Description of Service:

Tertiary Level Gynaecological Services are provided at both Lyell McEwin Hospital Family Clinic and Modbury Hospital Women’s and Paediatric Clinic.

Scope of Service:

- Advanced Laparoscopy Service
- General Gynaecology (Menstrual dysfunction, Fibroids, Pelvic Pain, Endometriosis, Ovarian pathology, PMB)
- Urogynaecology (Prolapse/Pelvic floor surgery, Urinary incontinence, Urodynamics)
- Colposcopy

NALHN does not provide a Fertility Service but is able to assist in diagnosis and treatment of surgical conditions that cause infertility. This includes the diagnosis and treatment of Endometriosis or tubal disease.

Conditions Seen Include:

- Post-menopausal Bleeding
- Menorrhagia / Menstrual irregularities
- Ovarian cyst / mass with low risk of malignancy
- Post Coital Bleeding
- Pelvic Pain
- Urinary Incontinence / Prolapse
- Abnormal Cervical Screening Test
- Vulval/vaginal disorders

Exclusions:

- Reversal of Tubal Ligation
- Confirmed gynaecological malignancy
- Routine (uncomplicated) Cervical Screening Test
- Patients requiring ovulation induction, assisted reproductive technology or IVF, see Fertility Pathway

Please Note

- Patients requesting pap smear under GA can now self-collect so referrals for pap smear will no longer be accepted.

Referral Criteria:

- Please include copies of all reports and results. If the results are unavailable or pending please include the name of the provider so they can be followed up.
- Patients are seen based on the urgency, as judged from the referral, so referring doctors are urged to give a full and detailed referral to ensure that this is equitably managed.
# Gynaecology

**NALHN Outpatient Service Information, Triage & Referral Guidelines**

**Acknowledgement:** Content for this document was primarily sourced through the SALHN Specialty Outpatient Guidelines 2014/15

## URGENT
**Target < 1month**

- Heavy bleeding with significant anaemia
- Note suspected gynaecological malignancies should be referred directly to the RAH

## SEMI-URGENT
**Target <3months**

- Post-menopausal Bleeding
- Complicated Menstrual dysfunction (anaemia or abnormal endometrium on ultrasound or age >35)
- Abnormal Pap Smear
- Ovarian mass with low risk of malignancy on scan and CA 125
- Severe prolapse (total eversion)

## NON-URGENT/ROUTINE

- Pelvic Pain
- Urinary Incontinence
- Prolapse
- Uncomplicated menstrual dysfunction in age <35
- Infertility

## NALHN Consultants

- Dr M Ritossa (Divisional Director)
- Dr A Parange (HOU, O&G, Lyell McEwin Hospital)
- Dr K Walsh (HOU, O&G, Modbury Hospital)
- Dr J Chapman-Wardy
- Dr C Cocchiaro
- Dr A Hubczenko
- Dr S Kane
- Dr A Limengo
- Dr A Munt
- Dr T Nguyen
- Dr M Rasekhi
- Dr H Waterfall

## For More Information or to Make a Referral

**Lyell McEwin Hospital Family Clinic**
Location: Ground floor
Referral Fax Number: 8282 1612
Phone Number: 8282 0255
Phone Number: via LMH Switchboard 8182 9000

**Modbury Hospital Women’s & Paediatric Clinic**
Location: Ground Floor
Referral Fax Number: 8161 2227
Phone Number: 8161 2593
Phone Number: via MH Switchboard 8161 2000


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<th>Amendment</th>
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<td>Aug 2019</td>
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### Post-menopausal Bleeding

**Definition:** Vaginal bleeding occurring after twelve months of amenorrhea in women of menopausal age.

<table>
<thead>
<tr>
<th>Information Required</th>
<th>Investigations Required</th>
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<tbody>
<tr>
<td>Investigation results including pap smear</td>
<td>Transvaginal (TV) ultrasound for endometrial thickness</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Warning Signs – Suggest immediate referral</th>
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</thead>
<tbody>
<tr>
<td>⚠️ High suspicion of endometrial cancer on US (ET &gt; 4mm, irregular endometrium)</td>
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<tr>
<td>⚠️ Women on Tamoxifen</td>
</tr>
<tr>
<td>⚠️ Family history of breast cancer or ovarian cancer</td>
</tr>
<tr>
<td>⚠️ Exposure to oestrogen without progesterone</td>
</tr>
</tbody>
</table>

### Suggested GP Management

- For endometrium < 4.1mm and one episode of bleeding
  - No further treatment other than to treat atrophic vaginitis, if bleeding continues or returns refer to NALHN
- For endometrium > 4mm or recurrent persistent bleeding refer to NALHN
Menorrhagia / Irregular bleeding

Definition

> Menorrhagia: abnormally heavy or prolonged bleeding over several consecutive menstrual cycles in a woman of reproductive years.
> Irregular Bleeding: abnormal variation in length of menstrual cycles.

Information Required

- Pelvic USS results
- Investigation results
- Duration of symptoms
- Associated symptoms

Investigations Required

- Pregnancy Test
- CBE, Ferritin levels
- TSH and prolactin
- Pelvic ultrasound
- STI Swabs
- Consider tests for polycystic ovarian syndrome if periods are irregular and there are symptoms consistent with elevated testosterone.
- CST (pap smear) result. Please perform if due

Warning Signs

- Endometrial thickness >12mm or irregular
- Weight greater than 90kg
- Age >35
- Suggestion of polyp or fibroids > 4 cm on Ultrasound scan
- Anaemia
- Failed medical management
- Exposure to oestrogen without progestogens

Suggested GP Management

Ideally uncomplicated menorrhagia should be treated with a first line treatment such as the OCP or Mirena IUD prior to referral. Avoid oral progesterone’s as they can make things worse.
Ovarian Cyst / Mass with low risk of malignancy

- **Definition:** Ovarian cyst / mass are an accumulation of fluid within or on the surface of an ovary, which is surrounded by a very thin wall.
- **Differential diagnoses include:**
  - Functional or Physiological
  - Haemorrhagic
  - Endometriosis
  - Dermoids
  - Ovarian Malignancy

### Information Required

- Transvaginal (TV) pelvic USS results (For premenopausal women, 2 scans 6 weeks apart should be included in referral)
- **Note:** Perform "**risk of malignancy index**". If RMI is high patient should be referred to the RAH

### Investigations Required

- **Pre-menopausal patient**
  - If cyst <6cm repeat ultrasound in 6 weeks in early follicular phase of cycle. Refer only if cyst persists.
  - If symptomatic consider torsion and ED referral
  - Liver Function Test, CBE, CA 125
- **Post-menopausal patient**
  - Perform CA 125 and CT Scan

### Warning Signs

- Suspected gynecology cancer on USS (refer RAH)
- Torsion
- Raised tumor marker (CA 125 > 35)
- Family history of breast cancer or ovarian cancer

### Suggested GP Management

- **Pre-menopausal patient:** ovaries < 6cms repeat USS in 6 weeks
  - If ovaries > 6cms, or cyst still present in 6 weeks
  - Perform LFT, CBE, CT scan and CA 125
  - Perform Risk Malignancy Index (RMI)
  - If low risk refer to NALHN **If high risk refer to the RAH**
- **Post-menopausal patients:** complex cyst or cyst >3cm
  - Perform LFT, CBE, CT scan and CA 125
  - Perform Risk Malignancy Index (RMI)
  - If low risk refer to NALHN **If high risk refer to the RAH**
- **Post-menopausal patients:** simple cyst <3cm normal CA 125
  - Repeat US and CA125 in 3 months. Refer if any changes.
Post Coital Bleeding

- **Definition:** Post Coital Bleeding defined as persistent non-menstrual bleeding that occurs within 24 hours of vaginal intercourse.

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<tr>
<th>Information Required</th>
<th>Investigations Required</th>
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<tr>
<td>Investigation results</td>
<td>Cervical smear</td>
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<tr>
<td>Duration of symptoms</td>
<td>STI swabs</td>
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<td></td>
<td>Pelvic examination</td>
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<td>Ultrasound Scan</td>
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<td>Pregnancy test</td>
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</table>

**Warning Signs**

- Age > 35 years
  - Frequent and heavy post coital bleeding
  - Abnormally appearing cervix
  - No previous smears
  - Smoker
  - Weight > 90 kg

**Suggested GP Management**

- Refer to NALHN
  - Refer for colposcopy
Pelvic Pain

- **Definition:** Pain perceived to be in the pelvis, has been continuous or recurrent for at least 6 months and is severe enough to cause functional disability or require treatment. Often presents a complex diagnostic problem which can be multifactorial.

- **Differential diagnoses include:**
  - Irritable Bowel Syndrome
  - Diverticular disease
  - Coeliac disease
  - Inflammatory bowel disease
  - Fibromyalgia

**Information Required**

- Investigation results
- Patterns of pain ie. Association with period, intercourse, bowel motions and micturition
- Recording symptoms over 2 to 3 months in a menstrual diary

**Investigations Required**

- CBE, CRP, urinalysis
- STI swabs
- Pregnancy test
- Transvaginal ultrasound scan
- Check gynaecological history and sexual, bowel, bladder history
- Musculoskeletal symptoms and weight loss
- Check for mood disorder and sexual or physical abuse
- CST (pap smear) result. Please perform if due

**Warning Signs**

- Abnormal US scan
- Signs of physical emotional or sexual abuse

**Suggested GP Management**

- Consider and treat PID or other pathology
- Consider counselling and support services
- Trial of conservative management including OCP if dysmenorrhoea
- Refer to NALHN if
  - Abnormal ultrasound
  - Symptoms fail to respond to medical treatment after 6 months or recurrence of symptoms after previous treatment.

**Acknowledgement:** Content for this document was primarily sourced through the SALHN Specialty Outpatient Guidelines 2014/15
Urinary Incontinence / Prolapse

- Incontinence is a term that describes any accidental or involuntary loss of urine from the bladder. There are different types of incontinence with a number of possible causes.
- The following are the most common.
  > Stress incontinence, Urge incontinence, Overflow incontinence, Functional incontinence
- Vaginal prolapse is a common condition where the bladder, uterus and or bowel protrudes into the vagina.
  > This can cause symptoms such as a sensation of a vaginal lump, constipation, difficulty emptying the bowel or bladder, or problems with sexual intercourse.

**Information Required**

- Detailed history
  > Frequency of incontinence
  > Quantities of leakage
  > Types of activities that trigger incontinence
  > Social implications for the patient
  > Patient’s BMI
  > Previous treatment i.e. physiotherapy, incontinence surgery, medication trialled
- MSU and Ultrasound scan
- Clinical findings
- Bladder Diary

**Investigations Required**

- Assess the type of incontinence, stress, urge, or mixed.
- Clinical examination, including assessment of prolapse
- Ultrasound examination
- MSU
  > Bladder diary over 2 days (incontinence)
- Diabetic screen (incontinence)

**Warning Signs**

- 🗿 recurrent of persistent UTI or Haematuria (both microscopic and macroscopic)
  > Refer to urology
- 🗿 Suspected pelvic mass
- 🗿 Urinary retention or severe prolapse protruding out of the vagina

**Suggested GP Management**

- Advise on weight loss if BMI is >30
- Treat any suspected or confirmed UTI
- **Physiotherapy consultation** for pelvic floor exercises – will not help significant prolapse
- For all patients with incontinence, advise modifying fluid intake eg reduce caffeine intake. Restrict fluids where appropriate
- Trial of anticholinergics for urinary urgency

**Clinical Resources**

- [Continence Foundation of Australia](https://www.contina.org.au)
- [Pelvic Floor Exercises](https://www.contina.org.au/PelvicFloorExercises)

Acknowledgement: Content for this document was primarily sourced through the SALHN Specialty Outpatient Guidelines 2014/15
Infertility

NALHN does not provide a fertility service but is able to assist in diagnosis and treatment of surgical conditions that cause infertility. This includes the diagnosis and treatment of Endometriosis or tubal disease.

**Information Required**
- Detailed history
  - Menstrual history
  - Medical history
  - Previous pregnancies
  - Previous treatments
  - **Semen Analysis** is essential

**Investigations Required**
- FSH, LH, Oestradiol, TFT, Prolactin
- Mid luteal progesterone
- Free testosterone, SHBG
- STI screen
- Up to date pap smear
- Up to date Ultrasound scan including pelvic scan & sonohysterogram

**NOTE:**

Patients with diagnosis of PCOS who cannot be managed at the GP level should be referred to the Endocrine Service in the Medical Division.

Patients with semen abnormalities, anovulation or unexplained infertility should be referred to a Fertility Service.

Patients with the suspected diagnosis of endometriosis, adhesions or tubal disease should be referred for consideration of surgery but an additional referral to a Fertility Service for IVF should be considered, particularly for those women over the age of 30.

**Warning Signs**
- Painful periods
- Pelvic mass on US scan
- Pelvic pain – refer for consideration of laparoscopy
- If there is an abnormal pelvic mass without signs of malignancy in an asymptomatic woman of reproductive age group, repeat ultrasound at 6 weeks looking for resolution of the mass, prior to referral.

**Suggested GP Management**
- If PCOS or obesity is a factor, advise on diet and exercise
- If PCOS is unusual or severe, refer to Endocrinology
- Ensure patients are taking folate supplements and consider vitamin D levels or supplementation
- Screen patient for rubella immunity and vaccinate if necessary
- Screen for Hep C and HIV
- Consider influenza vaccine
- Screen for and treat any STI’s
- **Ovulation induction must be managed by a specialist under ultrasound control. Refer to a specialist fertility Service.**
Risk Malignancy Index

RMI combines three pre-surgical features: serum CA125 (CA125), menopausal status (M) and ultrasound score (U). The RMI is a product of the ultrasound scan score, the menopausal status and the serum CA125 level (IU/ml).

\[ \text{RMI} = \text{U} \times \text{M} \times \text{CA125} \]

- The ultrasound result is scored 1 point for each of the following characteristics: multilocular cysts, solid areas, metastases, ascites and bilateral lesions. U = 0 (for an ultrasound score of 0), U = 1 (for an ultrasound score of 1), U = 3 (for an ultrasound score of 2–5).

- The menopausal status is scored as 1 = pre-menopausal and 3 = post-menopausal

- The classification of "post-menopausal" is a woman who has had no period for more than 1 year or a woman over 50 who has had a hysterectomy.

- Gynaecological oncology referral is required if RMI is >200
Abnormal Cervical Screening Test

All patients will be triaged as per the National Cervical Screening Guidelines and those patients who do not meet the indications for Colposcopy will be referred back for follow up with their GP.

Guidelines can be accessed via:


<table>
<thead>
<tr>
<th>Information Required</th>
<th>Investigations Required</th>
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<tbody>
<tr>
<td>• Printed copy of the referral cervical screening test as</td>
<td>• Consider STI screening and MC&amp;S for patients with</td>
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<tr>
<td>well as copies of previous smears or previous treatment</td>
<td>abnormal bleeding or abnormal cervical appearance</td>
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<tr>
<td>• Any patient symptoms or post coital bleeding should be</td>
<td>• Pelvic ultrasound should be arranged if abnormal bleeding</td>
</tr>
<tr>
<td>included in history.</td>
<td>or cervical polyp present</td>
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<td>• HPV vaccination status</td>
<td></td>
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<tr>
<td>• If patient immune compromised</td>
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</tbody>
</table>

Warning Signs

⚠ Immunocompromised patients are at significantly higher risk of high grade abnormalities.

Suggested GP Management

> Educate patient about the difference between a high risk HPV result and a high grade intraepithelial lesion (HSIL).
> A patient with HSIL will be seen in clinic within 6 weeks however a high risk HPV with normal cytology will usually wait around 6 months for a colposcopy.
> We will no longer be accepting referrals for routine cervical screening tests. If GP is unable to perform a routine cervical screening test smear for any reason then a self-collected HPV swab should be performed. Information on how to arrange this can be accessed via:

Please complete this confidential chart as accurately as possible for any 2 consecutive days before your appointment. Bring the completed chart to your appointment.

**Sample of how to complete the chart:**

Day 1: Date / /

1. Measure and record the cups, glasses or bottles you drink from so that you can record this amount without measuring every time. If you do not drink a full amount you will be able to guess this without measuring once you know how much the cup, glass or bottle holds i.e. 1 cup= 250mls ½ cup= 125mls

2. You will need a measuring jug that measures in millilitres and capable of holding 1 litre to record all urine passed and an old plastic container for the base of the toilet bowl to catch all urine passed

3. Then use the jug to measure your urine – record the time and measure the volume passed for ALL toilet visits

4. If you have wetness/leaks, record the time and letter “W” and what you were doing when this occurred

5. Measure and record all overnight drinks, urine passed as separate amounts

6. If you have a wet bed write the time and insert a *

7. Finish each full day when you have written in overnight drinks and urine passed overnight

8. Start the next day charting each morning when you get out of bed to start your day

<table>
<thead>
<tr>
<th>Time</th>
<th>Drinks (mls)</th>
<th>Urine measure (mls)</th>
<th>Leaks wet “W”</th>
<th>Wet Bed</th>
</tr>
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<tbody>
<tr>
<td>6am</td>
<td>400</td>
<td>“W”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8am</td>
<td>250</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>9am</td>
<td>150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.30am</td>
<td>200</td>
<td>“W” cough</td>
<td></td>
<td></td>
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<tr>
<td>12 lunch</td>
<td>300</td>
<td>80</td>
<td></td>
<td></td>
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<tr>
<td>1pm</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4pm</td>
<td>150</td>
<td>50</td>
<td></td>
<td></td>
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<tr>
<td>7pm</td>
<td>250</td>
<td>300</td>
<td>“W” going to toilet</td>
<td></td>
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<tr>
<td>7.30pm</td>
<td></td>
<td>100</td>
<td></td>
<td></td>
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<tr>
<td>10pm</td>
<td>250</td>
<td>100</td>
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<tr>
<td>Overnight</td>
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<tr>
<td>1am</td>
<td>250</td>
<td>100</td>
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<tr>
<td>3am</td>
<td>400</td>
<td>“W”</td>
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<tr>
<td>5am</td>
<td>300</td>
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FINISH
## Frequency voiding chart

**Patient label:**

### Day 1:

Start the chart when you get out of bed to start the day.

<table>
<thead>
<tr>
<th>Time</th>
<th>Drinks (mls)</th>
<th>Urine measure (mls)</th>
<th>Leaks Wet</th>
<th>Wet Bed</th>
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### Day 2:

Start the chart when you get out of bed to start the day.

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<th>Time</th>
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<th>Urine measure (mls)</th>
<th>Leaks Wet</th>
<th>Wet Bed</th>
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