Adult Gynaecology Pathways

Key
Green text – test type
Orange box – referrals/ end of pathway

Be aware there are numerous pathways and patients may have symptoms from more than one

Routes into Pathway

Patient presents with symptoms

Clinical Assessment - History

Symptoms – *present for how long?*

Bleeding
consider
Onset
Duration
Timing – post coital/ post menopausal
Heaviness
Regularity/Frequency - if irregular androgen excess symptoms
Gradual/ sudden onset

Pain
consider
- Location
- Onset
- Duration
- Severity
- Timing
- Exacerbation/ relieving factors (such as OTC treatment)

General
Discharge: clear/ purulent/ bloody/ odour
External skin symptoms: vulval soreness/ ulceration/ lumps

Additional Info

Additional Info Pop Up

Consider:
- Previous treatments? E.g. OTC NSAID, contraception
- History of pregnancy or sexually transmitted infection, partner change
  - Gender change
  - History of abnormal smears
  - Medications – HRT/ Tamoxifen
- Bloating/ weight loss/ change in bowel habit (esp. >50)
  - Family history, esp. of cancer
  - Detailed history of menses,
  - Diet and exercise,
  - Symptoms or signs of androgen excess,
- Risk factors for premature ovarian insufficiency (radiotherapy, chemotherapy, autoimmune disease)
  - Chronic medical conditions,
  - Gynaecology surgical history
  - Drug history

Clinical Assessment - Examination

General
New onset pain - pulse/BP/ temp/ BMI

Abdomen & Pelvic Exam
Tenderness/ mass
Cervical/ vulval changes
Please ensure speculum examination carried out unless ectopic pregnancy suspected

Urgent Referral and Admission Guidance

Urgent Referral
Unwell
Febrile with localised pain, peritoneal signs, new onset pain and pregnancy (consider ectopic pregnancy)
Cancer 2WW Referral
Cervix – examination, suspicious changes/ looking but excluding endo cervical polyps? Lesions on cervix
Vulva – suspicious vulval ulcer, examination and history.
Ovary – risk factors are age (post meno), genetic (strong family history), persistent bloating symptoms presenting more than 3 occasions over 12 months or gross abdominal distension, weight loss

1. Post-coital bleeding

Additional Info Pop Up
e.g. inter-menstrual bleeding
Discharge
Cervervsitis
Pain

Additional Info Pop Up
Please note if you are sure it is a cervical polyp and there are no other symptoms (PCB, vaginal discharge) and patient happy with explanation removal is not necessary.

Investigations

Additional Symptoms

- Suspicious of cancer → **UCR Referral**
- Cervical polyps → if >2cm or patient not happy without removal → Refer to appropriate provider

Cervical Appearances

- Cervical warts → Signpost to Sexual Health Service
- Ectropion → Reassure patient ectropion is benign Watch and wait for 6 months → Symptoms continue → Refer to appropriate provider*
- Normal → IUCD?
  - Yes → Remove IUCD to see if symptoms improve → No improvement → Refer to appropriate provider
  - No → Refer to appropriate provider
- Normal/ Cervicitis with discharge → Appropriate Swabs → Treat according to swab results. Refer Sexual Health if STD

2. Chronic pelvic pain

Additional Info Pop Up
Severe pain associated with period either few days before or during - consider endometriosis

Additional Info Pop Up
1. History is highly suggestive of endometriosis – additional management up to 6 months and if symptoms then persist refer to secondary care
2. Patient trying to conceive – refer to secondary care

Investigations

- Pain with intercourse with no other cause identified → Refer to Sexual Health Service
- Discharge/ abnormal swabs → Refer to Sexual Health Service
- Cyclical pain/ dysmenorrhoea → Initial management
  1. analgesia – NSAIDs
  2. COCP back to back
  3. POP/ Mirena IUS

  If symptoms persist → USS
  - Normal → Continue trial of therapy
  - Abnormal → Refer to appropriate provider
- Non cyclical pain → Consider non-gynae causes

3. Persistent vaginal discharge

Additional Info Pop Up
Discharge: clear/ purulent/ bloody odour
Check smear is up to date
HVS endocervical swab

Investigations

- Abnormal vulva/ cervical polyp → See other relevant parts of pathway
- Abnormal Smear → Refer for colposcopy → Discharge persistent > 6months → TV USS
  - normal → Reassure, likely physiological
  - abnormal → Refer to Gynae
- Negative smear and infection screen
  - Normal cervix
  - Ectropion → Initial management
    1. reassure
    2. consider lower does oestrogen COCP/ using alternative to COCP

    Persistent >6 months OR cautery required → Refer to appropriate provider*
- Positive infection screen
  - Chlamydia Gonorrhoea Trichomona → Refer to Sexual Health Service
  - Candida Bacteria Vaginosis → Lifestyle Advice: Cotton underwear Avoid soap and perfumes Standard thrush/ BV treatment

4. Vulval Symptoms

Pop Up over differential diagnosis /treatment
Herpes
LS
Bechets

Pop Up over differential diagnosis/ Referral/ treatment
Sign post to STI – treatment

Swabs advice
from micro
regarding
PCR

- Vulval soreness → Older women & red/ inflamed → Refer to appropriate provider
- Vulval ulceration
  - <50 → Treatment/ refer SH
  - >50 → 2WW Referral
- Lumps → Tender/ recent onset & younger women - Bartholin's cyst

5.1 Changes in menstual bleeding – Infrequent (Oligomenorrhoea, Primary and Secondary Amenorrhoea)

Additional Info Pop Up
"G21"
progesterone – ie 7 days before period due only if looking to conceive

Clinical Assessment – History & Examination

Symptoms
symptoms of androgen excess, risk factors for premature ovarian insufficiency (radiotherapy, chemotherapy, autoimmune disease) chronic medical conditions, gynaecology surgical history or pelvic infection and drug history

Examination
BMI, pregnancy.signs of androgen excess/ virilisation or thyroid dysfunction
Imperforate hymen

Investigations
- Blood: TSH, prolactin, FSH, LH, testosterone/SHBG
- Pregnancy Test (if appropriate)
- Pelvic USS

>45 DO NOT TEST – REFER TO GYNAE

Suspected Diagnosis

Primary Amenorrhoea Normal female anatomy vs not present
eg Hypothalamic Hypogonadotrophism
Imperforate Hymen

Normal vs Low FSH and LH/low E2 testosterone
Often caused by stress, diet, excess exercise, consider eating disorder
→ Refer to gynae or endocrinology

Polycystic Ovarian Syndrome NB do not diagnose unless >8years from menarche
Raised Testosterone and/or FAI

Diagnosis requires 2 of the 3 Rotterdam criteria:
Oligo/amenorrhoea
Clinical or biochemical evidence of androgen excess (testosterone > upper limit of normal)
Polycystic ovaries on USS (>8 years)
→ Refer to PCOS Management Pathway

Premature Ovarian Insufficiency (POI)
FSH > 30IU/L
Measured 6 week apart in women below the age of 40
→ Refer to Gynae

Ashermanns Syndrome Or IU Adhesions
Normal FSH, LH
History of recent/ repeated uterine surgery (e.g. ERPC) or pelvic infection or endometritis
→ Refer to Gynae

Abnormal Prolactin
Serum prolactin >1000mIU/L, or 500-1000mIU/L on two occasions

To note, certain drugs can affect readings. To measure macroprolactin if drug cannot be stopped >/= 700mIU/L
→ Refer to endocrinology

Thyroid Cause
→ Manage in primary care

No Cause Identified
Amenorrhoea without PCOS, POI, Physical Abnormality
→ Refer to endocrinology

5.2 Changes in menstrual bleeding – Inter Menstrual (min of 3 incidents)

Additional Info Pop Up
In one off presentations a diary should be advised to establish IMB is recurrent and persistent
Always take swabs

Patient has an IUCD (Cu or progesterone IUS)

- USS (check site)
  - Remove Cu IUCD Use barrier contraception → Review in 3 months
    - Not related to IUCD → Try COCP or minipill for 3 months
    - Related to IUCD → Discuss contraception options
  - If IUS → Try COCP or minipill for 3 months

Patient on hormonal contraception / No IUCD or hormonal contraception

- USS (Polyps)
  - Negative → Consider a change as per RCOG/ FPA guidelines

    Ask to keep a menstrual diary for 6 months
    - If symptoms persist → Refer to appropriate provider
  - Positive → Refer to appropriate provider

If symptoms persist → Refer to appropriate provider

5.3 Changes in menstrual bleeding – Heavy Menstrual Bleeding

Additional Info Pop Up
FBC
Note, other bloods not needed unless other indications

Does the patient have one or more of the following clinical features:
- Persistent IMB or prolonged bleeding, >10 days or short cycle <21 days
- Infrequent heavy bleeding obesity or have polycystic ovarian syndrome
- On Tamoxifen or Pharmacological treatment for HMB has been unsuccessful
- Painful periods or pressure symptoms
- Woman with palpable uterus

No
DO NOT USS

- Pharmacological Interventions:
  - Mirena
  - If declines, Tranexamic acid (2g tds 3-5days), or NSAIDS, COCP or minipill

  After 6 months treatment has not worked → Refer to appropriate provider

Yes

- Painful periods
- Pressure symptoms
- Palpable uterus

Above symptoms suggest a pelvic pathology

TV USS
- Endometrial polyp Submucous fibroid Fibroids > 3cm → Refer to appropriate provider
- Adenomyosis Fibroids <3cm → Mirena, Tranexamic acid, NSAIDS, COCP or minipill