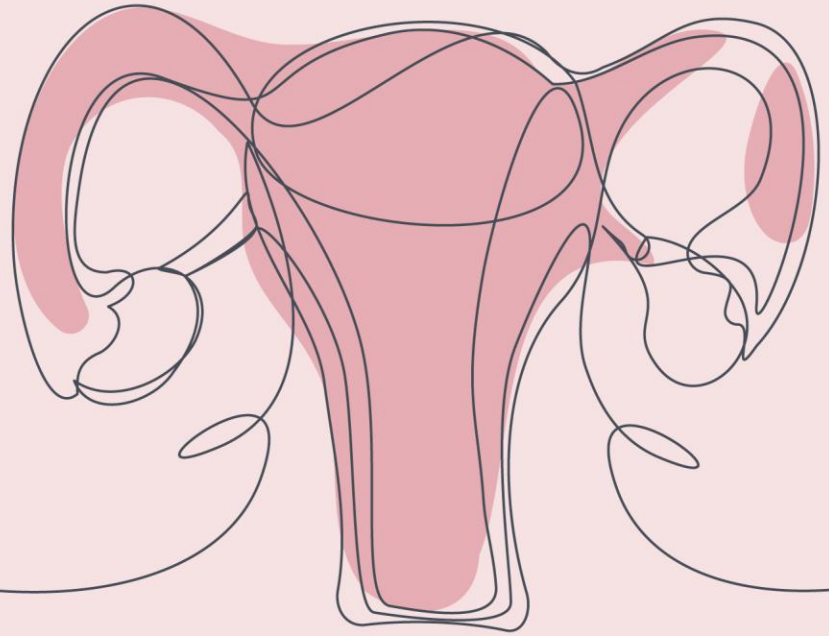
Metro North **GP Alignment Program**

Gynaecology Workshop



WEDNESDAY 26 AUGUST 2026

KEDRON-WAVELL SERVICES CLUB| CHERMSIDE

phn BRISBANE NORTH
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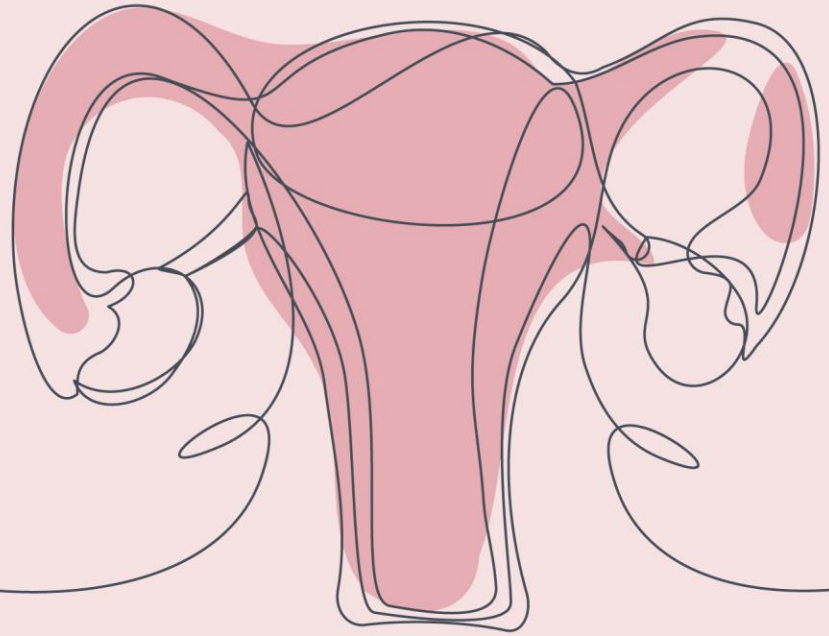
Queensland Government
Metro North Health

Metro North **GP Alignment Program**

Gynaecology Workshop



WELCOME ADDRESS

Dr Meg Cairns | GPLO

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Queensland Government
Metro North Health

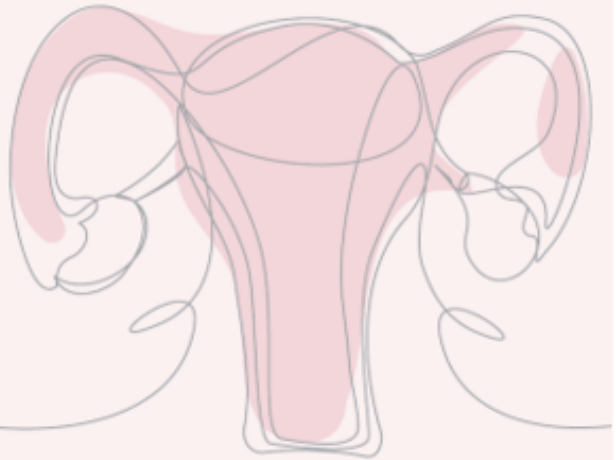
Metro North Hospital and Health Service and Brisbane North PHN respectfully acknowledge the Traditional Owners of the land on which our services and events are located. We pay our respects to all Elders past, present and future and acknowledge Aboriginal and Torres Strait Islander people across the State.

Acknowledgements

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

TONIGHT

6:00 PM	**Registrations, Stalls & Dinner**
6:30 PM	**Welcome**
6:35 PM	**Topic 1: Termination of Pregnancy** Stacey West
6:45 PM	**Service Update: AYA Pelvic Pain and Endometriosis Project** Dr Lee Minuzzo & Anna Forbes
6:55 PM	**Topic 2: Menstrual Management in Children and Adolescents** Dr Friyana Billimoria
7:25 PM	**Topic 3: Endometriosis and Pelvic Pain in Adolescents and Young Adults** Dr Keisuke Tanaka
7:55 PM	**Topic 4: Pelvic Pain in Adolescents and Young Adults** Catherine Willis & Molly Lewis
8:25 PM	**Evaluation**
8:30 PM	**Close**



Useful resources

Metro North Gynaecology Referral Guidelines

Gynaecology | Metro North Health

Brisbane North HealthPathways

Home - Community HealthPathways Brisbane North

GP Smart Referrals

GP Smart Referrals - Practice Support - Brisbane North PHN

Queensland Clinical Guidelines – Women & Girls

Queensland Clinical Guidelines | Queensland Health

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

Useful resources

TRUE

Factsheets & free resources | True

Jean Hailes

Jean Hailes | Creating a healthier future for all women

Australasian Menopause Society

Australasian Menopause Society

British Menopause Society

British Menopause Society

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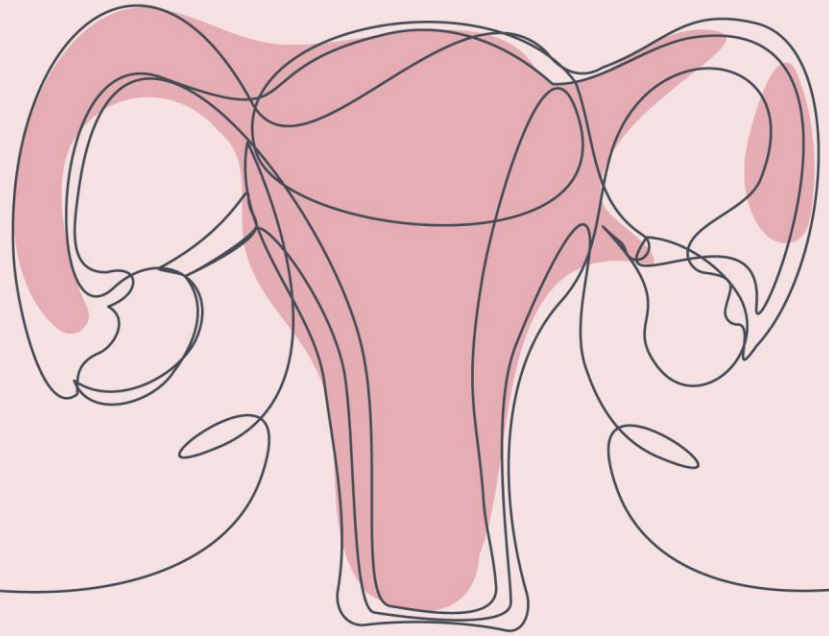

Termination of Pregnancy

Stacey West

Nurse Navigator- Termination of Pregnancy Service

phn BRISBANE NORTH
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Queensland Government
Metro North Health

Nurse Navigator Termination of Pregnancy Metro North Health

(RBWH, Caboolture & Redcliffe)

Referral Requirements

Mandatory requirement

USS Report
(Confirming live IUP – FHR)
Please note there is bulk billing sonography within the community.

Reside within Metro North Catchment

(Please discuss referrals with NNav if patient resides outside of catchment.)

Desirable

Blood group
STI Screen
Antenatal Screen

QVEMToPS

Qld Virtual Early Medical Termination of Pregnancy Service

- Patient can self refer.
- Service only provides MS2Step.
- Service provided by Telehealth.
- Bulk billed service.
- Only out of pocket expense is the medication.
- They do have a no scan pathway however this has set criteria

Thank you

STACEY WEST
NURSE NAVIGATOR - TOP
0408 940 183
metronorthtop@health.qld.gov.au

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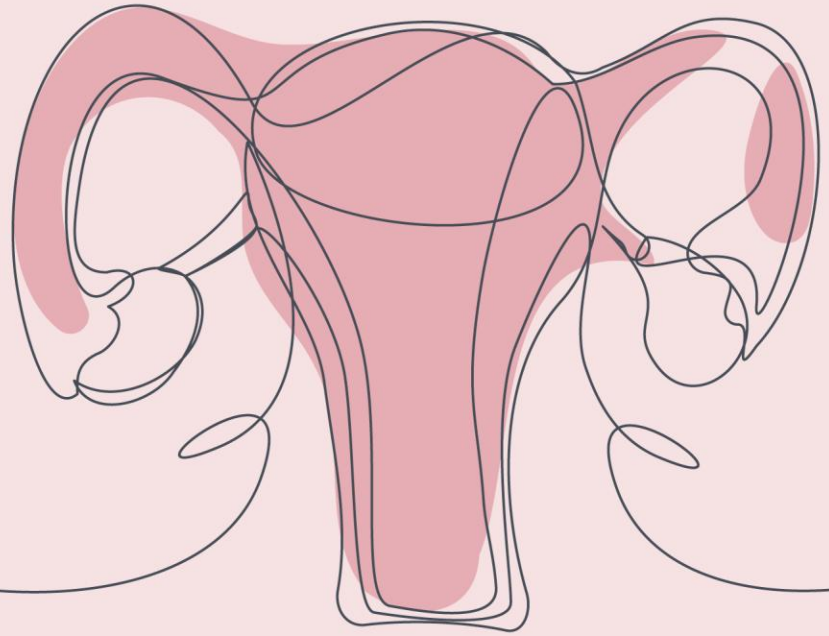


AYA Pelvic Pain & Endometriosis & Pelvic Pain Service (AYA PPES)

Dr Lee Minuzzo

Deputy Director O&G, Executive Director Women & Families Clinical Stream| Metro North

Anna Forbes

Clinical Nurse Consultant, Project Lead

phn BRISBANE NORTH An Australian Government Initiative

Queensland Government

Metro North Health

Metro North Health acknowledges the Traditional Custodians of the land upon which we live, work and walk, and we pay our respects to Elders past and present.

Metro North Health | Queensland Government

The Project

Metro North Health has received funding from The Women and Families Clinical Stream as part of the Queensland Women and Girls' Health Strategy 2032

To establish a service for adolescents and young adults experiencing pelvic pain, dysmenorrhea, and endometriosis symptoms across Metro North Hospital and Health Service

→ nurse-led, multidisciplinary, early intervention service

Current care models

- Paediatric & Adolescent Gynaecology
  - QCH OPD: under 14 years
  - RBWH Gynaecology OPD: 14-18 years
- General gynaecology
  - Specialist outpatients service at RBWH, Redcliffe Hospital & Caboolture Hospital
- Endometriosis clinic
  - At RBWH Gynaecology OPD - must have endometriosis diagnosis

Barriers

- Theses clinics offer Gynaecologist review only!
- Long waitlists
- No nursing care coordination or navigation
- Allied health referrals are dependant on what is available at the local facility

Our Service Objectives

- Early intervention and access to holistic care
- Minimise disease progression and chronic conditions including functional disability and central sensitisation
- Reduce quality of life impacts
- Empower young people with necessary tool and self-management principles
- Improve patients and family health literacy and menstrual knowledge
- Prevent or reduce acute presentations to Emergency Departments

Who is eligible?

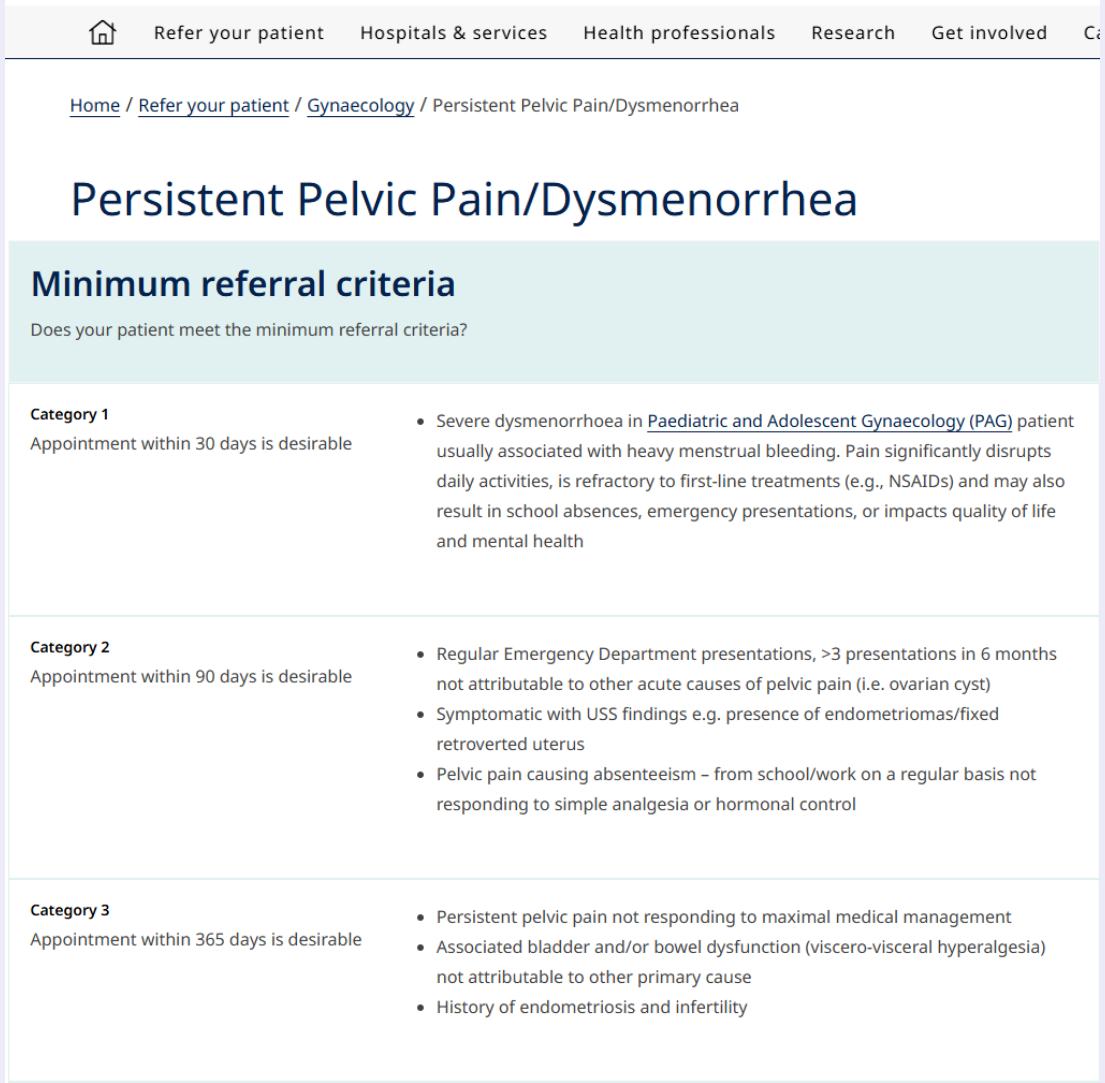
- Aged 14-25
- Female or assigned female at birth
- Reside within the MNHHS catchment area
- Referred to Gynaecology for pelvic pain or dysmenorrhea

Exclusions:

- Pelvic pain due to an acute diagnosis
- Heavy Menstrual Bleeding *without* pelvic pain/endometriosis
- Pregnancy

Requirements

- Current ultrasound (12 months)
  - TV preferred, TA appropriate for young adults/not sexually active
- FBC & Iron studies if heavy menstrual bleeding (HMB)
- If sexually active – STI screen, HVS, urine b-hCG
- Detailed biopsychosocial history & management to date



Refer your patient | Hospitals & services | Health professionals | Research | Get involved | Ca

Home / Refer your patient / Gynaecology / Persistent Pelvic Pain/Dysmenorrhea

Persistent Pelvic Pain/Dysmenorrhea

Minimum referral criteria

Does your patient meet the minimum referral criteria?

Category 1 Appointment within 30 days is desirable	• Severe dysmenorrhoea in Paediatric and Adolescent Gynaecology (PAG) patient usually associated with heavy menstrual bleeding. Pain significantly disrupts daily activities, is refractory to first-line treatments (e.g., NSAIDs) and may also result in school absences, emergency presentations, or impacts quality of life and mental health
Category 2 Appointment within 90 days is desirable	• Regular Emergency Department presentations, >3 presentations in 6 months not attributable to other acute causes of pelvic pain (i.e. ovarian cyst) • Symptomatic with USS findings e.g. presence of endometriomas/fixed retroverted uterus • Pelvic pain causing absenteeism – from school/work on a regular basis not responding to simple analgesia or hormonal control
Category 3 Appointment within 365 days is desirable	• Persistent pelvic pain not responding to maximal medical management • Associated bladder and/or bowel dysfunction (viscero-visceral hyperalgesia) not attributable to other primary cause • History of endometriosis and infertility

Patient Journey

Referral

- GP → local gynae facility
- (RBWH, Caboolture or Redcliffe Hospital)

Intake

- Patient choice to opt in
- Nurse assessment
- Introductory education
- Resources & supports explained: written, verbal & video

Care Delivery

Education sessions

Nurse navigation

Group appointments (MDT)

1:1 appointments

Case conferencing (MDCC)

- Nurse Navigator
- GP with Special Interest
- Physio
- Psychologist
- Dietician
- Social Worker

Discharge

- Re-connect to primary care
- May choose to either be removed from gynae waitlist or remain

Our Implementation plan

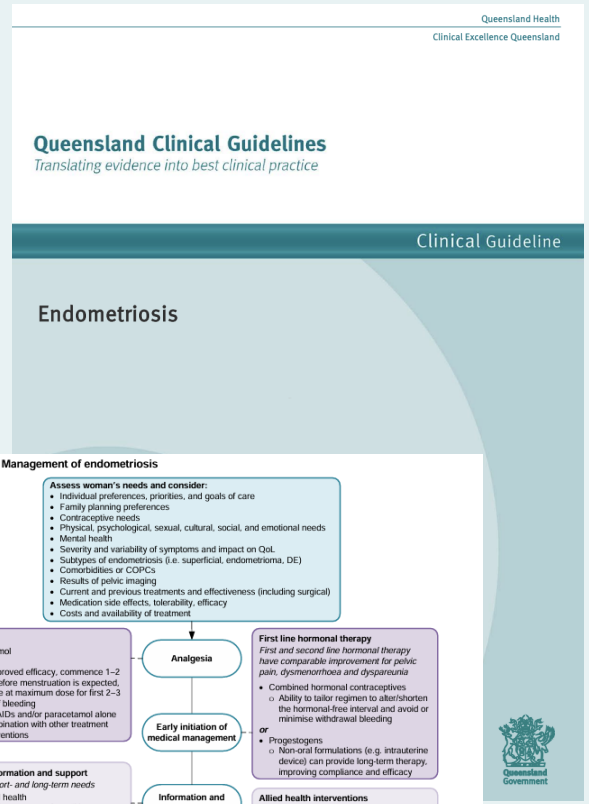
- Phase 1
  - Offer service to patients on current Gynaecology waitlists
- Phase 2
  - Offer service to patients at same time as Gynaecology referral received
- Phase 3
  - Accept referrals directly from GPs without need for Gynaecology referral

Milestone	Timeline
Phase 1	November 2026
Phase 2	Early 2027
Phase 3	2027

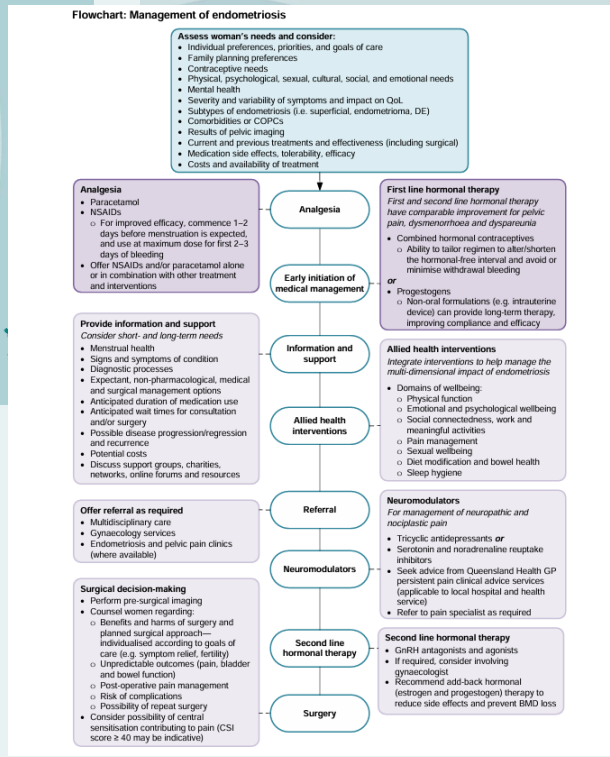
Design

Co-design:
We are asking patients to help us – what do you want to be educated on?

Data:
Patient demographics and factors will be analysed to enable continue service improvements



Seeking care	• Few adolescents seek medical care for symptoms of dysmenorrhoea[12,13] • The majority of adolescents use self-treatment methods including[87]: o Non-pharmacological methods (e.g. hot bath, heat pack, bed rest) o Over-the-counter medications—most use considerably less than the recommended dose o Discussing their pain with someone (e.g. parent or friend) o Missing school or other activities • Barriers to seeking care include[13]: o Normalisation of menstrual pain by healthcare providers and the general community[10,86,88,89] o Perceived lack of interest or knowledge from their healthcare provider
Prompt care	• Early identification and treatment: o Maximises opportunity to improve quality of life o Minimises absence from daily activities o Minimises negative physical and psychosocial impacts of dysmenorrhoea[13] o Minimises risk of dysmenorrhoea progressing to persistent pelvic pain and central sensitisation (a state where the central nervous system has an abnormal or amplified response to sensory input)[85,90,91]



Thank you

Dr Lee Minuzzo

Deputy Director O&G, Executive Director
Women & Families Clinical Stream Metro North

Anna Forbes

Clinical Nurse Consultant, Project Lead

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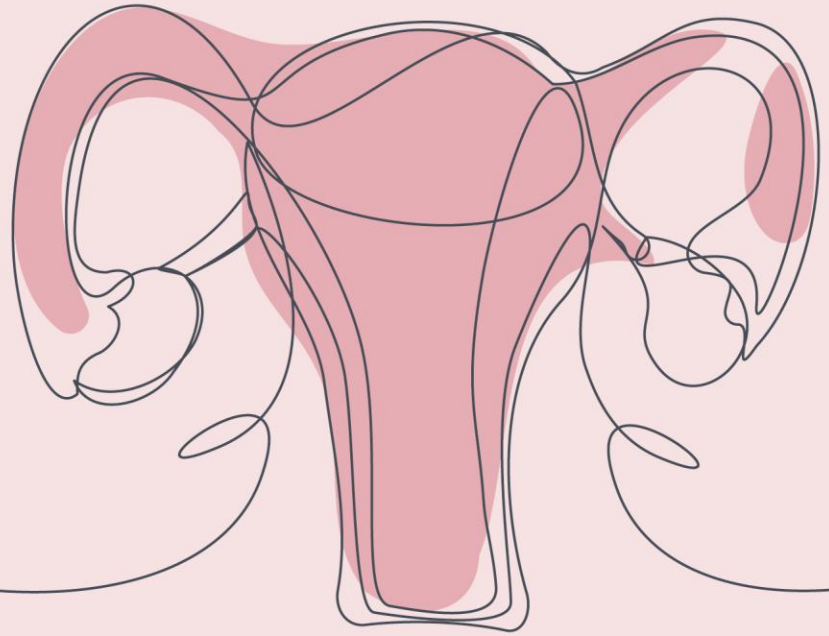

Paediatric & Adolescent Gynaecology

Dr Friyana Billimoria

Registrar Obstetrics & Gynaecology | RBWH

PAG Fellow for Professor Rebecca Kimble – Slides courtesy of Professor Kimble with thanks

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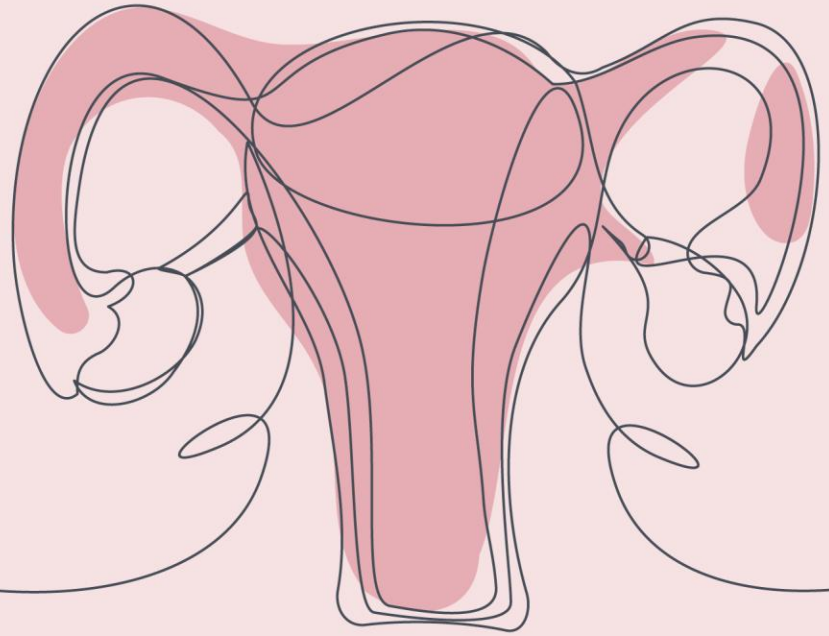

Endometriosis & Pelvic Pain in Adolescents & Young Adults

Dr Keisuke Tanaka - MB BCh BAO (Hons) FRANZCOG PhD

Senior Staff Specialist | RBWH

Gynaecologist, Northside Gynaecology / North West Private Hospital

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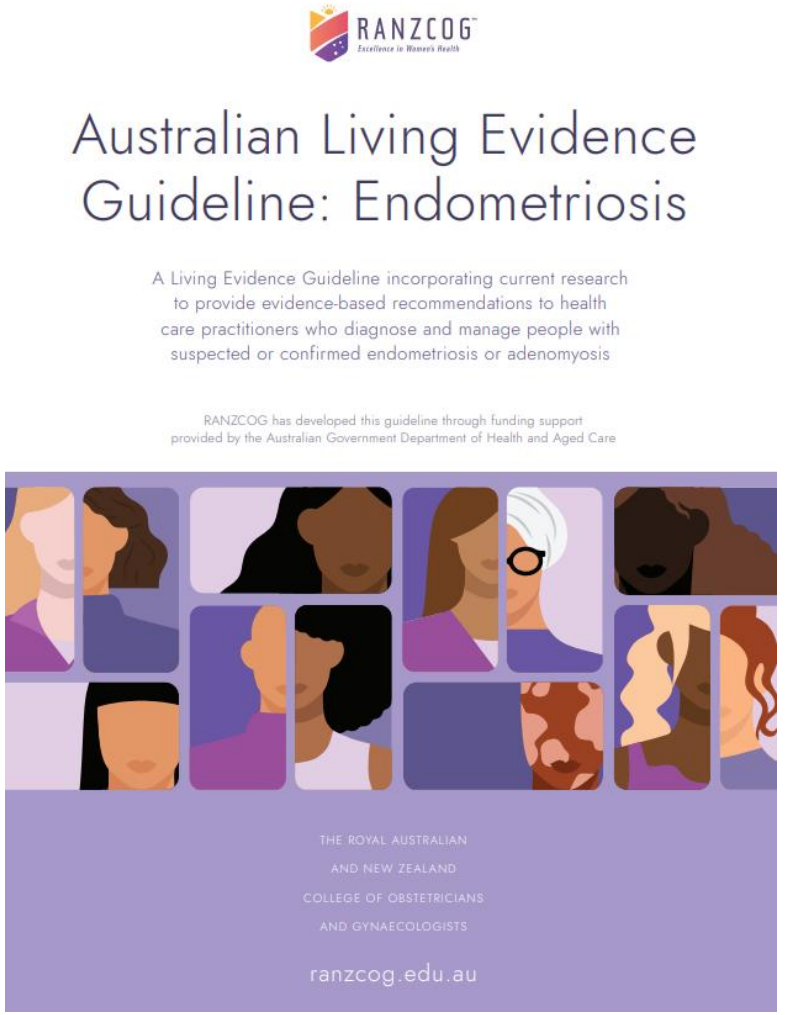
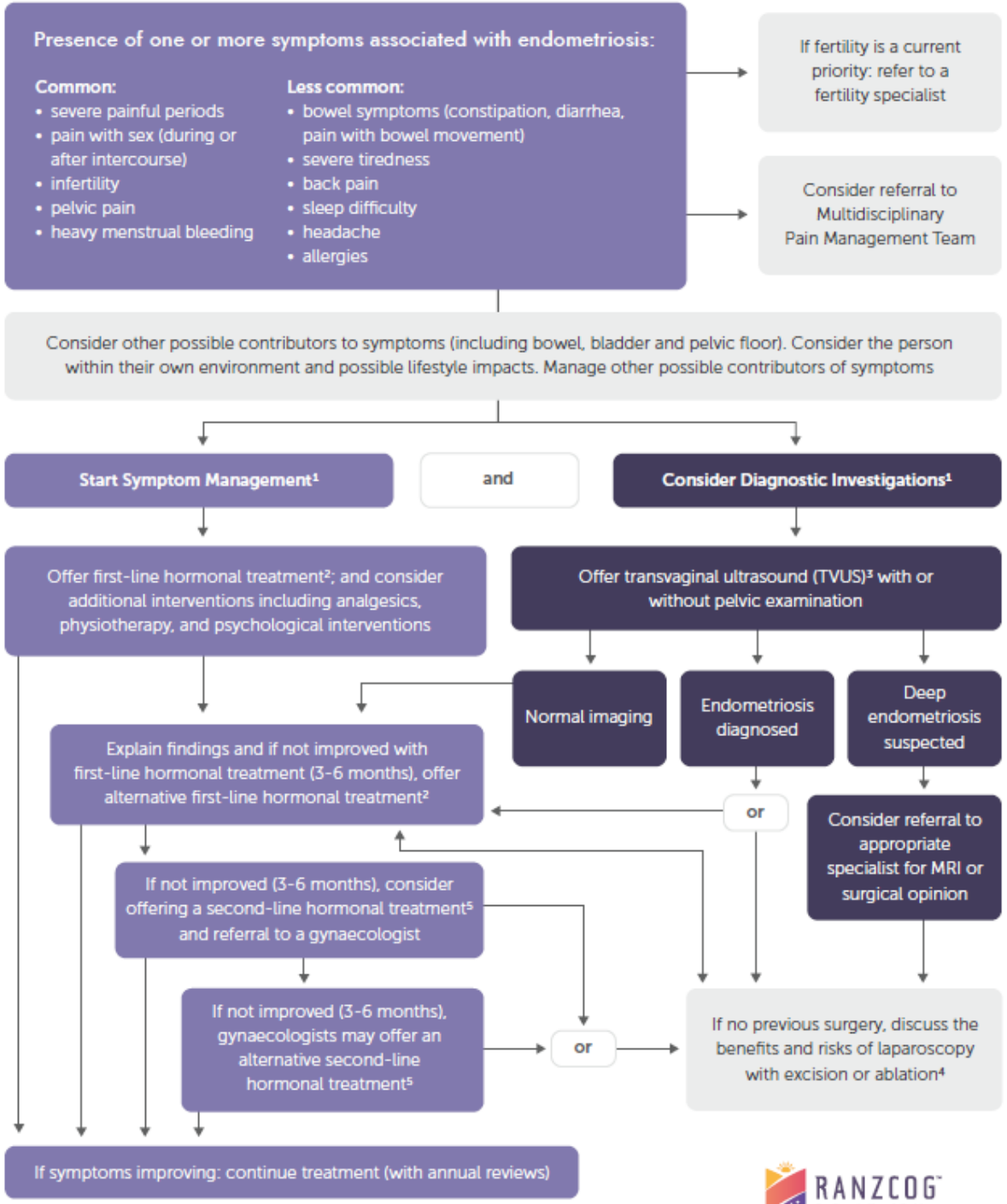
Metro North Health | Queensland Government

Clinical questions

- **When do we suspect endometriosis?**
- **What investigations do we organise?**
- **How do we manage initially?**
- **What do gynaecologists do?**
- **Special consideration for adolescents**



Summary of Diagnosis and Management



When do we suspect endometriosis?

Metro North Health | Queensland Government

Signs and symptoms

1. Conditional Recommendation

Endometriosis could be considered in people with the presence of one or more of the following symptoms:

- Commonest symptoms (associated with endometriosis in 25 to 70% of the cases):
  - severe painful periods
  - pain with sex (pain during or after intercourse)
  - infertility
  - pelvic pain
  - heavy menstrual bleeding.
- Less common symptoms (associated with endometriosis in 10 to 25% of the cases):
  - bowel symptoms (constipation, diarrhoea, pain with bowel movement)
  - severe tiredness
  - back pain
  - sleep difficulty
  - headache
  - urinary symptoms
  - allergies.

Certainty of Evidence: Low

What investigations do we organise?

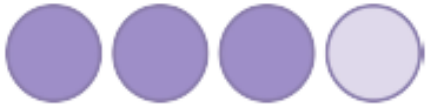
Metro North Health | Queensland Government

Medical imaging

14. Strong Recommendation

Offer to all people with symptoms suggestive of endometriosis, even if the vaginal and abdominal examination is normal:

- transvaginal ultrasound as the first-line investigation, or pelvic MRI where pelvic ultrasound is not appropriate
- if transvaginal ultrasound, and MRI are not available or appropriate, then transabdominal ultrasound can be offered
- if deep endometriosis is suspected on examination or transvaginal ultrasound, an MRI should be organised (to assist with surgical planning if required).



Certainty of Evidence: Moderate

How do we manage initially?

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Information and Support

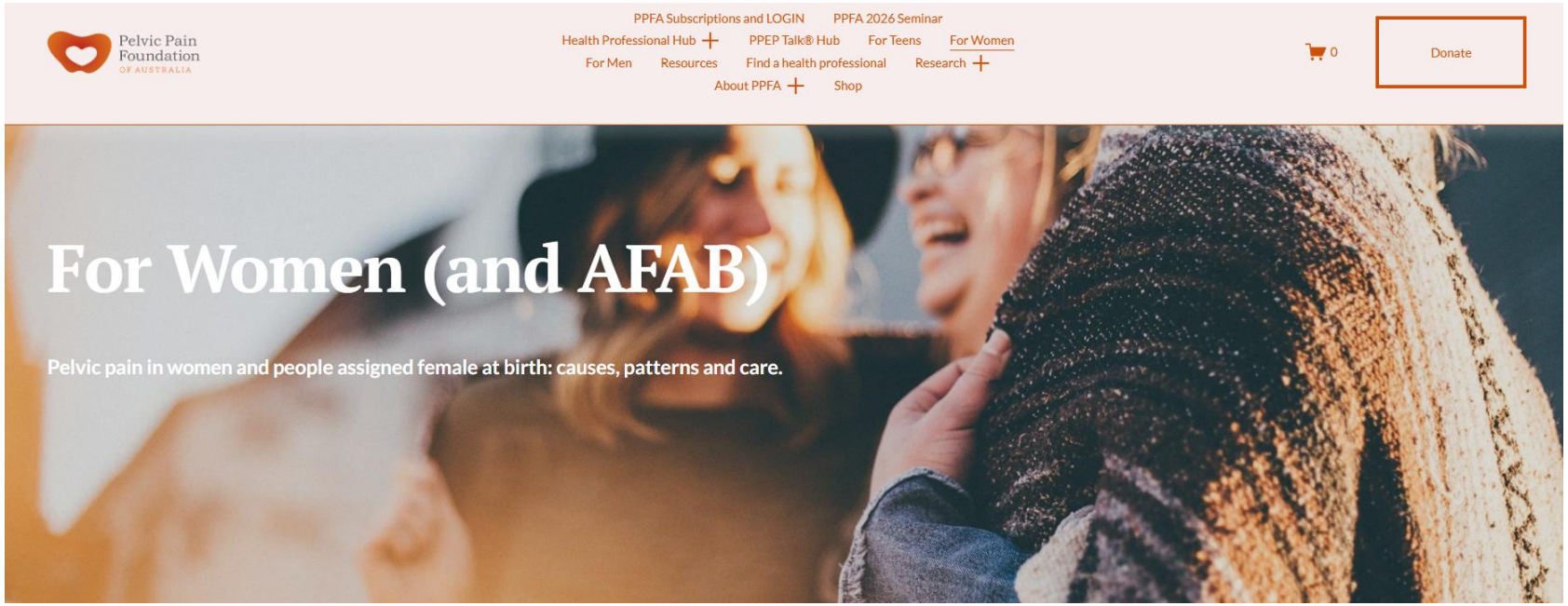
6. Conditional Recommendation

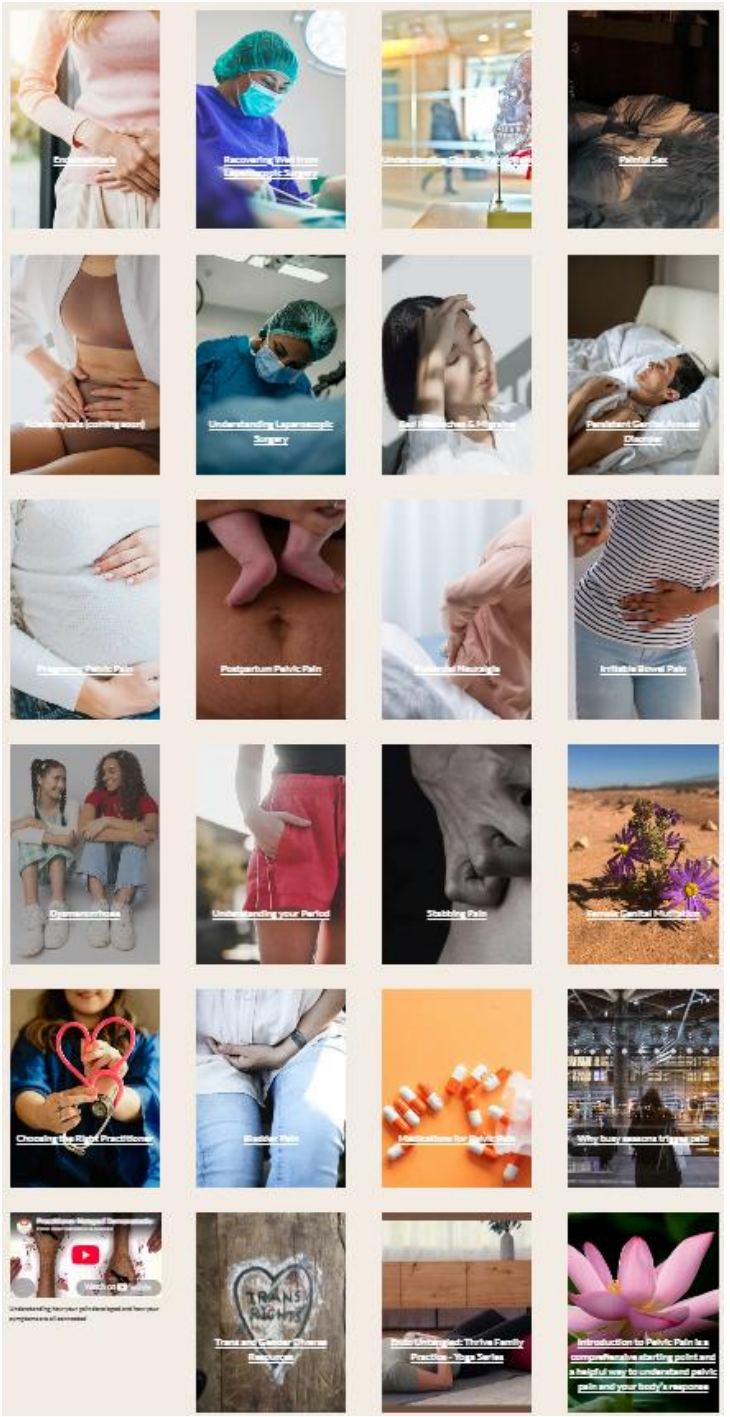
Provide ongoing information and support to promote their active participation in care and self-management on:

- what endometriosis is
- endometriosis signs and symptoms
- how endometriosis is diagnosed
- treatment options including expectant management, medical and surgical treatments, non-pharmacological or surgical interventions, follow-up, anticipated waiting times and out-of-pocket expenses
- national and local support groups or networks, and resources.

Certainty of Evidence: Low

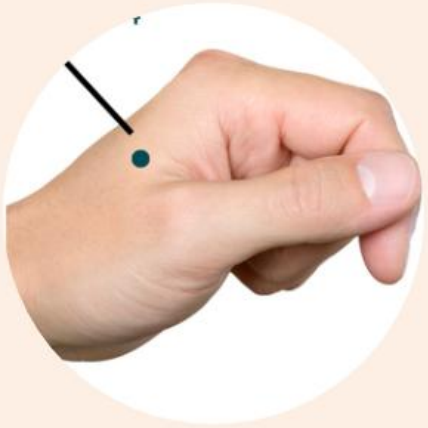
Pelvic Pain Foundation





Pelvic Pain Foundation

Workstation Stretches for Period and Pelvic Pain Relief

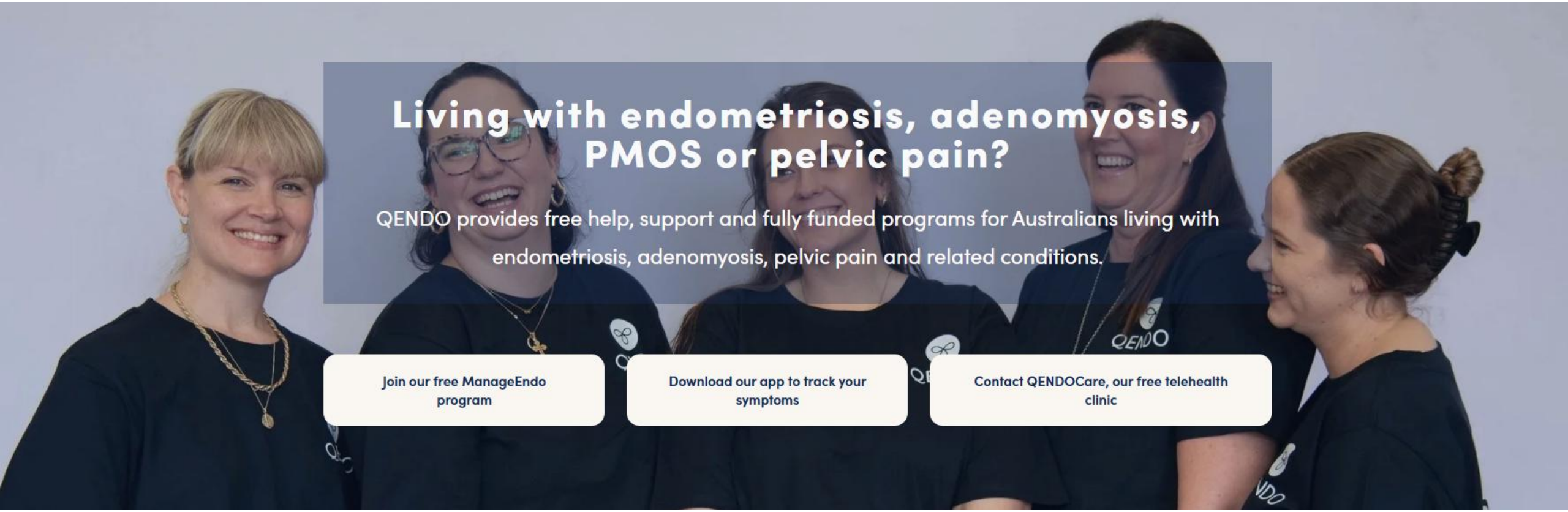


Acupressure Guide for Period and Pelvic Pain Relief

Stretches for Period and Pelvic Pain Relief

Pacing A really useful skill for people who live with persistent pain

QENDO


Living with endometriosis, adenomyosis, PMOS or pelvic pain?
QENDO provides free help, support and fully funded programs for Australians living with endometriosis, adenomyosis, pelvic pain and related conditions.
Join our free ManageEndo program
Download our app to track your symptoms
Contact QENDOCare, our free telehealth clinic
QENDO

QENDO

Services to meet your needs

QENDO's services range from a FREE multidisciplinary telehealth care program to community-based programs running across Australia.

QENDOCare Telehealth Clinic

Free, nationwide, multidisciplinary telehealth care offering one-to-one support from health professionals, including physiotherapists, counsellors, dietitians and nurses.

1800 ASK QENDO Helpline

A confidential space to speak with trained peers who understand what you're going through.

Mentoring Program

Sign up for 6 weeks of one-to-one guidance from someone who's been there before and can help you navigate day-to-day challenges.

Connected Communities

Volunteer-led groups offering coffee catch-ups, online support, and events in local areas.

Hormonal management

- **Hormonal medical treatments**
  - “hormonal treatment can reduce pain”
  - “Offer combined OCP, progestogen, subcutaneous implant or IUD”
  - “No hormonal treatment has been demonstrated to be superior”
  - “a shared decision-making approach and take individual preferences, side effects, individual efficacy, costs, and availability into consideration”

		Efficacy	Amenorrhoea (a)	Adverse Events
Combined Hormonal contraceptive (CHC) 20 or 30 mcg estrogen combined with progestogen		All hormonal interventions have comparable improvement for pelvic pain, painful period, and pain with sex	Depends on the type and cycle, amenorrhoea is more common with continuous cycle	Thrombosis risk increased from 2/10,000 to 10/10,000 [128] There may be a small increase in breast cancer risk from 5.5/10,000 to 6.4/10,000 events per person-year up to 5 years of use and to 7.6/10,000 with over 10 years of use (the risk may vary with different types of progestogens) [129]
Progestogens	MPA (5-30 mg daily continuously)		Amenorrhoea is common, more likely after 12 weeks of use	These include acne, breast tenderness, weight change and headaches May have a small increase in the risk of thrombosis [130]
	LNG-IUD 52 mg (release 15 mcg/ daily)		Spotting is common during the first 3 months. Amenorrhoea is common	May have a small increase in the risk of simple ovarian cyst [131] and pelvic inflammatory disease peri insertion and extraction [132, 133] May have little to no difference in the risk of thrombosis [128, 130]. There may be a small increase in breast cancer from 5.5/10,000 to 7/10,000 events per person-year [129]
	Implant		Spotting is common during the first 3 months. Amenorrhoea is common	May have little to no difference in the risk of thrombosis [130] or breast cancer [129] Spotting may be more likely for people with low BMI (<20kg/m²) [134]
	Dienogest (2mg daily continuously)		Amenorrhoea is common, more likely after 12 weeks of use	May slightly increase BMD loss, with unknown significance [135]
GnRH agonist/GnRH antagonists plus add-back(b) On specialist recommendation			Amenorrhoea is common	Add-back reduces the likelihood of having hot flushes, vaginal dryness, and BMD loss [136]
GnRH antagonist GnRH antagonist On specialist recommendation			Amenorrhoea is common, may have occasional spotting	More likely to have hot flushes, vaginal dryness, and BMD loss [136][137]
SERMs		Very limited evidence for its use [138]		
Aromatase inhibitors		Very limited evidence for its use (c) [139, 140]		
SPRMs		No evidence for the use of tibolone [141]		

MPA (medroxyprogesterone acetate), LNG-IUD (levonorgestrel-releasing intrauterine device), GnRH (gonadotrophin-releasing hormone), SERM (selective estrogen receptor modulator), SPRM (selective progestogen receptor modulator), BMD (bone mineral density)

(a) If dosage leads to amenorrhoea, then there is a very low likelihood of pregnancy (but not all are approved for contraception in Australia)
(b) Add-back therapy: progestogen monotherapy, SERM, tibolone and testosterone, HRT (although NETA has reported the same results as NETA combined with CC)
(c) Requires contraception as fertility may be enhanced

First line: can be used long-term | Second line:Could be used long-term | Second line: short-term use only < 6 months... | Not recommended

Non-pharmacological and non-surgical managements

Moderate to low certainty evidence suggests that physical and psychological therapies, and acupuncture may improve pain and quality of life for people with endometriosis. There is no evidence for diet (food) therapy. We are uncertain whether yoga or exercise improves or worsens pelvic pain.

The following could be considered for the treatment of endometriosis symptoms, according to person preferences and symptom severity.

- physiotherapy
- psychological interventions- mindfulness, psychotherapy, counselling
- diet
- dietary supplements
- acupuncture

Non-pharmacological and non-surgical managements

Physiotherapy

- Manual therapy (including abdominal muscle, pelvic, lumbar and thoracic mobilisation and soft tissue techniques) provided over 8 weeks with one session for 30 minutes every 15 days
- Pelvic floor (digital pressure) physiotherapy; provided over 11 weeks with 5 sessions of 30 mins each on weeks 1,3,5,8 and 11

Psychological Intervention

- Psychotherapy with somatosensory stimulation (acupuncture, moxibustion and heat): provided for 3 months with 30-60 mins sessions, with a median of 8.5 sessions
- Mindfulness: provided in a group face to face setting delivered once a week for 1.5 hours per session with a follow-up of weekly online mindfulness classes for 3 weeks
- Counselling: seven 60–90-minute self-care group counselling sessions held on a weekly basis

Dietary supplements:

- 1000 mg fish oil [720 mg omega-3 fatty acids, including 488 mg EPA (20:5n–3) and 178 mg DHA (22:6n–3)] daily, 2000 IU vitamin D3 (cholecalciferol): one per day
- Palmitoylethanolamine (PEA) + transpolydatin: micronized PEA/transpolydatin (400 mg + 40 mg) twice a day for three months

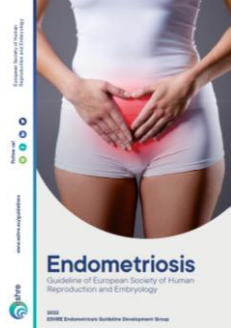
Acupuncture

- Acupuncture: provided over 12 weeks with 30-minute sessions, 3 times a week

What do gynaecologists do?

Metro North Health | Queensland Government

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.	⊕⊕⊕◯

AstraZeneca pulls critical breast cancer and endometriosis drug Zoladex from shelves

By national health reporter **Stephanie Dalzell** and Specialist Reporting Team's **Mary Lloyd**

Pharmaceuticals

Posted 4 Jun 2026 at 4:49am, updated 4 Jun 2026 at 10:51 am

Zoladex 3.6mg is prescribed to patients to slow the growth of breast cancer or reduce the risk of it recurring. *(ABC News: Chris Taylor)*

Zoladex withdrawal: Action needed to protect treatment

by Endo Australia Digital | Jun 4, 2026 | | Endo news and media

Endometriosis Australia

Endometriosis Australia calls for urgent action to protect access to essential treatment following Zoladex withdrawal

Endometriosis Australia is deeply concerned by the announcement that Zoladex® (goserelin 3.6 mg) will be withdrawn from the Australian market later this year.

For thousands of Australian women living with endometriosis and adenomyosis, Zoladex has been an important part of the therapeutic toolkit for managing severe symptoms and improving quality of life. While it is not a cure, it has provided meaningful relief for many women whose treatment options are already limited.

Endometriosis Australia is concerned not only about the loss of a medication, but about the message this sends to women living with chronic pelvic pain.

Women with endometriosis already face an average diagnostic delay of many years, repeated surgery, significant out-of-pocket costs and substantial impacts on education, employment and fertility. Removing an established treatment option risks further narrowing an already constrained pathway to care.

"Women with endometriosis already fight hard enough to access care. Australia cannot afford to make that journey even harder by allowing essential treatment options to quietly disappear."

AstraZeneca to provide breast cancer and endometriosis drug Zoladex to patients for free indefinitely

By national health reporter **Stephanie Dalzell** and Specialist Reporting Team's **Mary Lloyd**

AstraZeneca said the Australian price for the product, sold as Zoladex, was too low, "making it unsustainable to supply the medicine on the PBS".

The move triggered criticism from advocates, patients and the broader public and a Change.org petition calling for urgent action gathered more than 42,000 signatures in a matter of weeks.

Cancer and endometriosis drug to be pulled from shelves

Patients have been left frustrated and scared after learning that a life-saving breast cancer and endometriosis drug is to be pulled from shelves.

AstraZeneca had initially promised to set up a six-month access program to provide the medication for free to those without alternative treatments.

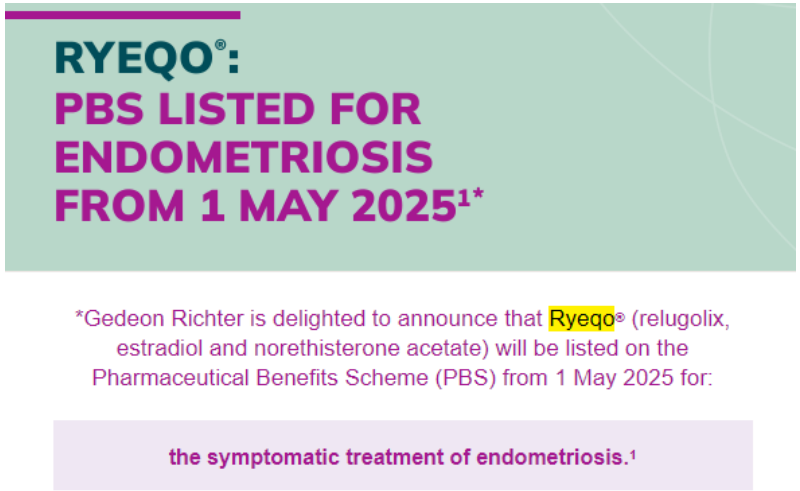
However, it has since announced it would supply the medication indefinitely to those whose doctors determine there are no other suitable treatments available.

"This includes patients who are currently prescribed and patients who may need to be prescribed the implant as a treatment option after 1 November 2026," an AstraZeneca spokesperson said.

GnRH antagonist

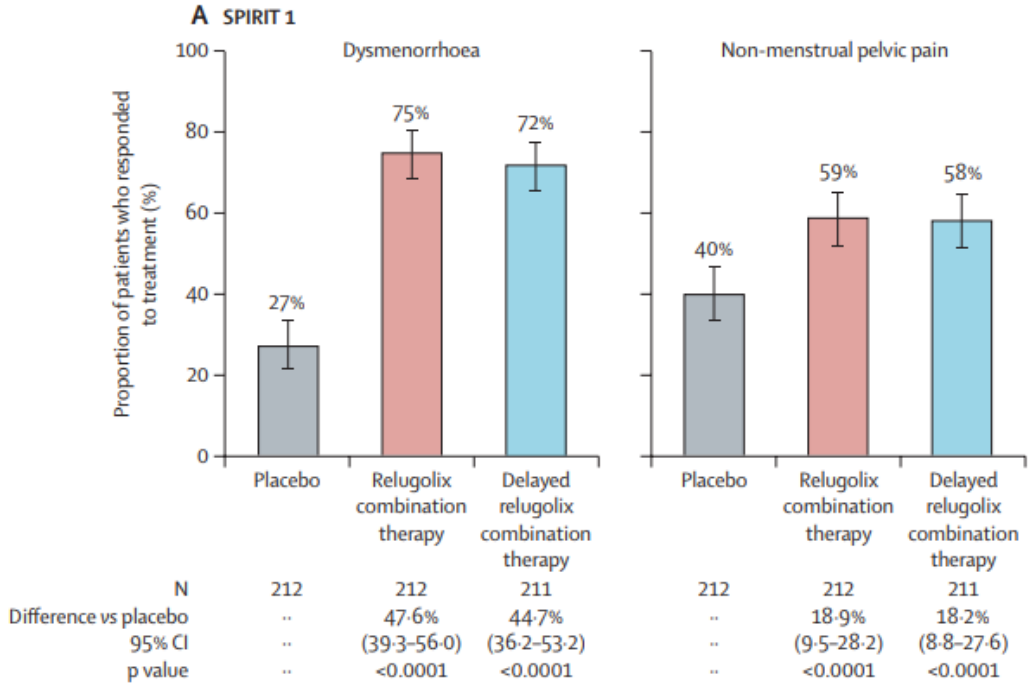
Ryeqo™

relugolix, estradiol, and norethisterone acetate



- GnRH antagonist combined with add-back therapy
- A single, once-daily pill
- Licenced for endometriosis and uterine fibroid
- Treatment recommended to be limited to 24 months
- Extension of therapy conditional on stability of DXA and reassessment of risk/benefit
- DXA scan recommended at baseline and then annually
- The most common adverse drug reactions were headache (17%) and hot flushes (11.7%)

Randomized Controlled Trial > Lancet. 2022 Jun 18;399(10343):2267-2279.
doi: 10.1016/S0140-6736(22)00622-5.



Once daily oral relugolix combination therapy versus placebo in patients with endometriosis-associated pain: two replicate phase 3, randomised, double-blind, studies (SPIRIT 1 and 2)

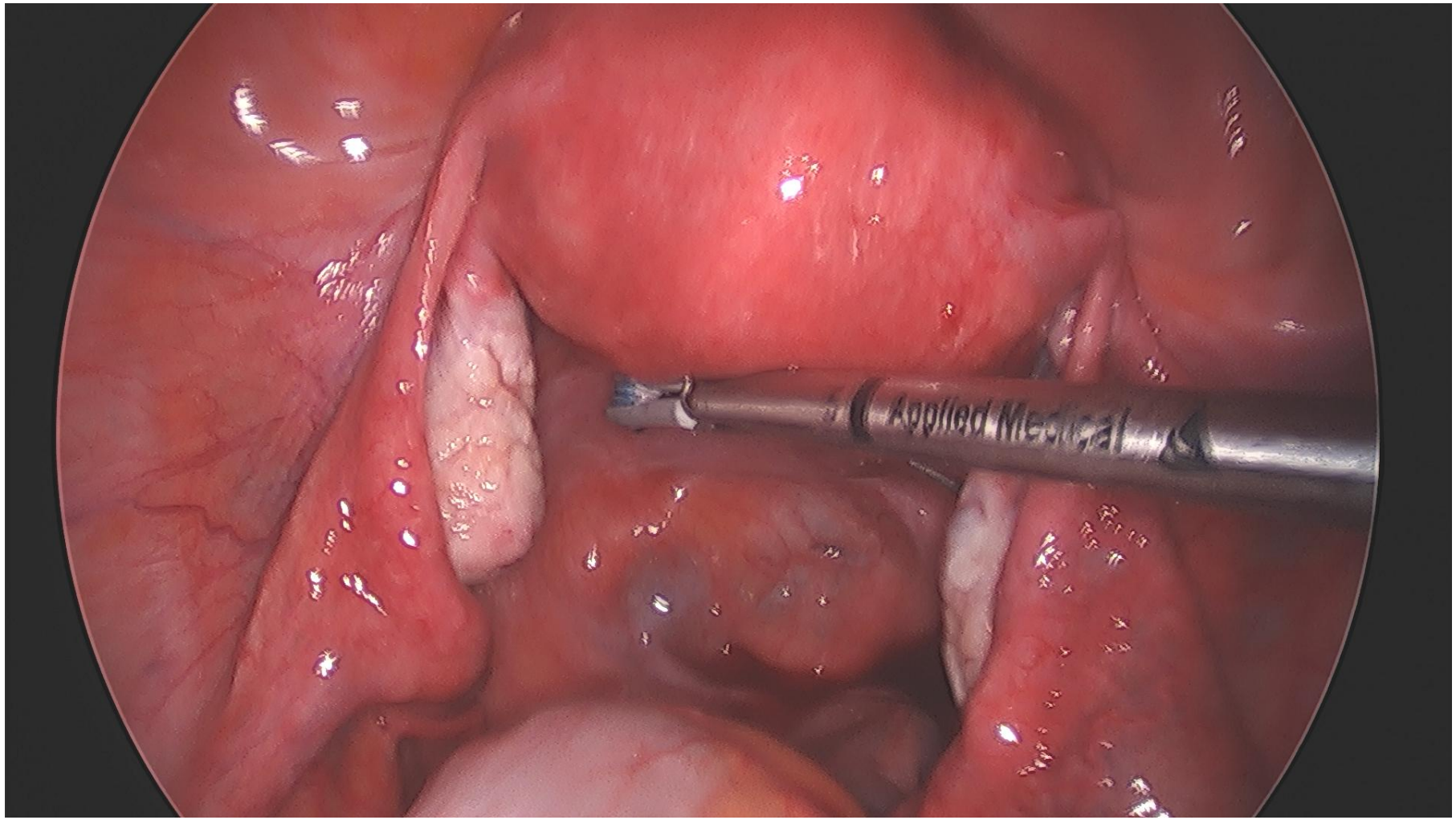
Linda C Giudice, Sawsan As-Sanie, Juan C Arjona Ferreira, Christian M Becker, Mauricio S Abrao, Bruce A Lessey, Eric Brown, Krzysztof Dynowski, Krzysztof Wilk, Yulan Li, Vandana Mathur, Qurratul Ann Warsi, Rachel B Wagman, Neil P Johnson

- Improvement in dysmenorrhoea
- Improvement in non-menstrual pelvic pain
- These improvements were observed as early as 4 weeks, with maximum effect at 8 weeks for dysmenorrhoea and at 12 weeks for non-menstrual pelvic pain, and maintained at 24 weeks

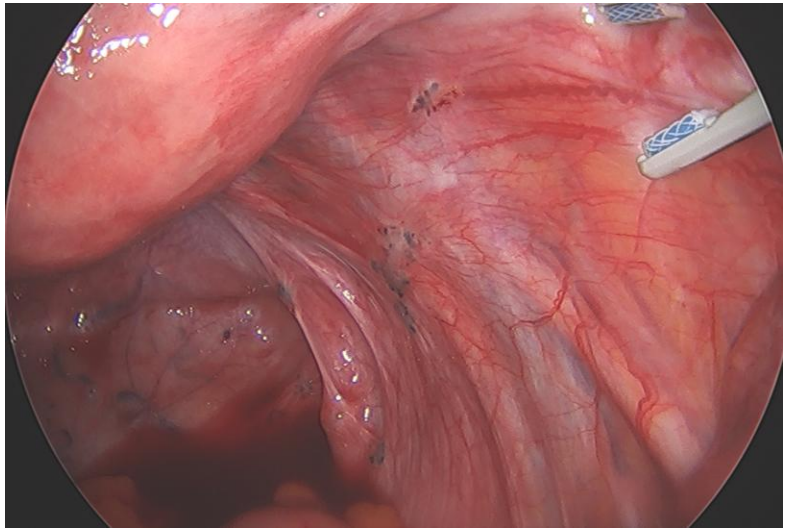
	SPIRIT 1	
	Placebo (n=212)	Relugolix combination therapy (n=212)
Adverse events	140 (66%)	151 (71%)
Suicidal ideation	1 (<1%)	0
Death	0	0
Adverse events of grade 3 or higher	12 (6%)	10 (5%)
Serious adverse events	5 (2%)	3 (1%)
Adverse events leading to trial-drug discontinuation	4 (2%)	8 (4%)
Adverse events reported in more than 5% of patients in any group		
Headache	46 (22%)	57 (27%)
Nasopharyngitis	12 (6%)	13 (6%)
Hot flush	21 (10%)	22 (10%)
Toothache	3 (1%)	5 (2%)
Back pain	5 (2%)	8 (4%)
Nausea	11 (5%)	13 (6%)
Arthralgia	2 (1%)	4 (2%)
Bone density decreased	4 (2%)	5 (2%)
Libido decreased	1 (<1%)	5 (2%)
Urinary tract infection	6 (3%)	4 (2%)
Acne	13 (6%)	2 (1%)
Vitamin D decreased	15 (7%)	4 (2%)

- Relugolix combination therapy minimises the risk of hypoestrogenic-related bone loss and vasomotor symptoms, potentially enabling long-term use

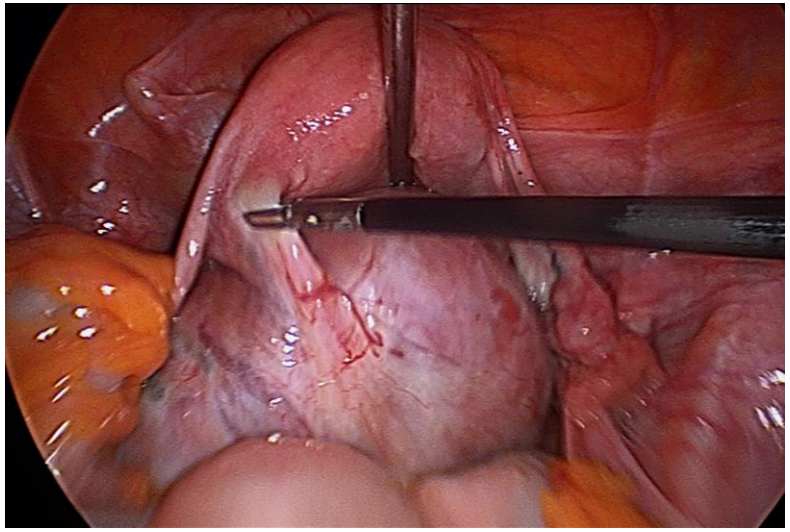
Surgical management



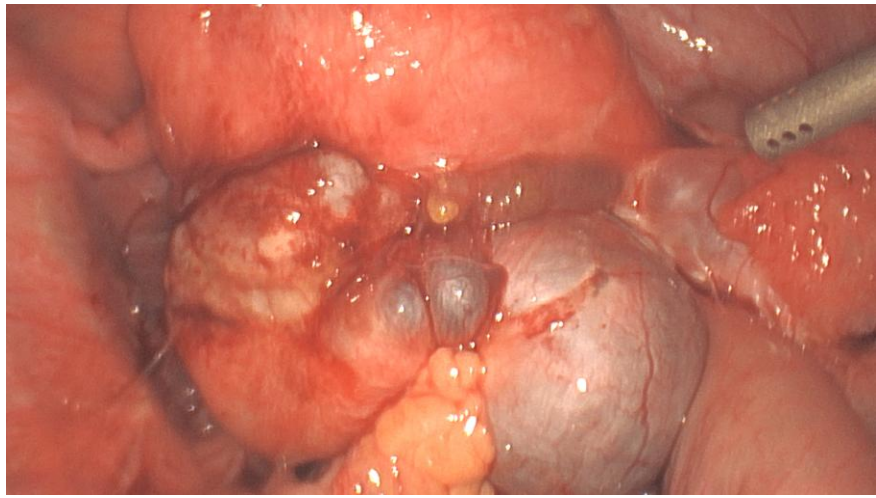
Endometriosis – 3 phenotypes



Superficial peritoneal endometriosis



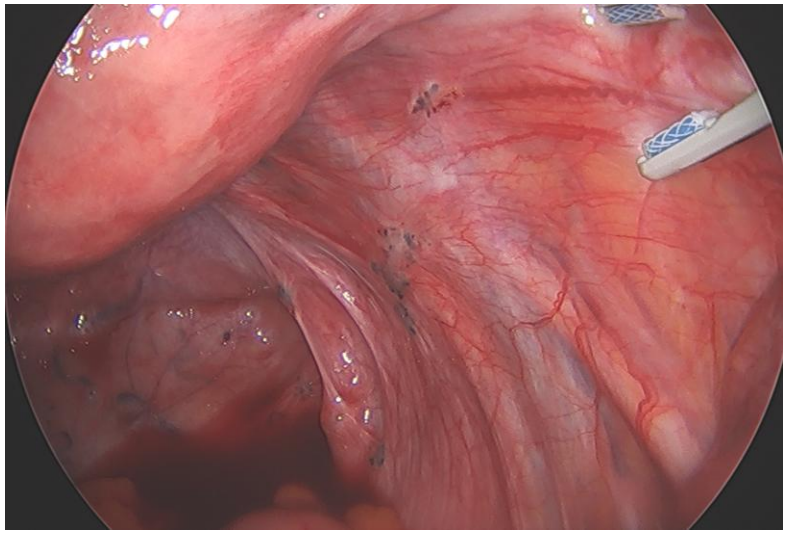
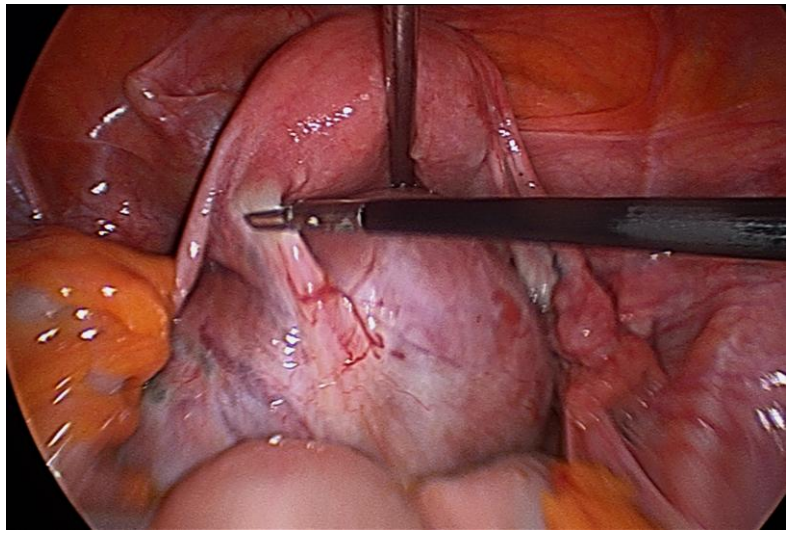
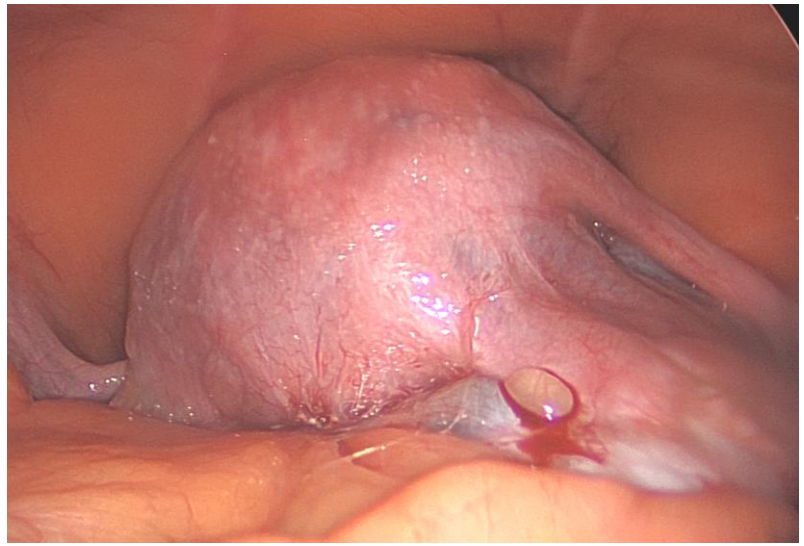
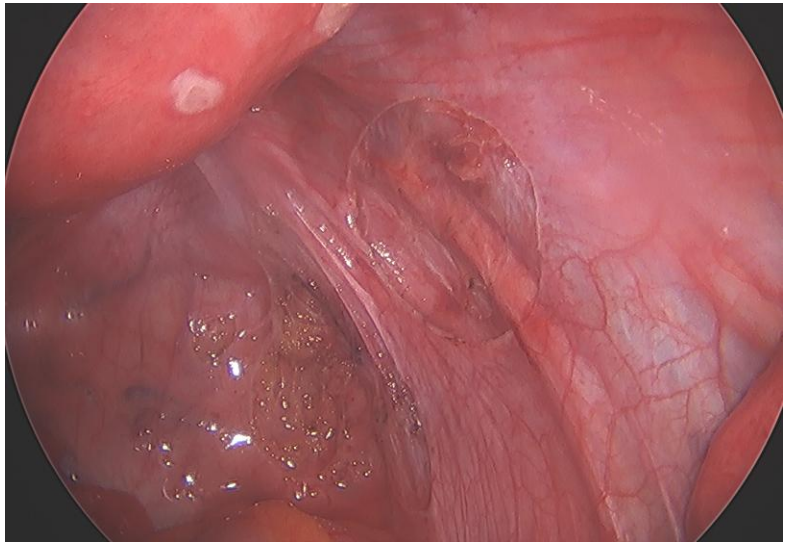
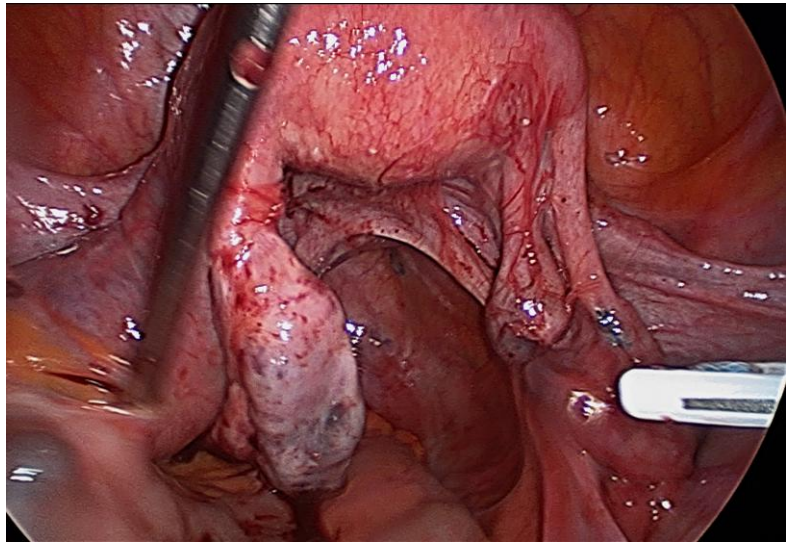
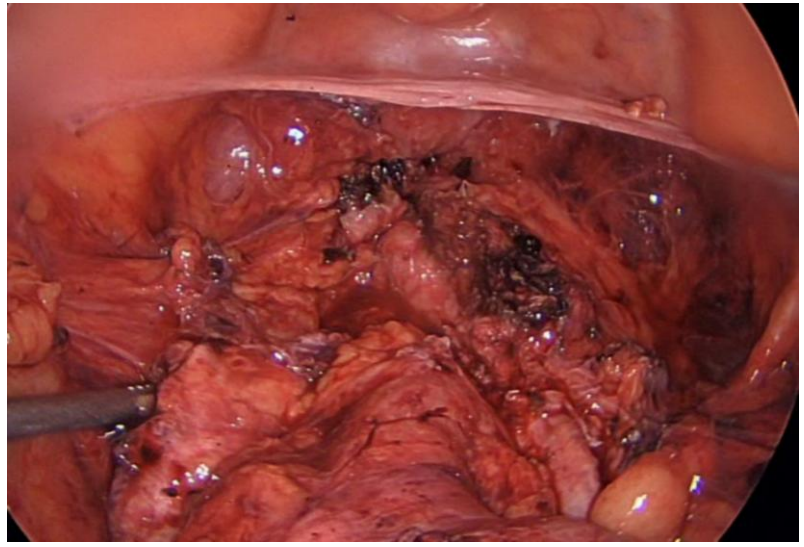
Ovarian endometrioma



DIE: Deeply infiltrating endometriosis

53

Surgical treatment

Special consideration for adolescents

Metro North Health | Queensland Government

Special consideration: Adolescents

74. Good Practice Statement

The GDG suggests that adolescents[5] with significant period pain should be validated, their symptoms investigated for possible causes, and prompt treatment started.

75. Conditional Recommendation

For young people with significant period pain ultrasound should be used to assess causes including endometriosis. Use transabdominal ultrasound when transvaginal ultrasound is not suitable. MRI or transperineal ultrasound also may be considered by a specialist experienced in these modalities.

Certainty of the Evidence: Low

76. Conditional Recommendation

All hormonal and simple analgesic options are suitable for young people. IUD is safe to use in young people and may be inserted under general anaesthetic (if necessary). Other management as outlined in this guideline may also be suitable for young people.

Certainty of the Evidence: Low

77. Good Practice Statement

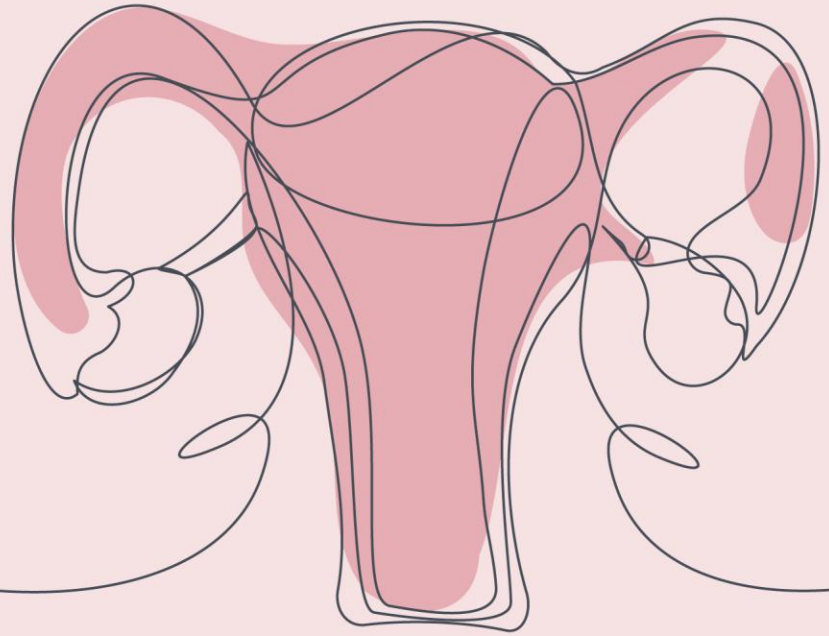
The GDG suggests that the role and place of laparoscopy should ideally be discussed with a gynaecologist with experience in management of endometriosis in young people. Other treatments should continue whilst awaiting laparoscopy to investigate symptoms.

78. Good Practice Statement

The GDG suggests referring adolescents[4] with suspected or confirmed endometriosis to a paediatric and adolescent gynaecologist with an interest in endometriosis depending on local service provision, or to a gynaecologist who is comfortable treating adolescents with possible endometriosis.

Metro North **GP Alignment Program**

Gynaecology Workshop



Pelvic Pain in Adolescents

Catherine Willis + Molly Lewis
Pelvic Pain Physiotherapists | RBWH

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Before Pain Becomes Persistent:

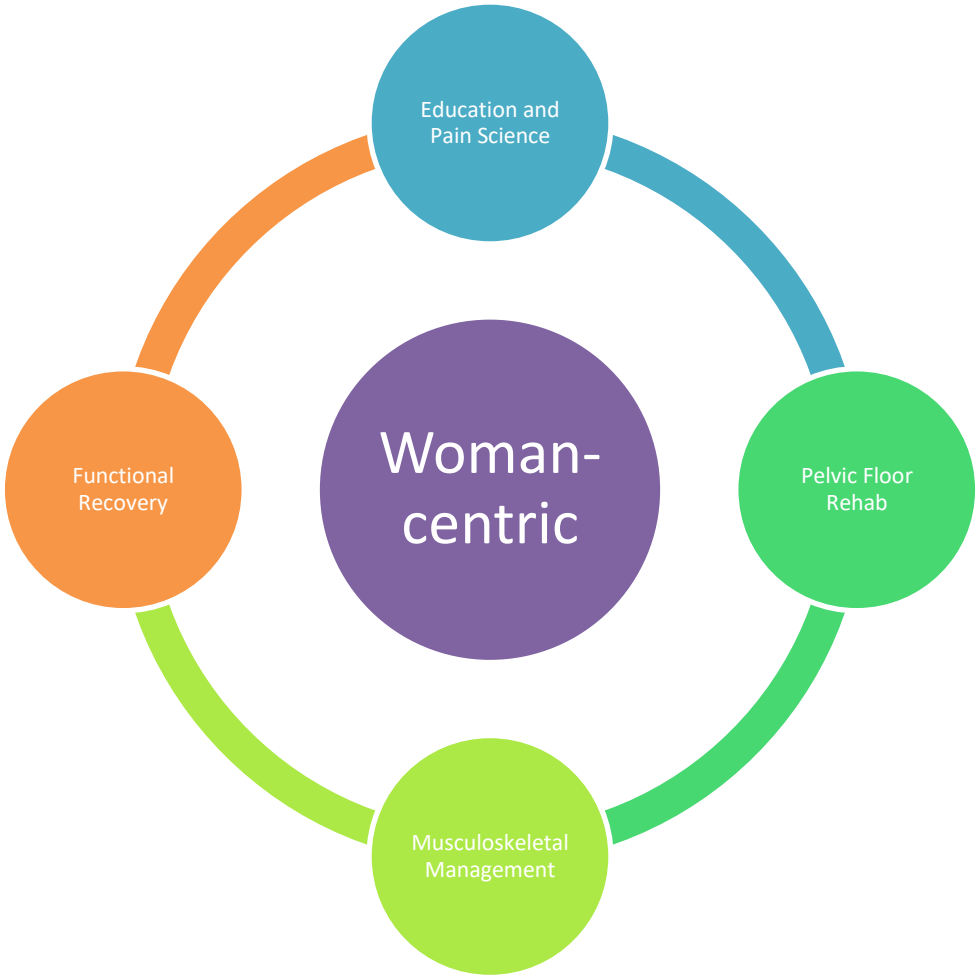
The role of early pelvic health physiotherapy intervention in Adolescents and Young Adults

Catherine Willis and Molly Lewis

Pelvic Health Physiotherapy Across the Pain Journey

- Pelvic Health Physiotherapy is more than the pelvic floor
- We have typically seen females/women with vaginismus, post partum perineal pain, dyspareunia related to perimenopause/menopause, and other conditions such as bladder pain syndrome

What Does Pelvic Health Physiotherapy Actually Do?



How Physiotherapy Improves Outcomes

- Less pain-related distress
- Improved confidence and self-efficacy
- Reduced pelvic floor overactivity
- Improved sexual function
- Improved bladder and bowel symptoms
- Increased participation in exercise and daily activities
- Better quality of life

Physiotherapy for Pelvic Pain: Adolescents and Young Adults

Our role: Optimise function and help patients achieve the things that are **important to them** alongside ongoing medical management

More than 1 in 5 girls and people assigned female at birth aged 16-18 have pain with periods

Moving from ‘What is **causing** this pain’ to ‘What is this pain **changing or inhibiting** in this young person’s life’

Adolescence and Young Adulthood

Why is this age group so important?

A vulnerable window

- Hormonal and physical changes
- Body image and developing identity
- Increasing social, educational and financial pressures
- Increasing independence
- Emerging awareness of sexual health and identity

‘Hidden’ symptoms

- Limited education about pelvic health
- Uncertainty about what is ‘normal’
- Shame, fear or embarrassment
- Symptoms may be normalised
- Young people may not know what to ask

AYA Physio for Pelvic Pain

1. Listen and understand

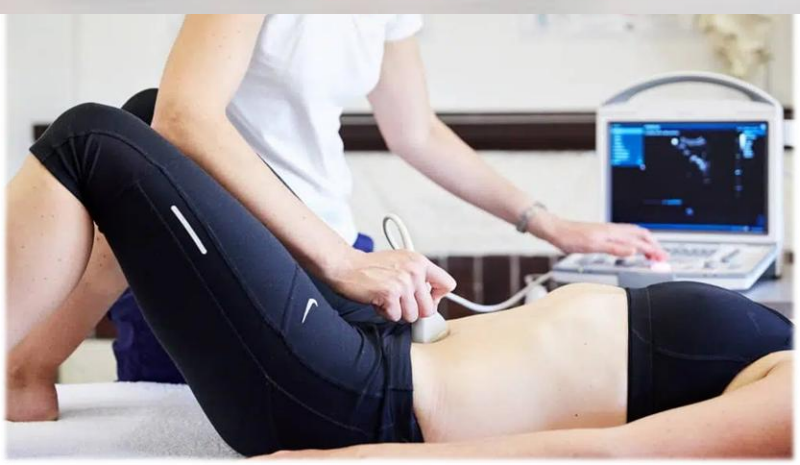
- Thoughts, beliefs, fears
- What do they know?
- What have they been told?
- How do they explain and experience pain?
- What is their pain stopping them from?

2. Educate – ‘meet them where they’re at’

- Pelvic anatomy
- Menstrual cycle and hormonal changes
- ‘Normal’ bladder and bowel habits
- Sexual health and safety (where appropriate)
- Slowly introduce pain education and desensitisation

AYA Physio for pelvic pain

3. Assess



AYA Physio for pelvic pain

4. Build skill and support function

‘Flare-up’ management plans

‘Pain Toolkit’

Diaphragmatic breathwork
Self-regulation strategies

Pelvic floor relaxation and flexibility

Hot/cold therapy

TENS

MOVEMENT OR SPORTS

SCHOOL OR STUDY

WORK

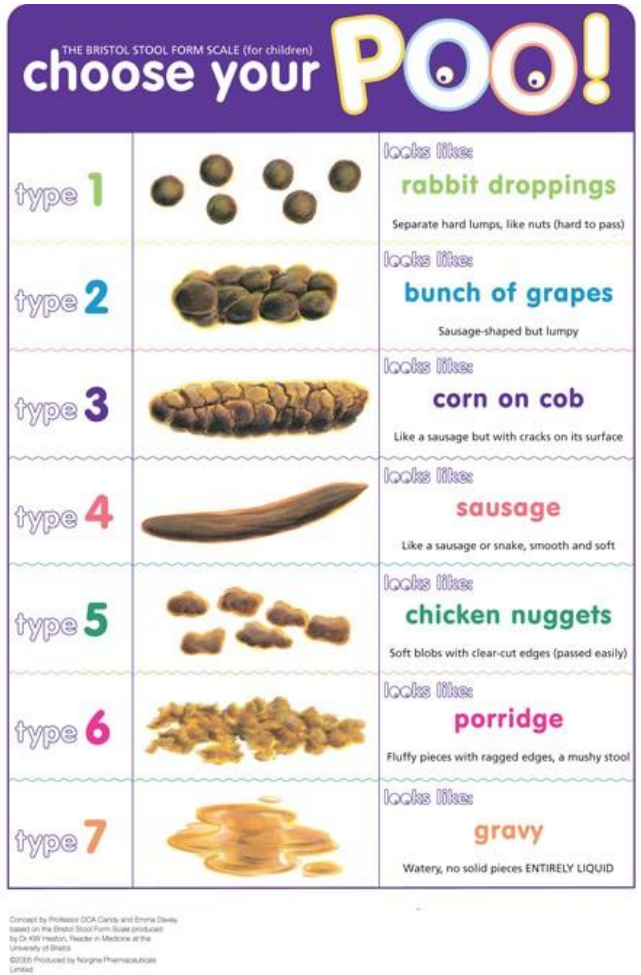
What do we want this young person to keep doing WHILE we work on their pain?

HOBBIES

RELATIONSHIPS WITH FRIENDS AND FAMILY

SLEEP

Bladder and bowel screening



Thank you

Helpful resources

ENDOMETRIOSIS AUSTRALIA

Pelvic Pain Foundation OF AUSTRALIA

Jean Hailes FOR WOMEN'S HEALTH