Gynaecology referral management guidelines

Director of Department: A/Prof Anne Sneddon

Specialist advice service: Please contact gynaecology registrar on-call (if unavailable ask to speak to the specialist on-call) if you need advice prior to referral via GCUH switchboard: 5687 0003

When considering a gynaecology referral please consider these referral guidelines for management of your patient prior to referral.

Minimum information required in all gynaecology referrals

When making a referral please ensure the letter is addressed to the Director of gynaecology: A/Prof Anne Sneddon.

The clinical information and pre-requisite investigations requirements are currently found on GP referral templates for GP software programs, the latest of which can be found at http://www.gpgc.com.au/cmsItem.aspx?CK=187.

Referrals cannot be accepted if they do not contain this minimum of information.

If the clinical information or pre-requisite investigations are not clearly provided, your referral may be returned to you asking for more information.

Clinical information

To safely categorise/prioritise your patient, the gynaecology department need the following information as a minimum to be clearly provided in every referral:

- Patient details
- Reason for referral
- Has the patient been seen by a GCHHS consultant in this specialty in the past?
  - If yes, provide GCHHS consultant’s name
- Duration of problem (e.g. days, weeks etc.)
- Examination findings
- Impact on the patient’s activities of daily living and / or employment
- Treatment and investigations to date

Pre-requisite investigations required

Please only send investigations relevant to the treating clinician (as requested).
Services provided by GCHHS (Gold Coast Hospital & Health Service):

- General Gynaecology
- Urogynaecology
- Mirena Clinic
- OASIS (Obstetric Anal Sphincter Injury Service) clinic
- Urinary incontinence nurse clinic
- Early Pregnancy Assessment (rapid access through ED) – 5687 5061

Click on a category to advance to that page:

**Chronic Pelvic Pain/Endometriosis**
- Chronic pelvic pain

**Contraceptive counselling**
- Request for permanent contraception

**Dysplasia**
- Abnormal PAP smear
- Vulval pathology
- Bartholin’s cysts/vaginal lesions

**Gynaecology Endoscopy**
- Ovarian cysts
- Fibroids
- Acute pelvic inflammatory disease

**Menopause**
- Premature menopause
- Surgical menopause
- Menopausal problems with complex medical problems

**Menstrual management**
- Abnormal menstruation
- Post-menopausal bleeding
- Post coital bleeding

**Pelvic Floor / Urogynaecology**
- Pelvic organ prolapse (POP)
- Urinary incontinence
- Voiding difficulty
- Recurrent UTIs

Services **NOT provided by GCHHS (Gold Coast Hospital & Health Service):**

- Infertility Management

Gold Coast University Hospital cannot provide the full range of services in a timely manner to be of assistance to women with fertility issues. It is strongly recommended that services in the private sector be sought.
**Condition specific guidelines**

**Chronic Pelvic Pain /Endometriosis**

(http://www.endometriosis.org)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Evaluation</th>
<th>Management</th>
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</tr>
</thead>
</table>
| Chronic pelvic pain       | Attempt to differentiate between gynaecological and gastroenterological causes of pain | Treat infection if present  
Simple analgesia  
Menstrual suppression with:  
OCP  
Depo Provera  
Implanon  
Mirena | If diagnosis is uncertain  
If primary care management is insufficient  
Consider concurrent referral to gastroenterology or chronic pain units if indicated |

**Contraceptive counselling**

(http://www.fpnsw.org.au/)

<table>
<thead>
<tr>
<th>Diagnosis</th>
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</table>
| Request for permanent contraception | Thoroughly discuss all options for contraception prior to referral including:  
Male sterilisation  
Mirena  
Implanon  
Depo provera | Referrals can be made directly to Mirena Clinic at GCUH/Robina  
**All women should have an up to date pap smear result and their Mirena prescription filled prior to attending Mirena clinic** | Requests for surgical sterilisation will be allocated as Category 3 for both clinic and surgical wait lists  
Please consider your community options before referring to the hospital as OPD waits |
OCP can be long for these procedures.

A list of Gold Coast accredited GPs that insert Mirenas & IUDs are list available here from FPQ

## Dysplasia


<table>
<thead>
<tr>
<th>Diagnosis</th>
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<th>When to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal PAP smear</td>
<td>An up to date pap smear</td>
<td>See Full NHMRC Cervical Screening guidelines here</td>
<td>Please refer as per the NHMRC guidelines to Colposcopy Clinic</td>
</tr>
<tr>
<td></td>
<td>Consider using Oestrogen cream and or a thin prep in post-menopausal patients</td>
<td>(Pages xi to xviii provide a summary)</td>
<td>In cases of frank malignancy ring the Gynae-Oncology Unit CNC on 0401 008 460</td>
</tr>
<tr>
<td></td>
<td>STD screen and vaginal/cervical swabs where appropriate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>History of previous abnormal pap smears</td>
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<tr>
<td></td>
<td>Sexual history/recent change of partner</td>
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<tr>
<td></td>
<td>HPV vaccination history</td>
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<tr>
<td></td>
<td>History of IMB, PCB, PMB or watery discharge</td>
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</tr>
</tbody>
</table>
## Diagnosis

### Vulval pathology

- History of itching/age of patient and onset of symptoms
- History of chronic itching
- Sexual history
- History of drug use or recent change of medication.
- History of chronic conditions such as Crohn's Disease
- Does the ulcer appear infective or non-infective?

### Bartholin's cysts / vaginal lesions

- Antibiotic treatment of Bartholin's cyst is of no value.
  - The older the patient and the more localised the lesion of the vulva, the more urgent the assessment.

## Evaluation

### Vulval pathology

- Swab ulcer if present to exclude infective cause
- Swabs for STD screen
- Bloods for serology as appropriate i.e. syphilis
- Treat systemic symptoms such as fever, dysuria and pain
- Exclude UTI
- Use of bland emollients such as Zinc/Castor oil cream
- Treat Herpes Simplex with appropriate anti-virals.
- Hospitalisation may be needed if unable to urinate
- Use of a mild topical cortisone cream for a short period might be appropriate

### Bartholin's cysts / vaginal lesions

- Bartholin's cyst, refer for specialist management
  - Older women with localised lesion
  - Acute painful enlargement of a Bartholins gland may require referral to ED.

## Management

### Vulval pathology

- All ulcers in post menopausal patients should be referred to gynaecology clinic

- Any ulcer or other vulval pathology that has not responded to a short course of emollients or a mild steroid cream should be referred to gynaecology clinic
# Gynaecology Endoscopy

## Ovarian cysts

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Evaluation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>History:</td>
<td>If &lt;=4cm size and simple in appearance - repeat scan after 6 weeks (can exclude such as corpus luteal cysts)</td>
<td><strong>If known cyst and symptoms of torsion, refer to ED</strong></td>
<td>Symptomatic with pain</td>
</tr>
<tr>
<td>• Asymptomatic?</td>
<td>Ultrasound should comment as to whether the cyst has any malignant features such as: Septae, solid areas, papillary projections, ascites or abnormal blood flow</td>
<td>Ultrasound with suspicious features:</td>
<td>Persistent simple cyst with 2 x ultrasound over 6 week period</td>
</tr>
<tr>
<td>• Incidental clinical or ultrasound finding</td>
<td>If age &lt; 35 years</td>
<td></td>
<td>Cyst AND elevation of tumour markers</td>
</tr>
<tr>
<td>• Symptomatic?</td>
<td>• Ca125</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cyclical symptoms</td>
<td>• Ca19.9</td>
<td></td>
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</tr>
<tr>
<td>• Pain</td>
<td>• hCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dyspareunia</td>
<td>• AFP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Irregular cycle</td>
<td>• LDH</td>
<td></td>
<td></td>
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<tr>
<td>• Gastrointestinal</td>
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<tr>
<td>• Note: Ovarian pathology (e.g. torsion and not least carcinoma) may present with gastrointestinal symptoms.</td>
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<tr>
<td>• Risk of malignancy greater pre-pubertally and with increasing age to 70+/-</td>
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<td></td>
</tr>
<tr>
<td>Investigations:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consistency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Contour</td>
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<tr>
<td>(b) Ultrasound scan x 2 6-12 weeks apart for simple cysts (specialist experienced in Gynaecological Ultrasound)</td>
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</tr>
<tr>
<td>(c) Tumour Markers (CA 125, Ca 19.3, AFP, CEA, hCG,</td>
<td></td>
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</tbody>
</table>

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**Gynaecology referral management guidelines**

Effective: December 2014

Approved by Gynaecology Endorsement Group

Review date: December 2015
<table>
<thead>
<tr>
<th>Fibroids</th>
<th>Assess menstrual pattern &amp; organ pressure symptoms with large fibroids</th>
<th>Ultrasound FBC</th>
<th>If asymptomatic with normal menstrual pattern and normal Hb, no need for referral. Refer if abnormal menses +/- anaemia. Refer if any obstructive symptoms due to size.</th>
</tr>
</thead>
</table>
| Acute pelvic inflammatory disease | Symptomatology – pain, discharge, pyrexia | Antibiotics for PIDs. Triple therapy:  
- Augmentin 500mgs TDS 10 days  
- Flagyl 400mgs TDS 7 days  
- Doxycycline 100mgs BID minimum 14 days | Acute PID: Acutely unwell, pelvic mass, unresponsive to treatment (12-16 hours). Refer for admission via ED |
|  | Out of phase bleeding ? presence of IUCD | Investigations:  
- FBC/ESR  
- HVS/Chlamydia smear/swabs  
- Urine specimen – Chlamydia  
- Endocx/urethral/rectal swab  
- HCG  
- ?Smear | Link and liaise with STI clinic as appropriate (Note: Erythromycin may be used as an alternative to Augmentin in cases of penicillin allergy) |
## Menopause

(http://www.menopause.org.au/)

<table>
<thead>
<tr>
<th>Diagnosis</th>
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<th>When to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature menopause</td>
<td>History of menopausal symptoms</td>
<td>Two FSH/E2 levels at least 1 month apart if spontaneous menopause</td>
<td>If &lt; 40 years, refer with elevated FSH or symptoms of menopause if primary management not providing relief.</td>
</tr>
<tr>
<td>Surgical menopause</td>
<td></td>
<td>See Menopause GP Toolkit</td>
<td>When complexity of medical or surgical issues impact on management of menopause symptoms</td>
</tr>
<tr>
<td>Menopausal problems with complex medical problems</td>
<td>Information about medical or surgical history</td>
<td></td>
<td></td>
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</tbody>
</table>

### Menstrual Management

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Abnormal menstruation – excessive / irregular menstrual loss (minimum of 3 months unless bleeding continues)</td>
<td>History:&lt;br&gt;  ● Symptomatology, e.g. pain, fatigue&lt;br&gt;  ● Family / personal history of haematological disorders&lt;br&gt;  ● Evidence of any genital tract abnormalities / abdominal mass&lt;br&gt;  ● Sexual history&lt;br&gt;  ● Ability to cope with bleeding, e.g. time off work</td>
<td>Hormonal control, e.g. oral contraceptive /HRT&lt;br&gt; Non steroidal, e.g. Mefenamic Acid 500 mgs TDS&lt;br&gt; Treat anaemia (Hb&lt;100g/l and low iron studies) for a minimum of 3 months&lt;br&gt; Dietary advice&lt;br&gt; Manage other abnormal investigations, e.g. hypo / hyper thyroidism</td>
<td>Anaemia Hb &lt; 80 g/l,&lt;br&gt; Pelvic mass&lt;br&gt; Abnormal smear&lt;br&gt; No response to other treatment modalities&lt;br&gt; Abnormal ultrasound</td>
</tr>
</tbody>
</table>
### Post-menopausal bleeding

(PVB after 12 months from last menstrual period)

- Drug history (contraception, HRT particularly oestrogen only regimens)
- Evidence of any genital tract abnormalities e.g. cervical polyps / atrophic change or abdominal mass
- Sexual / PID history

### Post coital bleeding

- Speculum examination
- Pap Smear
- HVS
- Chlamydia and gonorrhoea Swab or urinary PCR
- Ultrasound TV and TA

### Investigations:

- Smear
- HVS
- Transvaginal Pelvic ultrasound

### Support and counselling

- Report further episodes
- Encourage return if symptoms recur / change

### ALL cases of PMB should be referred to gynaecology clinic

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# Pelvic Floor / Urogynaecology


<table>
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<tr>
<th>Diagnosis</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Pelvic organ prolapse (POP)</td>
<td>History and examination</td>
<td>Vaginal oestrogen in post-menopausal women</td>
<td>Pelvic floor training – refer to women’s health physiotherapy</td>
</tr>
<tr>
<td></td>
<td>Symptomatology – lump, “something coming down”, dragging discomfort, vaginal laxity, difficulty with defaecation or micturition, urinary incontinence</td>
<td>Investigations:</td>
<td>For significant prolapse refer directly to gynaecology. Complex cases will be referred on to urogynaecology at triage.</td>
</tr>
<tr>
<td></td>
<td>Pelvic examination</td>
<td>Consider:</td>
<td>Pessary clinic may be accessed prior to gynaecology assessment in suitable cases. Please indicate whether this is an option the woman may wish.</td>
</tr>
<tr>
<td></td>
<td>Discuss pessary use</td>
<td>MSU</td>
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<td></td>
<td></td>
<td>FBC</td>
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<td></td>
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<td>Biochemistry</td>
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<tr>
<td></td>
<td></td>
<td>Pelvic US</td>
<td></td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>As for POP</td>
<td>Offer Pelvic floor muscle training and refer to women’s health physiotherapists</td>
<td>Troublesome urinary or faecal incontinence</td>
</tr>
<tr>
<td>Voiding difficulty</td>
<td></td>
<td>MSU – MCS</td>
<td>Urinary frequency without UTI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consider trial of anticholinergic medication if symptoms are predominantly that of urinary urgency or urge incontinence</td>
<td>Troublesome nocturia; Voiding difficulty</td>
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<td></td>
<td></td>
<td></td>
<td>Bladder pain</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Recurrent UTIs</td>
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<td></td>
<td></td>
<td></td>
<td>Haematuria</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Stress incontinence not responding to weight management, pelvic floor excercises.</td>
</tr>
</tbody>
</table>
### Diagnosis | Evaluation | Management | When to refer
---|---|---|---
**Recurrent UTIs** | MSU Renal and bladder ultrasound | Vaginal estrogen Cranberry Hiprex and vit C Postcoital or low dose antibiotics | Recurrent UTIs Haematuria

**Useful Resources for GPs & Patients**


Gold Coast Health acknowledges Monash Health as the original content developers for these guidelines which have been adapted locally for Gold Coast Health – [http://www.monashhealth.org](http://www.monashhealth.org)