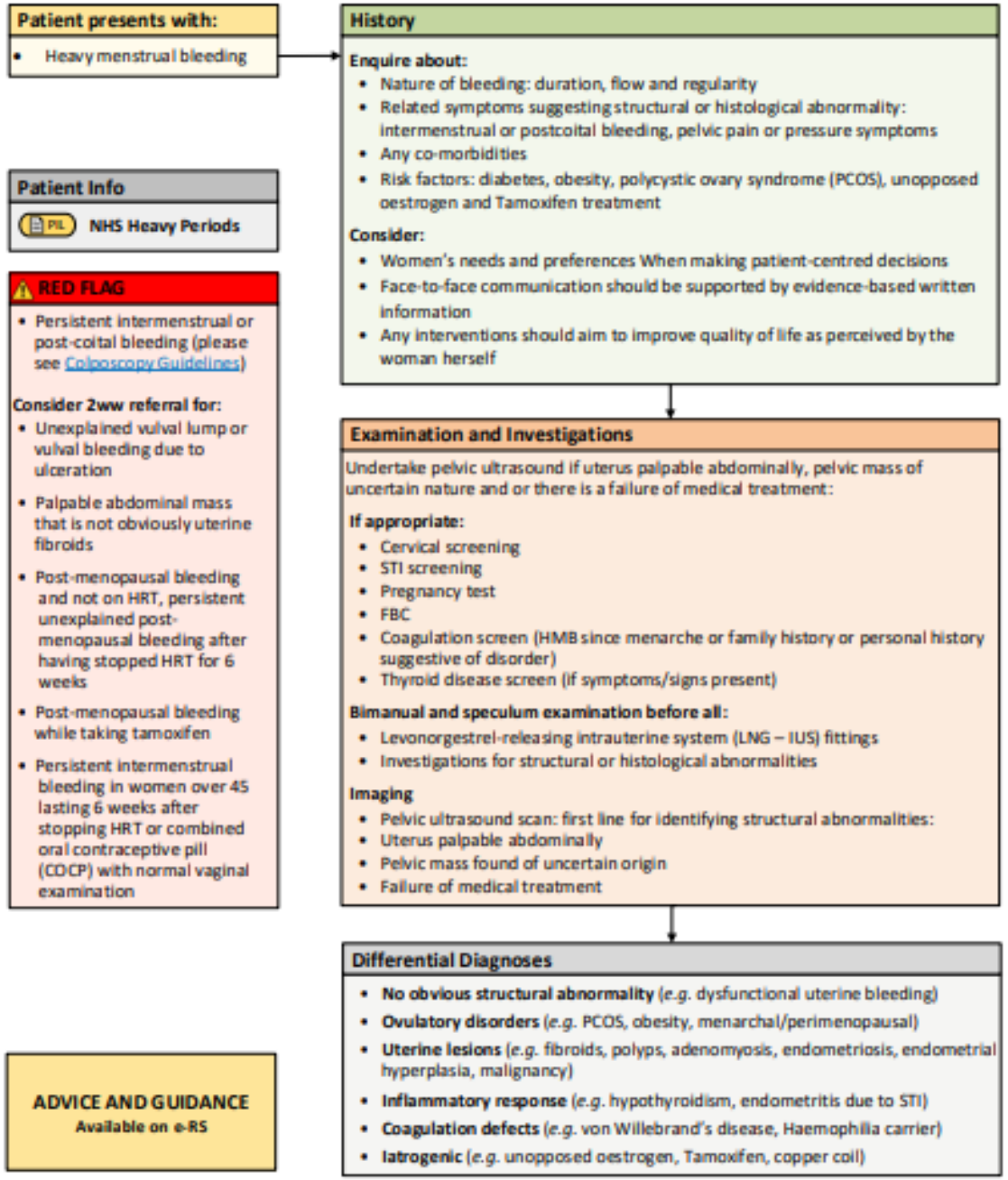
NHS
North East London
Clinical Commissioning Group

Overview of Gynaecology pathways developed with Homerton Hospital Gynaecology team

Meeting name: Gynaecology GP education session
Presenter: Anita Coutinho, GP Clinical Lead
Date: 19 November 2021

City and Hackney

Heavy Menstrual Bleeding



Heavy Menstrual Bleeding

Management

- Pharmaceutical treatment should be considered where no structural or histological abnormality is present and for fibroids < 3 cm which are not distorting the uterine cavity
- Tranexamic acid and/or NSAIDs or progestogens can be used whilst investigations and definitive treatment is awaited. For futher info, please click here

Medical management:

- If LNG-IUS (use Levosert® where possible) anticipate at least 12 months use; advise of changes in bleeding patterns and to persevere for at least 6 cycles
- COCP, tranexamic acid or NSAIDs (co-existing dysmenorrhoea)
- Norethisterone (15-30 mg) should be continued for 3 menstrual cycles and then stopped if no improvement or
- Medroxyprogesterone (30-60mg) daily from days 5 to 26 of menstrual cycle or
- Depo-Provera®/Nexplanon® can be used if patient has HMB and need for contraception

Considerations:

- Consider moving to a different pharmaceutical treatment if first ineffective
- Stop NSAIDs and/or tranexamic acid if no improvement within 3 menstrual cycles
- If PCOS/obese, advise weight loss

If unsure refer to:

ADVICE AND GUIDANCE
Available on e-RS

Specialist Referral

Refer to Community Gynaecology

- If unable to offer all medical options listed above in primary care
- Persistent heavy menstrual bleeding despite following above guidance
- Advice regarding fibroids or adenomyosis where patient does not require / desire surgery
- Complex menopause care
- Cervical polyp

Refer to Homerton Gynaecology (Refer via e-RS)

- For diagnostic hysteroscopy +/- surgical treatments
- Structural abnormalities: fibroids >3 cm, fibroid uterus palpable abdominally or cavity >12 cm, intracavity fibroids, endometrial polyps, cervical lesions, ovarian cysts etc.
- If medical treatment fails
- If risk factors for endometrial pathology – PCOS / obesity / >45 yrs / Inter-menstrual Bleeding (IMB) / irregular or prolonged bleeding

Surgical options

- Endometrial ablation
- Hysteroscopic removal of polyps / fibroids
- Laparoscopic / open myomectomy
- Laparoscopic / vaginal / open hysterectomy

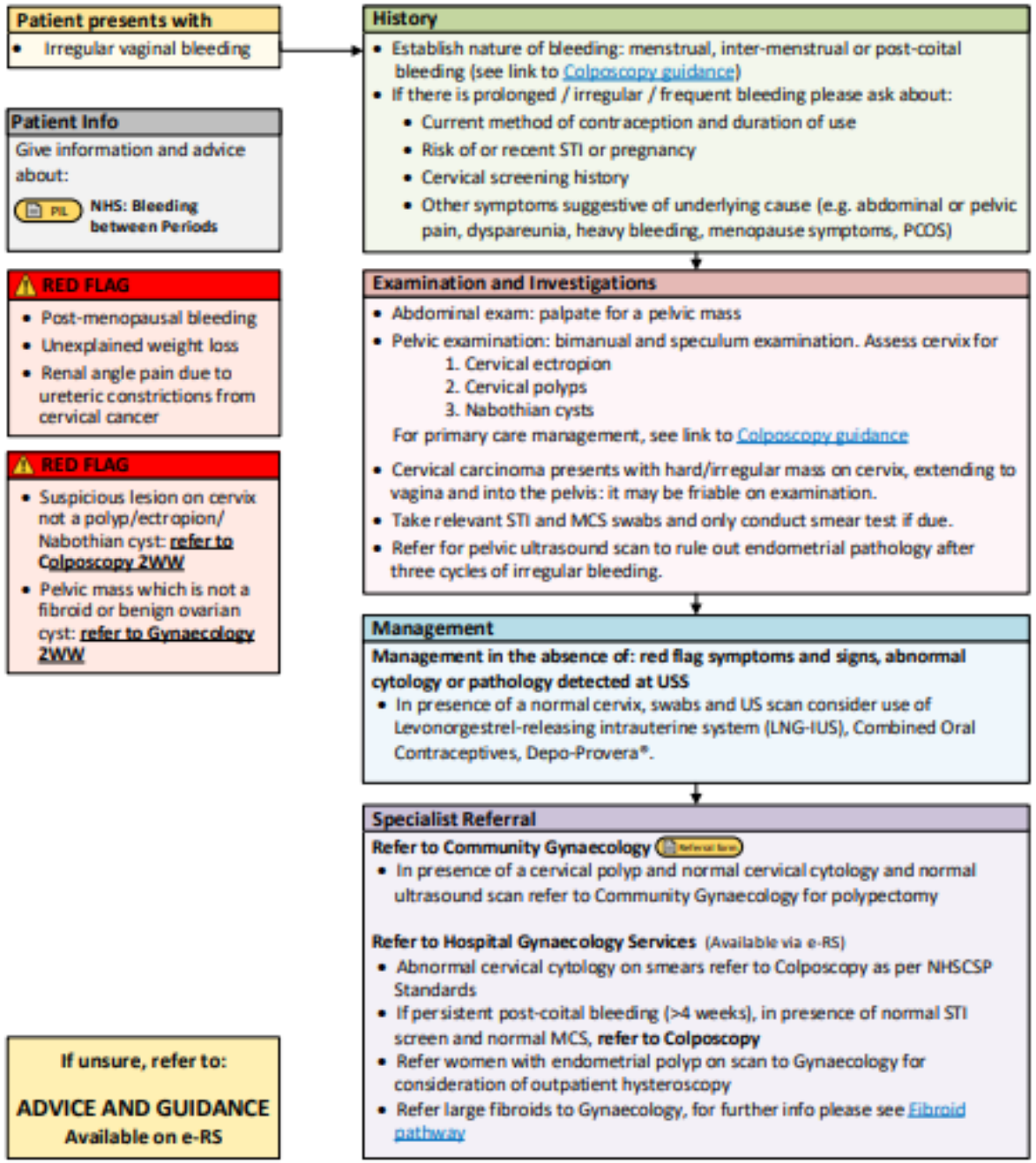
Refer to HAMU

- **If Hb <100g/L with symptoms,** Ferinject® will be considered so please refer with latest Ferritin/TIBC results if there. (Ferinject® should not be used during the first trimester of pregnancy)
- **If Hb <70g/L with symptoms** may need urgent treatment and transfusion: please discuss with Haematology team if not currently bleeding, or if currently bleeding excessively, refer to emergency Gynaecology Registrar (bleep 005) for review in ED.

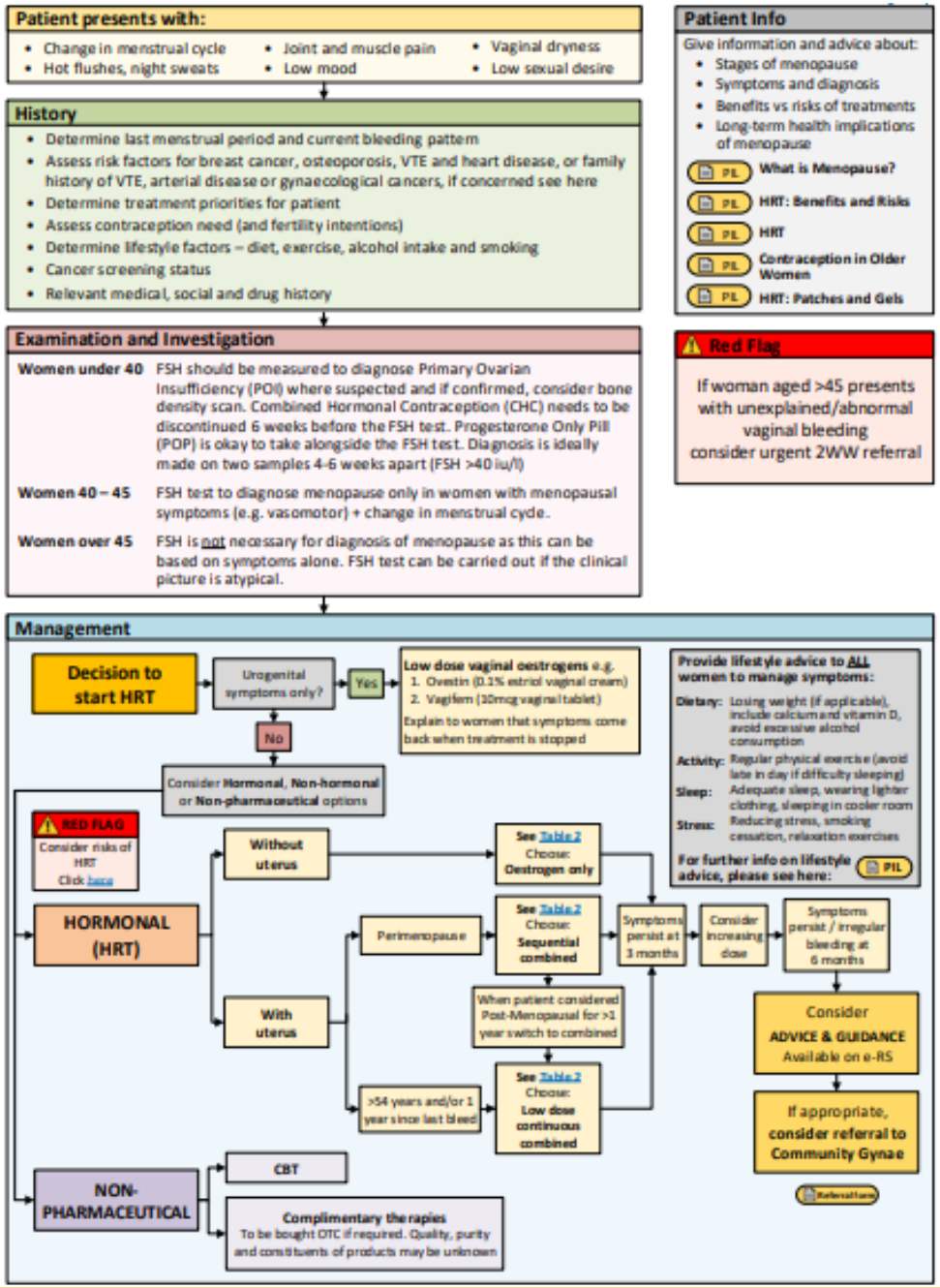
Other options for fibroids:

- Refer to Fibroids pathway

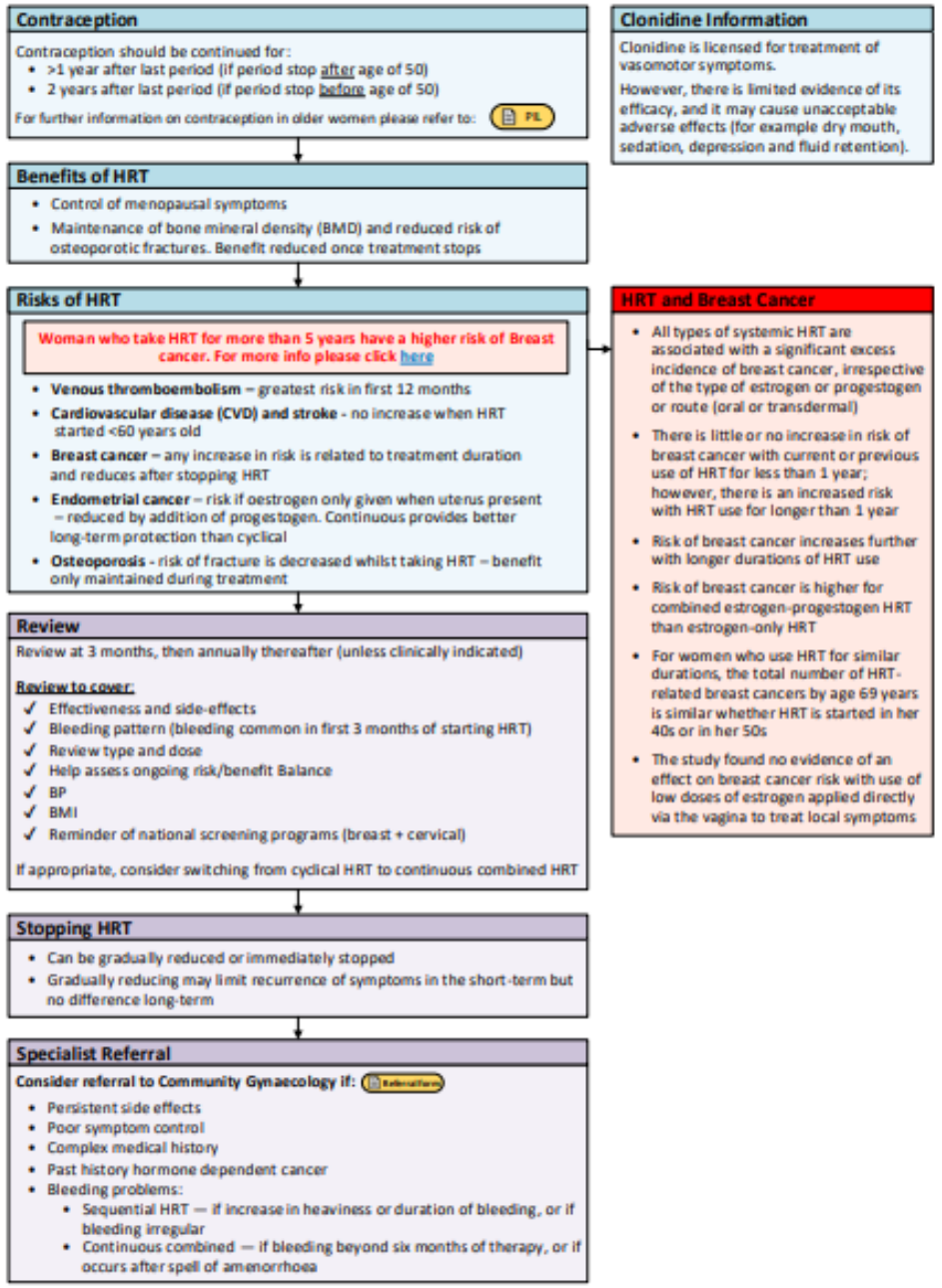
Irregular Vaginal Bleeding



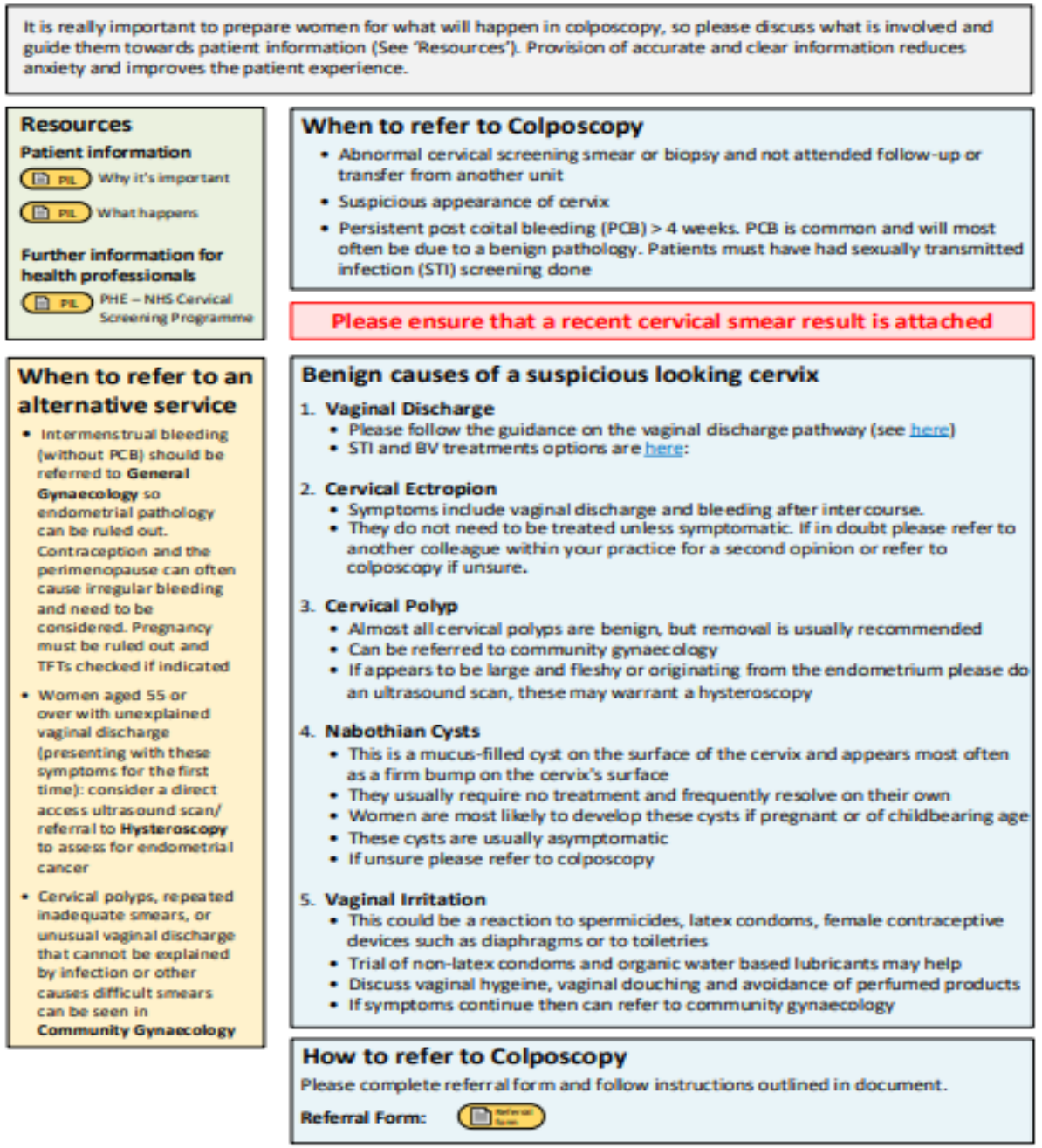
Menopause


Patient presents with:
Change in menstrual cycle
Hot flushes, night sweats
Joint and muscle pain
Low mood
Vaginal dryness
Low sexual desire
History
Determine last menstrual period and current bleeding pattern
Assess risk factors for breast cancer, osteoporosis, VTE and heart disease, or family history of VTE, arterial disease or gynaecological cancers, if concerned see here
Determine treatment priorities for patient
Assess contraception need (and fertility intentions)
Determine lifestyle factors – diet, exercise, alcohol intake and smoking
Cancer screening status
Relevant medical, social and drug history
Examination and Investigation
Women under 40
FSH should be measured to diagnose Primary Ovarian Insufficiency (POI) where suspected and if confirmed, consider bone density scan. Combined Hormonal Contraception (CHC) needs to be discontinued 6 weeks before the FSH test. Progesterone Only Pill (POP) is okay to take alongside the FSH test. Diagnosis is ideally made on two samples 4-6 weeks apart (FSH >40 iu/l)
Women 40 – 45
FSH test to diagnose menopause only in women with menopausal symptoms (e.g. vasomotor) + change in menstrual cycle.
Women over 45
FSH is not necessary for diagnosis of menopause as this can be based on symptoms alone. FSH test can be carried out if the clinical picture is atypical.
Patient Info
Give information and advice about:
Stages of menopause
Symptoms and diagnosis
Benefits vs risks of treatments
Long-term health implications of menopause
PIL What is Menopause?
PIL HRT: Benefits and Risks
PIL HRT
PIL Contraception in Older Women
PIL HRT: Patches and Gels
Red Flag
If woman aged >45 presents with unexplained/abnormal vaginal bleeding consider urgent 2WW referral
Management
Decision to start HRT
Urogenital symptoms only?
Yes
Low dose vaginal oestrogens e.g.
1. Ovestin (0.1% estriol vaginal cream)
2. Vagifem (10mcg vaginal tablet)
Explain to women that symptoms come back when treatment is stopped
No
Consider Hormonal, Non-hormonal or Non-pharmaceutical options
RED FLAG
Consider risks of HRT
Click here
HORMONAL (HRT)
Without uterus
See Table 2
Choose:
Oestrogen only
With uterus
Perimenopause
See Table 2
Choose:
Sequential combined
When patient considered Post-Menopausal for >1 year switch to combined
>54 years and/or 1 year since last bleed
See Table 2
Choose:
Low dose continuous combined
Symptoms persist at 3 months
Consider increasing dose
Symptoms persist / irregular bleeding at 6 months
Consider
ADVICE & GUIDANCE
Available on e-RS
If appropriate, consider referral to Community Gynae
NON-PHARMACEUTICAL
CBT
Complimentary therapies
To be bought OTC if required. Quality, purity and constituents of products may be unknown
Provide lifestyle advice to ALL women to manage symptoms:
Dietary: Losing weight (if applicable), include calcium and vitamin D, avoid excessive alcohol consumption
Activity: Regular physical exercise (avoid late in day if difficulty sleeping)
Sleep: Adequate sleep, wearing lighter clothing, sleeping in cooler room
Stress: Reducing stress, smoking cessation, relaxation exercises
For further info on lifestyle advice, please see here: PIL

Menopause


Contraception
Contraception should be continued for:
• >1 year after last period (if period stop after age of 50)
• 2 years after last period (if period stop before age of 50)
For further information on contraception in older women please refer to: PIL
Benefits of HRT
• Control of menopausal symptoms
• Maintenance of bone mineral density (BMD) and reduced risk of osteoporotic fractures. Benefit reduced once treatment stops
Risks of HRT
Woman who take HRT for more than 5 years have a higher risk of Breast cancer. For more info please click here
• Venous thromboembolism – greatest risk in first 12 months
• Cardiovascular disease (CVD) and stroke - no increase when HRT started <60 years old
• Breast cancer – any increase in risk is related to treatment duration and reduces after stopping HRT
• Endometrial cancer – risk if oestrogen only given when uterus present – reduced by addition of progestogen. Continuous provides better long-term protection than cyclical
• Osteoporosis - risk of fracture is decreased whilst taking HRT – benefit only maintained during treatment
Review
Review at 3 months, then annually thereafter (unless clinically indicated)
Review to cover:
✓ Effectiveness and side-effects
✓ Bleeding pattern (bleeding common in first 3 months of starting HRT)
✓ Review type and dose
✓ Help assess ongoing risk/benefit Balance
✓ BP
✓ BMI
✓ Reminder of national screening programs (breast + cervical)
If appropriate, consider switching from cyclical HRT to continuous combined HRT
Stopping HRT
• Can be gradually reduced or immediately stopped
• Gradually reducing may limit recurrence of symptoms in the short-term but no difference long-term
Specialist Referral
Consider referral to Community Gynaecology if:
• Persistent side effects
• Poor symptom control
• Complex medical history
• Past history hormone dependent cancer
• Bleeding problems:
• Sequential HRT — if increase in heaviness or duration of bleeding, or if bleeding irregular
• Continuous combined — if bleeding beyond six months of therapy, or if occurs after spell of amenorrhoea
Clonidine Information
Clonidine is licensed for treatment of vasomotor symptoms.
However, there is limited evidence of its efficacy, and it may cause unacceptable adverse effects (for example dry mouth, sedation, depression and fluid retention).
HRT and Breast Cancer
• All types of systemic HRT are associated with a significant excess incidence of breast cancer, irrespective of the type of estrogen or progestogen or route (oral or transdermal)
• There is little or no increase in risk of breast cancer with current or previous use of HRT for less than 1 year; however, there is an increased risk with HRT use for longer than 1 year
• Risk of breast cancer increases further with longer durations of HRT use
• Risk of breast cancer is higher for combined estrogen-progestogen HRT than estrogen-only HRT
• For women who use HRT for similar durations, the total number of HRT-related breast cancers by age 69 years is similar whether HRT is started in her 40s or in her 50s
• The study found no evidence of an effect on breast cancer risk with use of low doses of estrogen applied directly via the vagina to treat local symptoms

Colposcopy Guidelines



It is really important to prepare women for what will happen in colposcopy, so please discuss what is involved and guide them towards patient information (See 'Resources'). Provision of accurate and clear information reduces anxiety and improves the patient experience.

Resources

Patient information

PIL Why it's important

PIL What happens

Further information for health professionals

PIL PHE – NHS Cervical Screening Programme

When to refer to Colposcopy

- Abnormal cervical screening smear or biopsy and not attended follow-up or transfer from another unit
- Suspicious appearance of cervix
- Persistent post coital bleeding (PCB) > 4 weeks. PCB is common and will most often be due to a benign pathology. Patients must have had sexually transmitted infection (STI) screening done

Please ensure that a recent cervical smear result is attached

When to refer to an alternative service

- Intermenstrual bleeding (without PCB) should be referred to **General Gynaecology** so endometrial pathology can be ruled out. Contraception and the perimenopause can often cause irregular bleeding and need to be considered. Pregnancy must be ruled out and TFTs checked if indicated
- Women aged 55 or over with unexplained vaginal discharge (presenting with these symptoms for the first time): consider a direct access ultrasound scan/ referral to **Hysteroscopy** to assess for endometrial cancer
- Cervical polyps, repeated inadequate smears, or unusual vaginal discharge that cannot be explained by infection or other causes difficult smears can be seen in **Community Gynaecology**

Benign causes of a suspicious looking cervix

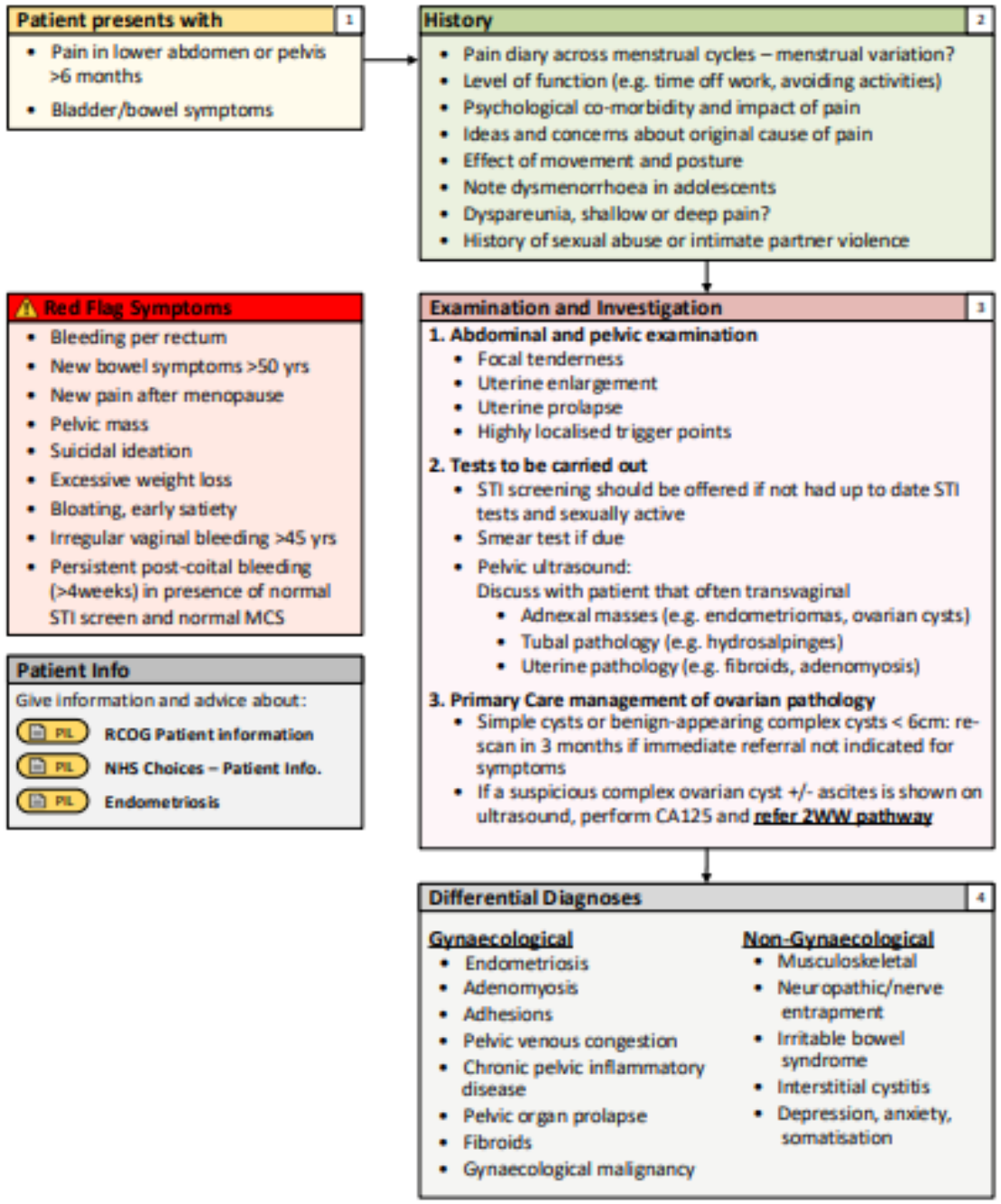
1. **Vaginal Discharge**
   - Please follow the guidance on the vaginal discharge pathway (see here)
   - STI and BV treatments options are here:
2. **Cervical Ectropion**
   - Symptoms include vaginal discharge and bleeding after intercourse.
   - They do not need to be treated unless symptomatic. If in doubt please refer to another colleague within your practice for a second opinion or refer to colposcopy if unsure.
3. **Cervical Polyp**
   - Almost all cervical polyps are benign, but removal is usually recommended
   - Can be referred to community gynaecology
   - If appears to be large and fleshy or originating from the endometrium please do an ultrasound scan, these may warrant a hysteroscopy
4. **Nabothian Cysts**
   - This is a mucus-filled cyst on the surface of the cervix and appears most often as a firm bump on the cervix's surface
   - They usually require no treatment and frequently resolve on their own
   - Women are most likely to develop these cysts if pregnant or of childbearing age
   - These cysts are usually asymptomatic
   - If unsure please refer to colposcopy
5. **Vaginal Irritation**
   - This could be a reaction to spermicides, latex condoms, female contraceptive devices such as diaphragms or to toiletries
   - Trial of non-latex condoms and organic water based lubricants may help
   - Discuss vaginal hygeine, vaginal douching and avoidance of perfumed products
   - If symptoms continue then can refer to community gynaecology

How to refer to Colposcopy

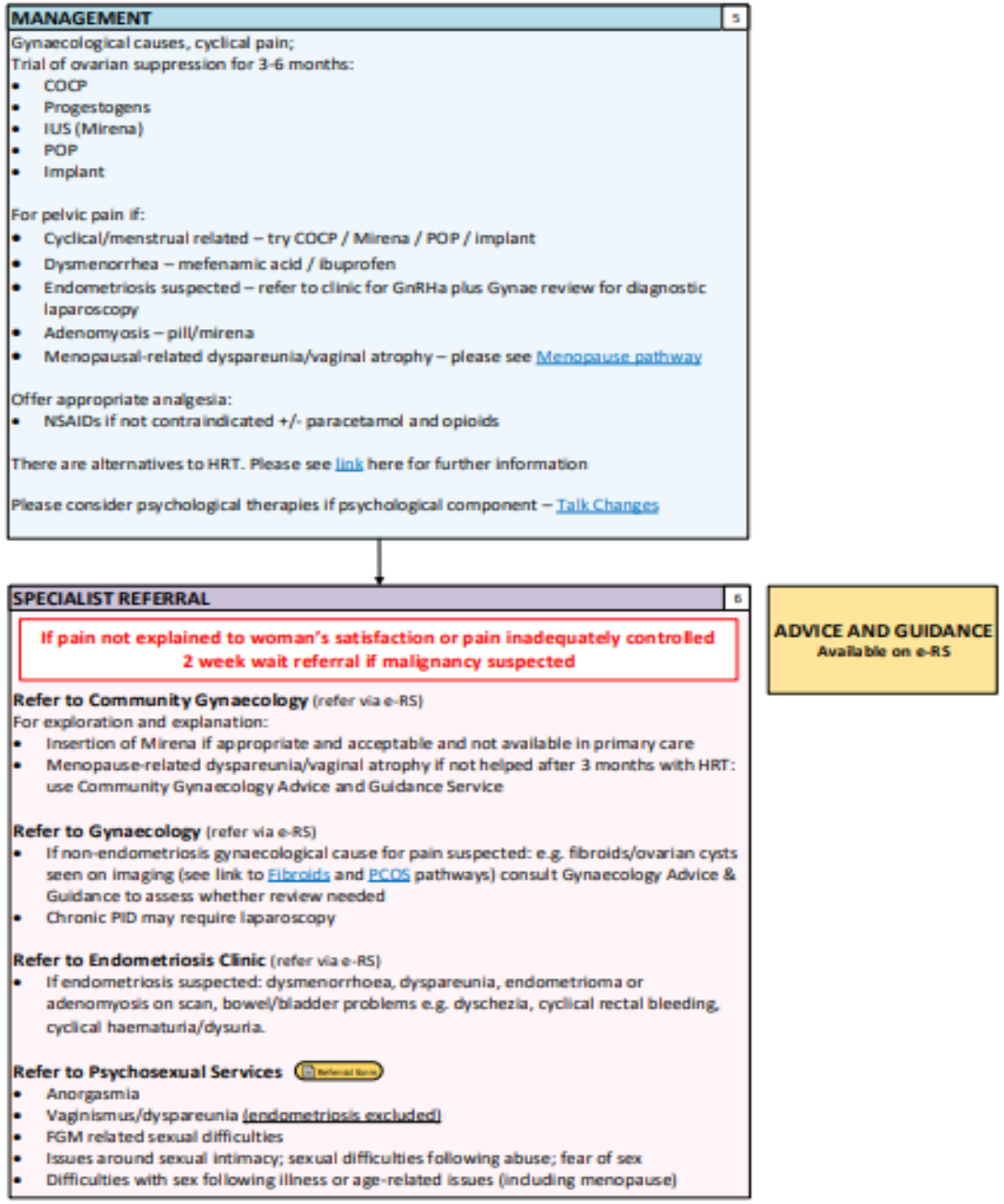
Please complete referral form and follow instructions outlined in document.

Referral Form:

Chronic Pelvic Pain



Chronic Pelvic Pain



MANAGEMENT 5

Gynaecological causes, cyclical pain;
Trial of ovarian suppression for 3-6 months:

- COCP
- Progestogens
- IUS (Mirena)
- POP
- Implant

For pelvic pain if:

- Cyclical/menstrual related – try COCP / Mirena / POP / implant
- Dysmenorrhea – mefenamic acid / ibuprofen
- Endometriosis suspected – refer to clinic for GnRHa plus Gynae review for diagnostic laparoscopy
- Adenomyosis – pill/mirena
- Menopausal-related dyspareunia/vaginal atrophy – please see Menopause pathway

Offer appropriate analgesia:

- NSAIDs if not contraindicated +/- paracetamol and opioids

There are alternatives to HRT. Please see link here for further information

Please consider psychological therapies if psychological component – Talk Changes

SPECIALIST REFERRAL 6

If pain not explained to woman's satisfaction or pain inadequately controlled
2 week wait referral if malignancy suspected

Refer to Community Gynaecology (refer via e-RS)
For exploration and explanation:

- Insertion of Mirena if appropriate and acceptable and not available in primary care
- Menopause-related dyspareunia/vaginal atrophy if not helped after 3 months with HRT: use Community Gynaecology Advice and Guidance Service

Refer to Gynaecology (refer via e-RS)

- If non-endometriosis gynaecological cause for pain suspected: e.g. fibroids/ovarian cysts seen on imaging (see link to Fibroids and PCOS pathways) consult Gynaecology Advice & Guidance to assess whether review needed
- Chronic PID may require laparoscopy

Refer to Endometriosis Clinic (refer via e-RS)

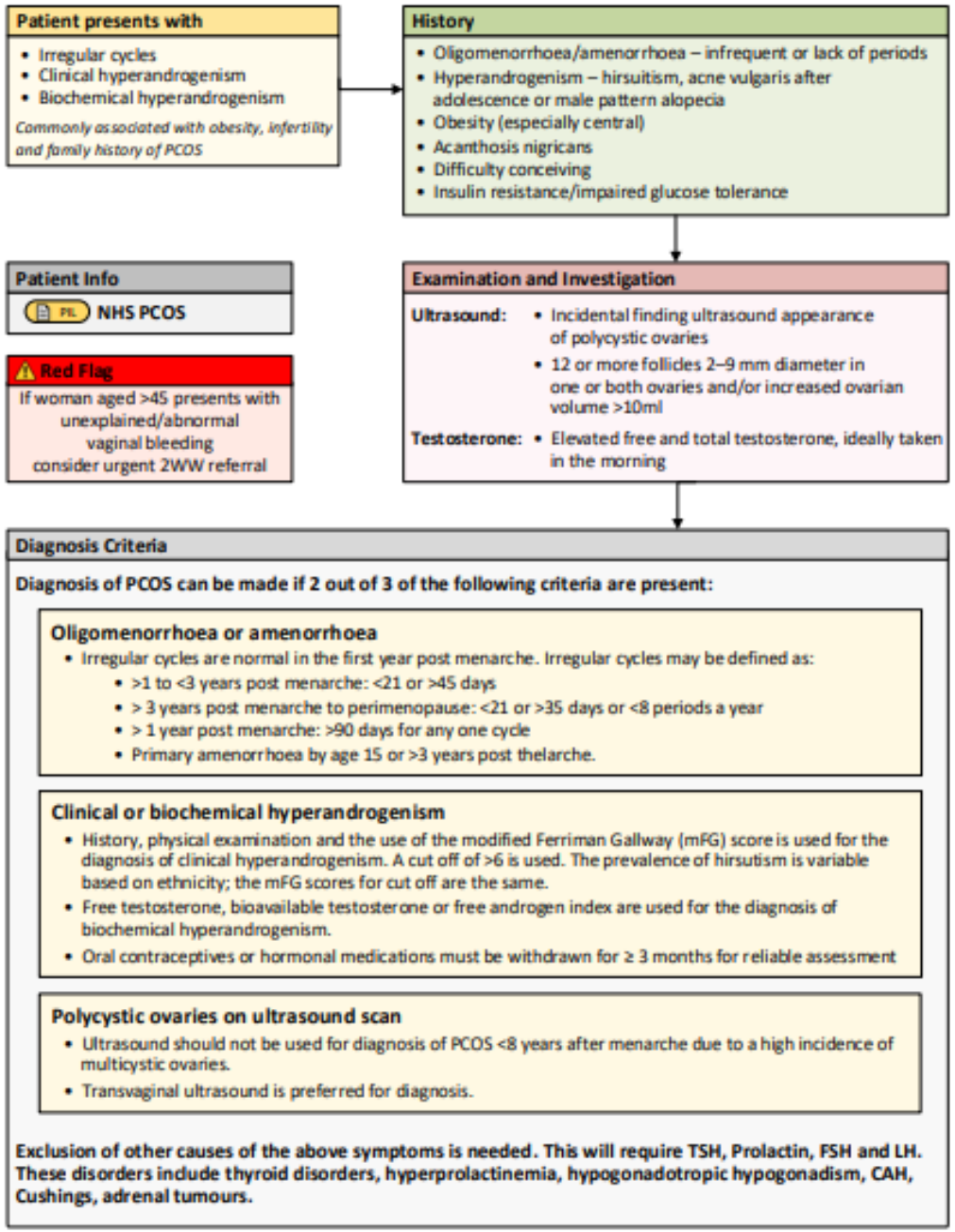
- If endometriosis suspected: dysmenorrhoea, dyspareunia, endometrioma or adenomyosis on scan, bowel/bladder problems e.g. dyschezia, cyclical rectal bleeding, cyclical haematuria/dysuria.

Refer to Psychosexual Services

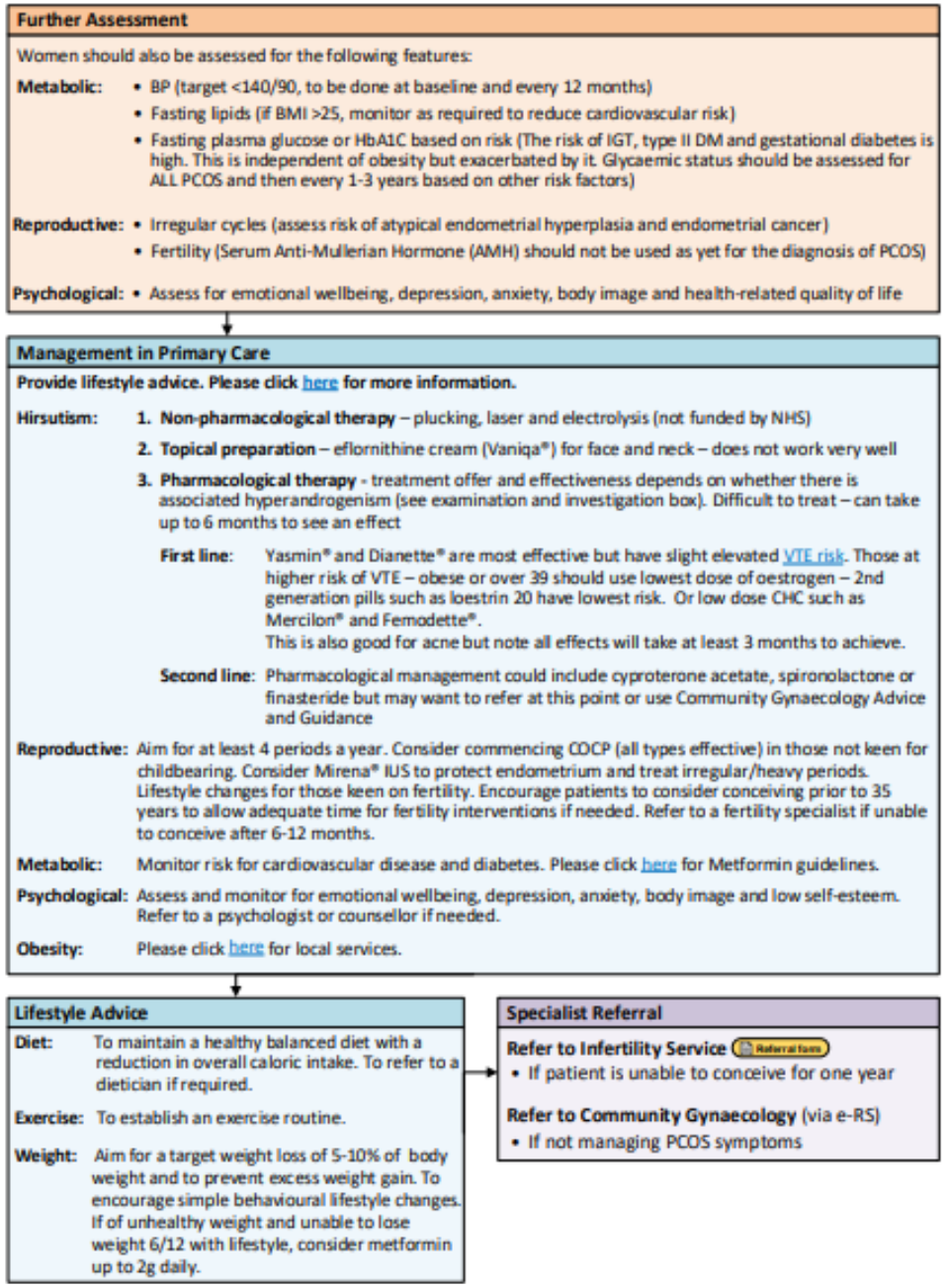
- Anorgasmia
- Vaginismus/dyspareunia (endometriosis excluded)
- FGM related sexual difficulties
- Issues around sexual intimacy; sexual difficulties following abuse; fear of sex
- Difficulties with sex following illness or age-related issues (including menopause)

ADVICE AND GUIDANCE
Available on e-RS

Polycystic Ovary Syndrome



Polycystic Ovary Syndrome



Further Assessment

Women should also be assessed for the following features:

Metabolic:
- BP (target <140/90, to be done at baseline and every 12 months)
- Fasting lipids (if BMI >25, monitor as required to reduce cardiovascular risk)
- Fasting plasma glucose or HbA1C based on risk (The risk of IGT, type II DM and gestational diabetes is high. This is independent of obesity but exacerbated by it. Glycaemic status should be assessed for ALL PCOS and then every 1-3 years based on other risk factors)

Reproductive:
- Irregular cycles (assess risk of atypical endometrial hyperplasia and endometrial cancer)
- Fertility (Serum Anti-Mullerian Hormone (AMH) should not be used as yet for the diagnosis of PCOS)

Psychological:
- Assess for emotional wellbeing, depression, anxiety, body image and health-related quality of life

Management in Primary Care

Provide lifestyle advice. Please click here for more information.

Hirsutism:
1. **Non-pharmacological therapy** – plucking, laser and electrolysis (not funded by NHS)
2. **Topical preparation** – eflornithine cream (Vaniqa®) for face and neck – does not work very well
3. **Pharmacological therapy** - treatment offer and effectiveness depends on whether there is associated hyperandrogenism (see examination and investigation box). Difficult to treat – can take up to 6 months to see an effect

   First line: Yasmin® and Dianette® are most effective but have slight elevated VTE risk. Those at higher risk of VTE – obese or over 39 should use lowest dose of oestrogen – 2nd generation pills such as loestrin 20 have lowest risk. Or low dose CHC such as Mercilon® and Femodette®.
   This is also good for acne but note all effects will take at least 3 months to achieve.

   Second line: Pharmacological management could include cyproterone acetate, spironolactone or finasteride but may want to refer at this point or use Community Gynaecology Advice and Guidance

Reproductive: Aim for at least 4 periods a year. Consider commencing COCP (all types effective) in those not keen for childbearing. Consider Mirena® IUS to protect endometrium and treat irregular/heavy periods. Lifestyle changes for those keen on fertility. Encourage patients to consider conceiving prior to 35 years to allow adequate time for fertility interventions if needed. Refer to a fertility specialist if unable to conceive after 6-12 months.

Metabolic: Monitor risk for cardiovascular disease and diabetes. Please click here for Metformin guidelines.

Psychological: Assess and monitor for emotional wellbeing, depression, anxiety, body image and low self-esteem. Refer to a psychologist or counsellor if needed.

Obesity: Please click here for local services.

Lifestyle Advice

Diet: To maintain a healthy balanced diet with a reduction in overall caloric intake. To refer to a dietician if required.

Exercise: To establish an exercise routine.

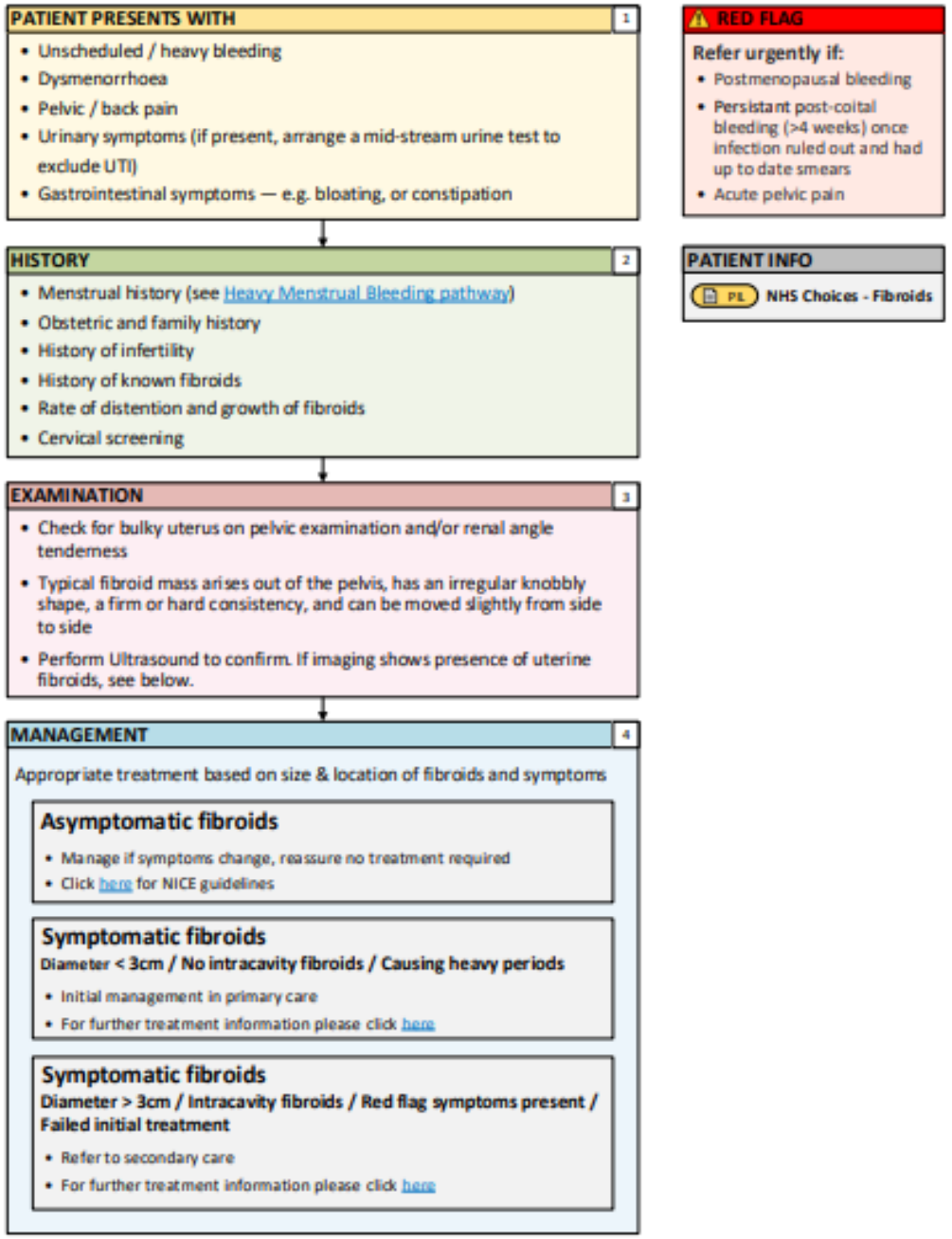
Weight: Aim for a target weight loss of 5-10% of body weight and to prevent excess weight gain. To encourage simple behavioural lifestyle changes. If of unhealthy weight and unable to lose weight 6/12 with lifestyle, consider metformin up to 2g daily.

Specialist Referral

Refer to Infertility Service (Referral form)
- If patient is unable to conceive for one year

Refer to Community Gynaecology (via e-RS)
- If not managing PCOS symptoms

Fibroids


PATIENT PRESENTS WITH
1
• Unscheduled / heavy bleeding
• Dysmenorrhoea
• Pelvic / back pain
• Urinary symptoms (if present, arrange a mid-stream urine test to exclude UTI)
• Gastrointestinal symptoms — e.g. bloating, or constipation
HISTORY
2
• Menstrual history (see Heavy Menstrual Bleeding pathway)
• Obstetric and family history
• History of infertility
• History of known fibroids
• Rate of distention and growth of fibroids
• Cervical screening
EXAMINATION
3
• Check for bulky uterus on pelvic examination and/or renal angle tenderness
• Typical fibroid mass arises out of the pelvis, has an irregular knobbly shape, a firm or hard consistency, and can be moved slightly from side to side
• Perform Ultrasound to confirm. If imaging shows presence of uterine fibroids, see below.
MANAGEMENT
4
Appropriate treatment based on size & location of fibroids and symptoms
Asymptomatic fibroids
• Manage if symptoms change, reassure no treatment required
• Click here for NICE guidelines
Symptomatic fibroids
Diameter < 3cm / No intracavity fibroids / Causing heavy periods
• Initial management in primary care
• For further treatment information please click here
Symptomatic fibroids
Diameter > 3cm / Intracavity fibroids / Red flag symptoms present / Failed initial treatment
• Refer to secondary care
• For further treatment information please click here
RED FLAG
Refer urgently if:
• Postmenopausal bleeding
• Persistant post-coital bleeding (>4 weeks) once infection ruled out and had up to date smears
• Acute pelvic pain
PATIENT INFO
PIL
NHS Choices - Fibroids

Fibroids

SYMPTOMATIC FIBROIDS

Diameter < 3cm / No Intracavity Fibroids / Causing Heavy Periods

Initial management in Primary Care:

1. **Levonorgestrel-releasing intrauterine system** (LNG-IUS) e.g. Mirena® or Levosert®
   - Provided long-term (>12 months) use is anticipated.
   - Change to Mirena if copper coil in situ, either at your practice or refer to community gynaecology service.

DO NOT USE copper intrauterine devices and the LNG-IUS in patients with distortion of the uterine cavity if they cannot be easily fitted. All other methods of contraception can be used without restriction

2. **Tranexamic acid** (dose is 1g TDS for maximum 4 days) and/or non-steroidal anti-inflammatory drugs (NSAIDs)
   - Stop if symptoms do not improve in three menstrual cycles.
   - **For NSAIDS:** Assess any contraindications, counsel for GI side effects and consider prescription for protective proton pump inhibitor
3. **Combined oral contraceptives** – review symptoms after 3 months
4. **Norethisterone**
   - 5mg TDS from days 5 to 26 of menstrual cycle. Use as temporary measure whilst awaiting review by a gynaecologist. Issue acute prescription and review after 1 month.
5. **Long-acting progestogen-only injectable** - review symptoms after 3 months

Back

SYMPTOMATIC FIBROIDS TO BE MANAGED BY SECONDARY CARE

Diameter > 3cm / Intracavity Fibroids / Red Flag Symptoms Present / Failed Initial Treatment

Refer to Secondary Care:

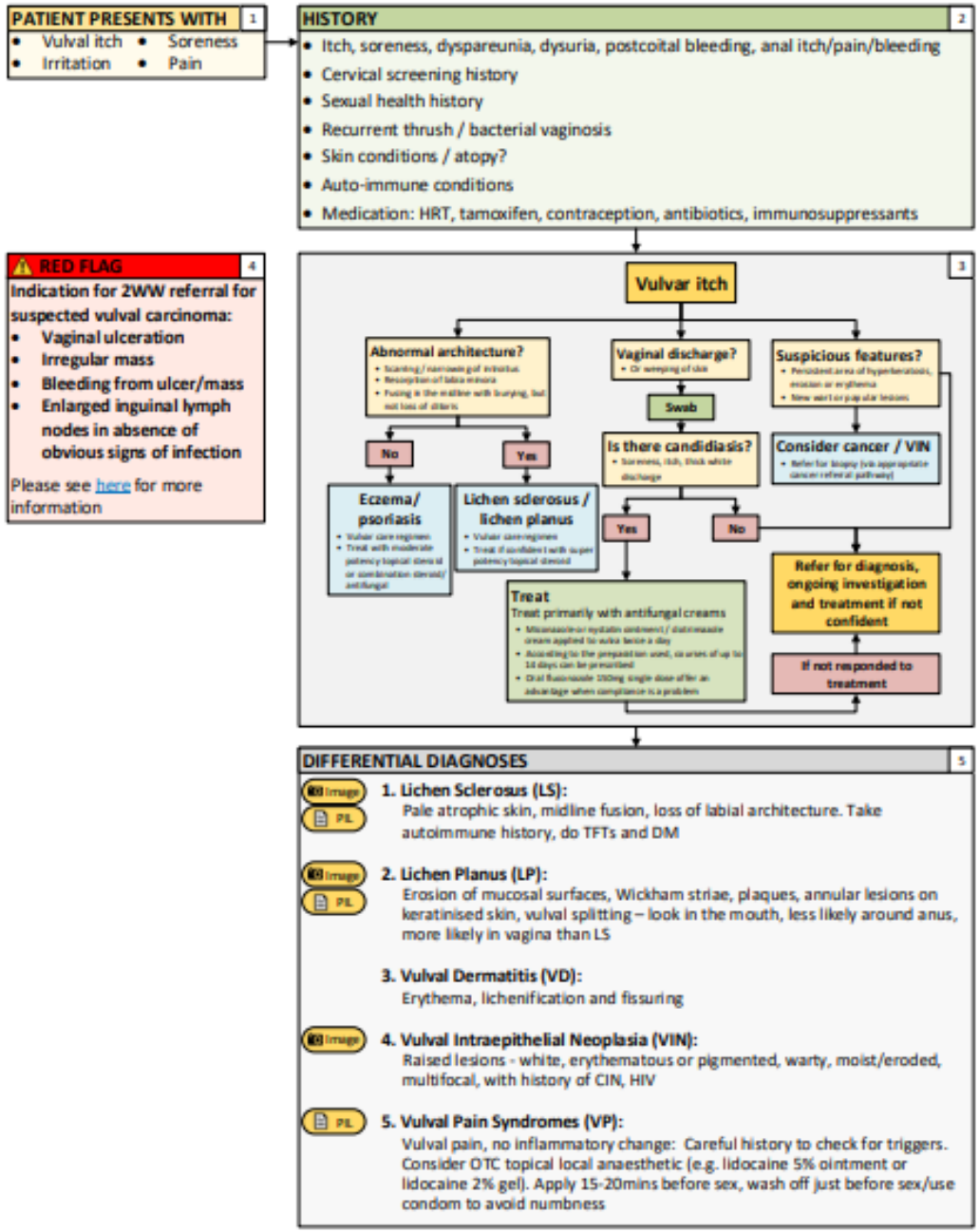
- Symptoms (e.g. heavy menstrual bleeding – click here for pathway) that have not improved despite initial treatments
- Fibroids and menorrhagia: consider referring to secondary care for hysteroscopy and endometrial ablation
- Large fibroids causing menorrhagia despite symptomatic treatment, or pressure symptoms (dyspareunia, pelvic/ abdominal pain, constipation, urinary symptoms): Myomectomy, hysterectomy, uterine artery embolisation (*performed at Royal London – not Homerton*) should be considered
- Intracavity (submucosal) fibroids: Transcervical Resection of a fibroid (TCRF) should be considered
- Women with fertility or obstetric problems associated with fibroids: consider myomectomy
  - **Submucous fibroids**: should be removed
  - **Intramural fibroids** causing distortion of endometrial cavity: consider removal
  - **Subserosal fibroids**: consider removal if obstructing ovary/fallopian tube

Although fibroids likely to grow in pregnancy - impossible to predict whether they will and by how much.

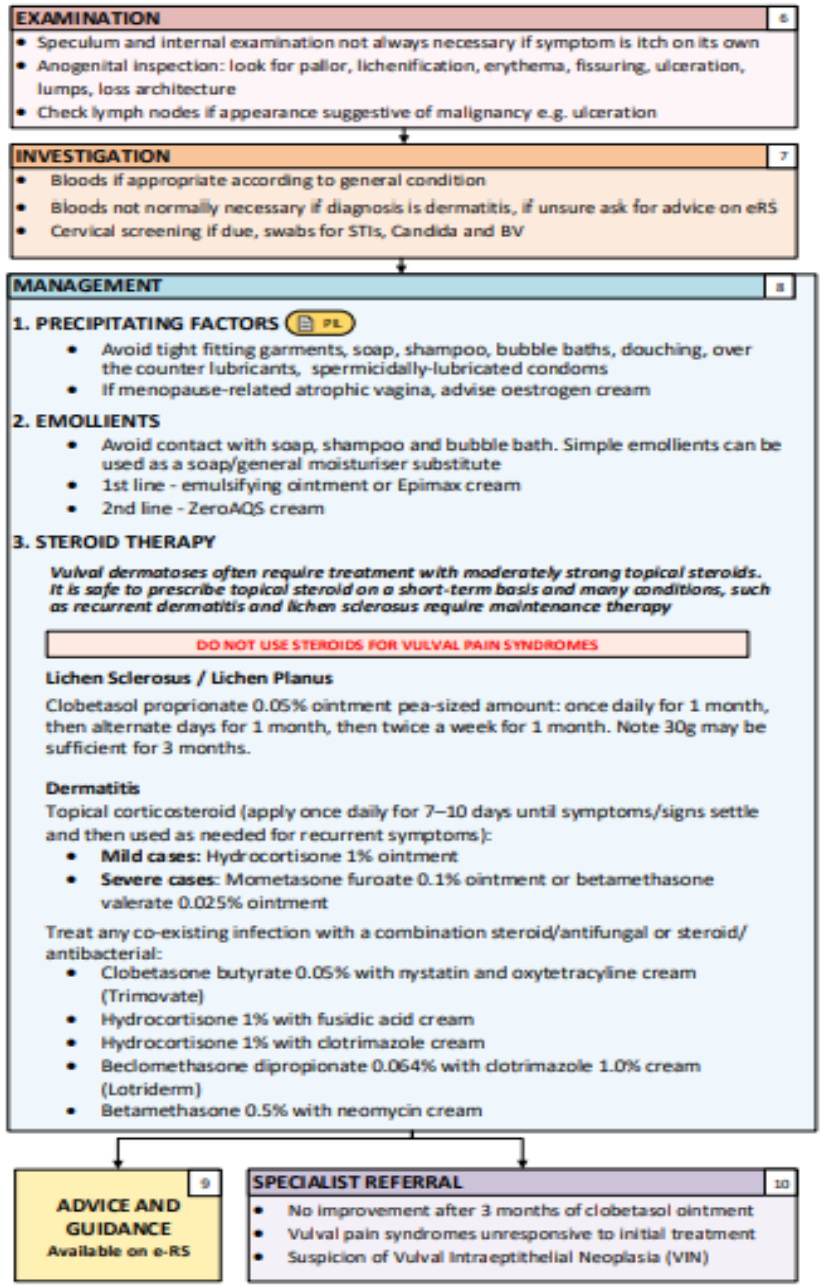
Doing a myomectomy (with risks of surgery including possible formation of adhesions potentially affecting future fertility) has to be weighed up against the chance of the fibroids adversely affecting the pregnancy.

Back

Vulval Dermatoses



Vulval Dermatoses



EXAMINATION 6

- Speculum and internal examination not always necessary if symptom is itch on its own
- Anogenital inspection: look for pallor, lichenification, erythema, fissuring, ulceration, lumps, loss architecture
- Check lymph nodes if appearance suggestive of malignancy e.g. ulceration

INVESTIGATION 7

- Bloods if appropriate according to general condition
- Bloods not normally necessary if diagnosis is dermatitis, if unsure ask for advice on eRS
- Cervical screening if due, swabs for STIs, Candida and BV

MANAGEMENT 8

1. PRECIPITATING FACTORS PIL

- Avoid tight fitting garments, soap, shampoo, bubble baths, douching, over the counter lubricants, spermicidally-lubricated condoms
- If menopause-related atrophic vagina, advise oestrogen cream

2. EMOLLIENTS

- Avoid contact with soap, shampoo and bubble bath. Simple emollients can be used as a soap/general moisturiser substitute
- 1st line - emulsifying ointment or Epimax cream
- 2nd line - ZeroAQS cream

3. STEROID THERAPY

Vulval dermatoses often require treatment with moderately strong topical steroids. It is safe to prescribe topical steroid on a short-term basis and many conditions, such as recurrent dermatitis and lichen sclerosus require maintenance therapy

DO NOT USE STEROIDS FOR VULVAL PAIN SYNDROMES

Lichen Sclerosus / Lichen Planus

Clobetasol proprionate 0.05% ointment pea-sized amount: once daily for 1 month, then alternate days for 1 month, then twice a week for 1 month. Note 30g may be sufficient for 3 months.

Dermatitis

Topical corticosteroid (apply once daily for 7–10 days until symptoms/signs settle and then used as needed for recurrent symptoms):

- **Mild cases:** Hydrocortisone 1% ointment
- **Severe cases**: Mometasone furoate 0.1% ointment or betamethasone valerate 0.025% ointment

Treat any co-existing infection with a combination steroid/antifungal or steroid/antibacterial:

- Clobetasone butyrate 0.05% with nystatin and oxytetracyline cream (Trimovate)
- Hydrocortisone 1% with fusidic acid cream
- Hydrocortisone 1% with clotrimazole cream
- Beclomethasone dipropionate 0.064% with clotrimazole 1.0% cream (Lotriderm)
- Betamethasone 0.5% with neomycin cream

ADVICE AND GUIDANCE 9
Available on e-RS

SPECIALIST REFERRAL 10

- No improvement after 3 months of clobetasol ointment
- Vulval pain syndromes unresponsive to initial treatment
- Suspicion of Vulval Intraeptithelial Neoplasia (VIN)