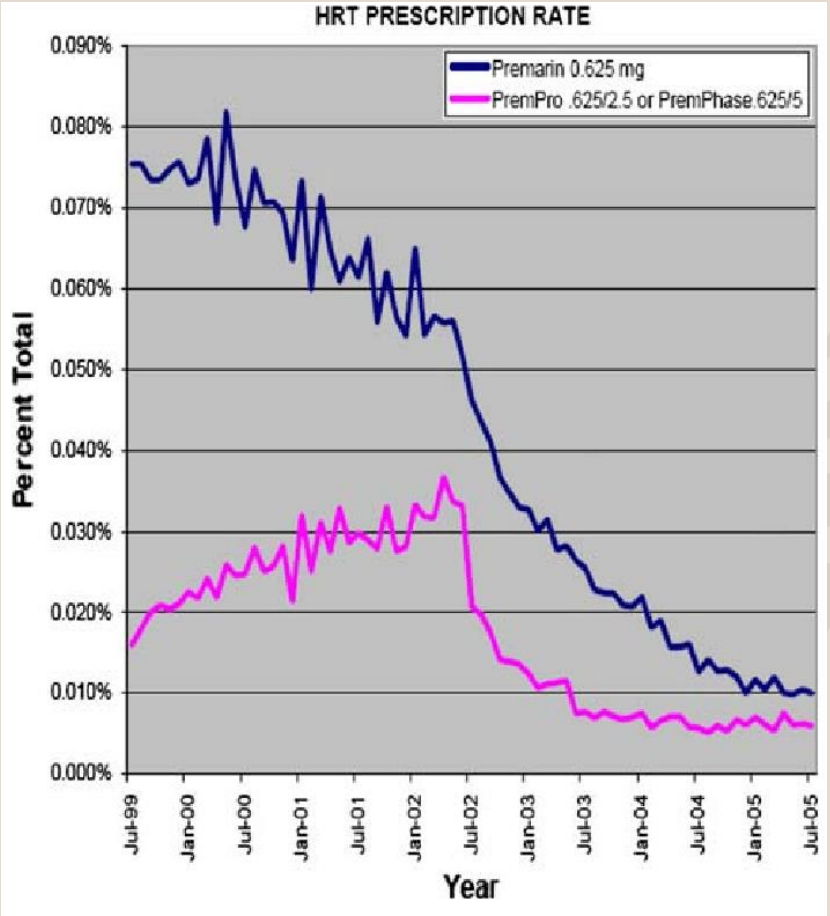
Risks and Benefits of Estrogen Plus Progestin in Healthy Postmenopausal Women

Principal Results From the Women's Health Initiative Randomized Controlled Trial

Writing Group for the Women's Health Initiative Investigators

» Author Affiliations

JAMA. 2002;288(3):321-333. doi:10.1001/jama.288.3.321

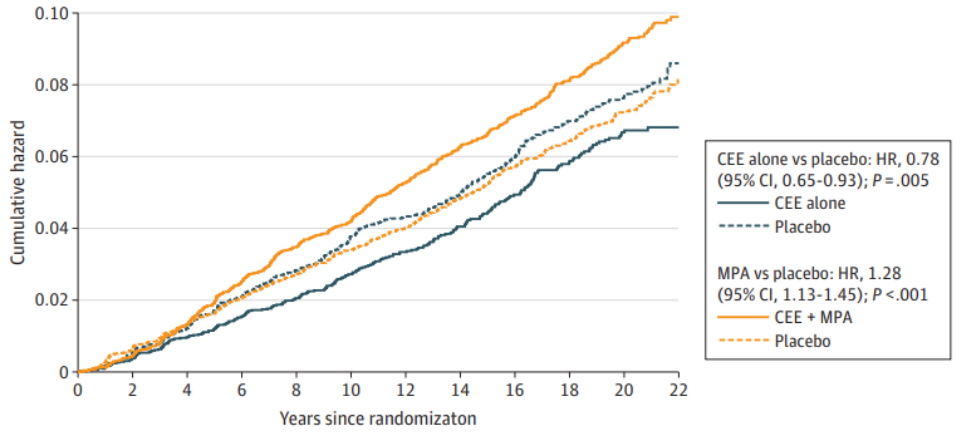


Parente et al 2008

Breast Cancer – WHI

- After 5 years use CEE + MPA- an extra 8 cases per 10,000 person-years (Rossouw et al. 2002)
- No difference in breast cancer mortality
- Long term f/u, CEE alone vs placebo :
  - breast ca incidence **HR 0.78**; 95% CI, (0.65-0.93; P = .005)
  - breast cancer mortality **HR 0.60**; 95% CI, 0.37-0.97; P = .04)

Figure 1. Kaplan-Meier Estimates for the Association of Menopausal Hormone Therapy With Invasive Breast Cancer During Cumulative Follow-up



No. at risk

CEE + MPA												
CEE + MPA	8506	8329	8114	7802	7016	6248	5743	5006	4517	4143	3239	881
Placebo	8102	7916	7726	7472	6700	5944	5515	4808	4360	3991	3159	769
CEE alone												
CEE alone	5310	5167	5010	4845	4271	3673	3378	2873	2565	2307	1811	496
Placebo	5429	5280	5105	4915	4307	3717	3387	2892	2567	2307	1807	498

Chlebowski et al. JAMA 2020

Breast Cancer

- 5 years of MHT from 50 yo, increases breast cancer incidence at ages 50-69 by:
  - 1 in every 50 combined continuous MHT users
  - 1 in every 70 combined intermittent MHT users
  - 1 in 200 oestrogen only users

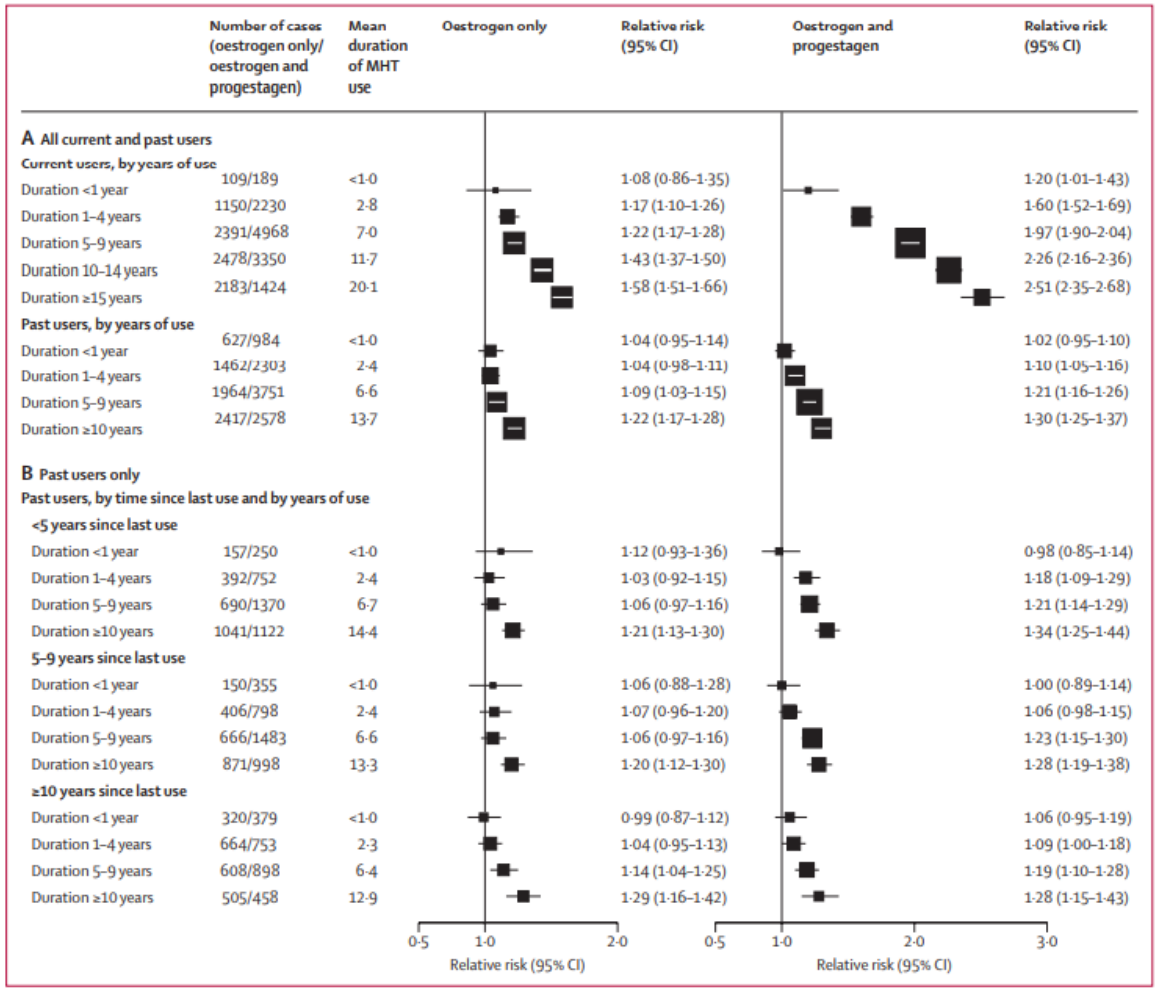


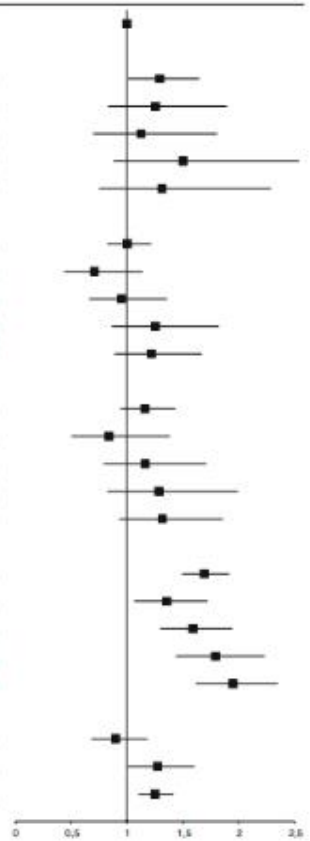
Figure 2: **Type and timing of MHT use in current users and past users**
(A) All current and past users. (B) Past users only, by time since last use of MHT. Fully adjusted relative risks for current versus never users by years of current use, and for past users versus never users by years of use and time since cessation of use (prospective studies). MHT=menopausal hormone therapy.

Collaborative Group on Hormonal Factors in Breast Cancer *Lancet* 2019

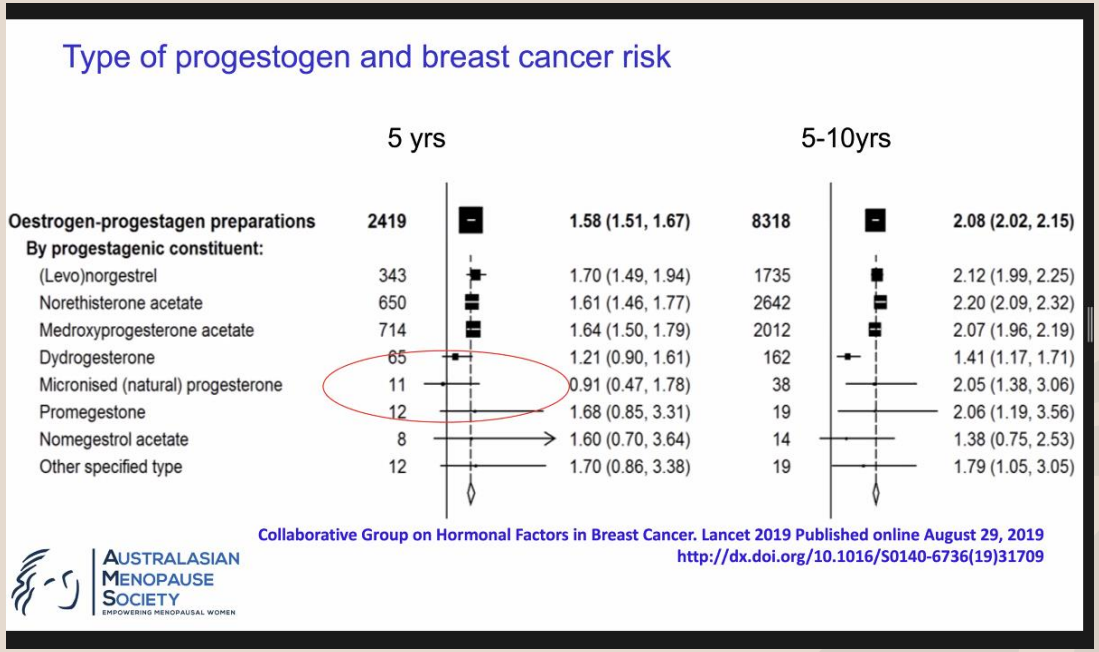
Breast Cancer – Progestogens

Table 3 Relative risks for invasive breast cancer by type of HRT and duration of exposure, compared with HRT never-use

HRT type and duration of exposure (years)	Cases/PY [a]	Relative risk [b] (95%CI)
None	**766/244,632**	**1 (ref)**
Estrogen alone	**76/20,347**	**1.29 (1.02-1.65)**
<2	24/6,747	1.26 (0.83-1.89)
[2-4[	18/5,705	1.13 (0.70-1.81)
[4-6[	14/3,172	1.50 (0.88-2.56)
6+	13/3,301	1.31 (0.76-2.28)
p for trend		0.73
Estrogen + progesterone	**129/40,537**	**1.00 (0.83-1.22)**
<2	18/8,697	0.71 (0.44-1.14)
[2-4[	33/11,647	0.95 (0.67-1.36)
[4-6[	30/7,619	1.26 (0.87-1.82)
6+	43/10,111	1.22 (0.89-1.67)
p for trend		0.04
Estrogen + dydrogesterone	**108/31,045**	**1.16 (0.94-1.43)**
<2	16/6,923	0.84 (0.51-1.38)
[2-4[	28/8,697	1.16 (0.79-1.71)
[4-6[	21/5,590	1.28 (0.83-1.99)
6+	35/7,876	1.32 (0.93-1.86)
p for trend		0.16
Estrogen + other progestagens	**527/104,243**	**1.69 (1.50-1.91)**
<2	86/22,792	1.36 (1.07-1.72)
[2-4[	134/30,189	1.59 (1.30-1.94)
[4-6[	106/19,942	1.79 (1.44-2.23)
6+	156/23,817	1.95 (1.62-2.35)
p for trend		0.01
Weak estrogens [c]	**56/17,091**	**0.90 (0.68-1.18)**
Others [d] / unknown HRT	**82/21,071**	**1.27 (1.01-1.60)**
Mixed [e]	**538/130,594**	**1.25 (1.11-1.41)**

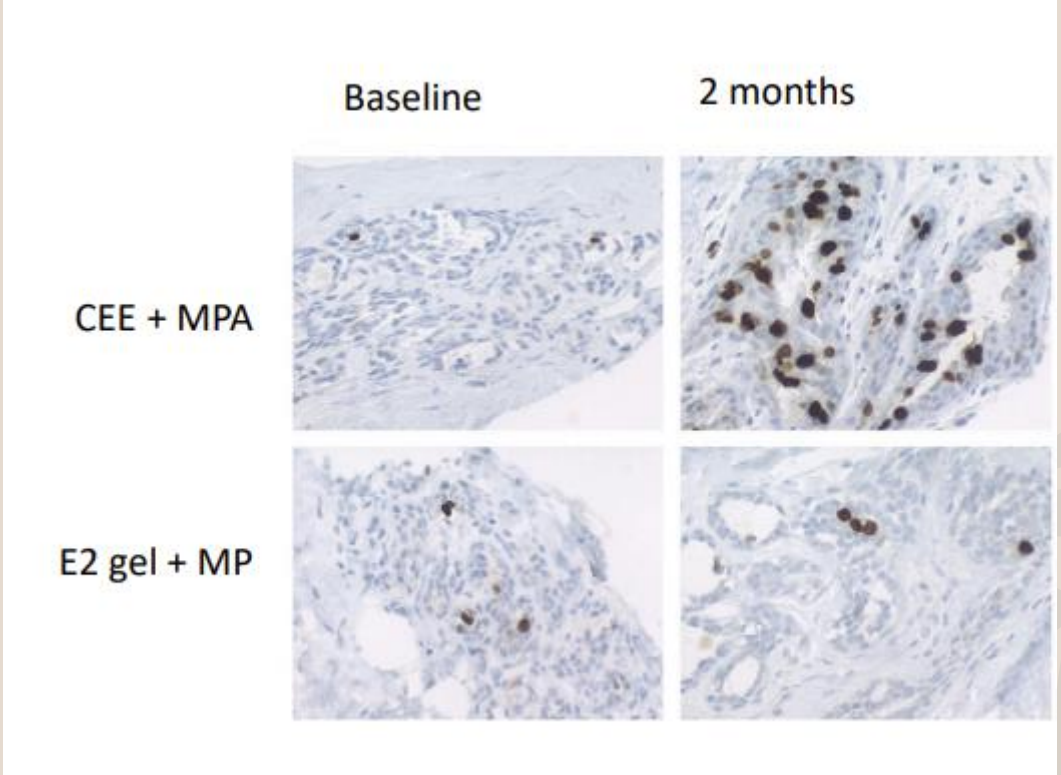


Fournier et al. Breast Cancer Res Treat (2008) 107:103–111



Breast cancer- Progestogens

- Breast core biopsy from healthy post-menopausal women
- 2 months of treatment with CEE + MPA or transdermal E2 and micronised progesterone
- Proliferation marker Ki67 measured
  - CEE + MPA mean 1%⇨10%
  - E2 gel + MP mean 3.1%⇨5.8%



Murkes et al. Fertil. Steril. 2011 Mar 1;95(3):1188-91.

MHT

- Discuss
  - Relative risk
  - Modifiable risk factor reduction
  - Duration
  - Preparation

Breast Cancer - Summary

- Different hormonal preparations
- Lowest dose, shortest time possible
- Contraindicated if history of breast cancer
- Mammographic screening as usual
- Contribution to women in their 50's is thought to be low, E+P > E
  - Risk varies with P

Risks – VTE with oestrogens

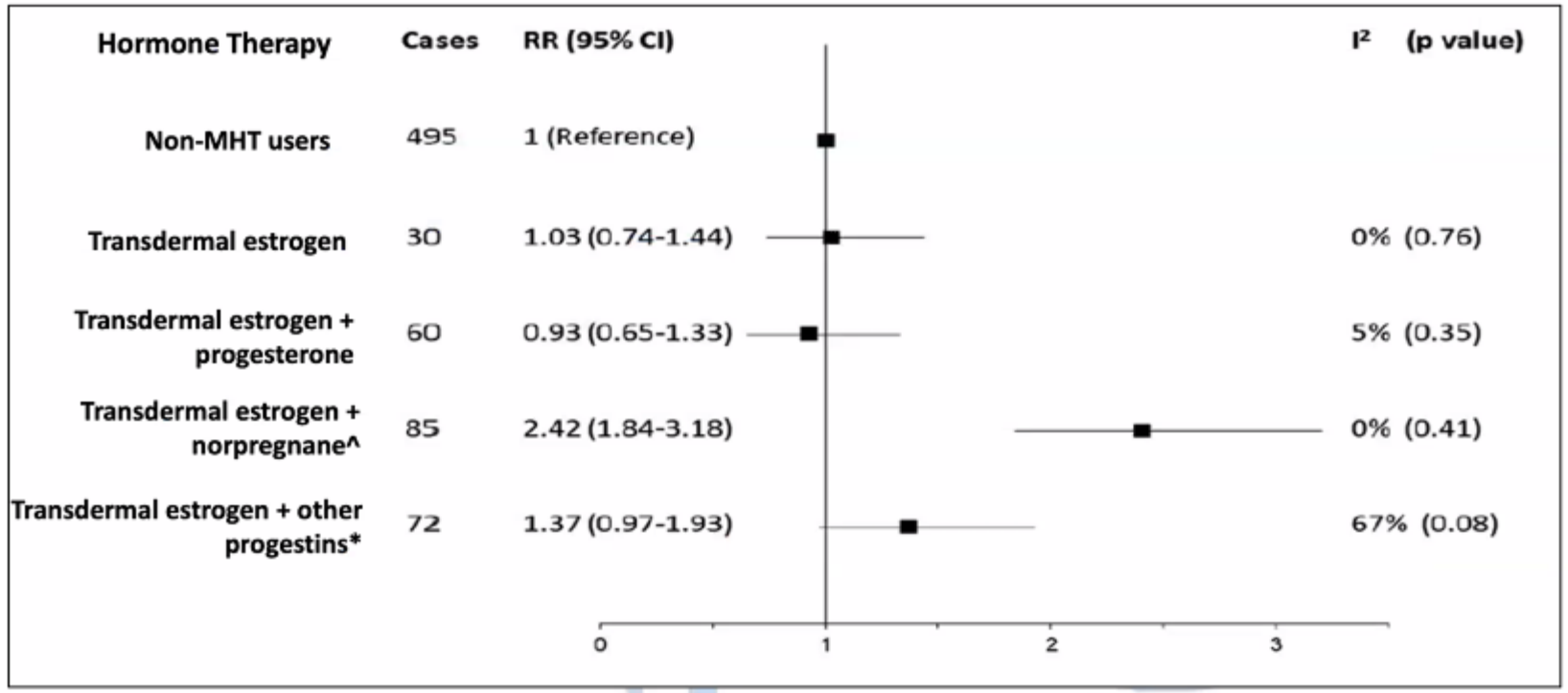
- Oral Oestrogen only MHT OR = 1.58 (1.52-1.64)
- Oral combined E+P MHT OR = 1.73 (1.65-1.81)
- Transdermal MHT not a/w increased risk
- Background risk women 50-60 years approx. 0.5-1 women per 1000 per year

Relative risk of VTE for different types of MHT vs case controls

Different types of HRT	Odds ratio (95% CI)
Oestrogen only oral HRT	
Conjugated equine oestrogen	1.49 (1.39 to 1.60)*
Estradiol	1.27 (1.16 to 1.39)*
Transdermal HRT	
Estradiol	0.96 (0.88 to 1.04)
Combined estradiol	0.86 (0.73 to 1.01)
Different doses of oestrogen in HRT	
Oestrogen only oral HRT	
Conjugated equine oestrogen ≤0.625 mg	1.40 (1.28 to 1.53)*
Conjugated equine oestrogen >0.625 mg	1.71 (1.51 to 1.93)*
Estradiol ≤1 mg	1.22 (1.09 to 1.37)*
Estradiol >1 mg	1.35 (1.18 to 1.55)*
Transdermal HRT	
Estradiol ≤50 µg	0.94 (0.85 to 1.03)
Estradiol >50 µg	1.05 (0.88 to 1.24)

Vinogradova et al. *BMJ* 2019

Risks – VTE with progestogens



Adapted from Scarabin P-Y, 2018. Relative risk of VTE by type of hormone therapy, compared to non-use. Results from an updated meta-analysis of the risk of VTE in hormone therapy users. Seven population-based observational studies (four case–control and three cohort studies) were included. The main clinical outcome was a first episode of idiopathic VTE (deep vein thrombosis and/or pulmonary embolism), except for two studies either focusing on VTE recurrence or including secondary VTE.

Scarabin *et al. Climacteric* 2018; 21(4):341-5.

Risks – Recurrent VTE

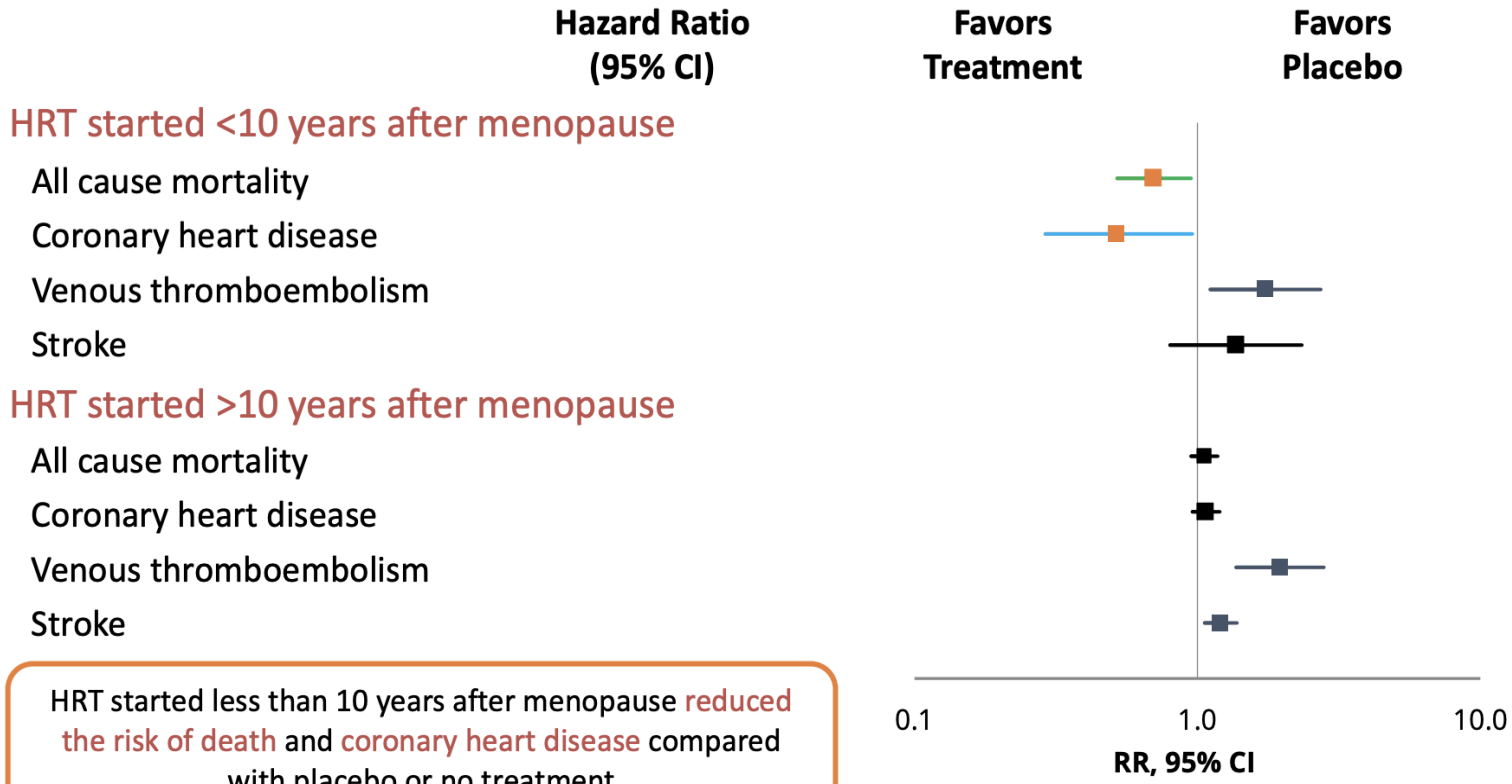
Hormone therapy	Cases (n = 76)	Person-years (n = 6,667)	Univariate HR (95% CI)	*P*	Multivariate HR (95% CI)[a]	*P*
Nonusers	68	6,064	1.0 (reference)		1.0 (reference)	
Oral estrogens[b]	2	50	5.7 (1.4-24.0)	0.02	6.4 (1.5-27.3)	0.01
Transdermal estrogens[b]	6	458	0.9 (0.4-2.1)	0.80	1.0 (0.4-2.4)	0.98
Estrogen alone	1	99	0.9 (0.1-6.3)	0.90	1.1 (0.2-8.1)	0.90
+Micronized progesterone	3	231	0.9 (0.3-2.8)	0.80	1.0 (0.3-3.2)	0.90
+Pregnane derivatives	0	94	NA		NA	
+Norpregnane derivatives	2	34	4.0 (0.9-16.5)	0.06	4.7 (1.1-20.0)	0.03
Unknown	0	86	NA		NA	

P for homogeneity between current use of oral estrogens versus current use of transdermal estrogens is significant ($P = 0.03$). *P* for homogeneity between progestogens subgroups among transdermal estrogen users is not significant ($P = 0.22$). Data for adjustment are missing for 32 patients. One case of use of tibolone was excluded from the analysis.

- Risk of recurrent VTE in this study 1.1%
  - Provoked 1-4% p.a. vs unprovoked 10%
- Transdermal oestrogen mHR 1 (0.4-2.4)
- Oral oestrogen mHR 6.4 (1.5-27.3)
- Norpregnane progestins mHR 4.7 (1.1-20)

Olie V et al Menopause 2011;18:488-493

Risks - Cardiovascular disease



Boardman HMP, et al. Cochrane Database Syst Rev 2015, Issue 3.

Risks – MHT after MI


BRITISH MENOPAUSE SOCIETY Tool for clinicians

Information for GPs and other health professionals

1 of 3

The specialist authority for menopause & post reproductive health

BMS British Menopause Society

HRT after myocardial infarction

https://thebms.org.uk/wp-content/uploads/2024/03/21-BMS-TfC-HRT-after-myocardial-infarction-MARCH2024-A.pdf

British Menopause Society Tool for Clinicians 2024

Menopausal Hormone Therapy

- Can initiate in women < 60 years or < 10 years since menopause
- Factors to consider:
    1. Uterus intact: E alone if hysterectomised or E + P for intact uterus
    2. Timing: <12 months since LMP : cyclical therapy, >12 months since LMP : continuous therapy
    3. Co-morbidities
    4. Need for contraception
    5. Patient preference

MHT - Oestrogens

- Estradiol –transdermal , Estrofem
- Estradiol valerate – Progynova
- Conjugated equine oestradiol – Premarin
- Ethinyl oestradiol : OCP

- Oral
  - Hepatic first pass effect
  - Increased TBG, CBG, HDL, TG, pro-cogaulation factors
- Transdermal
  - Patches – twice weekly
    - Estradot (25, 37.5, 50, 75, 100 microg/24 hours), Estraderm (25, 50, 100 microg/24 hours), Climara
    - Estalis Conti and Sequi 50/250 and 50/140
  - Gels – daily
    - Estrogel 1-4 pumps daily
    - Sandrena – sachets
- Vaginal
  - Vagifem – oestradiol 10 microg pessary
  - Ovestin – estriol pessary 500 microg or cream 0.5 mg/ 0.5g

MHT – Progestogens

- Micronised progesterone (Prometrium, Bijuva)
  - Benefit of sleep assistance
  - $$
- Dydrogesterone (Femoston)
- Medroxyprogesterone acetate (Provera)
- Norethistrone acetate (Trisequens, Estalis patches, Kliovance)
- Levonorgestrel IUD (Mirena)

Progestogen	"LOW DOSE" 1 pump of E2 gel 25ug patch 1mg estradiol tab CE 0.3mg	"MEDIUM DOSE" 2 pumps of E2 gel 50ug patch CE 0.625
Mic. progesterone Sequential 14 days	200mg daily for 14 days	200 mg daily for 14 days
Mic. Progesterone continuous	100mg daily	100 mg daily
Dydrogesterone sequential 14 days	10mg daily for 14 days	10 mg daily for 14 days
Dydrogesterone continuous	5mg daily	10 mg daily
MPA continuous	2.5 – 5mg daily	5 mg daily
NETA continuous	0.5mg daily	1mg daily

Mueck A and Romer T . Horm Mol Biol Clin Invest. 2018;37(2).

MHT – Combination Therapy

- Patch
  - Estalis Sequi or Conti
- Oral :
  - Femoston, Trisequens, Kliovance
  - Bijuvia
  - OCP : EE, oestradiol (Zoely), oestradiol valerate (Qlaira)
- Transdermal (or oral) oestrogen with oral progesterone or Mirena IUD

AMS Guide to Equivalent MHT/HRT Doses

AUSTRALIA ONLY

This Information Sheet has been developed as a guideline only to approximately equivalent doses of the different TGA registered MHT/HRT products available in Australia in August 2022. Hormone Replacement Therapy (HRT) is now referred to as Menopausal Hormone Therapy (MHT). The intention of this sheet is to help physicians change their patients to higher or lower approximate doses of MHT if needing to tailor therapy, or remain within the same approximate dose if needing to change brands of MHT. Private/non-PBS script products are marked with an*

CYCLIC MENOPAUSAL HORMONE THERAPY (MHT)

Use continuous oestrogen and cyclic progestogen combinations at peri-menopause or if less than 12 months amenorrhoea

LOW DOSE		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Femoston	tablet	1mg oestradiol/10mg dydrogesterone
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	1 pump (0.75mg oestradiol) daily, and 2 capsules (200mg) micronised progesterone orally for 12 days out of a 28-day cycle
MEDIUM DOSE		
Trisequens*	tablet	1 and 2mg oestradiol/1mg norethisterone
Femoston	tablet	2mg oestradiol/10mg dydrogesterone
Estalis sequi 50/140)	transdermal patch	50mcg oestradiol/140mcg norethisterone acetate (twice weekly application)
Estalis sequi 50/250 (same oestrogen, more progestogen than Estalis sequi 50/140)	transdermal patch	50mcg oestradiol/250mcg norethisterone acetate (twice weekly application)
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	2 pumps (1.5mg oestradiol) daily, and 2 capsules (200mg) micronised progesterone orally for 12 days out of a 28-day cycle

CONTINUOUS COMBINED MENOPAUSAL HORMONE THERAPY (MHT)

Should be used if 12 months since LMP or after 12 months cyclical MHT

LOW DOSE		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Angeliq 1/2*	tablet	1mg oestradiol/2mg drospirenone
Femoston-conti	tablet	1mg oestradiol/5mg dydrogesterone
Kliovance*	tablet	1mg oestradiol/0.5mg norethistrone
Bijuva*	capsule	1mg oestradiol/100mg micronised progesterone
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	1 pump (0.75mg oestradiol) daily, and 1 capsule (100mg) micronised progesterone orally for 25 days out of a 28-day cycle^
OTHER LOW DOSE HORMONAL OPTIONS		
Livial*, Xyvion*	tablet	2.5mg tibolone
Duavive* (oestrogen/SERM combination)	tablet	0.45mg conjugated equine oestrogens / 20mg bazedoxifene
MEDIUM DOSE		
Kliogest*	tablet	2mg oestradiol/1mg norethistrone
Estalis continuous 50/140	transdermal patch	50mcg oestradiol/140mcg norethisterone acetate (twice weekly application)
Estalis continuous 50/250 (same oestrogen, more progestogen than Estalis continuous 50/140)	transdermal patch	50mcg oestradiol/250mcg norethisterone acetate (twice weekly application)
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	2 pumps (1.5mg oestradiol) daily, and 1 capsule (100mg) micronised progesterone orally for 25 days out of a 28-day cycle^

^Can be given daily if adherence is an issue

AUSTRALASIAN MENOPAUSE SOCIETY
EMPOWERING MENOPAUSAL WOMEN

www.menopause.org.au

OESTROGEN ONLY THERAPY

Only use these if patient has had a hysterectomy or in combination with a progestogen or Mirena if intact uterus

LOW DOSE		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Estrofem*	tablet	1mg oestradiol
Progynova	tablet	1mg oestradiol
Premarin*	tablet	0.3mg conjugated equine oestrogen
Climara 25	transdermal patch	25mcg oestradiol (weekly application)
Estradot 25 or 37.5	transdermal patch	25 or 37.5mcg oestradiol (twice weekly application)
Estraderm 25 MX	transdermal patch	25mcg oestradiol (twice weekly application)
Estrogel*	gel	0.75mg oestradiol = 1 pump daily
MEDIUM DOSE		
Estrofem*, Zumenon	tablet	2mg oestradiol
Progynova	tablet	2mg oestradiol
Premarin*	tablet	0.625mg conjugated equine oestrogens
Climara 50	transdermal patch	50mcg oestradiol (weekly application)
Estradot 50, Estraderm 50 MX	transdermal patch	50mcg oestradiol (twice weekly application)
Sandrena	gel	1mg oestradiol daily
Estrogel*	gel	1.5mg oestradiol = 2 pumps daily
HIGH DOSE		
Climara 75	transdermal patch	75mcg oestradiol (weekly application)
Estradot 75, Estradot 100	transdermal patch	75 or 100mcg (twice weekly application)
Climara 100	transdermal patch	100mcg oestradiol (weekly application)
Estraderm 100 MX	transdermal patch	100mcg oestradiol (twice weekly application)
Estrogel*	gel	2.25mg oestradiol = 3 pumps daily or 3.0mg oestradiol = 4 pumps daily

OESTROGEN ONLY VAGINAL THERAPY

If prescribing vaginal oestrogen rather than systemic hormone therapy, a progestogen is not required.

PRODUCT	PRESENTATION	COMPOSITION
Ovestin	cream	0.5mg oestriol = 1 application
Ovestin	pessary	0.5mg oestriol
Vagifem Low	pessary	10mcg oestradiol

PROGESTOGEN

Suggested alternative doses for use with the oestrogen preparations above where fixed dose therapy is not suitable

LOW DOSE for use with low dose oestrogen		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Provera (1/2 of 5mg tablet)	tablet	2.5mg medroxyprogesterone acetate
Provera 2.5mg tablet*	tablet	2.5mg medroxyprogesterone acetate
Primolut N (1/4 of 5mg tablet)	tablet	1.25 mg norethisterone
Prometrium*	capsule	100mg micronised progesterone orally for 25 days out of a 28-day cycle^ or 200mg orally daily for 12 days out of a 28-day cycle
Mirena* (PBS indication for contraception/ menorrhagia)	device (5 years)	20mcg levonorgestrel
MEDIUM DOSE for use with medium dose oestrogen		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Primolut N (1/4 of 5mg tablet)	tablet	1.25 mg norethisterone
Provera, Ralovera	tablet	5mg medroxyprogesterone acetate
Prometrium*	capsule	100mg micronised progesterone orally for 25 days out of a 28-day cycle^ or 200mg orally for 12 days out of a 28-day cycle
Mirena* (PBS indication for contraception/menorrhagia)	device	20mcg levonorgestrel (5 years)
HIGHER DOSE (for use in cyclical therapy or continuous therapy with high dose oestrogen)		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Primolut N (1/2 5mg tablet)	tablet	2.5mg norethisterone
Provera, Ralovera	tablet	10mg medroxyprogesterone acetate
Prometrium*	capsule	200mg micronised progesterone orally daily for 12 days out of a 28-day cycle. Safe continuous dose unknown due to insufficient data
Mirena* (PBS indication for contraception/menorrhagia)	device	20mcg levonorgestrel (5 years)

^Can be given daily if adherence is an issue

Low dose progestogen-only contraceptive pills (Microlut (30mcg levonorgestrel), and Noriday (350mcg norethisterone) are used by some clinicians in various doses but there is limited data for dosages of these pills required for endometrial protection. 1 mg norethisterone was considered the minimum dose (cyclical or continuous) for adequate endometrial protection in the Cochrane Review (Cochrane Database Syst Rev. 2009 Apr 15;(2):CS000402).

AUSTRALASIAN MENOPAUSE SOCIETY
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www.menopause.org.au

Co-morbidities

- Endometriosis – consider addition of progesterone, even if previous hysterectomy
- Hypertriglyceridaemia – transdermal oestrogen
- Hypertension - transdermal oestrogen, avoid COCP
- Gallbladder disease/abnormal LFTs - transdermal oestrogen
- Increased VTE risk - transdermal oestrogen
- Malabsorption - transdermal oestrogen
- Migraines – transdermal oestrogen

Contraception

- < 50 years: contraception for two years after final menstrual period
- > 50 years: contraception should be offered for one year after final menstrual period

Magraith and Stuckey 2019

Side Effects

- Oestrogen :
  - Mastalgia – lower dose, tibolone
  - Bleeding – lower dose, increase progesterone
  - Skin irritation – change formulation
  - Exacerbation of hormonally sensitive migraines
- Progesterone :
  - Mood changes
  - Nausea
  - Dizziness

MHT - Tibolone

- Synthetic steroid hormone
- Estrogenic:
  - Treats hot flushes
  - Prevents post menopausal bone loss, reduces risk of spinal #
  - Treats vaginal dryness
- Progestogenic:
  - At uterus to prevent endometrial proliferation and bleeding
- Androgenic:
  - Enhances libido (variable effect)

Tibolone – Risks

- Side Effects:
  - All uncommon - headache, dizziness, nausea, abdominal pain, itch, breast tenderness
  - Initial spotting may occur, amenorrhoea achieved in 80% after first month and 90% after third month
- One uncontrolled study suggested increased breast cancer risk, although not seen in placebo controlled randomised trials
  - Contraindicated in women with history of breast cancer
- Increases the risk of stroke, mainly in women > 60 years (extra 13 cases per 1000 women, vs extra 4 cases in women in 50's)
- Inconclusive re thrombotic risk

Australian Menopause Society Factsheet
'Tibolone for post-menopausal women'

Testosterone

- Decreases throughout adult life, no drop-off in menopause
  - Nadir at 62 years
- Immunoassay is an unreliable test
- Replacement:
  - No supported benefit for cognition, fracture, lean muscle mass, psychological symptoms
  - Evidence for hypoactive sexual desire disorder (HSDD) in postmenopausal women
    - Slow effect, 12 weeks
    - Risk of hair growth and acne
  - Androfeme 0.5mL to outer thigh, check testosterone at 4 weeks and follow-up for s/e and titration at 3 months

Susan R Davis et al. Global Consensus Position Statement on the Use of Testosterone Therapy for Women, *JCEM*, Volume 104, Issue 10, October 2019, Pages 4660–4666,

My Approach

1. History and exam
    1. Co-morbidities/contraindications, ? hysterectomy, medications, symptom burden (AMS score sheet), need for contraception
2. BP, weight
3. Consider alternative causes (and Ix) for symptoms
4. Optimise CVD, breast cancer, VTE risk factors, cancer screening
5. Low dose
    1. Topical preferred
    2. Micronised progesterone preferred
6. Follow up 6-12 weeks

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SYMPTOM SCORE (Modified Greene Scale)[1]

	Score before MHT	3 months after starting MHT	6 months after starting MHT
Hot flushes			
Light headed feelings			
Headaches			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle pains			
New facial hair			
Dry skin			
Crawling feelings under the skin			
Less sexual feelings			
Dry vagina			
Uncomfortable intercourse			
Urinary frequency			
TOTAL			

SEVERITY OF PROBLEM IS SCORED AS FOLLOWS
SCORE: None =0; Mild =1; Moderate =2; Severe =3

Non Hormonal Options

- Don't forget lifestyle – weight loss, exercise, CBT
- SSRI/SNRI
  - Hot flushes, mood benefits
    - Equiv. to 25 microg patch E2 (Joffe 2014)
  - s/e: dry mouth, hot flushes (at higher doses), constipation, low libido, HTN, nausea, insomnia
- Gabapentin
  - Insomnia, hot flushes, pain
  - As effective as oestrogen for hot flushes in one 12 week study 71% reduction (although strong placebo effect noted 54%)
  - Rash, dizziness, somnolence, oedema, weight gain
- Clonidine
  - Hypertension, hot flushes, migraines
  - 38% reduction in hot flushes vs 24% placebo oral
  - 80% vs 46% patches (not available)
  - Equal efficacy to venlafaxine in one trial, better tolerated
  - S/e: drowsiness, dizziness, constipation, insomnia

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Information Sheet

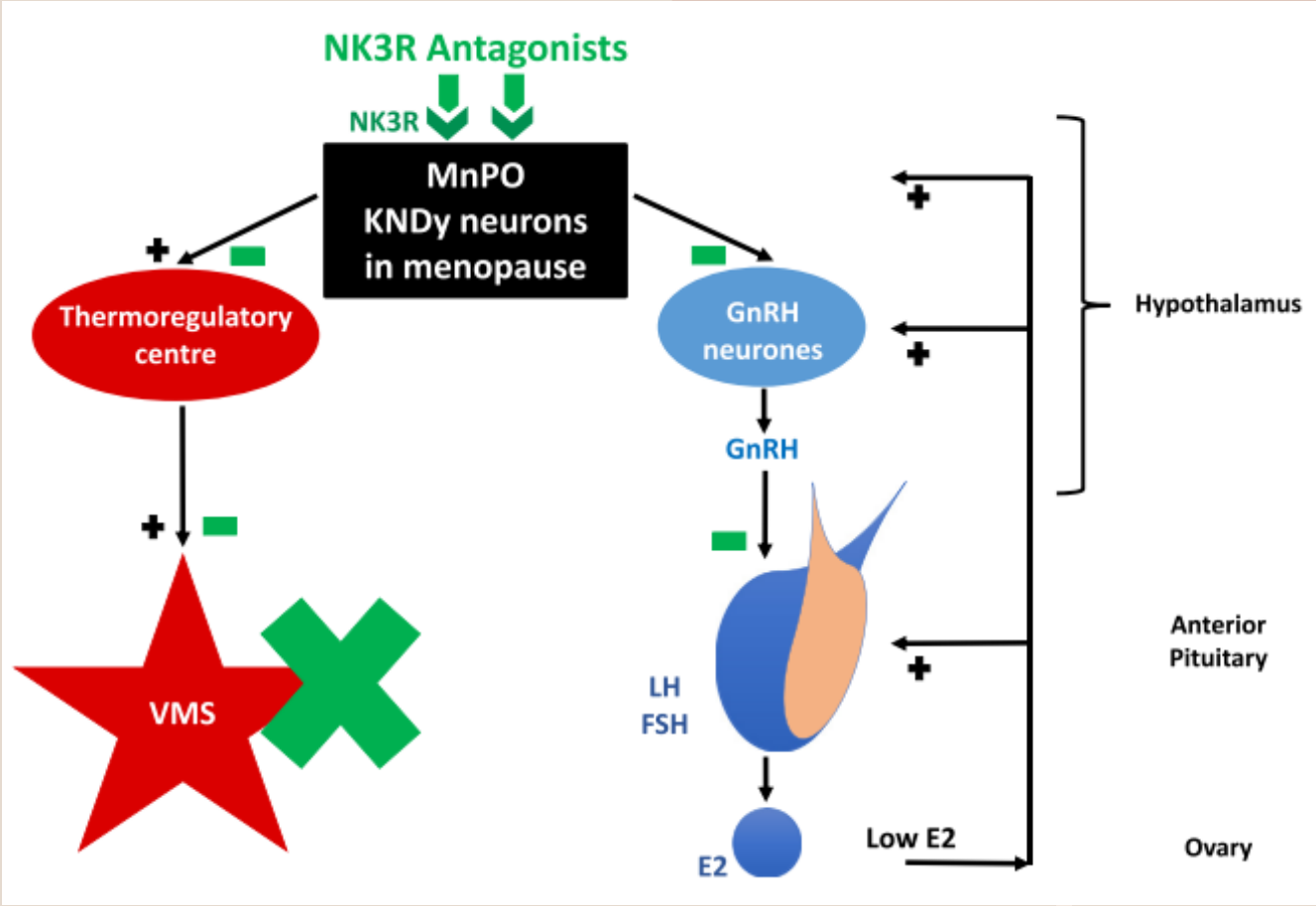
Non-hormonal Treatments for Menopausal Symptoms

KEY POINTS

- Most non-hormonal treatments only treat hot flushes and night sweats.
- There is a substantial placebo effect.
- Non-prescription remedies have generally shown no or minimal benefit.
- There is evidence that some antidepressants, gabapentin and clonidine all reduce hot flushes.

NK3R inhibitors

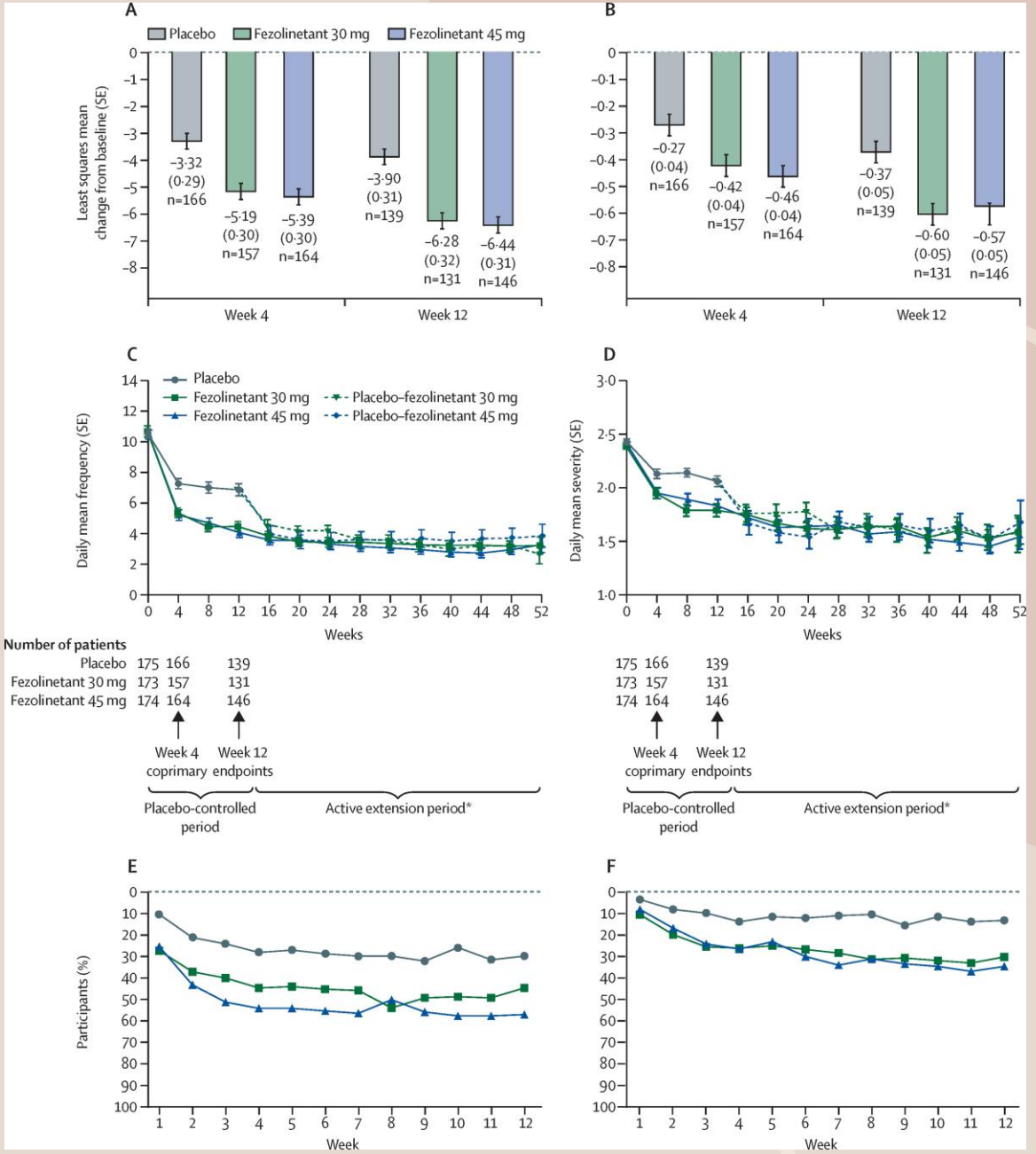
- Theory – not just drop in oestrogen that⇨hot flushes
  - Men and pre-pubertal girls don't experience hot flushes
  - KNDy (Kisspeptin, neurokinin and dynorphin neurons) important in thermoregulation – link between oestrogen and heat response
  - Comparable VMS reduction to MHT
  - Possible LFT derangement



Patel, Dhillo 2022

Fezolinetant

- Indicated for VMS
- 45mg PO daily
- $60.99/month
- ? Increased rate of malignancy
- Under Ix for women with a h/o breast cancer



Lederman et al. 2023 The Lancet

thank you

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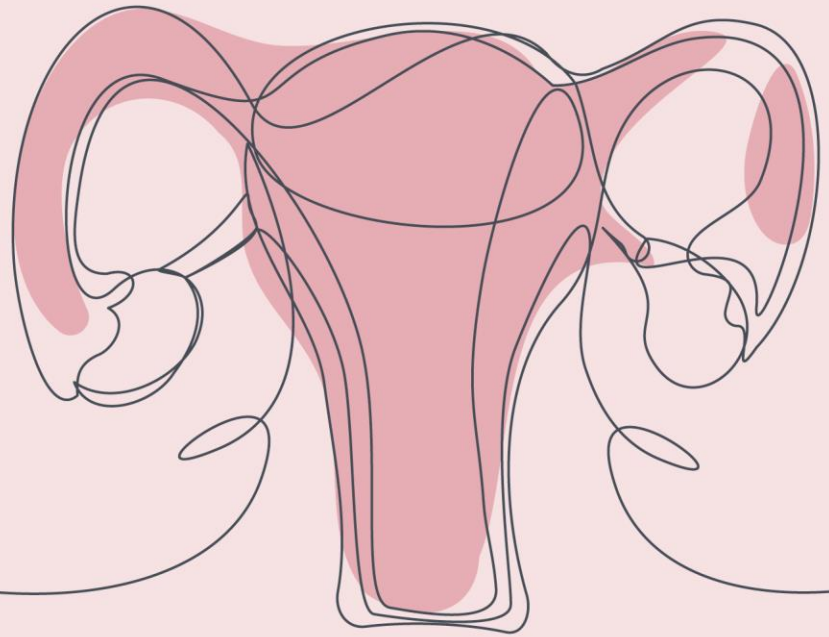
Metro North **GP Alignment Program**

Gynaecology Workshop



Workshop close

Dr Meg Cairns | GPLO

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