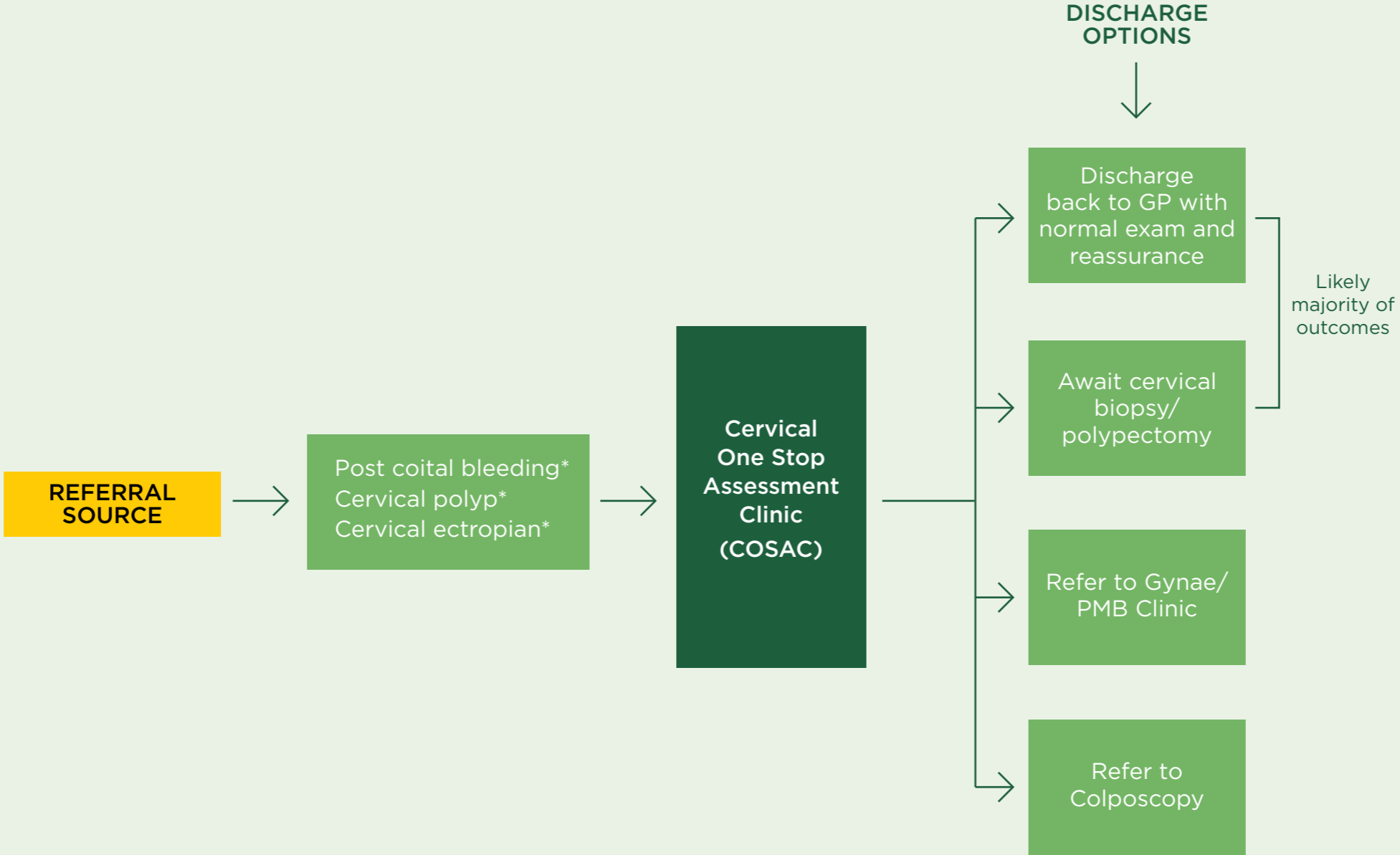




Gynaecology Care Pathways

Cervical One Stop Assessment Pathway



If you suspect cervical malignancy please call St Finbarrs Clinic B and request an urgent review

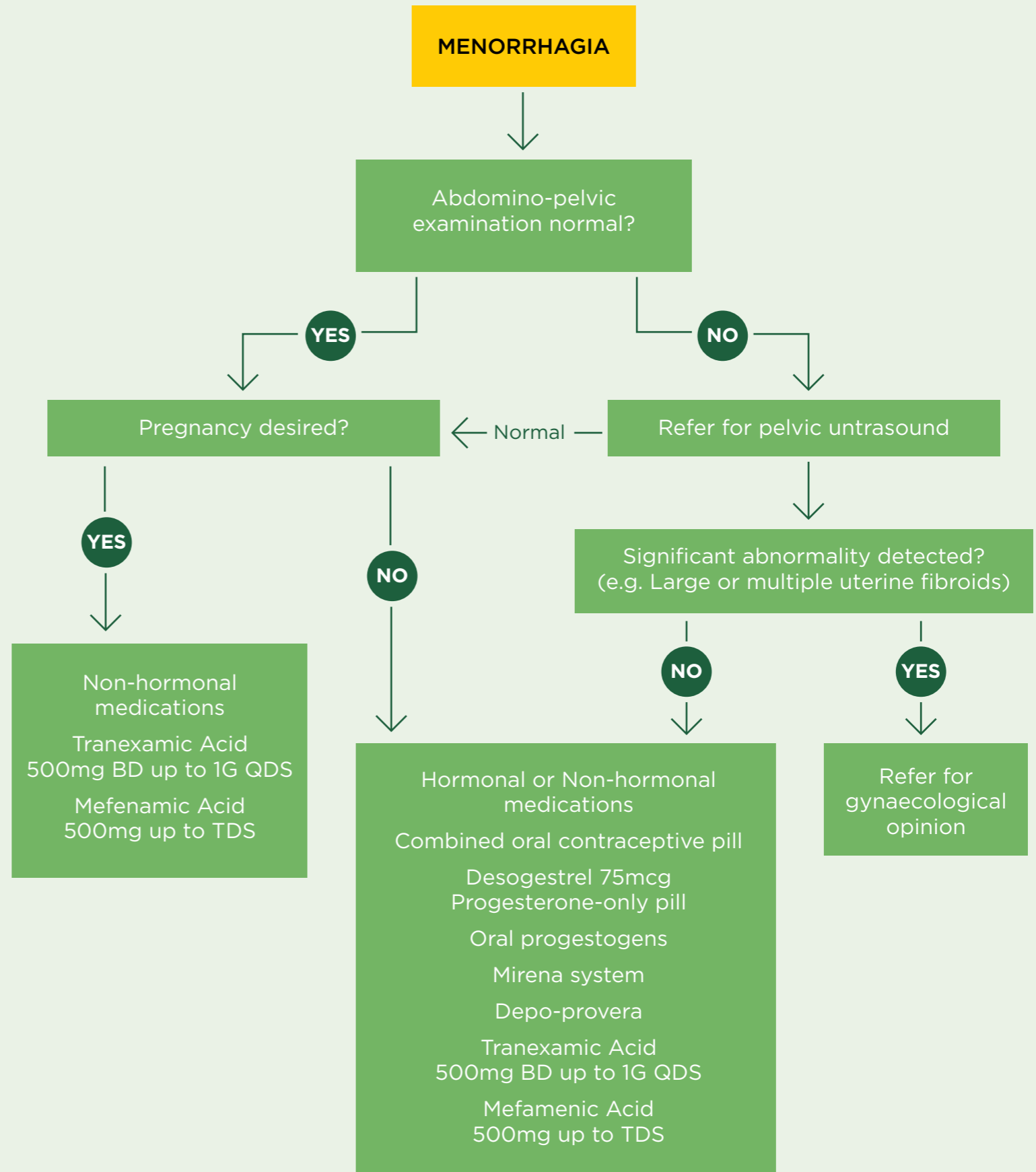
*With normal cervical screening test where eligible.

Menorrhagia Care Pathway

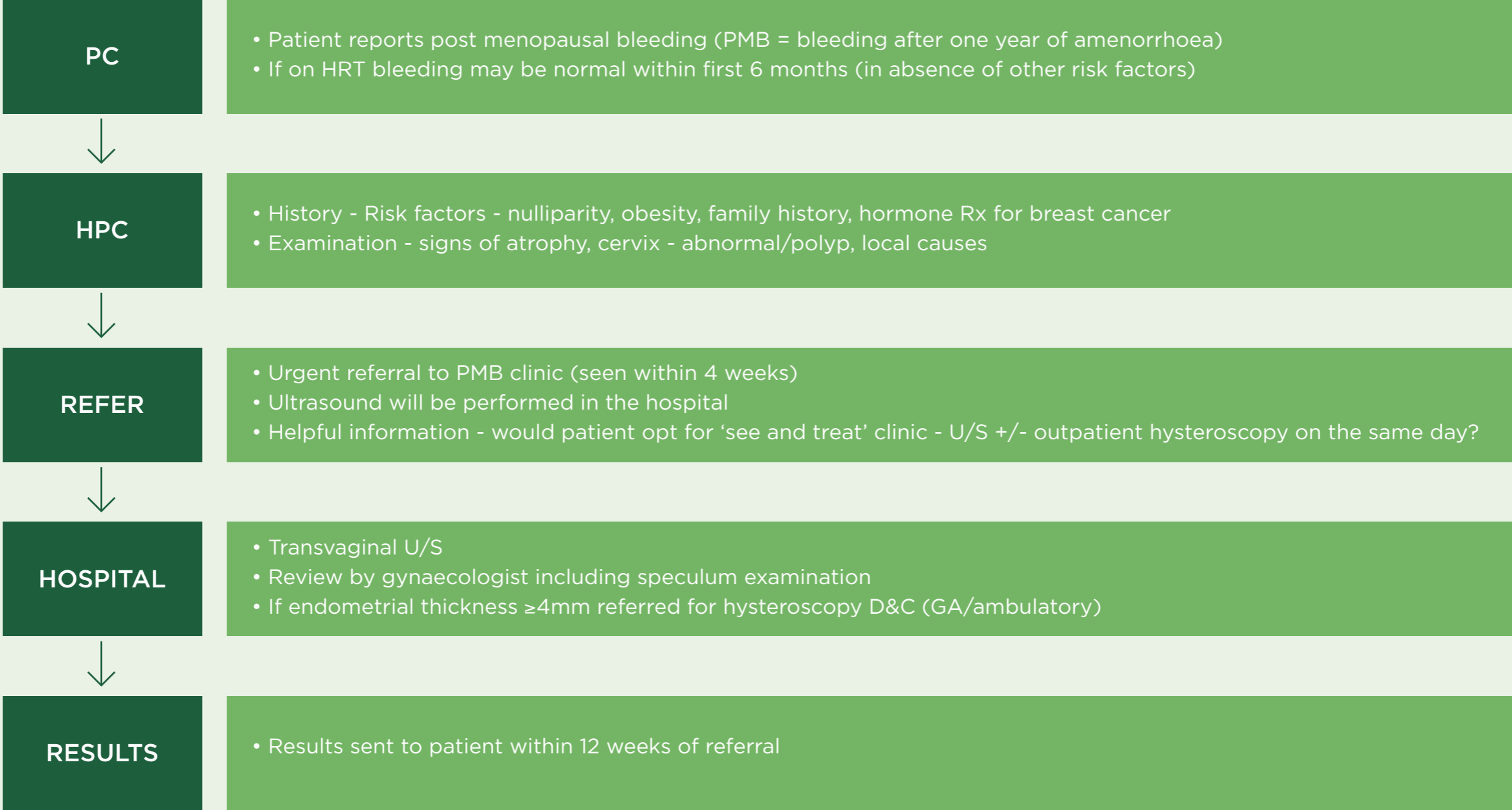
Features concerning for significant pathology prompting early referral include:

1. New-onset or worsening menorrhagia after the age of 45 years.
2. Menorrhagia in women with obesity (BMI >30).
3. Women with a history of PCOS.
4. The presence of a palpable abdominal mass.
5. Accompanying intermenstrual or post-coital bleeding.
6. Failure of medical management to adequately treat symptoms.
7. Anaemia in patients not responding to medical management.
8. Tamoxifen or anastrozole use.
9. Strong family history of endometrial carcinoma, or Lynch syndrome cancers.
10. Inability to use medical treatments due to side-effects or contraindications.

History
Examination
FBC
TFTs if clinical sxs/signs



Postmenopausal Bleeding Care Pathway



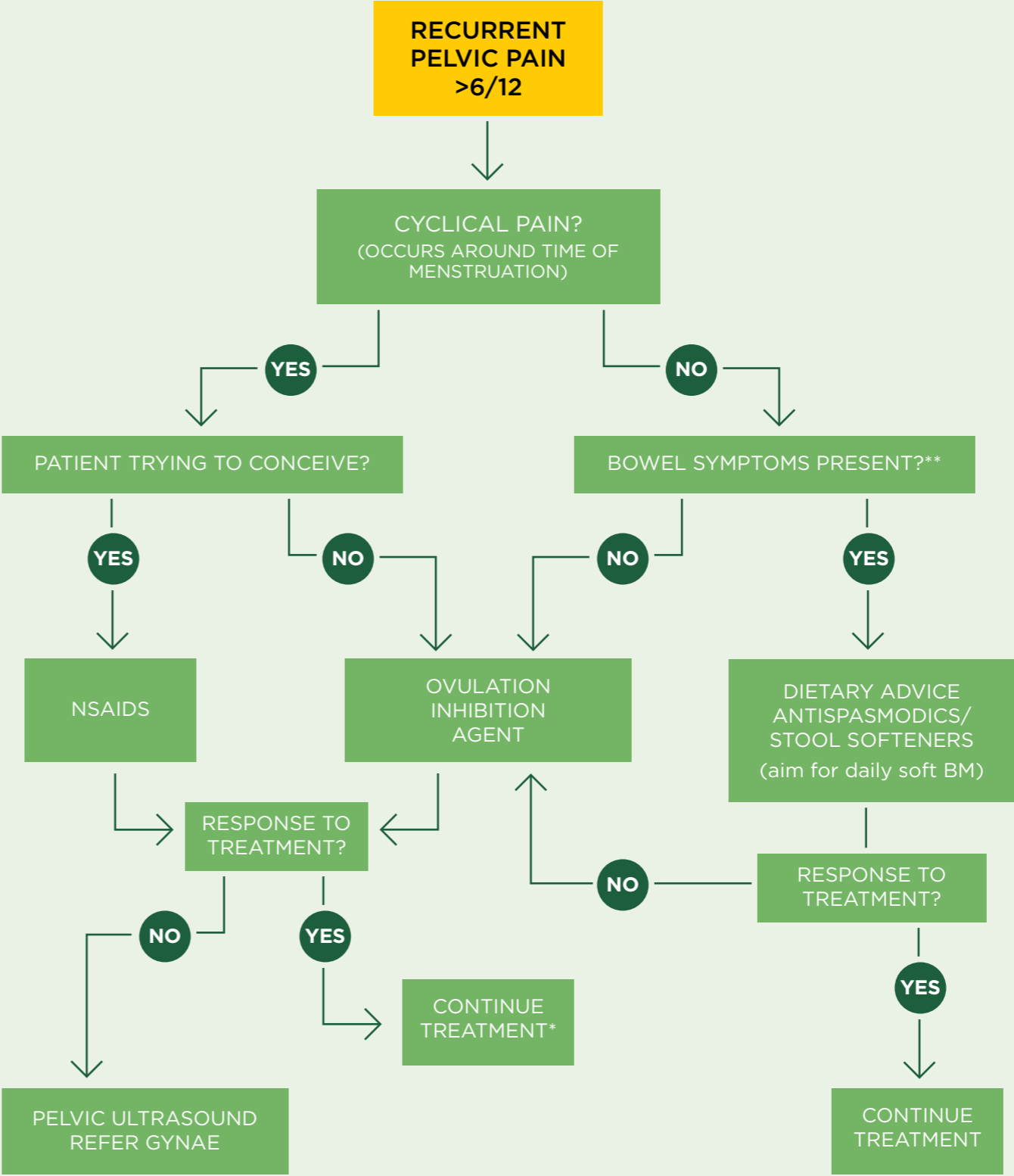
Chronic Pelvic Pain Pathway

* Inform patient that gynae condition such as endometriosis may be present but current treatment is appropriate.

Advise that there is a potential for difficulty in conceiving if endometriosis present; do not excessively delay trying for pregnancy if desired.

** Cyclical rectal bleeding and rectal pain should prompt gynae referral. Non-cyclical rectal bleeding and/or weight loss should prompt GI investigations.

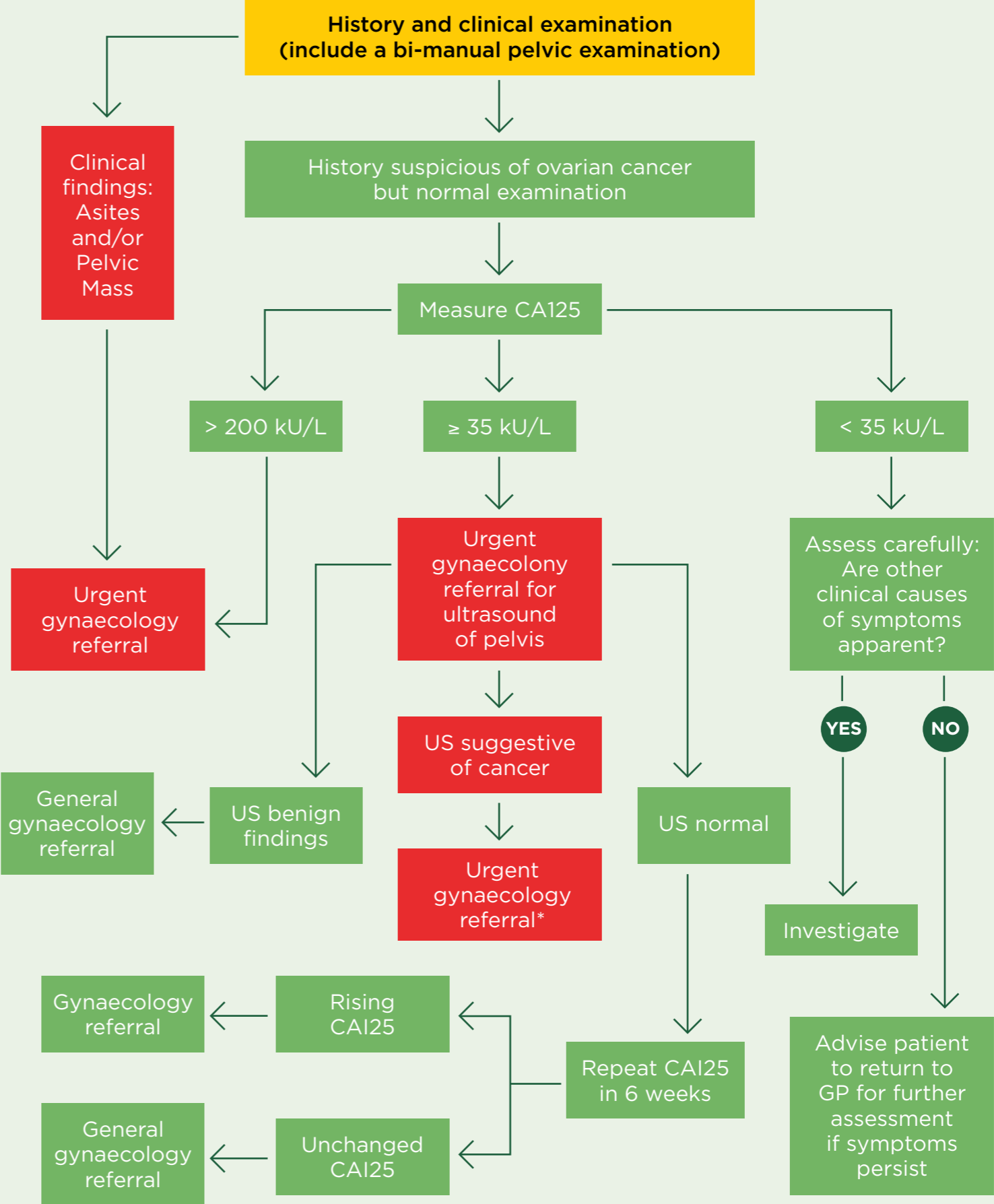
Constipation or IBS symptoms should be treated initially with dietary or medical treatment.



Postmenopausal Ovarian Cysts Care Pathway

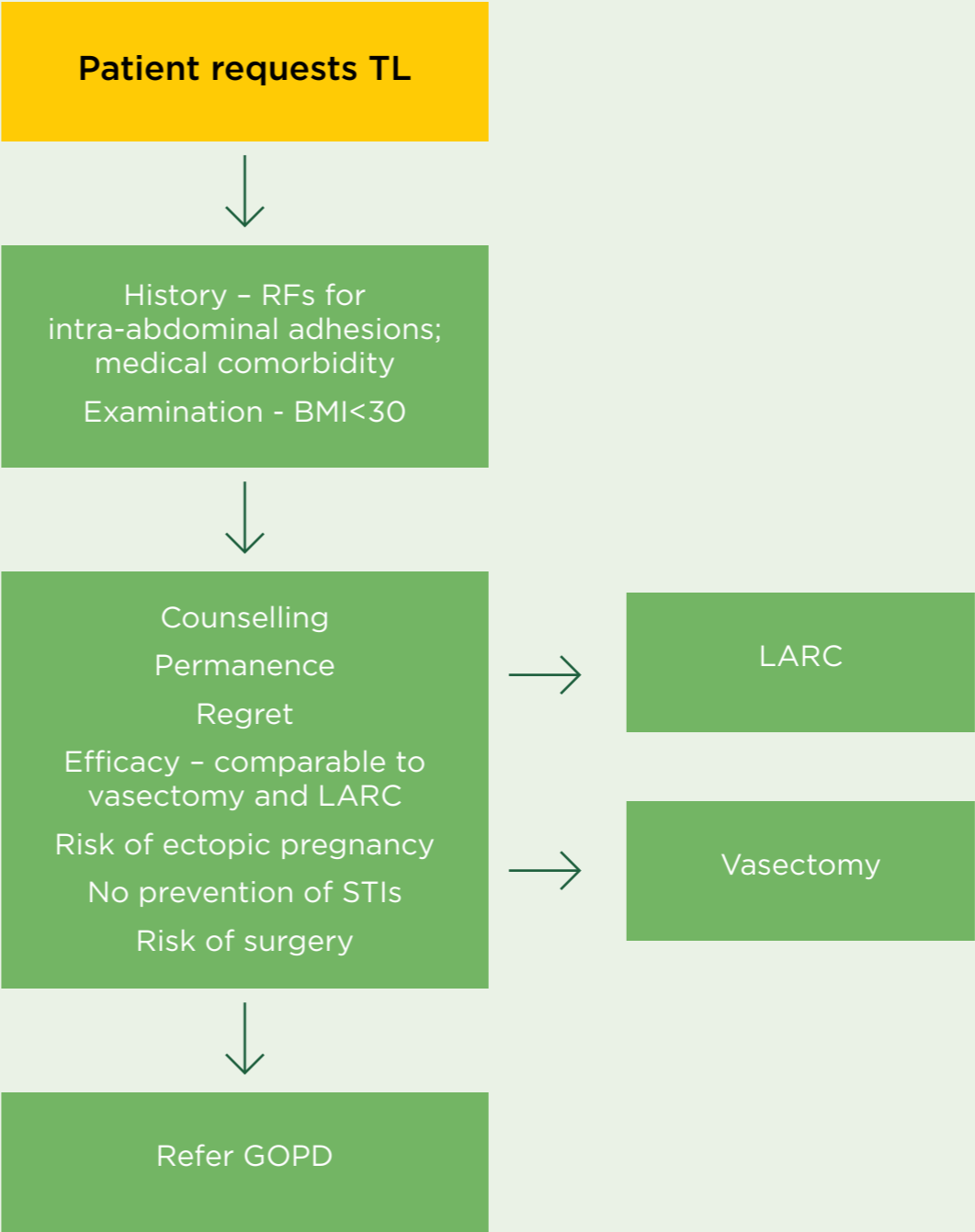
Risk factors:

1. Prolonged exposure to oestrogen (early menarche or late menopause)
2. Polycystic ovarian syndrome
3. Nulliparity
4. Genetic mutations BRCA1, BRCA2, Lynch Syndrome
5. Personal history of breast cancer
6. Family history of breast or ovarian cancer
7. Obesity
8. Smoking
9. Never having used COCP
10. Fertility treatment
11. HRT



*Note: In some hospitals radiology may trigger a referral to gynae-oncology, but this should not be assumed. In general, you (the GP), will be asked to inform the patient that she is being referred to this service.

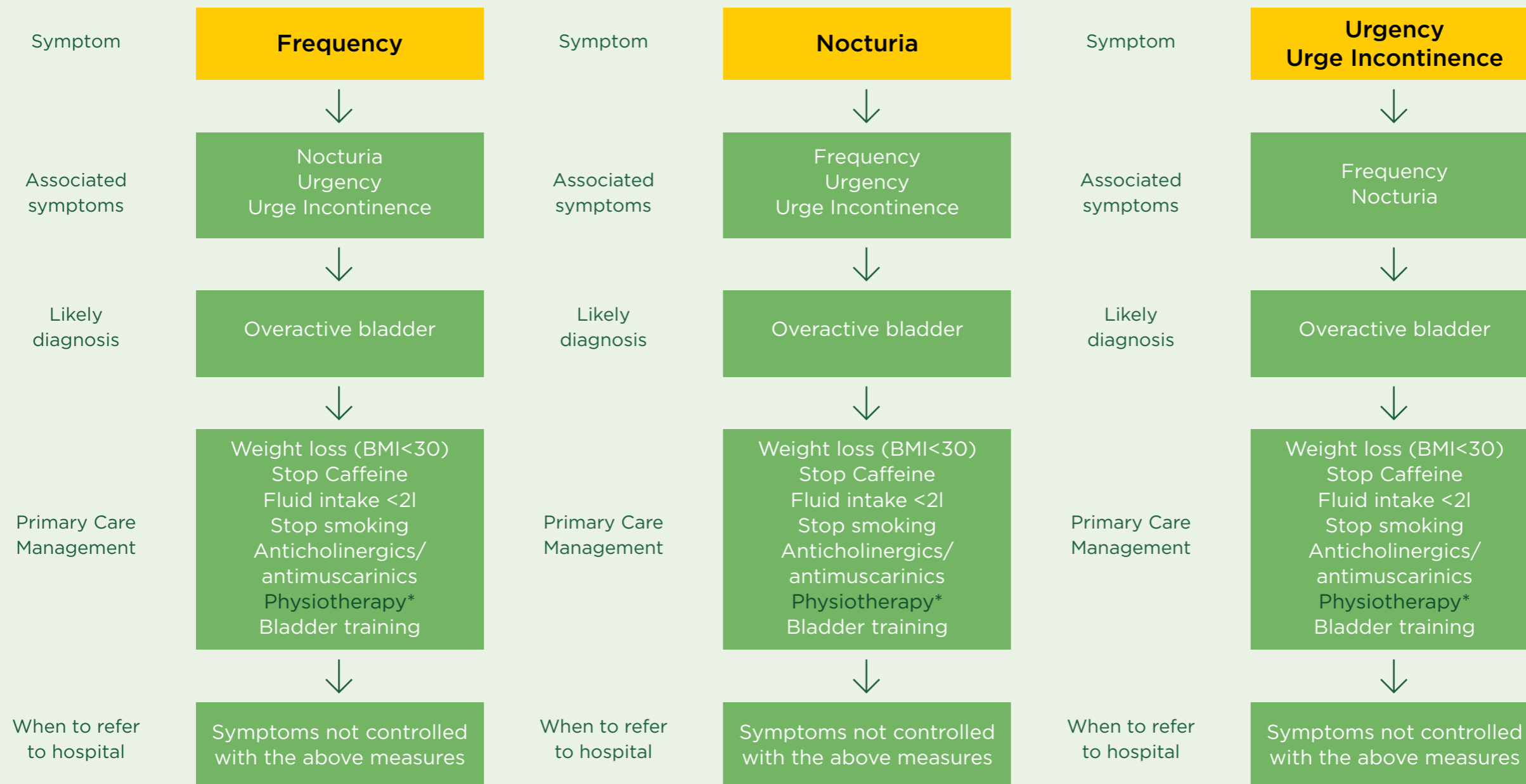
Tubal Ligation/Female Sterilisation Care Pathway



TL, tubal ligation; RF, risk factor; BMI, Body Mass Index;
LARC, long-acting reversible contraception;
STI, sexually transmitted infection

GP and Hospital Guide to Urogynaecology

This document is designed as a tool for both general practitioners and hospital doctors. It should be used to direct management of this group of patients, whereby ensuring that the level of care received is uniform across the care setting. It outlines in a step wise pattern the management plan and when advisable for patients to be referred into the hospital.



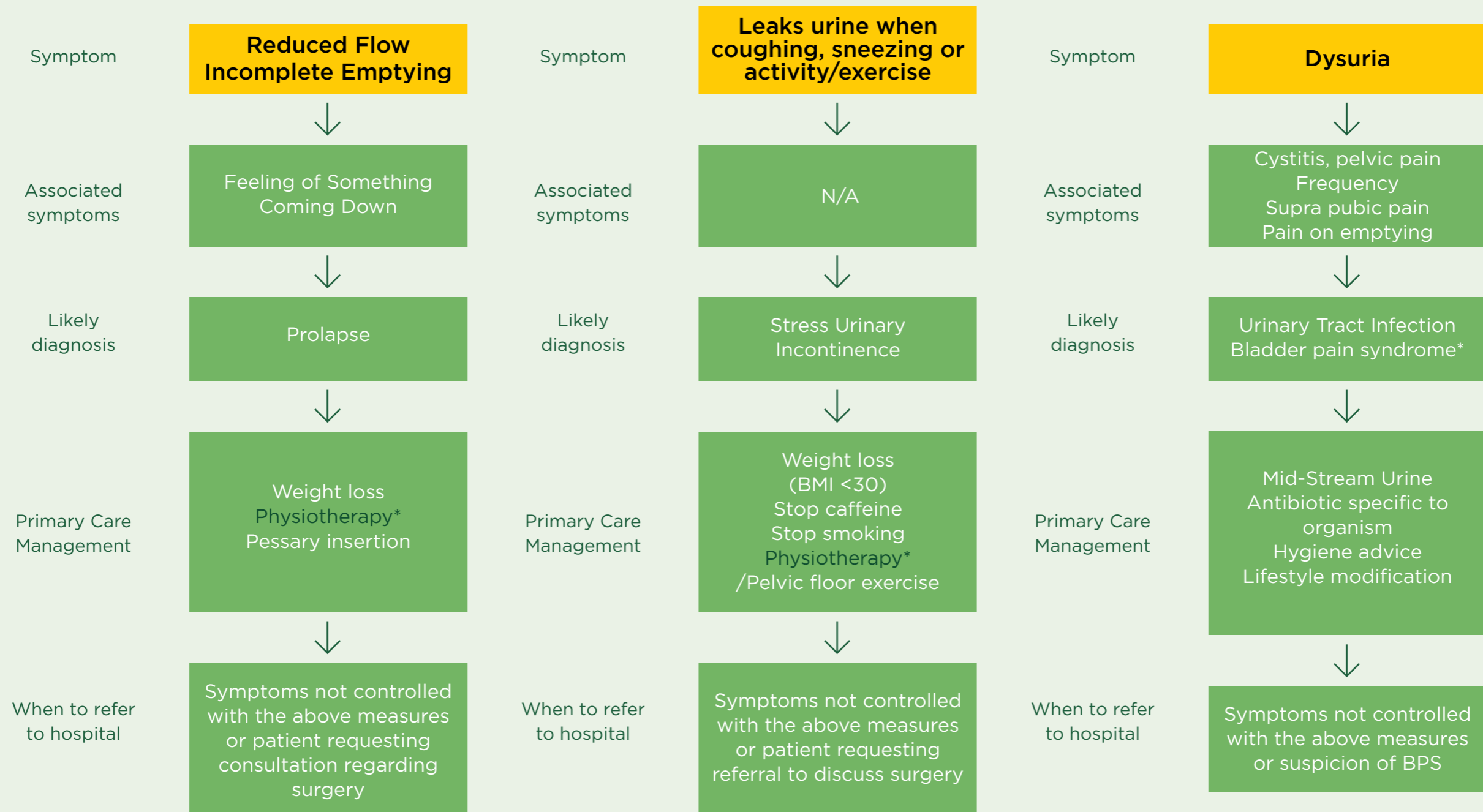
Hygiene advice includes the use of cotton underwear, full briefs, avoidance of thongs, wiping front to back, regular changing of sanitary wear/pads, use of barrier cream if necessary and avoidance of douching and fragranced lotions affecting the vaginal pH.

*Availability varies according to address.

Continued on following page

GP and Hospital Guide to Urogynaecology

*Bladder pain syndrome needs to be considered in patients with irretractable dysuria, cystitis and bladder pain. In saying this UTI is the most common cause for these symptoms. Any patient with symptoms relating to MESH either for incontinence or prolapse needs to be referred to the hospital. During the consultation a care plan will be drawn up which will usually consist of investigations initially which will form the basis for a more definitive management.



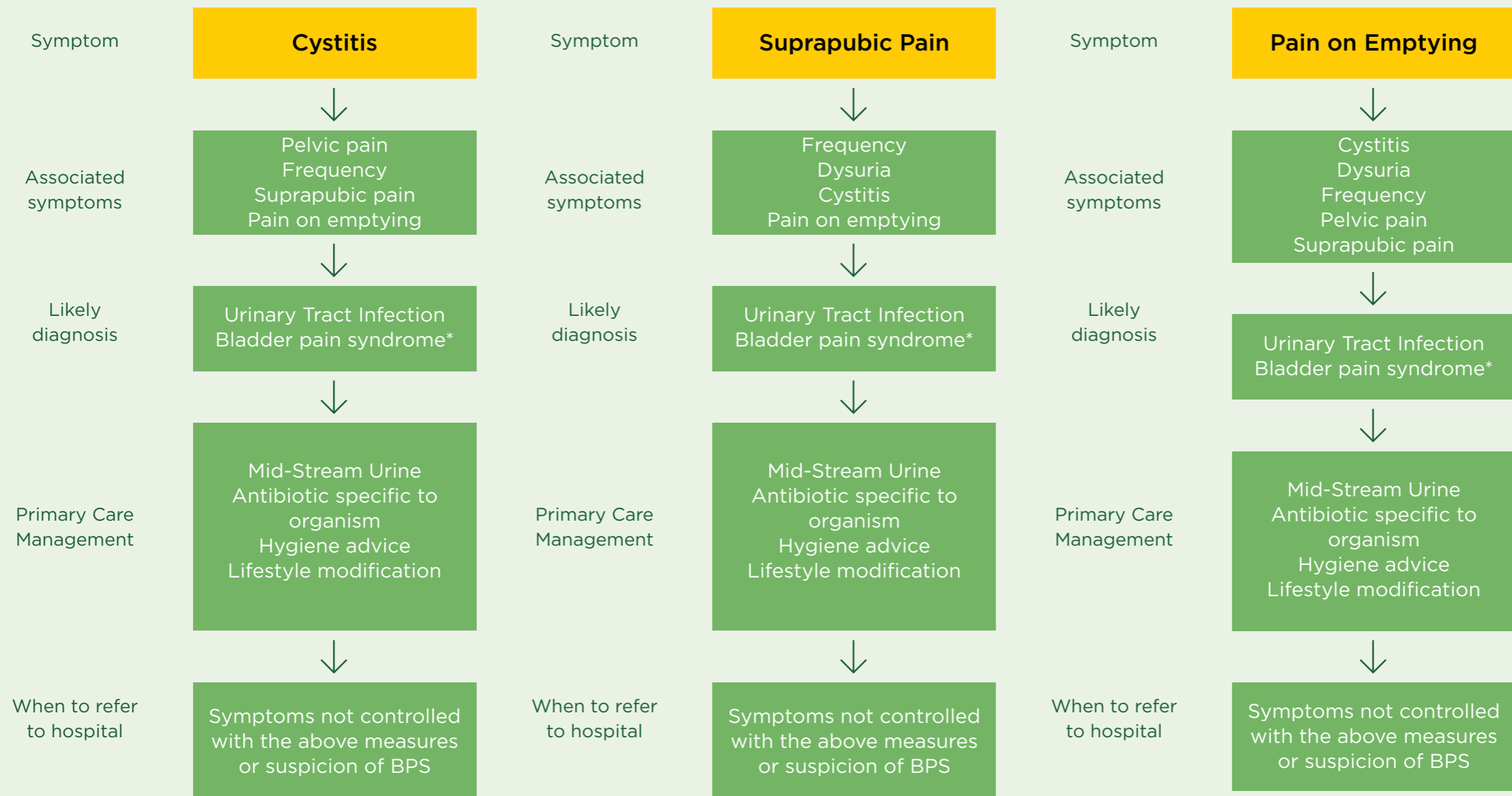
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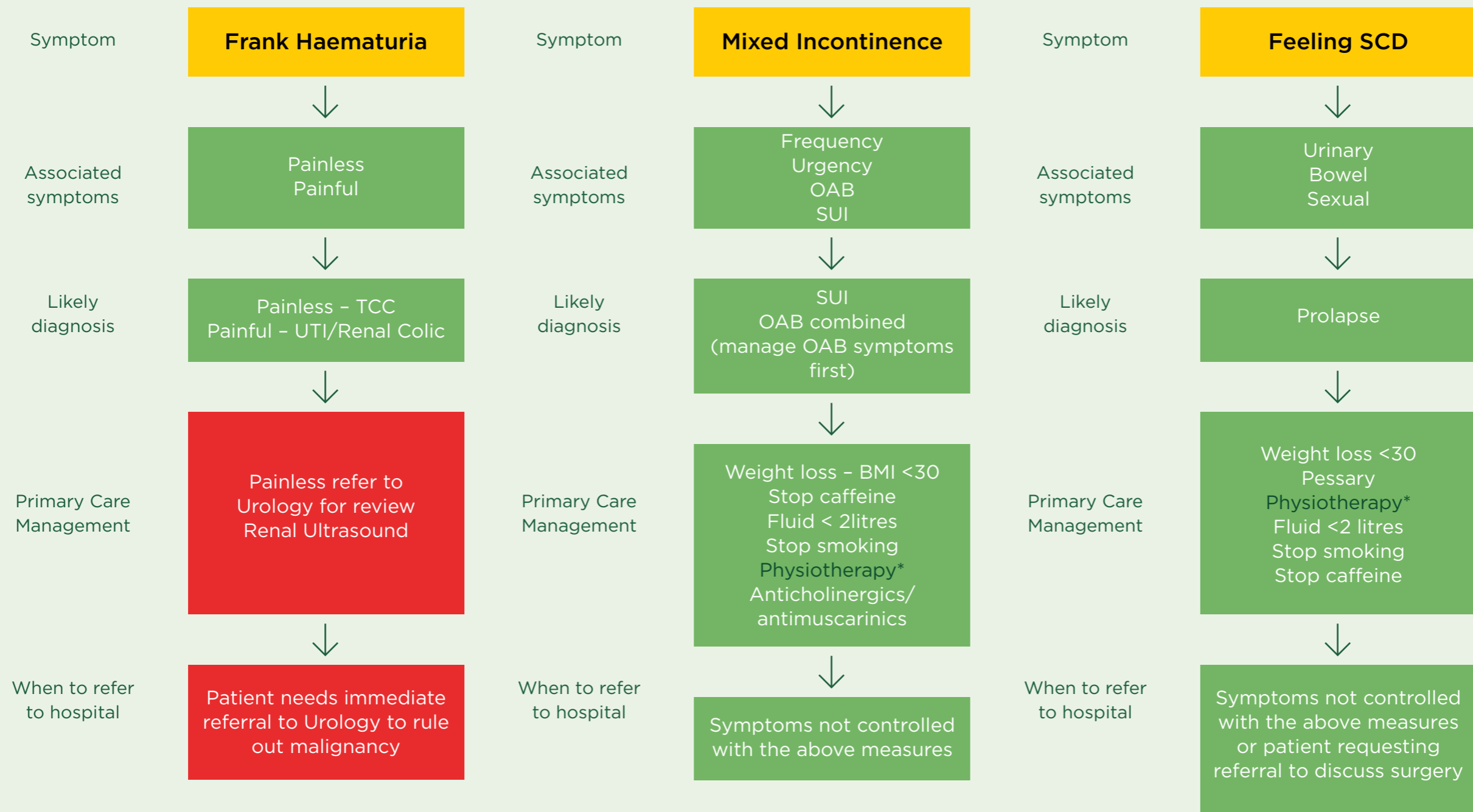


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Continued on following page

GP and Hospital Guide to Urogynaecology

TCC - transitional cell carcinoma
 UTI - urinary tract infection
 OAB - over active bladder
 SUI - stress urinary incontinence
 SCD - something coming down



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