GYNAECOLOGY

National Referral Guidelines

SPECIFIC GYNAECOLOGY REFERRAL LETTER GUIDELINES

- Referrals can be accepted from registered Medical Practitioners, smear takers and midwives.
- Referrals should include GP diagnosis and categorisation with reference to National Gynaecology ACA.

NATIONAL REFERRAL GUIDELINES : GYNAECOLOGY

Diagnosis	Evaluation	Management Options	Referral Guidelines
Gynaecology problems are addressed under the following headings: **Page No.** • Amenorrhoea 2 • Cervical Dysplasia (CIN) 2 • Dysmenorrhoea 6 • Ectopic Pregnancy 6 • Infertility 8 • Miscarriage 9 • Menorrhagia 9 • Ovarian cysts 15 • Pelvic pain 15 • Pelvic inflammatory disease 16 • Postcoital bleeding 16 • Postmenopausal bleeding 16 • Postpartum bleeding 17 • Prolapse 17 • Urinary symptoms 17 • Vaginal discharge 18 • Vulval disease 18	A thorough history and examination is required to determine a specific diagnosis and its degree of urgency. Some appropriate investigation by the referrer will facilitate the referral process.	Specific treatments – see relevant sections.	These guidelines are provided (below) to give greater clarity in situations of the primary/secondary interface of care. Local communication requirements may be annotated here:-

Note: *These national referral recommendations have been prepared to provide guidelines for referral to specialist gynaecology services. They should be regarded as examples or guidelines for referring health professionals and are not an exhaustive list. The referring health professional should ensure that in using these national referral recommendations generally accepted clinical practice should be properly taken into account. If there is a conflict between the national referral recommendations and generally accepted clinical practice, then generally accepted practice should prevail.*

NATIONAL REFERRAL GUIDELINES : GYNAECOLOGY

Diagnosis	Evaluation	Management Options	Referral Guidelines
AMENORRHOEA Primary and Secondary * *Note: only one is necessary if initial test is normal.*	**HISTORY:** • Age > 15 years • Weight/height BMI • Diet • Exercise • Family • Sexual • Galactorrhoea • Hirsutism • Contraception and Drugs • Environmental factors • Stress and anxiety • Past gynaecological and surgical history **EXAMINATION:** • Secondary sexual characteristics • Evidence of any congenital gynaecological abnormality/abdominal mass • Masculinisation/hirsutism **INVESTIGATIONS:** • FSH/LH/HCG • Prolactin x 3***** • Thyroid function test • Ultrasound • Testosterone • Chromosomal studies may be requested in consultation with the specialist service (if unsure).	Counselling and support	Refer: • Where there are abnormal results • Failure of secondary sexual development • If associated with infertility • Significant patient stress and anxiety. All category 4 *[Note: Endocrinology referral recommendations]*
CERVICAL DYSPLASIA (CIN)	**HISTORY:** • Intermenstrual bleeding • Post coital bleeding • Smoking • Sexually transmitted diseases **EVALUATION:** • Visualise cervix **INVESTIGATION:** • Consider endocervical swabs	• See attached flow chart • Treat infections • Advise re: Smoking Safer sex	**See attached Flow charts. Refer to: 'Guidelines for the management of women with Abnormal Cervical Smears" Sept 1998: Published by the HFA for the National Cervical Screening Programme** **Glossary attached as appendix 1 (page 3)**

GYNAECOLOGY

Summary of the revised Bethesda System (1991) (TBS)[15]

APPENDIX 1

Adequacy of the Specimen

- Satisfactory for evaluation
- Satisfactory for evaluation but limited by.... (specify reason)
- Unsatisfactory for evaluation.... (specify reason)

General Categorisation

- Within normal limits
- Benign cellular changes : See descriptive diagnosis
- Epithelial cell abnormality : See descriptive diagnosis

Descriptive Diagnosis

Benign cellular changes

Infection

- Trichomonas vaginalis
- Fungal organisms morphologically consistent with Candida
- Predominance of coccobacilli consistent with shift in vaginal flora
- Bacteria morphologically consistent with Actinomyces
- Cellular changes associated with Herpes simplex virus
- Other

Reactive epithelial changes

- Inflammation (includes typical repair)
- Atrophy with inflammation ("atrophic vaginitis")
- Radiation
- Intrauterine contraceptive device
- Other

Epithelial cell abnormalities

Squamous cell

- Atypical squamous of undetermined significance (ASCUS)

  Qualify: favour reactive or favour premalignant/malignant process
- Low grade squamous intraepithelial lesion (LSIL): encompassing CIN 1 and/or human papillomavirus (HPV)
- High grade squamous intraepithelial lesion (HSIL): encompassing moderate and severe dysplasia, CIN 2 and CIN 3/Carcinoma in situ (CIS)
- Squamous cell carcinoma

Glandular cell

- Endometrial cells in a post menopausal woman who is not on hormone replacement therapy
- Atypical glandular cells of undetermined significance (AGUS)

  Qualify: favour reactive or favour premalignant/malignant process
- Endocervical adenocarcinoma in situ (AIS*)
- Endocervical adenocarcinoma
- Endometrial adenocarcinoma
- Extrauterine adenocarcinoma
- Adenocarcinoma, not otherwise specified

Other malignant neoplasms: Specify

* NZ addition to TBS

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Action Plan for Cervical Smear Results

1. NORMAL OR BENIGN/REACTIVE CHANGES

Smear Result	Smear History	Action
Satisfactory	Previous normal smears	Smear in 3 years
	First smear, or more than 5 years since last smear	Smear in 1 year
	Previous abnormal smears	Refer to flow chart
Satisfactory but limited *	Previous normal smears	Smear in 1 year
	First smear, or more than five years since last smear	Smear in 1 year
	Abnormal smear in last five years	Smear in 6 months
Unsatisfactory Smear		Smear in 1-3 months

** Except absent endocervical/metaplastic cells – in which case; If the cervix has been visualised and adequately sampled and there is no other indication to repeat the smear earlier, repeat the smear in three years.*

2. ABNORMAL

Smear Result	Smear History	Action
Ascus: unqualified or favour reactive or LSIL AGUS: unqualified or favour reactive LSIL: CIN 1 and/or HPV	Previous normal Smears	Smear in 6 months
	Previous abnormal smear	**Refer to flow chart**
* AGUS: favour dysplasia * AIS HSIL: CIN 2-3 * HSIL in pregnancy ASCUS: possible HSIL * Suspicious or diagnostic of invasive carcinoma		

* *Refer to an experienced colposcopist*

* *See Appendix 1 for glossary (page 3)*

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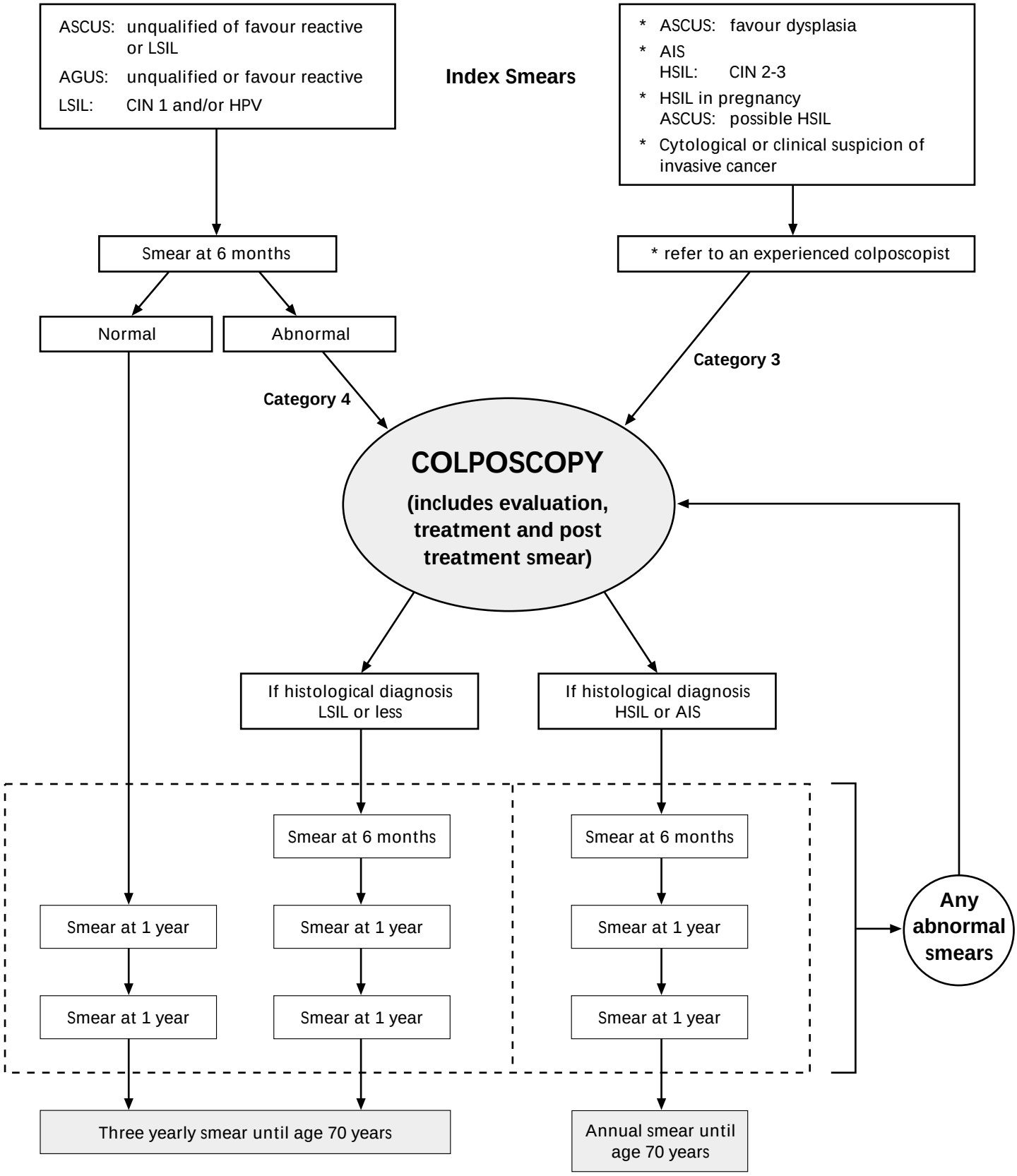
Management of the Abnormal Smear



NATIONAL REFERRAL GUIDELINES : GYNAECOLOGY			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
DYSMENORRHOEA	• Pain (suspect Endometriosis), • Fever • Vomiting • Associated discharge • Deep dyspareunia • Pain with bowel movement • Fainting • Time off activities **EXAMINATION:** • Pelvic mass • Cervical excitation **INVESTIGATIONS:** • If PID suspected (see below). • Ultrasound if pelvic mass suspected.	1. The key to adequate pain control is to treat at first hint of pain/period. Symptomatic analgesia. NSAIDs – Any short acting NSAID O.K. Response to NSAID can be idiosyncratic. The addition of paracetamol may be helpful. Ponstan for refractory cases may be tried. 2. COCPs with appropriate warnings re VTE 3. Depo Provera	• Unresponsive to treatment (no improvement in 90 days) – category 4. • If symptoms severe – category 3. • Evidence of mass or endometriomas - category 3.
ECTOPIC PREGNANCY	• Diagnosis relies heavily on suspicion radiological and biochemical evidence • Non-acute - Quantitative serum HCG • Ultrasound	• An intrauterine pregnancy should be visible on trans-vaginal scan if the HCG >1000 mIU/ml • If not, and the patient is >6 weeks pregnant, there is a 95% chance of ectopic – D/W O & G specialist. • If <6 weeks, and no intrauterine or ectopic pregnancy is seen, the HCG should be repeated in 2 days (provided the patients condition is stable) • HCG should increase by at least 80% every 2 days in established pregnancy • If the repeat HCG has increased >80%: re-scan in 10 days • If the repeat HCG has fallen, or increased by <80%: D/W O& G specialist	Acute – refer category 1 Refer Refer

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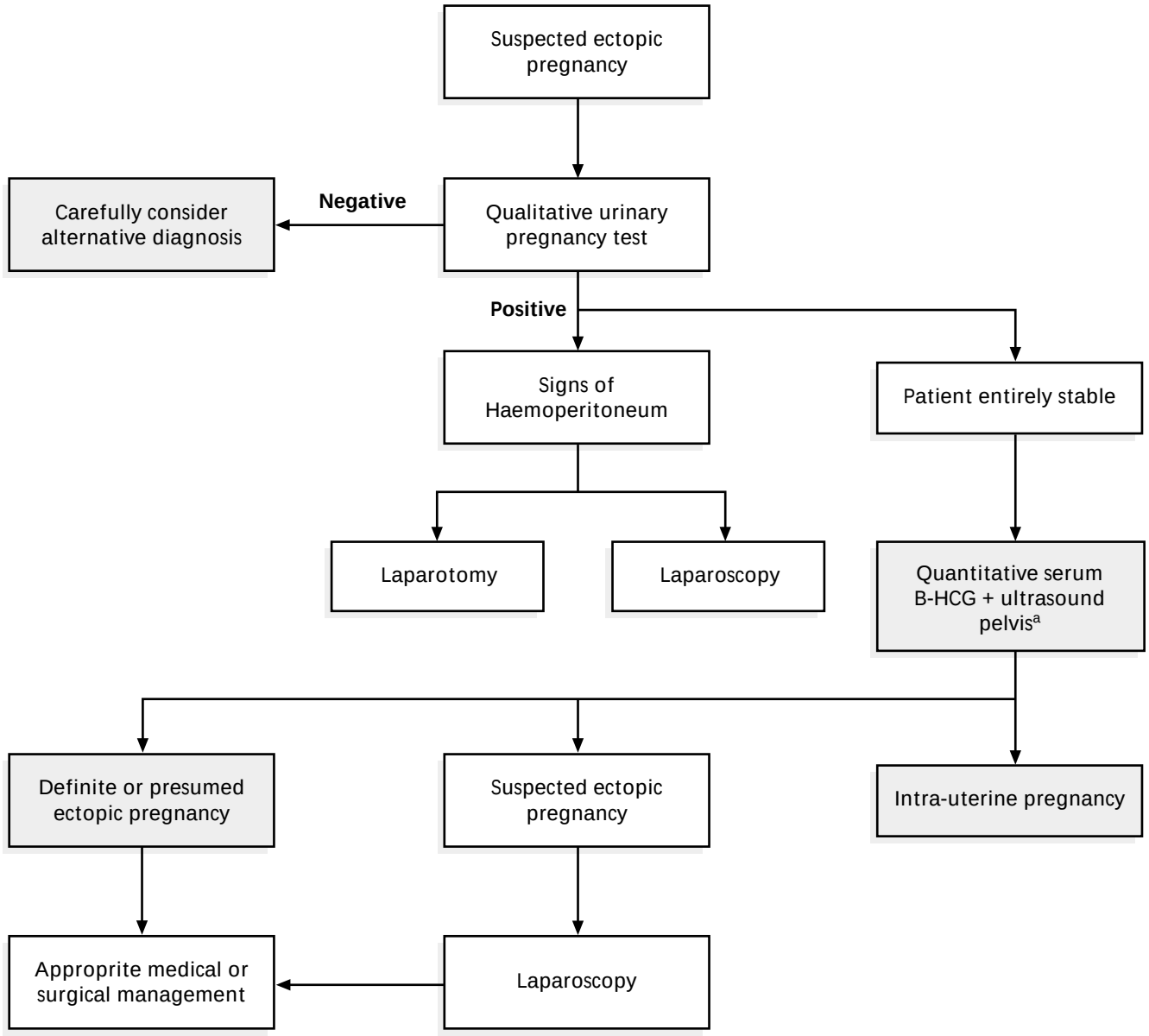
Investigation of a patient with suspected Ectopic Pregnancy



[a] An intra-uterine gestational sac should be seen with abdominal ultrasound when the B-HCG level is above 2000 mIU/ml. If a transvaginal probe is used, a gestational sac should be seen if the level is above 1000 mIU/ml.

Abbreviation: HCG - Human chorionic gonadotrophin

NATIONAL REFERRAL GUIDELINES : GYNAECOLOGY			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
INFERTILITY	**INVESTIGATIONS:** • History and examination of both partners includes assessment of fertility awareness[1] • Health screening tests for the female partner – rubella immunology, VDRL, hepatitis B antigen, blood group antibodies[2] • Routine semen analysis, repeated in 4-6 weeks if abnormal[3] • Assessment of menstrual cycle including[3] - a plasma progesterone timed for 5-9 days before the next expected period. If cycle is long to be repeated at weekly intervals until next period - plasma FSH, LH, prolactin, thyroid function if the cycle is prolonged and/or irregular. FSH (day 2-5 cycle) for older women (is measure of biological age of ovary). - Ultrasound of pelvis in some cases[4]	* Early Management - Fertility awareness - Both partners should be advised to give up smoking and limit alcohol intake - A supervised weight improving programme is advised outside of the BMI range 18-32 - GPs should advise women presenting with infertility to take 0.4 mg folic acid as a supplement and during the first 12 weeks of a pregnancy. - Counseling and grief support - Plan for ongoing support in primary care after referral The fertile phase is a 5 day period preceding ovulation and ending on last day of ovulation. There is no evidence that the use of temperature charts and LH detection kits to time intercourse improves outcome and their use should be discouraged. Couples should be advised to have regular intercourse throughout the cycle.	• Refer if any abnormality in history, examination or investigation - Refer if unexplained infertility > 18 months duration BUT • Early referral if: - female age ≥ 35 - a female history of any pelvic surgery, STDs, PID, severe cyclical pain - male history of genital pathology, urogenital surgery, STD Category 4

Notes:

1. *These will establish predictive factors for various disease processes. Awareness of the fertile time may not only facilitate rapid resolution of their infertility, but improve the response to treatment programmes.*
2. *Tests that should be performed early. Treatments should be withheld until pregnancy risk factors and their prevention are addressed. (Note HIV and Hep C tests for both partners are also recommended if the couple go onto assisted reproductive procedures).*
3. *To be completed early in the evaluation.*
4. *To be completed early in the evaluation if there is a menstrual or ovulation disorder or for assessment of pain. Its predictive values for menstrual disorders are outstandingly high. It is also useful for the definition of ovarian disorders, including the PCOS and endometriomas.*

NATIONAL REFERRAL GUIDELINES : GYNAECOLOGY			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
MISCARRIAGE	• Most pregnancies failing in the first 8 weeks are likely to completely abort • After 8 weeks an incomplete abortion is more likely. • Assess for cardiovascular shock, degree of pain, amount of bleeding, and social circumstances • Vaginal examination is mandatory: if the cervical os is open there is no need for ultrasound scanning; if closed, a scan is indicated to distinguish – threatened abortion - ongoing pregnancy - missed abortion - incomplete abortion - ectopic pregnancy	• When clinical assessment suggests a simple, uncomplicated miscarriage, and when social circumstances permit, events can be allowed to run their course without admission to hospital • Reassessment for any worsening of symptoms or signs, or persistence of bleeding beyond 36 hrs • Note: Remember anti-D (within 72 hrs) for any bleeding or trauma in pregnancy if patient is Rh-ve	• Refer acute category 1 • Non acute category 2 - the next available operating list
MENORRHAGIA	• Menstruation associated with flooding and/or hourly pad changes. • Consider pictorial bleeding chart (see appendix 2) • Pelvic examination • Investigations: - FBC - Ultrasound scan - Pipelle if experienced in technique (If endometrial thickness >12mm or if patients weight > 90 kg or if patients age > 45 years	Medical Treatment: • NSAIDs • Tranexamic Acid (with Consultant approval) • OCP • Levonorgestrel Intrauterine System (Mirena) See NHC Guidelines	• Abnormal ultrasound scan • Failed medical treatment • To access pipelle sampling • Category 3-4 See NHC Guidelines

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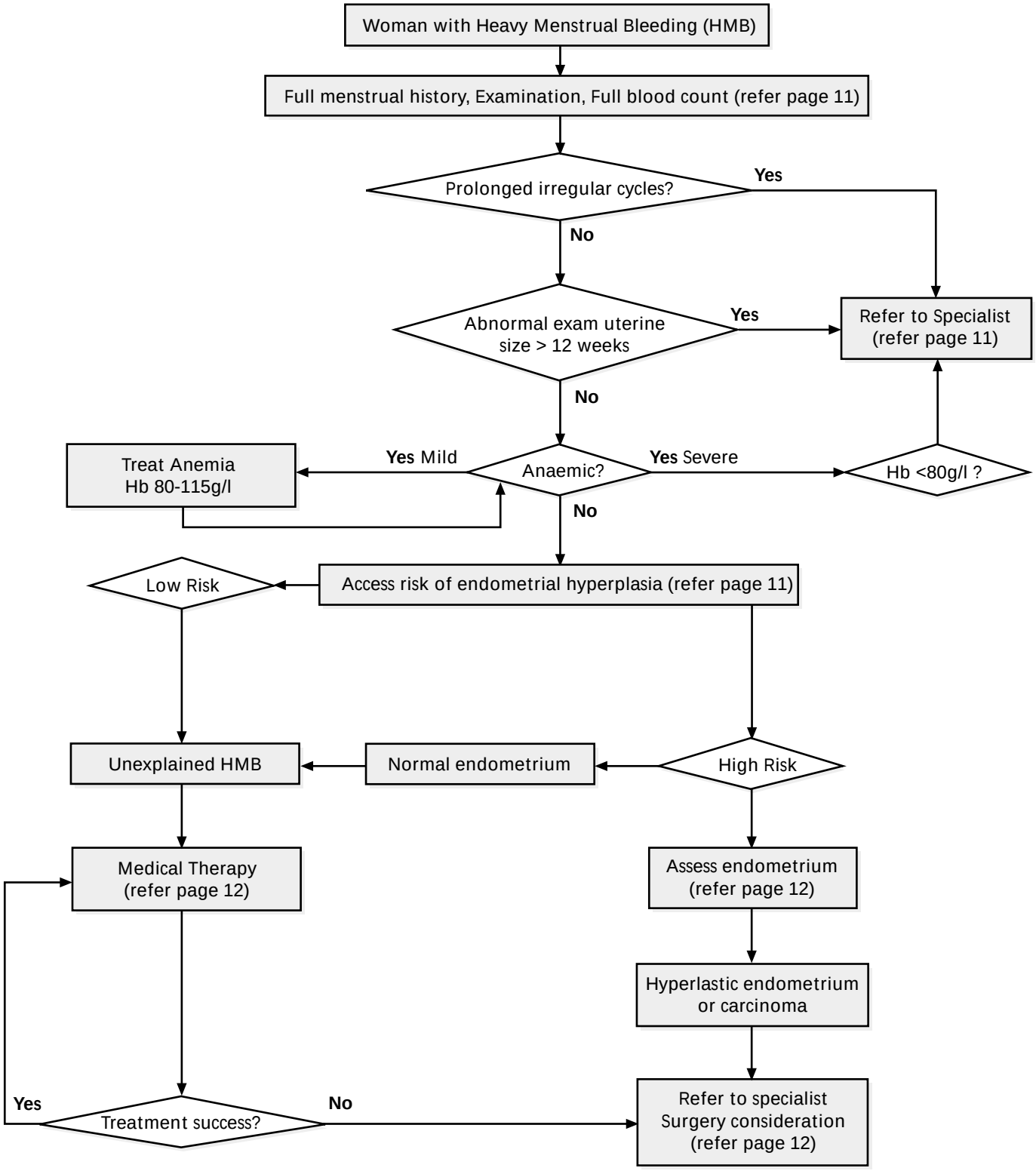
National Guidelines for Management of Heavy Menstrual Bleeding Alogorithm



NOTE : NHC Guidelines Website: *http://www.nzgg.org.nz/library/gl_complete/gynae_hmb/index.htm*

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Explanation of Grading Evidence: The working party accepted a grading of evidence recommended by the Department of Health, UK and endorsed by the National Health Service Executive, UK (Mann 1996).

Grade A - *based on randomised controlled trials**

Grade B - *based on robust experimental or observational studies*

Grade C - *based on more limited evidence but the advice relies on expert opinion and has the endorsement of respected authorities*

* in diagnostic testing comparative cross sectional studies with a gold standard are Grade 'A'. A gold standard test is defined as best available test.

Full menstrual history, Examination, Full blood count

- Of women who present with HMB, only 50% have menstrual blood loss >80 mls/cycle **(Evidence Grade B)**.
- In women <20 years old pelvic examination is unlikely to contribute to management of heavy bledding and the likelihood of pathology is small **(Evidence Grade C)**.
- Increased likelihood (70%) of heavy menstrual blood loss .80 mls/cycle if Hb ,120 g/l **(Evidence Grade A)**.
- Consider pictorial blood loss assessment charts (appendix 6.5) for women with normal Hb **(Evidence Grade A)**.

Refer to Specialist

The following women are recommended to see a specialist at the initial consultation because of increased likelihood of pathology: (it is beyond the scope of this guideline to provide recommendations for management in these instances).

- Women with erratic menstrual cycles (regardless of loss) **(Evidence Grade B)**.
- Women with an abnormal pelvic examination (confirmed by transvaginal ultrasound if possible) **(Evidence Grade C)**.
- Perimenopausal women with less frequent cycles but normal blood loss do not require referral **(Evidence Grade C)**.
- Women with severe anemia **(Evidence Grade C)**.

It is estimated that approximately 15% of all women with HMB will require specialist referral at the initial consultation.

Assess risk of endometrial hyperplasia

Risk of endometrial hyperplasia or carcinoma in women with heavy menstrual bleeding:

All women	4.1%
<45 years old & <90 kg	2.3%
90 kg	10.0%
45 years old	6.0%

Other risk factors for endometrial hyperplasia **(Evidence Grade B)**:

- Infertility + nulliparity
- Exposure to unopposed endogenous or exogenous estrogen / tamoxifen
- Family history of endometrial and colonic cancer **(Evidence Grade C)**.

Endometrial hyperplasia with atypia may progress (if untreated) to endometrial carcinoma in 20%-75% of cases over a 13 year period **(Evidence Grade B)**.

It is estimated that 20% of women with regular HMB will require endometrial assessment because of increased risk factors.

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Assess endometrium

- Transvaginal ultrasound is recommended as first option for endometrial assessment but if not possible then an endometrial sample should be taken **(Evidence Grade A)**.
- If endometrial thickness on transvaginal ultrasound > 12 mm then an endometrial sample should be taken **(Evidence Grade A)**.
- Consider specialist referral if abnormal transvaginal ultrasound suggestive of submucous fibroids **(Evidence Grade B)**.
- Fifty percent of women >90 kg, who have an endometrial thickness >12 mm on TVS, have endometrial hyperplasia **(Evidence Grade A)**.
- Less than 1% of women >90 kg, who have an endometrial thickness <12 mm have endometrial hyperplasia **(Evidence Grade A)**.
- The number of endometrial samples needed to detect 1 case of endometrial hyperplasia overall is 23. In women > 90 kg the number needed to detect 1 case is 8 **(Evidence Grade B)**.

Medical Therapy

- Comparative Table of Medical Therapy
- The Choice of Medical Therapy
- Decision Analysis of Medical Therapy

Comparative Table of Medical Therapy for the Treatment of Heavy Menstrual Bleeding

Drug	Mean Reduction in Blood Loss	Women Benefiting*	Specific Benefits	Adverse Effects
Levonorgestrel IUS	94 %	100 %	Contraception No requirement to take tablets	Menstrual cramps Expulsion of system (5%) Intermenstrual bleeding (27%)
Oral Progesterone (days 5-25)**	87 %	86 %	Cycle regularity	Bloating, Mood swings, PMS
Tranexamic Acid	47 %	56 %	None	Nausea, Diarrhoea
NSAIDs	29 %	51 %	Relief of dysmenorrhoea, Headaches	Nausea, Diarrhoea, Headaches
OC pill	43 %	50 %	Contraception Relief of dysmenorrhoea, PMS	Nausea, Breast tenderness, Headache
Danazol	50 %	76 %	None	Weight gain, Acne
Oral Progesterone (luteal phase)	-4 %	18 %	Cycle regularity	Hot flushes, Bloating, Mood swings, PMS

* Proportion with MBL <80 ml/cycle

** Based on only one randomised controlled trial.

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The Choice of Medical Therapy

The Choice of Medical Therapy will be dependent on individual patient requirements. For example:

Does the patient require contraception ?

Consider:

- LNG-IUS
- OC pill

Does the patient have painful menstruation ?

Consider:

- LNG-IUS
- NSAIDs
- OC pill

Is the patient unable to tolerate hormone treatments ?

Consider:

- NSAIDs
- Tranexamic Acid
- LNG-IUS

See decision analysis at the following table

Some women who have completed their family may decline medical therapy and choose surgery as a first option.

Decision Analysis of Medical Therapy	
Medical Therapy*	**Ranking According to Decision Analysis** (Evidence Grade A)**
Levonorgestrel IUS	1
Tranexamic acid	2
NSAIDs	2
OC pill	3
Norethisterone (D5-25 15 mg daily)	3
Danazol	4

* More than one therapy can be considered

** Based on efficacy, side effect profile and acceptability to women over 12 months (Lethaby et al, 1998) (see appendix 6.5 for full description)

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Pictorial Bleeding Assessment Chart

EXAMPLE OF COMPLETED CHART

Name: _____ _____

TOWEL	1	2	3	4	5	6	7	8
1	II	I	I	I	II	I		
5		~~HH~~	III	II				
20		II	II					

TAMPON	1	2	3	4	5	6	7	8
1		I			I			
5		II		II				
10		~~HH~~ I	III					
DAILY SCORE	2	137	101	21	3	1		

TOTAL SCORE = 265

SAMPLE

Name: _____ Date: _____

TOWEL	1	2	3	4	5	6	7	8
1								
5								
20								

TAMPON	1	2	3	4	5	6	7	8
1								
5								
10								
DAILY SCORE								

TOTAL SCORE = _____

If score of > 185 then likelihood of menstrual blood loss ≥80 mls/cycle is increased.

NATIONAL REFERRAL GUIDELINES : GYNAECOLOGY			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
OVARIAN CYST *1 CA 125 is associated with epithelial irritation of the ovary so may also be raised in benign conditions such as endometrosis etc*	**HISTORY** • Cyclical symptoms • Pain • Dyspareunia • Irregular cycle • Gastrointestinal *Note: ovarian pathology (e.g. torsion or carcinoma) may present with gastrointestinal symptoms.* • Risk of malignancy greater pre-pubertally and with increasing age to 70+. **EXAMINATION:** • Abdominal • Pelvic **INVESTIGATIONS:** • Ultrasound scan • CA 125[1] in post menopausal women and all cysts >5cm	• If 5 cms and larger refer. • If less than 5 cms repeat scan after a menstrual period when applicable (can exclude corpus luteal cysts).	• Refer torsion – category 1. • Refer others– category 2.
PELVIC PAIN	**HISTORY** • Severity and duration – pain on at least 14 days each month x3 months • Pain calendar (relative to menstruation) • GI function • GU function • Dyspareunia • Dysmenorrhoea • Sexual history/PID/Surgery • ? Sexual abuse in the past • Time off activities **EXAMINATION** • Swabs/smear – current • Bimanual examination • Rectal examination **INVESTIGATIONS** • HVS/Endo Cx swabs • MSU • Ultrasound	• Symptomatic analgesia • COCPs • Psychological support	• Unresponsive to treatment refer Category 4 • If symptoms severe category 3

NATIONAL REFERRAL GUIDELINES : GYNAECOLOGY

Diagnosis	Evaluation	Management Options	Referral Guidelines
PELVIC INFLAMMATORY DISEASE Acute (c.f. Sexual Health Referral Recommendations)	• Pain, discharge, pyrexia • Recent sexual history **EXAMINATION:** • Pelvic tenderness • Adnexal masses • Discharge **INVESTIGATIONS:** • FBC/ESR • Endocx/urethral swabs(consider rectal & throat swabs) for culture & sensitivity • Pregnancy test • Smear if due	1. Link and liaise with STD clinic as appropriate for contact tracing etc. All cases of resistant gonorrhoea should be referred to STD 2. Antibiotics: Augmentin 500mg 8 hrly p.o. for 14 days Plus Doxycycline 100mg p.o. 12 hourly for 14 days, Antibiotics used should be determined by local sensitivities. Note: In pregnancy: Augmentin as above Plus Erythromycin ethyl succinate (EES) 400mg 6 hrly p.o. for 14 days. Ceftriaxone 1 gram can be used as stat doses in the treatment of gonorrhoea Ciprafloxacin 500 mg (needs specialist recommendation)	Acutely unwell, pelvic mass, unresponsive to treatment (24 hours). Refer category 1. If septic abortion is suspected refer to category 1 Unresponsive to treatment - refer category 1.
Chronic	Chronic pain, discharge, erratic bleeding, recurrent episodes of acute PID, dyspareunia **INVESTIGATIONS:** • See acute • Ultrasound scan for pelvic mass	1. May require prolonged course of antibiotics: Augumentin; or Amoxil and metronidazole instead of augmentin	Unresponsive to treatment - refer category 1.
POSTCOITAL BLEEDING	• Examine • Smear • HVS/endocervical swab	• Small endocervical polyps (less 2cm) in premenopausal woman with normal smear can be avulsed and sent for histology • Ectropion with normal smear – Rx silver nitrate	1. Refer if recurrent – category 2 2. If polyps are large, broad based or the base is not visible refer – category 3
POSTMENOPAUSAL BLEEDING (6 months from last menstrual period)	• Drug history. (Contraception, HRT) • Evidence of any genital tract abnormalities e.g. cervical polyps[1]/atrophic change or abdominal mass • Sexual/PID history **INVESTIGATIONS:** • Smear • HVS/endocervical swab • Pipelle (if experienced in technique[2] • Pelvic transvaginal ultrasound[3] • Pregnancy Test (unnecessary > 55 years)	Treatment options for atrophic vaginitis include short term local oestriol, or longer term combination HRT therapy[4] (only if ultrasound exam is normal) If PMB is a single event, the ultrasound is normal and no other cause is suspected then repeat ultrasound in 3 months to exclude proliferative endometrium. **If bleeding recurs then refer for specialist assessment**	1. Refer to specialist service - category 2 2. Irregular bleeding on HRT[4] – category 2 3. If patient on tamoxifen and has post menopausal bleeding refer for specialist opinion- category 3

Notes:

1 Cervical polyps are almost always a benign condition, but referral indicated if associated with post menopausal bleeding, to exclude other serious causes.

2 If pipelle fails to sample sufficient tissue ultrasound or referral is necessary

3 Endometrial thickness (ET) double thickness measurements are highly predictive of endometrial carcinoma. If ≤ 5 mm then carcinoma is unlikely

4 It is felt that HRT, its risk assessment and management is the domain of the General Practitioner but referral of women with abnormal bleeding on HRT after 6 months of therapy is recommended.

NATIONAL REFERRAL GUIDELINES : GYNAECOLOGY			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
POSTPARTUM BLEEDING (within 6 weeks) **Notes:** Ultrasound scan can be confusing in postpartum bleeding and has little value in aiding diagnosis.	• Drug history incl. contraception • Delivery history • Pain, fever. **EXAMINATION:** • Uterine size, tenderness, temperature **INVESTIGATIONS:** • Endocervical swab • Chlamydia test • Hb	• Treat with Augmentin 500mg TDS 5 to 7 days (dependent on local sensitivities)	1. Heavy bleeding or pain. Refer – category 1 2. No response to treatment – refer – category 2
PROLAPSE (Pelvic anatomical relaxation)	**HISTORY:** • Swelling/Lump • Interference with micturition/defaecation • Dyspareunia • Oestrogen deficiency (includes post partum, depo provera) **EXAMINATION:** • Grade prolapse **INVESTIGATIONS:** • MSU • FBC	1. If post menopausal, symptoms of prolapse without signs may resolve on treatment with local oestriol which is worth a try before referral (i.e., 3 months) 2. Consider ring pessary.	Symptomatic prolapse - category 4.
URINARY SYMPTOMS	**UROLOGICAL HISTORY:** - stress, urge incontinence - frequency, nocturia, enuresis - Voiding difficulty (hesitancy) - Haematuria dysuria **GYNAECOLOGICAL HISTORY** (Prolapse Symptoms) • Medical/Drug History • Previous Gynaecological/ Obstetric History • Abdominal/Pelvic/ Neurological Exam **INVESTIGATIONS:** • MSU/Urinalysis (if infected treat and reassess) • Urinary diary • Assess post void residual • (physical exam/ catheterization/ ultrasound	1. Lifestyle Interventions (decrease caffeine, weight and smoking; treat constipation; appropriate fluid intake) 2. Pelvic Floor Muscle Training (PFMT) and Bladder retaining by trained continence therapist for 3/12 3. Topical vaginal oestriol /HRT if postmenopausal unless contraindictated. 4. Trial of Bladder Relaxants if presumed overactive bladder (and no significant post void residual)	Referral to Gynaecological or Urological Service in the following circumstances: • Failed conservative treatment (PFMT and Bladder retraining) • Complex History e.g. - Recurrent incontinence - Incontinence associated with: • Pain • Haematuria • Recurrent Infection • Voiding symptoms • Pelvic irradiation • Radical pelvic surgery • Suspected fistula • Significant Post Void Residual • Significant Pelvic Organ Prolapse

NATIONAL REFERRAL GUIDELINES : GYNAECOLOGY			
Diagnosis	**Evaluation**	**Management Options**	**Referral Guidelines**
VAGINAL DISCHARGE (C.F. Sexual Health referral recommendations)	1. Sexual and PID history 2. Characteristics - odour, quantity, irritation, blood staining. **INVESTIGATIONS:** • Smear • Swab, HVS, Chlamydia, Viral (if indicated by vesicles) • Blood Glucose (if recurrent candida)	1. STD's - treat patient and partner. If GP unable to arrange contact tracing and couselling referral to STD clinic. 2. Candida: Topical Azole e.g. Clotrimazole. Recurrent candida: Topical Azole course premenstrually for 3 months or oral medications e.g. Fluconazole or Itraconazole 3. Vaginal antiseptic Aci-Jel 4. Physiological – counselling and education.	1. Refer those women with copious physiological discharge and a wide ectropion for cryotherapy. 2. Unexplained post menopausal discharge – category 2 3. Recurrent or failure to respond to therapy – category 4
VULVAL DISEASE	**HISTORY:** • pain, swelling, pruritus, dyspareunia, localised lesions (pigmented or non-pigmented lesions) • Current treatment to date • Systemic dermatological problems. **INVESTIGATIONS:** • Consider swabs/scrapings • Consider biopsy for a generalised skin condition	1. Antibiotic treatment of Bartholins abscess is of little value. Acute referral for drainage recommended. 2. The older the patient and/or the more localised the lesion of the vulva, the more urgent the assessment. 3. Topical treatment appropriate to diagnosis.	• Bartholins abscess/ category 1. • Bartholins cyst refer category 4. • Persisting symptoms despite treatment – category 2.