Community Gynaecology

Top Tips for GPs

Top Tips for GPs

- Case Scenarios- common referral themes
    - 6 topics

- What you can do in Primary Care to avoid or before referral.
- What we don't need to see

- Triage – ensures patient is seen at in the right place the first time.

Referral

- 26 y.o.
- 3m history of post-coital bleeding
- Smear June 15- negative
- TVUSS- NAD
- HVS and Chlamydia negative
- Please see for smear as we are unable to do it early

Cervical Screening

- Cervical screening is the process of detecting and removing pre-cancerous cells of the cervix to prevent cervical cancer.
- Screening can prevent approx. 70% of cervical cancers
- It is NOT a diagnostic test
- Cervical smears are NOT taken outside of the guidelines of the screening programme.
- If the cervix looks abnormal and/or the symptoms are concerning, the patient should be referred urgently to colposcopy
- A suspected ectropion in a postmenopausal women is concerning and should be investigated.

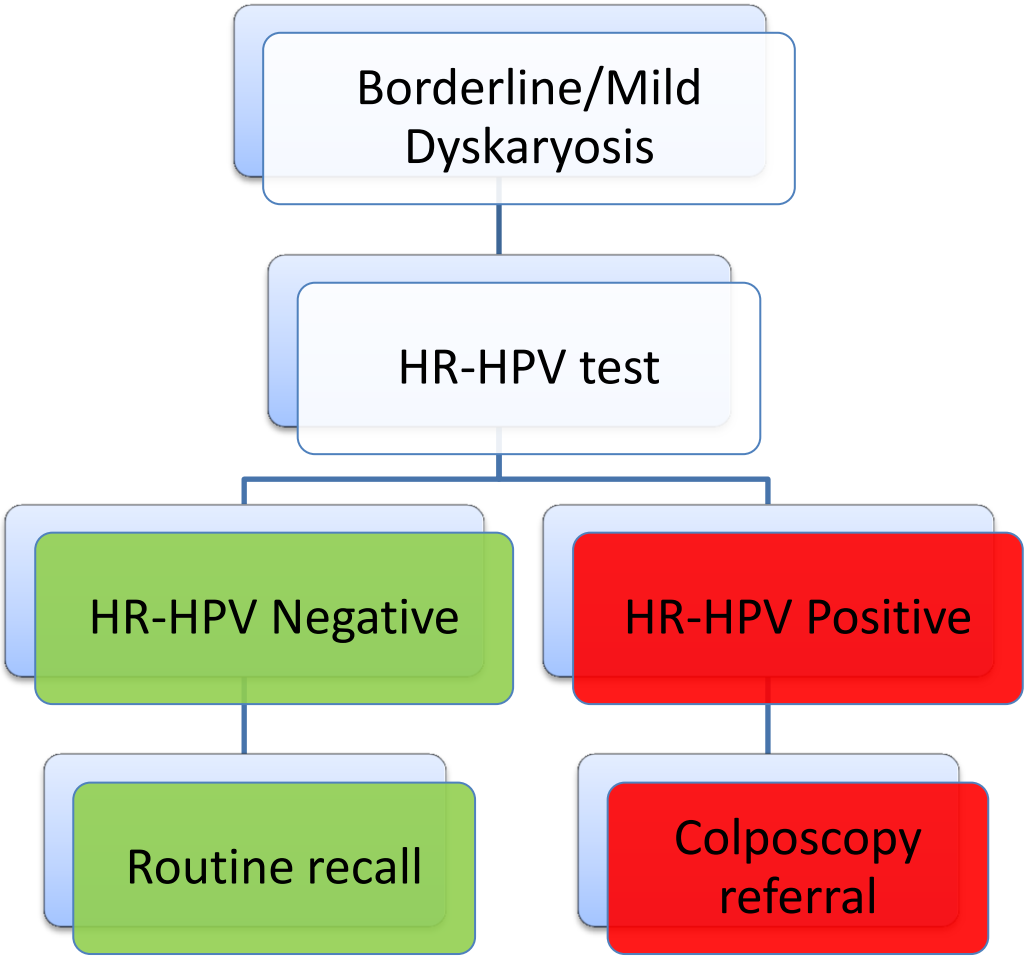
Screening intervals in England

Age	Screening interval
25 – 49 yrs	3 years
50 – 64 yrs	5 years

HPV

- >100 types – only small number cause cervical cancer (HR-HPV)
- Transient infection very common - 8 in 10 people infected in lifetime
- Can’t be treated but can clear on its own
- Prevalence decreases with age (Manchester study)
  - 40% of 20-24yr olds with HR HPV, 5% of 60-64 yr olds
- Infection persists in 20-30% of women

Triage Pathway



Referral

- 59 y.o
- Vulvitis, recurrent cystitis with negative MSUs
- Unable to have sexual intercourse
- Evorel conti
- Unable to perform smear as too painful to pass speculum

Urogenital Atrophy

thinner, drier, less elastic and more fragile

- Topical oestrogens are safe long term and do not require progesterone cover
- Systemic HRT only may not help with vaginal symptoms. You may need to give both
- Taking a smear may be very painful or impossible. Give vagifem 2 weeks before the next attempt
- Topical oestrogens may help urinary symptoms
- Long-term use required

Symptoms of Urogenital Atrophy

urinary	Genital
urgency	dryness
frequency	itching
dysuria	dyspareunia
Haematuria - microscopic	Post Coital Bleeding
stress incontinence	
recurrent cystitis	
decreased urinary stream	
Incomplete emptying	

Vaginal treatment

Oestrogen

Pessary: *Vagifem10mcg*
Orthogynest
Cream: *Gynest / Ovestin*
Ring: *Estring*

Use once daily for 2 weeks then twice weekly for maintenance

Lubrication

Non-hormonal re-moisturiser

Replens MD

What to prescibe?

- Vagifem 10mcg pessary- nightly for 2 weeks then twice a week thereafter
- Ovestin 0.1% cream (as above)
- Gynest (estriol) 0.01% cream , peanut oil (as above)
  - ❖If used as prescribed over a year 1mg of Oestrogen absorbed systemically.

- Estring 7.5mcg/daily- leave in for 3m

Referral

- 22 y.o
- Acne
- Had 4 periods in the last year
- TVUSS – suggestive of PCOS
- Referred for Diagnosis and treatment.

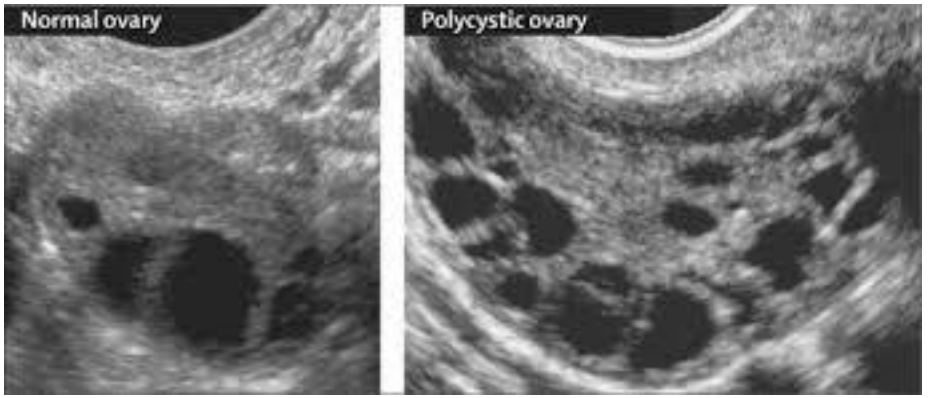
Diagnostic Criteria for PCOS

- Polycystic ovary syndrome should be diagnosed if two of three of the following criteria are present:

- 1) Clinical or biochemical signs of hyperandrogenism (such as hirsutism, acne, or male pattern alopecia), or elevated levels of total or free testosterone.
- 2) Infrequent or no ovulation (usually manifested as infrequent or no menstruation).
- 3) Polycystic ovaries on ultrasonography, defined as the presence of 12 or more follicles in at least one ovary, measuring 2–9 mm diameter, or increased ovarian volume (greater than 10 mL).

The diagnostic criteria for polycystic ovary syndrome (PCOS) are based on the Rotterdam diagnostic criteria, which are widely accepted [Rotterdam ESHRE/ASRM-Sponsored PCOS Consensus Workshop Group, 2004; Ehrmann, 2005].

- Polycystic ovaries do not have to be present to make the diagnosis, and **the finding of polycystic ovaries does not alone establish the diagnosis.**



Top Tips

- Importance of Diet and exercise.
- Treatment is with COCP – normalises hormones and clears ovaries of cysts.
- Don’t investigate on the COCP as test will be normal.
- Only need to refer if problems with COCP.
- Advise to stay on COCP until want to conceive then stop and try the next month.
  - The longer they are off COCP the risk of bulky ovaries increases.

Referral

- 28 y.o
- Complaining of discharge and itching
- Taken multiple OTC single dose Fluconazole which work for a week then the symptoms come back.

Recurrent Thrush

- Defined as 4 or more episodes a year

with at least partial resolution between episodes

- Take a high vaginal swab for microscopy and culture to confirm the diagnosis, and identify the presence of:
  - A moderate/heavy growth of *Candida albicans* when symptomatic on at least two occasions.
  - Non-albicans *Candida* species.
  - A mixed infection such as candidiasis with bacterial vaginosis or trichomoniasis (up to 10% of infections are mixed)

BASHH (2007) *National guideline on the management of vulvovaginal candidiasis.British Association for Sexual Health and HIV*. www.bashh.org

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- Induction therapy ensures clinical remission and is followed immediately by maintenance therapy.
- Two options are:
  - Three doses of fluconazole 150 mg. One 150 mg dose to be taken every 72 hours, or
  - Topical imidazole therapy for 10–14 days according to symptomatic response.
- For vulval symptoms, consider using a topical antifungal cream, *in addition to* the oral or intravaginal antifungal.
- Once the induction course is completed, offer *either* 'treatment as required' with a prescription to be used if symptoms recur,
- *Or* a maintenance regimen of 6 months' treatment with an oral or intravaginal antifungal (off-label use).
- Options for maintenance therapy include:
  - Intravaginal clotrimazole 500 mg once a week.
  - Oral fluconazole 150 mg once a week.
  - Oral itraconazole 50–100 mg daily.

Top tips

- Check for the diagnosis – if swabs are negative then it is not Thrush.
  - Tell patient to take swab themselves when the symptoms are worst to convince them if negative
- Think of other diagnosis – don't forget Lichen, eczema, psoriasis
- Refer if they are not responding to treatment or unsure of diagnosis.

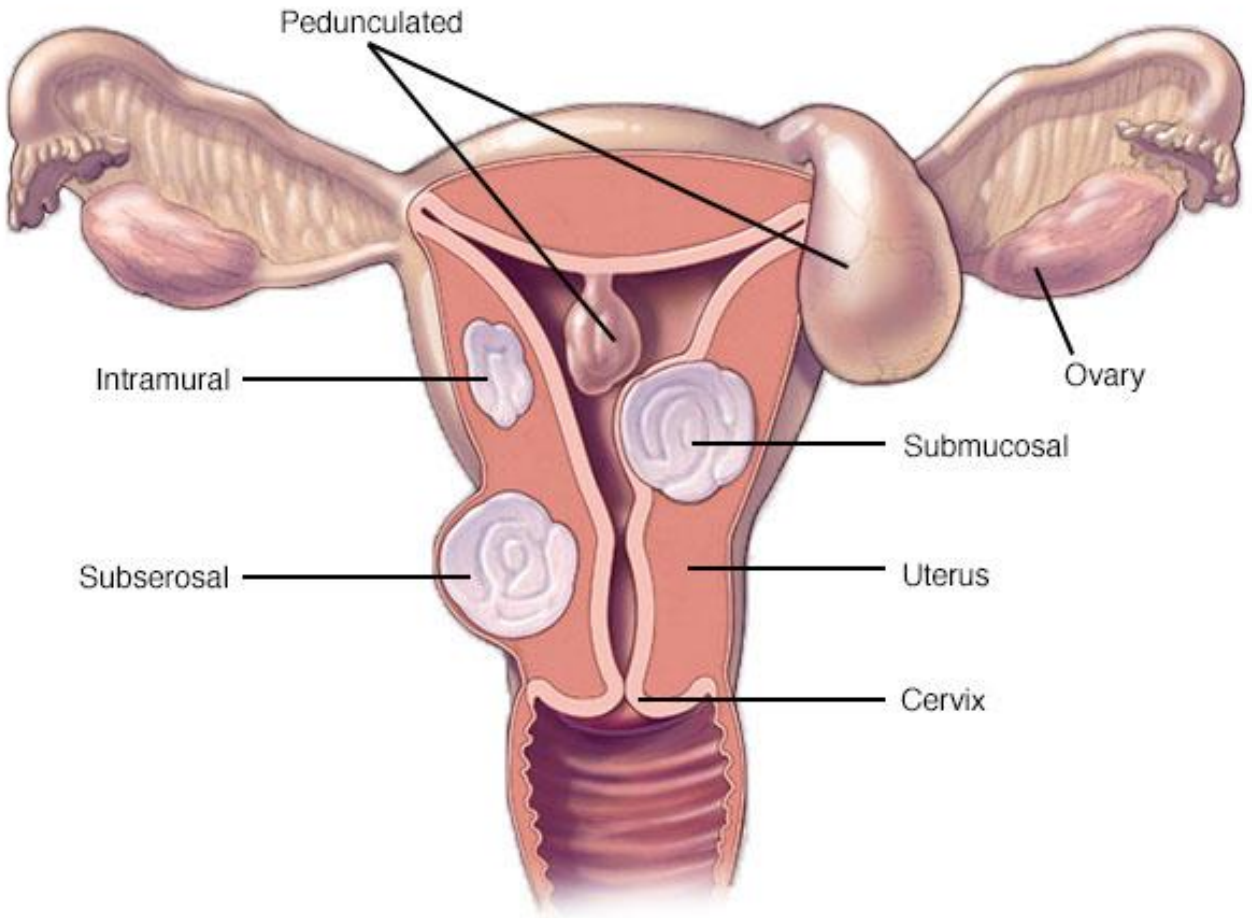
Referral

- 48 y.o
- Menorrhagia with irregular cycle in the last 6 months
- Hb 10.7
- USS – 2 intramural fibroids largest 2.4cm
- Anxious does not want hormonal treatment

Fibroids

- 20-50% of women have fibroids
- promoted and maintained by exposure to oestrogen and progesterone.
- Many are asymptomatic and are incidental findings.
- Can cause
  - Menorrhagia
  - Pressure symptoms (including effects on bladder/bowels) – if large

Fibroids
Position is the key!



Tips

- Asymptomatic fibroids do not need to be referred.
- Try medical management for Menorrhagia
  - Tranexamic Acid
  - Progesterones – Mirena, POP
  - Especially useful if women near menopausal age
- Refer if these have failed to consider further interventions – Please let us know if they would not want surgery.

Referral

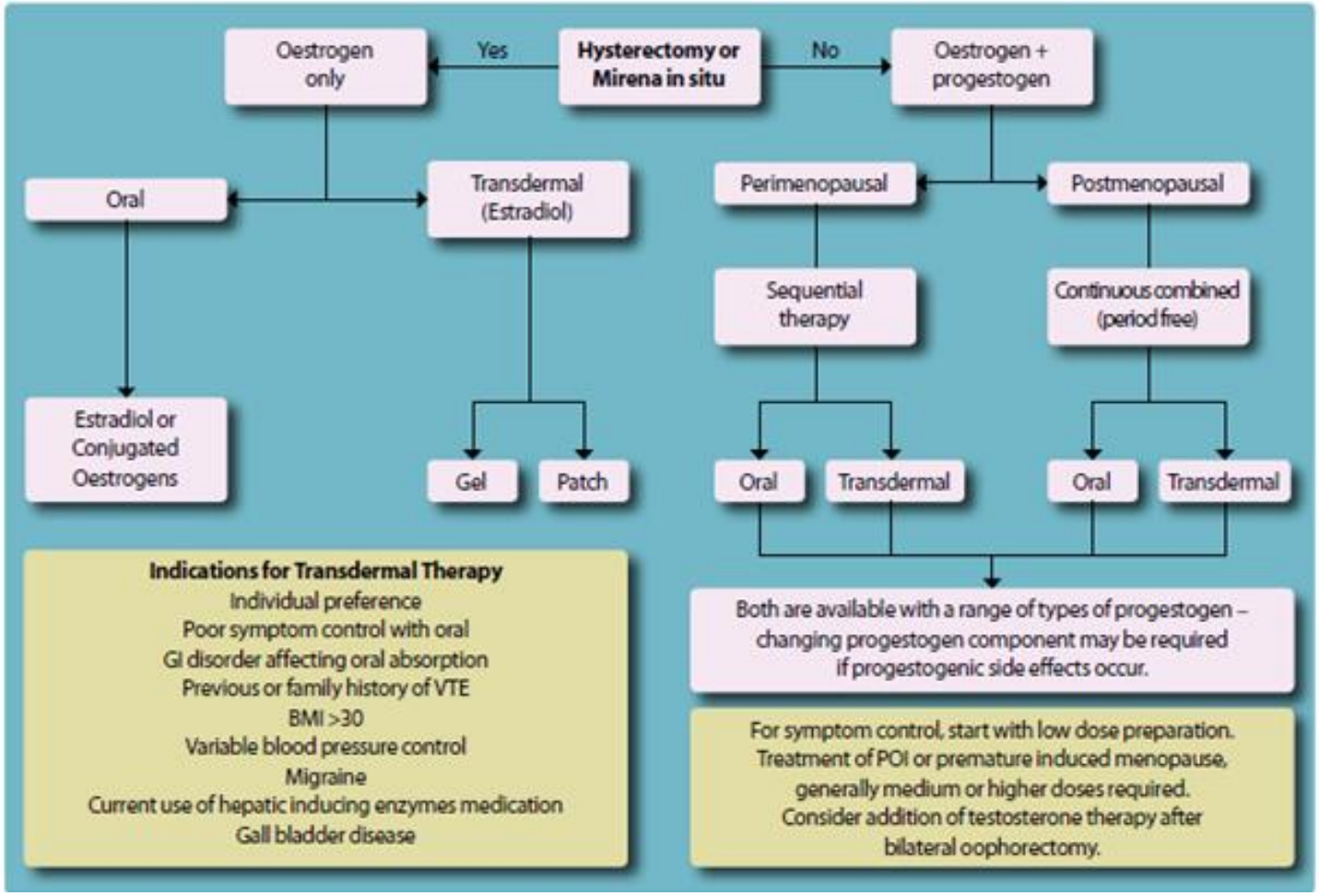
- 44 y.o
- No period for 5months
- Complaining of occational hot flushes
- FSH 39

- ? menopause

Menopause

- Normal physiological change.
- Normal between 40 and 55
- Below 40 is premature ovarian insufficency – triaged to specialist clinic with yearly review
- 40 – 45 year early menopause – it is highly recommended they are treated with HRT.
- In over 45 - Only need to treat if the patient has symptoms and wishes to be treated.
- Transdermal is safer than oral.

Systemic HRT Treatment



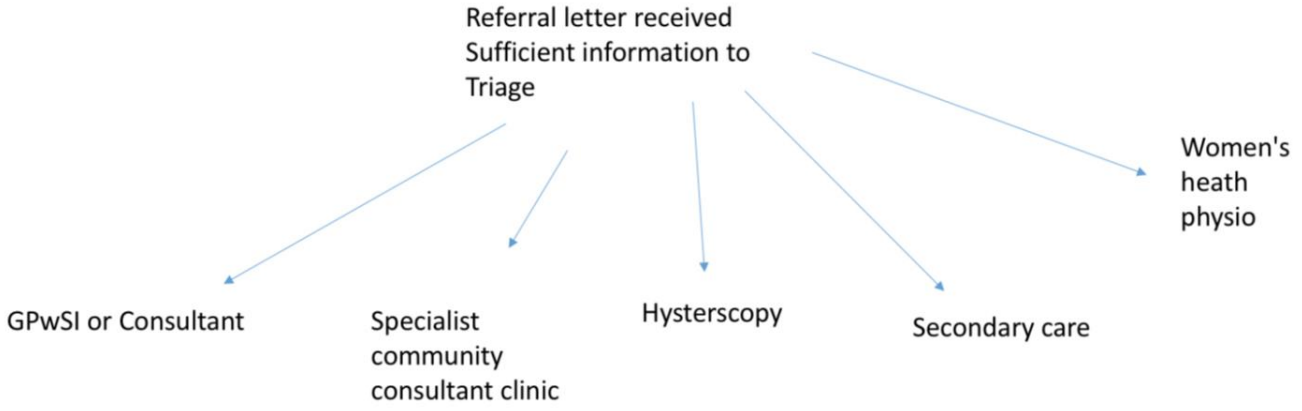
Menopause

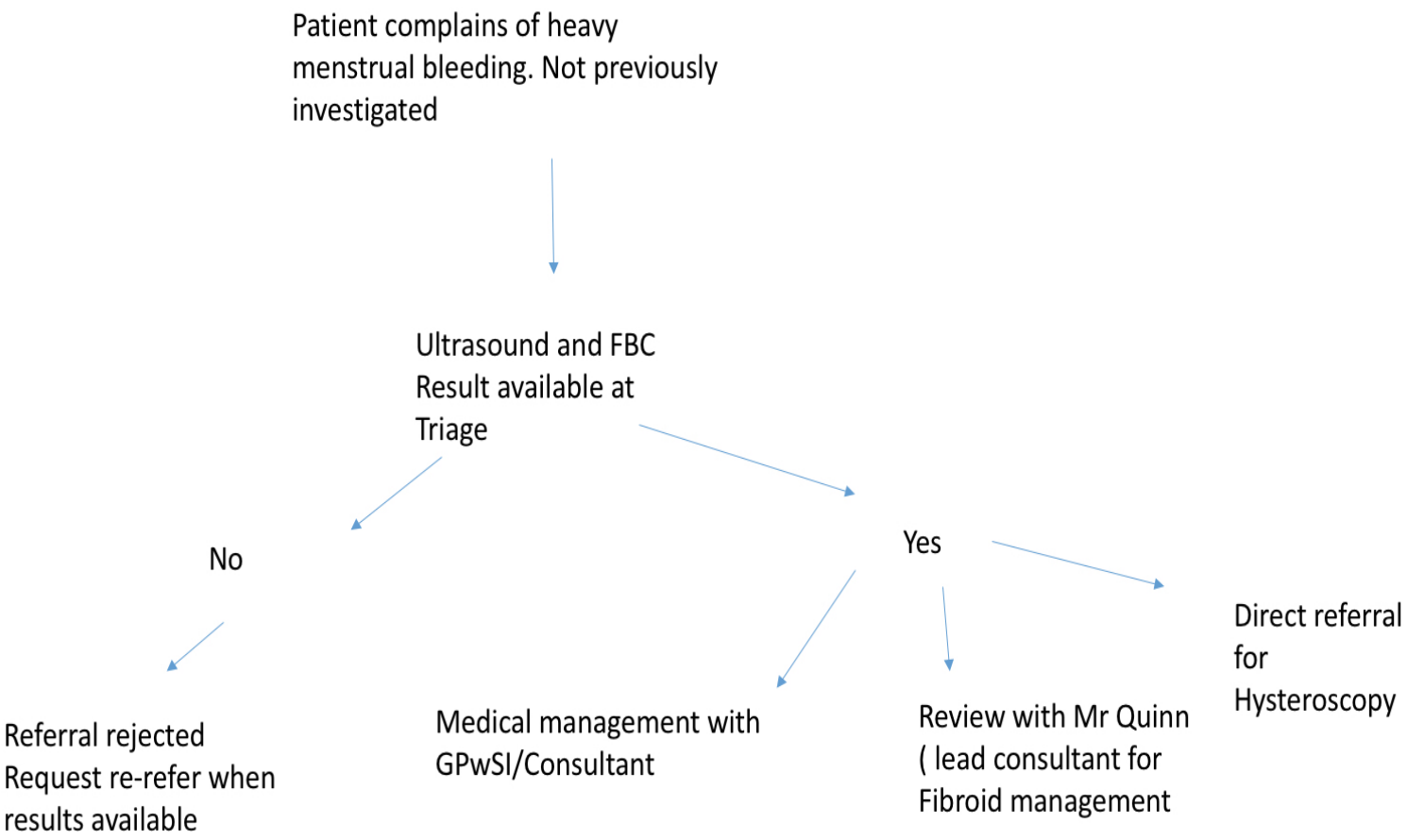
- Refer
  - Women under 40 – These will be traiged to the Menopause clinic
  - Poor Symptom control - Women who have not had benefit with HRT they have tried
  - Side Effects - Persistent side effects following logical therapy changes.
  - Bleeding Problems
    - Sequential therapy - change in pattern of bleeding including increased duration, frequency and/or heaviness, and irregular bleeding.
    - Continuous combined therapy or tibolone - if still bleeding after 6 months of therapy or if bleeding occurs after a spell of amenorrhoea.
  - Complex medical history
  - Past history of hormone dependent cancer

- Don’t forget contraception
- Resources
  - Menopause matters. www.menopausematters.co.uk
  - British Menopause Society www.thebms.org.uk

Triage

- Triage is the first step of the service
- Ensures patient is seen in the right place first time
  - Less repeated attendance
  - Seen in clinic with all investigations completed




Patient complains of heavy menstrual bleeding. Not previously investigated
Ultrasound and FBC Result available at Triage
No
Yes
Referral rejected Request re-refer when results available
Medical management with GPwSI/Consultant
Review with Mr Quinn (lead consultant for Fibroid management
Direct referral for Hysteroscopy

- Any Questions?