WHY YOU WANT TO PICK UP THAT GYNAE PATIENT!

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July 2020

TALK OUTLINE

- Career outline
- Common ED gynae presentations:
  - Vaginal Bleeding
  - Pelvic Pain
  - Other
- Cases presentations

Acknowledgement of country

We respect and honour Aboriginal and Torres Strait Islander Elders past, present and future.

We acknowledge the stories, traditions and living cultures of Aboriginal and Torres Strait Islander peoples on this land and commit to building a brighter future together.

MY CAREER

- Grew up in Bangalow, NSW
- Studied undergraduate Medicine at UNSW
  - Spent 2 years at the Port Macquarie Rural Clinical School
- Internship and residency at John Hunter Hospital in Newcastle
- Senior resident year at the Mercy Hospital for Women (2011)
    - Didn't get on to O&G training with first application


Ikigai
A JAPANESE CONCEPT MEANING "A REASON FOR BEING"
What you LOVE
Satisfaction, but feeling of uselessness
Delight and fullness, but no wealth
PASSION
MISSION
What you are GOOD AT
Ikigai
What the world NEEDS
PROFESSION
VOCATION
Comfortable, but feeling of emptiness
What you can be PAID FOR
Excitement and complacency, but sense of uncertainty

MISSION 1 - AFGHANISTAN

- 2012
- ‘Medical doctor with obstetric skills’
- Khost
- Lashkargah

MISSION 1 - AFGHANISTAN

- A rich and deeply satisfying experience
  - Terrifying
    - Life affirming

- ~10% stillbirth
- Regular maternal deaths – many preventable
- Hygiene

- Severe pathology
  - Anaemia
  - Eclampsia
  - Excessive oxytocin
  - Infections
  - Medications +++

O&G TRAINING

- 2013, 2014 and 2015 O&G training in Australia
- Mercy Hospital for Women and Barwon Health

MISSION 2 - LEBANON

- October 2015 – March 2016
- Assessment of MSF primary health sexual and reproductive health

  - Primarily Syrian refugees
  - Palestinian refugees in camps
  - Occasional Lebanese patients

MISSION 3 - YEMEN

DAILY WORK

- Maternity
- OPD
- Future planning
- Complaints
- Performance management
- Reporting..

O&G TRAINING

- 6 month of work in Yemen was accredited by RANZCOG

- 2018 Senior Registrar at Sunshine
- 2019 Chief Registrar at Sunshine

    - **FRANZCOG!**!

- 2020 and 2021 Gynaecology Endoscopy Fellow at Monash

CAREER ADVICE

- Remind yourself frequently our job is a **privilege**
- Do what makes **you** feel complete
- Judge yourself by your own yardstick
- Make decisions without fear

QUESTIONS?

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WHY YOU WANT TO PICK UP THAT GYNAE PATIENT…

- Gynae is easy!
- Empathy can heal…
- Most patients can be seen and sorted quickly
- O&G registrars are highly* approachable
- The patient is unlikely to have a disease you've never heard of

VAGINAL BLEEDING

- Common reasons people present with vaginal bleeding to the ED:

1. Bleeding in early pregnancy
2. Abnormal menstrual bleeding
3. Post coital bleeding
4. Post surgical bleeding
5. Post menopausal bleeding

EARLY PREGNANCY BLEEDING

- Priority:
  - Is it ectopic or intrauterine?
  - Is it viable or non-viable?

EARLY PREGNANCY BLEEDING

- Clinical gems:
  - Hx, Exam, Ix, Mgt
  - **Speculum** – don't tell the gynae reg you don't know how!
    - Useful for quantifying bleeding, excluding products of conception in the cervix and looking for cervical pathology
    - You CAN do a CST with bleeding – cc a copy to the GP
  - **Blood group and antibodies** – if not a recent one on the hospital system, send one. If the patient is bleeding heavily, send a G&H. If not sure, take the tube but don't send it…
  - **HCG**
    - **Yes:** Early pregnancy with an unsited pregnancy
    - **No:** Viable pregnancy, test <48h previously*
    - Miscarriages can be suggested but not diagnosed by HCG…

EARLY PREGNANCY BLEEDING

- Ectopic pregnancy:
  - All women of child-bearing age are pregnant until proven otherwise, and all are ectopic until sited intrauterine
  - Classic presentation is with 6-7 weeks of amenorrhoea, light vaginal bleeding and lateralising pain, +/- outpatient ultrasound suggesting ectopic pregnancy
  - Pregnancy of unknown location:
    - ? Too early to see intrauterine or extrauterine pregnancy
    - ? Complete miscarriage
    - Most are suitable for outpatient management and close follow up

EARLY PREGNANCY BLEEDING

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EARLY PREGNANCY BLEEDING

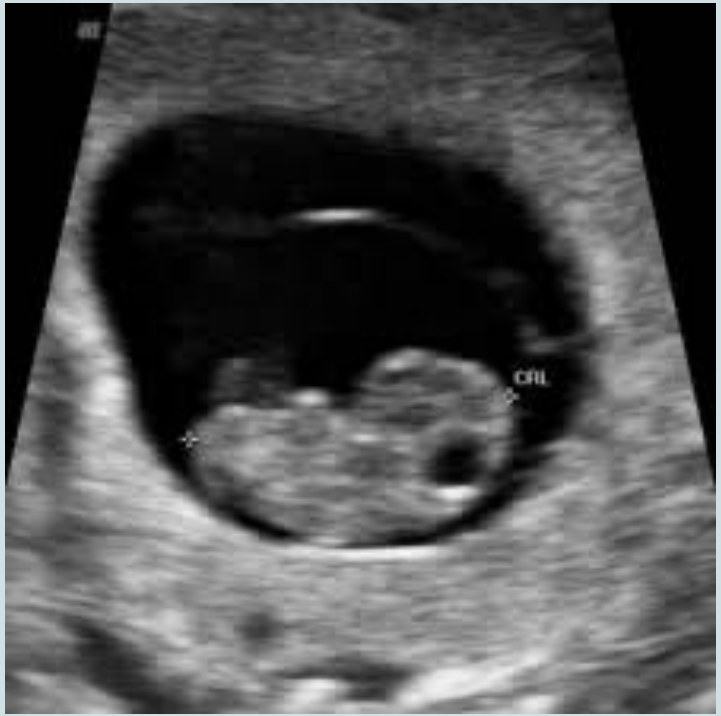
Q1:

A 27y G1P0 LMP 12 weeks ago presents with light vaginal bleeding.

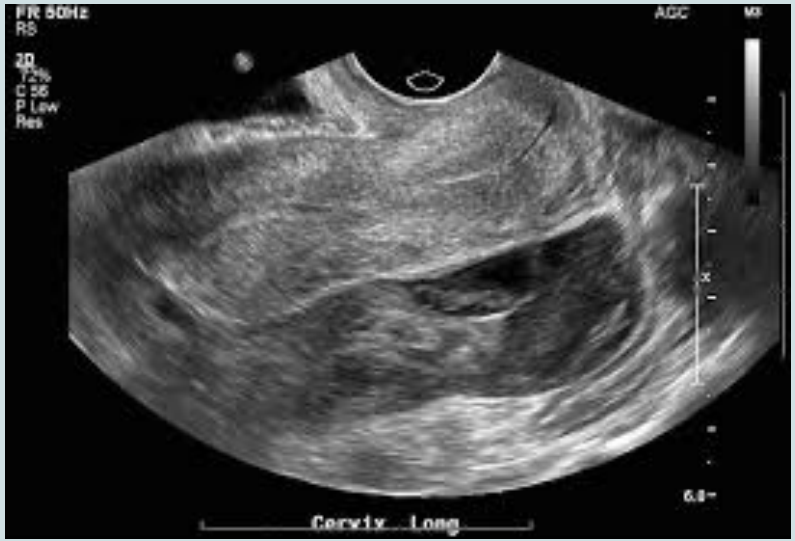
She shows you an ultrasound done at 8 weeks which shows a single, live intrauterine gestation.

She shows you a blood card indicating she is O Rh +.

Investigations required include:



EARLY PREGNANCY BLEEDING



Q2:

Most ectopic pregnancies present in extremis, with a large haemoperitoneum and a positive FAST scan.

ABNORMAL MENSTRUAL BLEEDING

- Acute or prolonged heavy vaginal bleeding

37%

PALM-COEIN classification

Category	Number of patients n=300 (%)
Polyp (P)	8(2.66)
Adenomyosis (A)	28 (9.33)
Leiomyoma (L)	68 (22.66)
Malignancy (M)	8 (2.66)
Coagulopathy (C)	3 (1)
Ovulatory dysfunction (O)	85 (28.33)
Endometrial (E)	62(20.66)
Iatrogenic (I)	13 (4.33)
Not yet classified (N)	25 (8.33)

- Priority:
  - Exclude pregnancy
  - Quantify amount and hemodynamic stability
  - Most are not emergency issues, but unless you offer a good explanation and follow up plan then patients are likely to represent to the emergency department

ABNORMAL MENSTRUAL BLEEDING

- Clinical gems:
  - A **speculum** examination will allow you to quantify the volume
  - Most abnormal bleeding represents either a chronic hormonal imbalance (e.g. PCOS, irregular heavy perimenopausal bleeding), uterine abnormality or malignancy (e.g. endometrial carcinoma) – <u>neither will be diagnosed or resolved in an emergency department visit</u>
  - Patients CAN **exsanguinate** from heavy periods

ABNORMAL MENSTRUAL BLEEDING

- Clinical gems:
  - Almost all abnormal menstrual bleeding can be slowed significantly with high dose progesterone and tranexamic acid, and are safe in most situations…
    - TXA 1g QID until the bleeding stops
    - AND
    - Progesterones:
      - Primolut – Norethisterone – 10mg Q4H until the bleeding stops
      - Provera – Medroxyprogesterone acetate – 10mg Q4H until the bleeding stops

ABNORMAL MENSTRUAL BLEEDING

- Clinical gems:
    - Urgent referrals should be for women in whom the risk of malignancy is high, for example post menopausal women, or those with a very high BMI

POST COITAL BLEEDING

- Priorities:
  - Assess for trauma
  - Ascertain consent, risk of STIs / pregnancy, and consider emergency contraception

- Clinical gems:
  - Commonly it will be ectropion, but we look seriously for other pathology too
  - Is it cervical dysplasia or malignancy? A **speculum** exam will help you!
  - If it's HEAVY it is often trauma, which most often needs to be repaired in theatre. Keep the patient fasted!

POST SURGICAL BLEEDING

- Priorities:
  - Consider vault dehiscence (if hysterectomy)
  - Clinical gems:
    - **Mirena**s take time to settle in…
    - Bleeding from one place, always consider bleeding from other sites...
    - The **time line** from surgery will tell you the likely cause:
      - Inadequate haemostasis / surgical bleeding
      - Infection
      - Vault dehiscence
- The surgeon always wants to know…

POST MENOPAUSAL BLEEDING

- Priorities:
  - Ensure haemodyanmic stability and access to follow up

- Clinical gems:
  - These are the easiest patients to pick up!
  - 10% will have endometrial cancer
  - Workup includes diagnostic co-test, TV pelvic USS and urgent clinic RV
  - Ideally, a **speculum** is helpful – if you see a mass, we can biopsy it in the ED and have a tissue diagnosis by the time they come to clinic…

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PELVIC PAIN

- Acute pelvic pain
- Chronic pelvic pain
- Acute on chronic pelvic pain

ACUTE PELVIC PAIN

- The pelvis is pretty busy –

- Uterus (cervix, vagina)
- Tubes
- Ovaries
- Bladder
- Ureters
- Rectum
- Pelvic floor
- (Appendix)

- Listen to what the patient tells you…
  - "This happens every month…"
  - "This is the worst pain of my life!"

ACUTE PELVIC PAIN

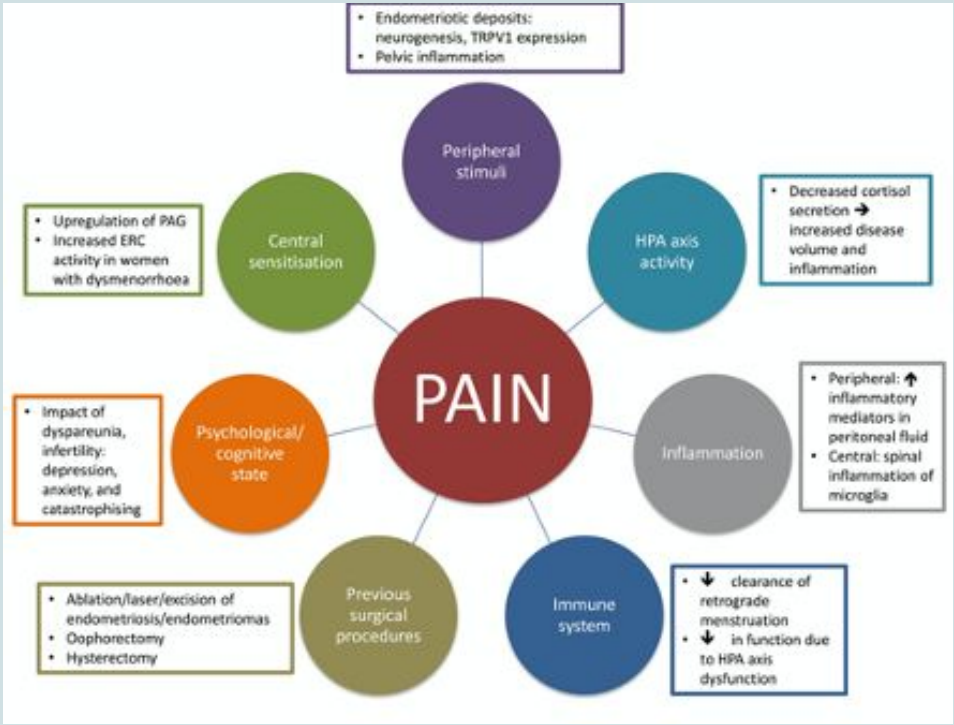
- Priorities:
  - Do not miss ovarian torsion
  - Successfully walk the line between O&G and Gen Surg…

- Clinical gems:
  - Ovarian torsion most commonly happens mid cycle, after exercise/sex, with an enlarged ovary.
  - Patients are typically distressed with pain ++ despite analgesia.
  - There is usually an element of nausea.
  - Ovarian cyst accident is a challenging diagnosis

CHRONIC PELVIC PAIN

- ED presentations will be acute on chronic, or an exacerbation of chronic pelvic pain
-
- Chronic pelvic pain is a complex problem, involving multiple organ systems and psychosocial confounders.
-
- Depression, anxiety, multiple chronic pain issues or complex psychosocial situations do NOT mean that pain is not real.
-
- Simple problems, like a UTI or constipation or menstruation, can cause severe pain exacerbations in patients with chronic pelvic pain.

CHRONIC PELVIC PAIN



THERE ARE MANY FACTORS THAT CONTRIBUTE TO PAIN IN CPP (CIRCLES). THESE FACTORS MIGHT PLAY A ROLE IN CPP IN WOMEN WITH ENDOMETRIOSIS (RECTANGLES). PAG, PERIAQUEDUCTAL GREY; TRPV1, TRANSIENT RECEPTOR POTENTIAL CATION CHANNEL SUBFAMILY V MEMBER 1; ERC, ENTORHINAL CORTEX; HPA, HYPOTHALAMIC PITUITARY AXIS.

CENTRAL CHANGES ASSOCIATED WITH CHRONIC PELVIC PAIN AND ENDOMETRIOSIS

HUM REPROD UPDATE. 2014 ; 20(5): 737–747. DOI:10.1093/HUMUPD/DMU025.

BRAWN, J; MOROTT, M; ZONDERVAN, K; M. BECKER, C; VINCENT, K.

CHRONIC PELVIC PAIN

- Priorities:
  - Allow the patient to feel heard and validated
  - Elucidate contributors to this presentation
  - Exclude ‘organic’ disease
- Clinical gems:
  - Many of these patients will know the system well and have had bad experiences. Allow enough time to build rapport and demonstrate empathy.
  - Try to avoid opiates if possible, and work on an escalating analgesia regime:
  - Paracetamol
  - NSAIDs (PR Voltaren is often good)
  - Tramadol
  - +/- Buscopan +/- Tapentadol +/- Targin +/- ??
  - Ketamine if required…

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OTHER

Who needs Anti D?

What about post-partum bleeding?

Does PID exist?

What do I need to know about vaginal mesh?

Can I call a gynaecologist about a trans woman?

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CASE 1

TRIAGE:

Rose Knight

28y female. Abdo pain. Period today. Paracetamol at home at 3pm.

Given 10mg Oxycodone.

CASE 1

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CASE 1

Hx:

- Normally regular period, K4/28, not heavy or painful
- LMP 26/6/20
- Pain began just after lunch while at work - initially thought might have worn pants that were too tight
- Light vaginal bleeding only
- G0P0
- PMHx: Psoriasis, Acne
- Meds: Roaccutane
- All: NKDA
- D&A: Nil, ex alcohol dependence
- SHx: living with parents, recent relationship breakdown, working as a librarian

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What else do you want to know?

CASE 1

CST - never

Contraception - not currently sexually active, previously used condoms. Used morning after pill in mid June in context of alcohol relapse. Sex was consensual to the best of her knowledge.

STI risk - relationship break down in the context of infidelity.

CASE 1

OE:

- P 82bpm
- BP 98/65mmHg
- Aftebrile
- Abdo soft, mildly tender generally lower abdo, no guarding or rigidity
- Spec - small volume of vaginal bleeding seen, cervix long and closed, minimal vaginal discharge
- Bimanual - small mobile AV uterus, adnexal mass palpable L adnexa, tender ++

Ix:

- Hb 125
- WCC 8.6
- CRP 4
- Endo cx swab for Chlamydia and GOnorrhoea PCR, and CST for routine cervical screening

CASE 1

WHAT OTHER INVESTIGATIONS DO YOU WANT?

BHCG 1437

Blood group A Rh -

TV pelvic USS: empty uterus, 34mm L adnexal mass suspicious for ectopic pregnancy, moderate pelvic free fluid

CASE 1

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CASE 1

Well done!

You keep her fasted and call the O&G reg. She last ate a vegan burrito bowl at 4pm, and drank water just now. She is haemodynamically stable, so with IV access and a valid group and hold they will await theatre until she is fasted.

CASE 1

When you go and speak to the patient, she is understandably upset, and has a few questions...

CASE 1

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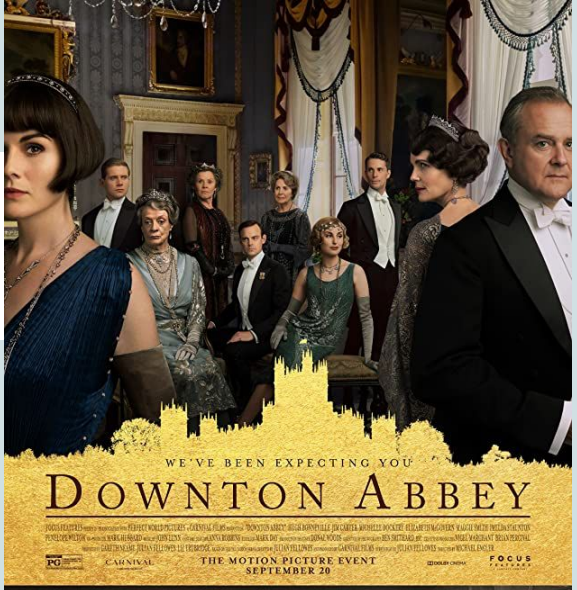
CASE 1

You are back on shift after spending a week in isolation lock down watching Downton Abbey.

You look up her notes and see she had a lap salpingectomy with a 750mL haemoperitoneum. She was discharged D1 post op.



CASE 1

You see her Chlamydia PCR is positive.

What do you do?

CASE 1

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The end!